SCHOOL MEDICATION ORDER

(To be completed by LA Licensed Physician or Dentist)

Student's Name: _____ Date of Birth: _____

Physician's Name: _____ Office Phone: _____

Diagnosis: _____ Medication: _____

Time of Administration: _____ Allergies: _____

Dosage: _____ Route: ___ Oral ___Inhalant ___Other _____

Desired Effects: _____

Adverse Effects: _____

Other medications taken at home: _____

Asthma Section:

*If applicable **Asthma** medication is to be administered when child is experiencing: (circle all that apply)*

Coughing Shortness of Breath Trouble Speaking Audible Wheezing Other _____

***USE THIS SPACE IF STUDENTS WILL BE ADMINISTERING THEIR OWN MEDICATION**; SUCH AS USING ASTHMA INHALER*
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 the school nurse has determined it safe and appropriate for this student in this particular school setting. _____*Yes* _____ *No*

_____ _____

Signature of Physician or Dentist **Date**

**Please note: Whenever possible, medication should be scheduled at times other than school hours. Only oral, inhalant (by premeasured aerosol), topical, and emergency medications may be given at school by unlicensed personnel trained to give medication at school. All orders must be renewed at the beginning of each school year.*

School Nurse Signature _____ Date _____

To be completed by parent/guardian:

Request for Administering Medication at School and Release from Liability:

I/We, the undersigned parent/guardian of the minor child, _____, a student at MAX
Student's Name

Charter School, hereby request the MAX Charter School to allow said child to attend school in spite of his/her health condition and to be given _____ as prescribed by _____ from
Name of Medication Prescribing Doctor Name

_____ To _____under supervision of the nurse or designated, unlicensed, trained school personnel.
Start Date End Date

The medication is to be furnished by me and labeled as detailed in the medication administration policy. I/We assume all responsibility for mistakenly furnishing an incorrect dosage. I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if not picked up following termination of the order or end of the school year. For and in consideration of allowing said child to attend school in spite of his/her special health condition, I/We hereby release, relieve and discharge the MAX Charter School Board, and/or any of its agents or employees from 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 medication during school hours. I give permission to the school nurse to share with appropriate school personnel information relative to the medication necessary for my child's health and safety.

_____Yes _____No I give permission to the school nurse to share with appropriate school personnel information relative to the medication necessary for my child's health and safety.

_____Yes _____No I have administered the initial dose at home and have allowed sufficient time to observe for adverse reactions.

_____Yes _____No I have received a copy of the Medication Administration Policy

NOTICE: THIS BOX IS TO BE COMLETED ONLY FOR STUDENTS WHO WILL ADMINISTER HIS/HER OWN MEDICATION, SUCH AS AN <u>ASTHMA INHALER</u>.

_____Yes _____No Do you give permission for your son/daughter to self-administer medication if the school nurse determines it is safe and appropriate in the school setting

_____Yes _____No Do you feel that your child is sufficiently responsible and informed to administer his/her own medication?

_____Yes _____No Do you assume responsibility for your child's actions in his/her self management of medication at school?

_____Yes _____No Do you understand that regular medication orders must be provided for students who self-administer medication at school?

Parent/Guardian Name:_____

Parent/Guardian Signature: _____ Date:_____

Home Phone Number: _____ Cell/Work Number:_____

Emergency Contact Name:_____ Emergency Number:_____