FINAL 11/06

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): ____
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 ❑ 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
3. If training has not occurred, may the school nurse conduct a training program? ❑Yes ❑ No

____

Licensed Provider's Signature Date

Parental Request for Administration of Medication and Release from Liability

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

MAX Charter School, hereby request the MAX Charter School to administer ______________________
Name of Medication

as prescribed by _______________________________ from ____________ to _____________ under
Prescribing Doctor Start Date End Date

the supervision of the nurse or designated, unlicensed, trained school personnel.

The medication is to be furnished by me and labeled as detailed in the medication administration policy. I assume all responsibility for mistakenly furnishing 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. I hereby 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, which can be found on MAX Charter School's website.

NOTICE: This section to be completed only for students who will administer his/her own medication.

_____ Yes _____ No I give permission for my child to self-administer medication if the school nurse determines it is safe and appropriate.

_____ Yes _____ No My child is sufficiently responsible and informed to administer his/her own medication.

_____ Yes _____ No I assume responsibility for my child's actions in his/her self-management of medication at school.

_____ Yes _____ No I understand that medication orders must be provided for students who self-administer medication at school, including when there is a medication change.

Parent/Guardian Name: ______________________________________ Date: ____________________

Parent/Guardian Signature: ___________________________________

Best Phone # in case of Emergency: _____________________________

100 Afton Drive
Thibodaux, LA 70310
Phone: (985) 227-9500 Fax: (985) 227-9515

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Physician: ______________________________ Date: ______________________________

Phone: ______________________________ Fax: ______________________________

I am authorizing the above named physician to answer the following items regarding my child, ____________________________, (Date of birth _____/_____/________). This information is requested for educational purposes.

☐ My child does not take any prescribed medications or have any medical diagnoses. (Check only if applicable)

Parent/Legal Guardian Signature: ______________________________ Date: ____________________

Relationship to Student: ______________________________

For Physician Only

1. What are the medical diagnoses of this child? Please list each diagnosis separately and indicate the degree to which each condition affects the child.

Medical Diagnosis/Impairment (Describe)	Severity (Mild, Moderate, Severe)	Last Date of Treatment

2. Please list medical implications/limitations for instructional time:

3. Please list medical implications/limitations for physical education:

4. Do any of these conditions result in reduced efficiency in school work because of a temporary and/or chronic lack of (Please select all that apply):

- ☐ Strength
- ☐ Vitality
- ☐ Alertness

5. Do any of these conditions substantially limit one or more of the following life activities (Please select all that apply)?

☐ Self-care ☐ Performing Manual Tasks ☐ Walking
☐ Vision ☐ Hearing ☐ Speaking
☐ Breathing ☐ Learning ☐ Working
☐ Other: ______________________________

6. Does the child require medications to treat the listed medical condition(s)? If yes, list the medication name, dosage, frequency, and possible side effects below.

Medication	Dosage	Frequency	Possible Side Effects

7. Does the student require other health technology, management, or other treatments, such as a special diet or assistance with ADL's?

Physician's Name (Print): ______________________ Date: ______________

Physician's Signature: ______________________