

STATE OF LOUISIANA MEDICATION ORDER

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE

Student's Name _____ DOB: _____

School: _____ Grade: _____

Parent or Legal Guardian Name (print): _____

Parent or Legal Guardian Signature: _____ Date: _____

(Please note: A parental/legal guardian consent form must also be filled out. Obtain from the school nurse.)

PART 2: LICENSED PRESCRIBER TO COMPLETE

Relevant Diagnosis(es): _____ ICD-10 Code: _____

1. Student's General Health Status: _____

2. Medication: _____ Strength of medication: _____ Dosage: _____

Route: ☐ By Mouth ☐ By Inhalation ☐ Other ☐ Frequency ☐ Time of each dose _____

(ALL PRN MEDICATION MUST DENOTE TIME INTERVAL BETWEEN DOSAGE

***School medication orders shall be limited to medication that cannot be administered before or after school hours. Special circumstances must be approved by the school nurse.)

3. Duration of medication order: ☐ Until end of school term ☐ Other

4. Desired Effect: _____

5. Possible side-effects of medication: _____

6. Any contraindications for administering medication: _____

7. Allergies to food or medicine include: _____

8. Other medications taken at home: _____

9. Next visit date _____

Licensed Prescriber's Name (Printed)

Address

Phone/Fax Numbers

Licensed Prescriber's Signature

(MD, NP, DO)

NIP#

APRN#

Date

Each medication order must be written on a separate order form. Any future changes in directions for medication orders require new medication orders. Orders sent by fax are acceptable. Legibility may require mailing the original to the school. Orders to discontinue also must be written.

PART 3: LICENSED PRESCRIBER TO COMPLETE AS APPROPRIATE

Inhalants/Emergency Drugs

Release Form for Students to be Allowed to Carry Medication on His/Her Person

Use this space only for students who will self-administer medication such as asthma inhalers.

1. Is the student a candidate for self-administration? ☐ Yes ☐ No

2. Has this student been adequately instructed by you or your staff and demonstrated competence in self-administration of medication to the degree that he/she may self-administer his/her medication at school, provided that the school nurse has determined it is safe and appropriate for this student in his/her particular school setting? ☐ Yes ☐ No

Licensed Prescriber's Signature

(MD, NP, DO)

NIP#

APRN#

Date

Louisiana Department of Education

doe.louisiana.gov | P. O. Box 94064 □ Baton Rouge, LA □ 70804-9064

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