Union Parish School Board

Post Office Box 308
Farmerville, Louisiana 71241

www.unionparishschools.org

Phone (318) 368-9715 **FAX (318) 368-3311**

MEDICATION FORM

Name of Student:_____ School:_____ Grade _____

Date of Birth:_____ Sex_____

Name of Parent/Guardian: _____
(Please Print)

Address: _____

Tel. Number (Home):_____ Tel. Number (Work): _____

Tel. Number (Where parent/guardian can be reached in case of emergency): _____

Other Persons to be notified in case of emergency if parent/guardian is unavailable:

Name:_____ Telephone: _____

Relationship:_____

My son/daughter is currently receiving the following medications: Please list all medicines the child is receiving, including those given during the school day.

1. _____ 2. _____ 3. _____ 4. _____

My son/daughter is known to have the following allergies: _____

Parent's Consent

1. I hereby give permission for the school nurse or the designated unlicensed to give the following medicine

_____ prescribed by_____ to _____
(Name of Medicine) (Licensed Prescriber) (Name of Student)

2. I give permission for my son/daughter to self-administer medication if the school nurse determines it is safe and appropriate in the school. Yes_____ No _____

3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration, e.g., adverse side effects, as she/he determines necessary for my son's/daughter's health and safety.

Yes_____No_____ Restrictions on release _____
*Doctor has to order self-administering of medications.

(Please note: I understand that I may retrieve the medicine from the school at any time and that the medicine will be desroyed if it is not picked up within one week following termination of the order or_____beyond the close of school.)

Signature of Parent/Guardian_____

Relationship of Student_____ Date_____

1) School 2) School Nurse 3) Parent

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