MEDICATION FOR SCHOOL USE GUIDELINES AND PROCEDURES

Dear Parents/Guardians,

Please follow these guidelines to determine the need for medication administration during school hours. If your child needs medication during school hours, school approval is required. All medication must be delivered to and from school by the student's parent or guardian in the original pharmacy-labeled or manufacturer's container.

1. Short-term medicines such as antibiotics and cough syrups can be given before school, after school, and at bedtime instead of during school hours. Eye and ear drops are not permitted at school.
2. If midday medicine is needed temporarily, prescription or non-prescription, the parent/guardian may bring it to school and administer it to their child through the front office. If this is not possible, follow the procedure outlined in number three.
3. Students with long-term medical conditions who require prescription or over-the-counter medication during the school day, students who need medication to manage occasional symptoms such as headaches, and students who require emergency medications, such as inhalers or EpiPens, must complete the following documentation and meet the below requirements:

FORMS: PARENT AUTHORIZATION/HEALTH FORM AND MEDICATION ORDER FORM

1. Form 1: Parent Authorization/Health Information Form-must be completed by the parent or guardian of the student, indicating the health condition(s) diagnosed by a physician and the permission given to the school district to assist the student in matters set forth in the physician's orders.
2. Form 2: Medication Order Form-must be completed by an authorized Health Care Provider detailing the diagnosis, medication name (one medication per form), dosage, schedule, side effects, and method of administration. The physician must sign and print name, address, and phone number.
    - All medication should be labeled and prepared in a sealed container by the pharmacist or physician with no more than a 20-day supply. Ask the pharmacist to put the prescription in two containers if the medication is used both at home and at school. If medication is ordered to be a half a tablet, the parent is responsible for halving the tablets prior to bringing them to school. Students must receive the first dose before school use. An exception to this rule applies to emergency medications.

Authorization forms are only valid for the current school year; submit new authorization forms each school year, dated after July 1st.

Sincerely,
CPSB Nursing Department

Calcasieu Parish School Board
BUILDING FOUNDATIONS FOR THE FUTURE
Dr. Jason VanMetre, Superintendent

PARENT AUTHORIZATION/HEALTH INFORMATION FORM

PARENT OR LEGAL GUARDIAN TO COMPLETE

Student Name_____Birthdate _____

School_____ Grade_____ Homeroom_____

Parent/Guardian Name (print)_____Phone Number_____

Emergency Contact Name(print)_____Phone Number_____

If school-administered medication or procedures are needed, I give permission for licensed or unlicensed trained school personnel to administer them. I also permit exchanging information between the prescriber, school staff, and school nurse.

Has the first dose of medication been administered at home? ☐Yes☐ No☐ N/A

Can your child's medication dosage be withheld while attending a field trip?

☐Yes☐No ☐ N/A

PARENT SIGNATURE:_____**Date:**_____

HAS YOUR CHILD HAD ANY OF THESE MEDICAL CONDITIONS DIAGNOSED BY A PHYSICIAN?
Please mark all that apply.

CONDITION	YES	CONDITION	YES
ADD/ADHD	☐	Heart Condition	☐
Asthma	☐	Blood or Bleeding Disorder	☐
Cystic Fibrosis	☐	Cerebral Palsy	☐
Diabetes	☐	Down Syndrome	☐
Gastrostomy (Feeding Tube)	☐	Sickle Cell Disease	☐
Spina Bifida	☐	Shunt	☐
Seizures	☐	Cancer	☐
Arthritis	☐	Migraines	☐
Food Allergy **(SEVERE)**	☐	Insect Allergy **(SEVERE)**	☐
Traumatic Brain Injury	☐	Tracheostomy	☐
Breathing Disorder	☐	Immunodeficiency Disease	☐
Hearing Loss	☐	Vision Loss	☐
Other **(EXPLAIN BELOW)**	☐	Genitourinary (Catheter)	☐

If yes, please explain below:_____

_____

Other/Explanation:_____

_____

Any/All medications taken by student at home and school:_____

_____

CPSB Nurse Consultant_____ Date_____

Calcasieu Parish School Board
BUILDING FOUNDATIONS FOR THE FUTURE
Dr. Jason VanMetre, Superintendent

MEDICATION ORDER: TO BE COMPLETED BY A 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 Parent Authorization/Health Information Form must also be completed

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Part 2: LICENSED PRESCRIBER TO COMPLETE

1. Student Diagnosis:_____ICD-10 Code:_____
2. Medication:_____
   Strength of medication:_____Dosage (amount to be given):_____
   Route: ☐ by mouth ☐by inhalation ☐by nasal ☐Other:_____Time:_____
   As Needed Frequency:☐ every 2 hours ☐every 4 hours ☐every 6 hours

(*All as needed medication must note time interval between doses. School medication orders shall be limited to medications that cannot be administered before or after school hours. Special circumstances must be approved by the school nurse. The frequency and the time of the medication order must match the prescription bottle.)*

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. Student allergies:_____
8. Other medications taken at home:_____
9. Licensed Prescriber's Name and credentials (printed):_____
10. Address:_____Phone/Fax Numbers:_____

Licensed Prescriber's Signature:_____NPI#:_____ Date: _____
(Each medication order must be submitted on a separate order form. Any changes to medication directions require a new order. Faxed orders are acceptable; however, if the fax is unclear, please mail the original to the school. Written orders are also required to discontinue medication.)

Part 3: LICENSED PRESCRIBER TO COMPLETE AS APPROPRIATE:

Release to allow a student to self-carry medication such as asthma inhalers and EpiPens.

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 so they may self-administer it at school, provided the school nurse has determined it is safe and appropriate for this student in the school setting? ☐Yes ☐ No

Licensed Prescriber's Signature:_____Date:_____

Part 4: PARENT AUTHORIZATION TO CARRY/SELF ADMINISTER MEDICATION

Release to allow a student to self-carry medication such as asthma inhalers and EpiPens.
Do you give permission for your child to self-administer medication at school? ☐Yes ☐ No
Do you assume responsibility for your child's actions in his/her self-administration of medication at school? ☐Yes ☐ No
Parent/Legal Guardian Signature:_____Date:_____