

STATE OF LOUISIANA

MEDICATION ORDER

TO BE COMPLETED BY LA, TX, AR, OR MS LICENSED PRESCRIBER

(In most instances, medications will be administered by unlicensed personnel.)

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE.

Student's Name _____ Birthdate _____

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.

1. Relevant Diagnosis(es): _____ ICD Code: _____

2. Student's General Health Status: _____

3. Medication: _____

4. Strength of medication: _____ Dosage (amount to be given): _____

Check Route: ☐ By mouth ☐ By inhalation ☐ Other _____

Frequency _____ Time of each dose _____

*School medication orders shall be limited to medication that cannot be administered before or after school hours. Special circumstances must be approved by school nurse.*5. Duration of medication order: ☐ Until end of school term ☐ Other _____

6. Desired Effect: _____

7. Possible side-effects of medication: _____

8. Any contraindications for administering medication: _____

9. Other medications being taken by student when not at school: _____

10. Next visit is: _____

Prescriber's Name (Printed)

Address

Phone and Fax Numbers

Prescriber's Signature

Credential (i.e., MD, NP, DDS)

Date

*Each medication order must be written on a separate order form. Any future changes in directions for medication ordered require new medications orders. Orders sent by fax are acceptable. Legibility may require mailing 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 inhaler.*1. Is the student a candidate for self-administration training? ☐ Yes ☐ No2. 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 ☐ No3. If training has not occurred, may the school nurse conduct a training program? ☐ Yes ☐ No

Licensed Provider's Signature

Date

St. Martin Parish School Nurse Program Medication Acceptance Procedure

- 1) Parents may come to the school and administer medication anytime during the school day, after checking in at the school office and signing the necessary document.
- 2) School nurses will observe trained school personnel before approving staff to administer medication.
- 3) **Parents will be responsible for medication at school until staff has completed training.**
- 4) School nurses will be responsible for accepting and/or reviewing new medication (only one medication per form). Please do not bring new medication to school, unless appointment made to meet with nurse.
- 5) A parent/guardian is required to call the school nurse and schedule an appointment. The school nurse will meet with the parent/guardian and student at his/her school. See below for nursing staff numbers.
- 6) When appointments are scheduled, an assessment of the child and pertinent health information from the parent and child will be obtained.
- 7) If the medication is for a student participating in the special education program, a special services nurse will review the medication. This includes students enrolled in *gifted, resource, self-contained, and speech classes*.
- 8) Refilled medications will continue to be accepted by the school personnel, after being checked in by nurse, if the orders remain the same for that school year.
- 9) According to state policy, a parent may not refill a pharmacy bottle with medications from another container. The medication must have the original bottle when filled from the pharmacist.
- 10) If your child needs a medication at school the guardian/parent should contact the nurse responsible for that school.
- 11) The parent/guardian will provide the school principal with a written request for the medication to accompany their child prior to the day of scheduled field trip. The principal/designee will attempt to assign a trained staff member for medication delivery on the field trip. If a problem arises with assignment, the principal or designee will call the parent.
- 12) **School medication orders shall be limited to medication that cannot be administered before or after school hours.** Special circumstances must be approved by school nurse. (example: emergency medicine or court ordered medicine)

NURSES			
BBP, BBE, St Bernard, Virtual, NIS BB	Cell 337-342-9185	TE. CSH, NIS Cecilia	Cell 337-342-9195
BBJ, BBHS, CCRC	Cell 337-342-9198	SMSA, SMJH, NIS SE & SE	Cell 337-886-5203
CP, CJH	Cell 337-342-9212	SMESA, SMSH, NIS SM	O: 337-909-3320 Cell: 337-944-9866
CE, PP, PMS, JCEP, SE	Cell 337-342-9174		

I have read and agree to follow the above medication acceptance procedures provided by the St. Martin Parish School Board nurses.

Parent's signature

Date



Louisiana Parental Notice for One time Consent to Allow the School District To Access Louisiana Medicaid Benefits

School District Name: St. Martin Parish School Board

School District Contact Information: St. Martin Parish School Board; (337)909-3040

Dear Parent/Guardian:

The purpose of this letter is to ask you for your permission (also known as consent) to share information about your child with the Louisiana Department of Health Medicaid program. Schools in Louisiana have been approved to receive partial reimbursement from Louisiana Medicaid for the cost of certain health-related services provided by the district to your child. In order for your child's school to get back some of the money spent on services, the school district needs to share with Louisiana Medicaid the following types of information about your child: name; date of birth; gender; type of services provided, when and by whom; diagnosis (if any) and Louisiana Medicaid ID. If your child is eligible to receive services to meet his/her needs, the services may be provided by the school system and/or you may take your child to another provider that accepts Medicaid.

With your permission, the school district will be able to seek partial reimbursement for services provided by Louisiana Medicaid including, among others, a hearing test or eye exam; occupational or speech or physical therapy; some school nurse visits; and counseling services. Each year, the district will provide you with notification regarding your permission; you do not need to sign a form every year.

The school district cannot share information about your child with Louisiana Medicaid without your permission. As you consider giving permission, please be advised of the following:

1. The school district cannot require you to sign up for Louisiana Medicaid in order for your child to receive the health related and/or special education services to which your child is entitled.
2. The school district cannot require you to pay anything towards the cost of your child's health-related and/or special education services.
3. If you give the school district permission to share information with and request reimbursement from Louisiana Medicaid:
 - a. This will not affect your child's available lifetime coverage or other Louisiana Medicaid; nor will it in any way limit your own family's use of Louisiana Medicaid benefits outside of school.
 - b. Your permission will not affect your child's special education services or IEP rights in any way, if your child is eligible to receive them.
 - c. Your permission will not lead to any changes in your child's Louisiana Medicaid rights; and
 - d. Your permission will not lead to any risk of losing eligibility for other Medicaid funded programs.
4. If you give permission, you have the right to change your mind and withdraw your permission at any time.
5. If you withdraw your permission or refuse to allow the school district to share your child's records and information with Louisiana Medicaid for the purpose of seeking reimbursement for the cost of services, the school district will continue to be responsible for providing your child with the services, at no cost to you.

I have read the notice and understand it. Any questions I had were answered. I give permission for the school district to share with Louisiana Department of Health (LDH) records and information concerning my child and their health-related services, as necessary. I understand that this will help my child's school seek partial reimbursement for Louisiana Medicaid covered services.

Child's Name

School

Child's Date of Birth

Parent/Guardian Name

Parent/Guardian Signature

Date

STATE OF LOUISIANA

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

PART 1: CONTACT INFORMATION		
Student's/Child's Legal Name _____	Date of Birth _____	Social Security # _____
Parent/Legal Guardian _____		Telephone # _____
Mailing Address _____		
PART 2: RECORD REQUEST		
Complete box A OR box B below. Both boxes may not be completed on the same form.		
A. Specify the records to be released for the treatment date(s) listed below in Part 3: ☐ COMPLETE RECORD(S) ☐ Discharge Summary ☐ History & Physical ☐ Operative Report ☐ Consultation ☐ Progress Notes ☐ Cardiopulmonary <i>(Indicate EKG, Stress Test, Sleep Study)</i> ☐ Emergency Room ☐ Lab ☐ Pathology ☐ Radiology Results ☐ Other _____	B. If initialed below, I specifically authorize release of the following: Psychotherapy notes and records indicating psychological or psychiatric impairment(s) _____ Initials of parent/legal guardian	
PART 3: AUTHORIZATION		
This does not authorize the release of the following: drug and alcohol use counseling and treatment and HIV/AIDS and sexually transmitted disease testing and treatment.		
I authorize: _____ (School System) Name: _____		
☐ TO RELEASE Information TO AND/OR ☐ TO OBTAIN Information FROM <i>(Place an "X" in the box that indicates if the information is being released AND/OR requested.)</i>		
Name: _____ (Hospital, Physician, Service Agency, School RN and/or other health provider)		
For treatment date(s): _____		
The information is to be released for the purpose(s) of:		
☐ Evaluation to determine eligibility or continued eligibility for special education services ☐ Providing physical therapy treatment ☐ Providing occupational therapy treatment	☐ Designing an individual educational program ☐ Determining appropriate placement for treatment needs ☐ _____	
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the same medical records department receiving this authorization form. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ If I fail to specify an expiration date, event or condition, this authorization will expire in nine (9) months from the date of authorization. An authorization is voluntary. I will not be required to sign an authorization as a condition of receiving treatment services or payment, enrollment, or eligibility for health care services. Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected under the Health Insurance Portability & Accountability Act of 1996.		
_____ Signature of Student or Legal Representative (Parent/Legal Guardian must sign if student < 18)	_____ Date	_____ (Relationship to student)
_____ Signature of Witness	_____ Date	

ST. MARTIN PARISH SCHOOL NURSE PROGRAM

PARENT INTERVIEW AND CONSENT

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR
(IN ADDITION TO STATE OF LOUISIANA HEALTH INFORMATION FORM)

PART 1: STUDENT INFORMATION					
Student's/Child's Legal Name		Date of Birth	School	Grade	Teacher
Contact with both parents?	Length of time at residence:	Siblings at Residence:			
# people living in household:	# bedrooms:	# bathrooms:	Type of heating:	Bus or Car Rider:	
Hospital Choice:		Cultural beliefs re: meds:			

PART 2: PARENTAL CONSENT	
Do you give your permission to the school nurse to share information with the physician, pharmacist, and appropriate personnel relative to the prescribed administration of this medication?	Yes ☐ No ☐
Do you understand that you may pick up the medication from school at any time and that you must pick up the remaining medication when it is discontinued, expired, or at the end of the school year or it will be destroyed?	Yes ☐ No ☐
Have you administered the initial dose at home and have allowed sufficient time (overnight) for observation of adverse reactions before asking school personnel to administer the medication?	Yes ☐ No ☐
Do you understand if med is discontinued, the parent must send written notification to the school?	Yes ☐ No ☐
Do you authorize the trained school personnel and/or school nurse to administer medication to your child or monitor self-administering?	Yes ☐ No ☐
Do you understand that it will be necessary that you put in writing if your child will attend a field trip and need access to medications?	Yes ☐ No ☐
Do you understand that unless ordered for student to self-carry / administer medication that it will not be available on the bus?	Yes ☐ No ☐
(FOR SELF-ADMINISTERED MEDS ONLY) Do you agree to release from all liability, the St. Martin Parish School Board and/or any of its employees in regard to allowing your child to carry and self-administer his/her medication as directed by his/her physician?	
For and in consideration of allowing said child to attend school in spite of his specific health problem, I hereby release, relieve and discharge the St. Martin Parish School Board and/or any of its agents or employees from liability for any injury or damage to the health of the said child arising out of, or resulting from the necessity of said child having to take this medication during school hours. I realize that frequently people without medical training will be giving the medication to my child. I am also aware that if my child has an emergency in school and I am unavailable, the school principal or alternate will have my child transported to the emergency room. I will be responsible for payment of the emergency care. **I have read and agree to the school's regulations concerning giving medication at school.**	

PART 3: SIGNATURES	
Parent/Guardian Signature:	Date:
School Nurse Signature:	Date:

STATE OF LOUISIANA

HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed. Use additional sheets, if necessary, for further explanation.

Name of School:		Grade:	
Student's Name: Last		First M.I.	
Student's Date of Birth:	Sex: ☐ M ☐ F	State or Country of Birth:	
Student's Mailing Address:	City:	State:	Zip Code:
Student's Physical Address:	City:	State:	Zip Code:
Name of Mother or Legal Guardian:	Home Phone: ()	Work Phone: ()	Cell Phone: ()
Name of Father or Legal Guardian:	Home Phone: ()	Work Phone: ()	Cell Phone: ()
Name of child's pediatrician or primary care provider:		Names of medical specialists or special clinics caring for your child:	

Parent or Legal Guardian Signature _____ Date _____

Please check the type of health insurance your child has: ☐ Private ☐ Medicaid/LaCHIP ☐ None

If your child does not have health insurance, would you like information on no cost health insurance? ☐ Yes ☐ No

In case of emergency—if parent or legal guardian cannot be reached—contact the following:
Name _____ Complete Phone Number () _____

My child has a medical, mental, or behavioral condition that may affect his/her school day: ☐ No ☐ Yes (If yes, please complete Part 2.)

PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent/Legal Guardian is responsible for providing the school with any medication and may be responsible for providing the school with any special food or equipment that the student will require during the school day. Check with the school nurse to obtain correct medication and procedure forms.

☐ ALLERGIES

Allergy Type:

- ☐ Food (list food(s)) _____
- ☐ Insect sting (list insect(s)) _____
- ☐ Medication (list medication(s)) _____
- ☐ Other (list) _____

Reactions: (Date of last occurrence if yes.)

- ☐ Coughing (Date: _____) ☐ Hives (Date: _____) ☐ Rash (Date: _____)
- ☐ Difficulty breathing (Date: _____) ☐ Local swelling (Date: _____) ☐ Wheezing (Date: _____)
- ☐ Generalized swelling (Date: _____) ☐ Nausea (Date: _____) ☐ Other (Date: _____)

Currently prescribed medications and treatments:

- ☐ Oral antihistamine (Benadryl, etc.) ☐ Epi-pen ☐ Other _____

☐ ASTHMATriggers: ☐ Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) _____ ☐ Other (list) _____Does your child experience asthma symptoms with exercise? ☐ No ☐ Yes

Symptoms:

- ☐ Chest tightness, discomfort, or pain ☐ Difficulty breathing ☐ Coughing ☐ Wheezing ☐ Other _____

Currently prescribed medications and treatments: _____

Date of last hospitalization related to asthma _____ Date of last emergency room visit related to asthma _____

Does your child have a written asthma management plan? ☐ No ☐ YesIs peak flow monitoring used? ☐ No ☐ Yes

☐ **DIABETES****Currently prescribed medications and treatments:**

- ☐ Insulin: ☐ Syringe ☐ Pen ☐ Pump
- ☐ Blood sugar testing
- ☐ Glucagon
- ☐ Oral medication(s) List medication(s) _____

Is special scheduling of lunch or Physical Education required? ☐ No ☐ Yes☐ **SEIZURE DISORDER**

Type of seizure:

- ☐ Absence (staring, unresponsive) ☐ Complex Partial ☐ Generalized Tonic-Clonic (Grand Mal/Convulsive)
- ☐ Other (explain) _____

Physical Education Restrictions: ☐ No ☐ YesMedication(s): ☐ No ☐ Yes List medication(s) _____

Date of last seizure _____ Length of seizure _____

☐ **OTHER HEALTH CONDITIONS**

- ☐ Anemia ☐ ADD/ADHD ☐ Cancer ☐ Cerebral Palsy ☐ Chicken Pox ☐ Cystic Fibrosis
- ☐ Depression ☐ Digestive disorders ☐ Emotional/Psychological ☐ Juvenile Rheumatoid Arthritis
- ☐ Hemophilia ☐ Heart condition ☐ Physical disability ☐ Sickle Cell Disease ☐ Skin disorders
- ☐ Speech problems ☐ Other (explain) _____

Physical Education Restrictions: ☐ No ☐ Yes (explain): _____Medication(s): ☐ No ☐ Yes List medication(s) _____Special procedures required (i.e., catheterization, oxygen, gastrostomy care, tracheostomy care, suctioning): ☐ No
☐ Yes (explain): _____Special diet required (i.e., blended, soft, low salt, low fat, liquid supplement): ☐ No ☐ Yes (explain): _____Are there anticipated frequent absences or hospitalizations? No Yes
(explain): _____☐ **VISION CONDITIONS**

- ☐ Contacts/glasses
- ☐ Other _____

☐ **HEARING CONDITIONS**

- ☐ Hearing aid(s)
- ☐ Other _____

☐ **ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION**Special school environmental adjustments of the school environment or schedule: ☐ No ☐ Yes (explain): _____

(i.e., seizures, limitations in physical activity, periodic breaks for endurance, part-time schedule, building modifications for access)

Special school environmental adjustments to classroom or school facilities: ☐ No ☐ Yes (explain): _____

(i.e., temperature control, refrigeration/medication storage, availability of running water)

Special safety considerations: ☐ No ☐ Yes (explain): _____

(i.e., special precautions in lifting, positioning, special transportation emergency plan, special safety equipment, special techniques for positioning, feeding)

Special assistance with activities of daily living: ☐ No ☐ Yes (explain): _____

(i.e., eating, toileting, walking)

PART 3: SCHOOL NURSE TO COMPLETE if parent/legal guardian indicates medical condition._____
School Nurse Signature_____
Date

Notes:

RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE