Delta Charter School
PARENT'S ROLE IN MEDICATION ADMINISTRATION

The Louisiana State Legislature has in place medication laws for Louisiana parish schools. R.S. 17;436; I, enactment may be referred to. The Delta charter School has established guidelines and procedures regarding these laws. In order to be compliant with state regulations. In order for a student to receive medication at school, the following must be on file: completed medication order, release of liability form, parental consent for medication administration at school, and emergency information.

Prior to the beginning of each school year OR for any new medication to be given at school during the school year, parents must make an initial appointment with the school nurse to sign appropriate medication forms. These forms must be completed before any medication may be given at school. These medication forms are found in a **MEDICATION PACKET.** These medication packets can be found at the student's school office OR at the School Nurse's office at Delta Charter School. The **MEDICATION ORDER** form inside the medication packet must be filled out by the child's doctor before medication can be given at school. After all the forms inside the medication packet have been completed by the parent/guardian and the medication order form completed by the child's doctor, call the office at Delta Charter School to make an appointment with the School Nurse. If she is not available, please leave a message. **Bring the completed MEDICATION PACKET forms, and THE MEDICATION THE STUDENT IS TO RECEIVE AT SCHOOL.**

After medication has been given at school and all the forms are in place, future refills of the same medicine the student is receiving at school may be brought to the School Nurse OR the student's school. The student's medication would then be released to the School Nurse OR a school employee trained in medication administration. This must be released by a parent or guardian in a current medication container appropriately labeled by the pharmacy. Parents or guardians must sign a form stating the medication was received to tna from whom, and how much was received. No more than a **35-day** supply in tablet form can be kept at the school for each child. If a medication dosage or dispensing information should change, the same guidelines should be followed to initial medicine doses. A new **MEDICATION ORDER** Form from the doctor with the

new changes must be given to the School Nurse. A new pharmacy label must also be issued with the correct medicine.

At the end of school, all medication must be picked up from the school by the student's parent/guardian. Proper documentation must be signed with pickin up any medicine. The School Nurse will designate medication pickup days at the school. A letter will be sent near the end of school to indicate these dates. Any medication remaining at school one week after the last day of the school year will be wasted according to State/Parish policy. This includes tablets, liquids, Epi-pens, glucagon, insulin, etc.

Students are strictly prohibited from having any drugs in their possession (prescription or over-the-counter) on the school grounds, unless ordered and dispensed by the student's doctor. DO NOT SEND MEDICATION WITH THE STUDENT TO SCHOOL. ACCORDING TO SCHOOL POLICY, STUDENTS WHO VIOLATE THE DRUG POLICY SHALL BE SUBJECT TO DISCIPLINARY ACTION.

Acutely ill students should be sent home or stay home from school. Students recovering from an acute illness should remain at home until the need for medication no longer exists. No over-the-counter or prescription medication can be given without a doctor's order. These may include: Tylenol, Motrin, cough syrup, antibiotic ointment, Tums, Rolaids, anti-itch creams or sprays, first aid pain relieving ointment or sprays, etc.

Other medication information:

1. No medication will be accepted in plastic bags or mislabeled bottles.
2. No ear or eye drops can be given at school by school personnel; but, a student may self-administer the medicine if the doctor orders and approves it.
3. Antibiotics should be given in a time frame so that they can be given at home if at all possible.
4. Each medicine ordered must be on a separate medication order form, to be completed by the doctor.
5. Annual renewals to continue medications require new orders each school year.

6. Parents/Guardians of students may come to the school to administer medication without any required paperwork or meeting with the school nurse.
7. Medication should be administered before or after school hours, whenever possible.
8. The first dose of any medication will be given outside the school jurisdiction, allowing at least 12 hours for observation for adverse reactions before the student returns to school.
9. All medication must have a current pharmacy label.
10. No more than a 35 day supply of medicine can be kept at school. If any student has an inhaler or Epi-pen, etc. that they deep with them at all times, (as ordered by physician), they MUST go to the office as soon as possible to sign the medication log for the time it was used. If the student does carry medication on themselves, as listed above, it is advisable that the school office be provided with an extra dose for local storage.

I HAVE READ AND AGREE TO THE TERMS OF MY ROLE IN MY CHILD'S MEDICATION ADMINISTRATION AT SCHOOL.

PARENT SIGNATURE:_____

PARENT NAME (Printed):_____

DATE:_____

Delta Charter School
300 Lynwood Drive
Ferriday, La. 71334
318-757-3202

REQUEST FOR ADMINISTERING MEDICATION AT SCHOOL AND RELEASE FROM LIABILITY

I/We, the undersigned parents/ guardians of the minor child,_____, a student at _____ hereby request the Delta Charter School Board allow said child to attend school in spite of his/her special health problem, and to be given medication prescribed by _____(Physician's Name) from _____(Date) to _____(Date) under the supervision of the nurse or other school personnel. The mediation is to be furnished by me and labeled by the physician or pharmacist with said child's name, doctor, drug store, name of drug, dosage, and the specific time it is to be given at school. I/We, assume all responsibility for any mistake in furnishing an incorrect dosage.

For and in consideration of allowing said child to attend school in spite of his special problem, I/We hereby release, relieve, and discharge the Delta charter School System and/ or any of its agents or employees form any and all liability for any injury or damage to the health of said child arising out of or resulting from the necessity of said child having to take mediation during school hours.

I/We have read, understand, and agree to the school's regulations concerning giving medication at school.

SIGNATURE_____**DATE**_____

ADDRESS_____**TELEPHONE#**_____

STATE OF LOUISIANA
MEDICATION ORDER
TO BE COMPLETED BY LA, TX, AR, OR MS LICENSED PRESCRIBER

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

1. Relevant Diagnosis(es): _____
2. Student's General Health Status: _____
3. Medication: _____ Strength of medication: _____ Dosage (amount to be given): _____

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 school nurse.

4. Duration of medication order: ☐Until end of school term ☐Other _____
5. Desired Effect: _____
6. Possible side-effects of medication: _____
7. Any contraindications for administering medication: _____
8. Allergies to food or medicine include: _____
9. Other medications taken at home: _____
10. Next visit is: _____

Licensed Prescriber's Name (Printed)	Address	Phone/Fax Numbers
Licensed Prescriber's Signature	Credentials (i.e., MD, NP, DDS)	APRN # Date

Each medication order must be written on a separate order form. Any future changes in directions for medication ordered require new medication 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? ☐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	Credentials (i.e., MD, NP, DDS)	APRN #	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
- ☐ Cardiopulmonary (Indicate EKG, Stress Test, Sleep Study)
- ☐ Emergency Room
- ☐ Lab
- ☐ Pathology
- ☐ Radiology Results
- ☐ Other ____________ ____________________

B. If initialed below, I specially authorize release of the following:

Psychotherapy notes and records indicating psychological or psychiatric impairments(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 <u>**Delta Charter School, MST**</u>

☐ TO RELEASE Information <u>TO</u> AND/OR ☐ TO OBTAIN Information <u>FROM</u>

(Place an "X" in the box that indicates if the information is being released AND/OR requested.)

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 occupational therapy treatment
- ☐ Determining appropriate placement for treatment needs ____________________
- ☐ Designing an individual educational program
- ☐ Providing physical therapy treatment

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	