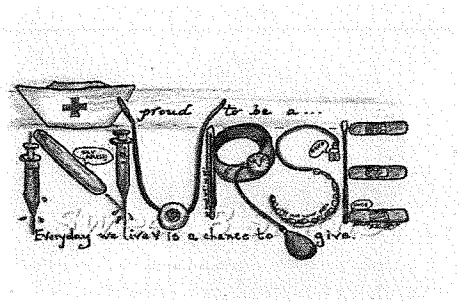

OUACHITA PARISH SCHOOL NURSES

Dear Parents,

The Louisiana State Legislature has passed a new school medication law. The Ouachita Parish School Board has established new guidelines and procedures in order to be in compliance with this law.

As a general principle, medications will not be given at school. However, when circumstances arise in which a student must take medication at school; the following will be adhered to:

1. Medications must have proper medication order form completed by the physician detailing the name of the medicine, dosage, and exact time to be given.
2. Parents must meet with the school nurse to sign appropriate medication forms bore any medication can be administered at school.
3. Medication must be brought to school by a parent or guardian in a current container appropriately labeled by the pharmacy. Parents/guardians must was received No more than 25 dosages in a tablet form can be kept at the school for each child. NO MEDICINE WILL BE ACCEPTED IN PLASTIC BAGS OR MISLABELED BOTTLES!
4. If a dosage should change the office must receive a written order from the doctor or dentist stating what changes have been made and a new pharmacy label issued, whereby a childproof cap bottle must be given to office with the correct dosage and dispensing information. If the medication and dosage should change and a written statement is not received, then that child will not be given his/her medication.

NO OVER THE COUNTER MEDICATION CAN BE GIVEN unless prescribed by a doctor or dentist. A pharmacist with the child's name, correct dosage and dispensing information also must it. (This means aspirin, Tylenol, cough syrup, cough drops, antacids, etc.).

NO EYE OR EAR DROPS CAN BE GIVEN AT SCHOOL.
Antibiotics should be given in a time-span so they may receive it at home if at all possible.

Thank you for your understanding and cooperation in this matter. If you have any questions, please call your school nurse.

Sincerely,
Ouachita Parish School Nurses

Ouachita Parish School Board
Medication Administration Consent/Release From Liability

Student_____DOB_____

Parent/Guardian_____PHONE_____

I, the parent/guardian of the above named child, request that an OPSB school nurse or designated Trained school employee (under the indirect supervision of the school nurse) monitor, assist, and/or Administer as necessary the following medication per MD order.

Medication_____Dose_____

From_____to_____As prescribed by:_____

____I release the OPSB & its employees of any/all liability, injury or damage related to the observation/ Administration of this medication at school. I understand a nurse will not always be at the school.

____I agree to provide the medication in a container properly labeled by the pharmacy and understand that the label must match a doctor's written order. I assume all responsibility for mistakes in furnishing an incorrect dosage or medicine to the school.

____I agree that I or a responsible adult will deliver the prescribed medication to the school to observe and verify the count. Up to a 25 day supply can be stored at the school.

____I give consent for the school nurse to assess my child in the school setting.

____I give permission to the school nurse to share with & obtain from appropriate school personnel, physicians and other healthcare sources information relative to my child's health and prescribed medication administration as the nurse determines necessary for health and safety reasons.

____I understand that I may retrieve the medication from the school at any time and understand that the medication will be destroyed if it is not picked up within two weeks following expiration or termination of the order and at the end of the school year.

____I have administered the initial does and have observed for adverse reactions for at least 12 hours. For "as needed" medication, I agree to notify school personnel of all doses given before school hours.

____In case of a life-threatening emergency, 911 will be called immediately and I or an emergency contact will be notified. I give permission for my child to be transported to the nearest ER. I take full responsibility for any/all expenses incurred.

My signature indicates that I have read, understand and agree with the state/OPSB regulations concerning medication administration at school. I have been given the opportunity to ask questions.

Signature:_____Witness:_____

Initials:_____Relationship:_____Date_____

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