LINCOLN PARISH SCHOOL BOARD MEDICATION GUIDELINES

In compliance with R.S. 17:436, Act 87 LA Legislature.

PARENTS:

- Must transport all medication to and from school.
- Must have a completed **MEDICATION ORDER FORM** by a LA, TX, AR, or MS licensed physician, healthcare provider, or dentist.
- Must sign a **PARENTAL CONSENT FORM.**
- Must give first dose of medication at home.
- Are responsible for medication given on field trips.

Contact the school nurse if medication is for a life-threatening condition.

MEDICATIONS:

- Will be limited to acceptable medications that cannot be administered before or after school.
- Must be in a limited quantity. Only a one month supply will be accepted.
- Must be in a pharmacy-approved container. Prescription label must include: a prescription number, child's name, name of medication, dosage, frequency, prescriber's name, date, and pharmacist's name.
- Will be kept in a locked place in either the school office or a designated special ed. classroom.

ACCEPTABLE MEDICATIONS

ORAL (for these conditions):
ADHD
ASTHMA
SEIZURES
CHRONIC CONDITIONS
LIFE-THREATENING CONDITIONS

INJECTIONS (emergency use only):
EPI-PEN
GLUCAGON

INHALANTS
(Nebulizers must be self-administered)

TOPICAL
For diaper rash only.

TRANSDERMAL PATCH
To be applied and removed at home.

SPECIAL CIRCUMSTANCES
Must be approved by the school nurse.

SELF-ADMINISTERED MEDICATIONS:

- Must be authorized by the prescribing physician, healthcare provider, or dentist and must be an "acceptable medication."
- Will be limited to inhalers and emergency medications for grades Pre-K-6. Students must demonstrate competence in self administration.
- Must be kept with the student, in a purse or backpack, in the student's locked locker, or in the school office / special ed. classroom. ***CONTROLLED" or "SCHEDULED" MEDICATIONS ARE NOT TO BE SELF-ADMINISTERED.***
- Lincoln Parish School Board and its employees will not be held liable for students who self-administer medication.

FIRST AID

- Will be limited to the use of ice, water, and band-aids.

EMPLOYEES of the Lincoln Parish School Board who administer medications at school have a limited training by the school nurse. They are not medically-licensed personnel. If a scheduled dose of medication is missed, or there is an unusual occurrence, a reasonable attempt will be made to notify the parent or guardian. If they cannot be reached, the school personnel shall not be held responsible. If necessary, 911 may be called for emergency or urgent situations. Any unusual occurences will be documented by school employees.

PARENTAL CONSENT FORM and MEDICATION ADMINISTRATION PLAN AT SCHOOL

STUDENT NAME ______________ DATE OF BIRTH ________ GRADE ____ TEACHER ______________

NAME OF MEDICATION ______________ REASON FOR TAKING MEDICATION ______________ SIDE EFFECTS ______________

DOSE ______________ EXACT TIME TO BE GIVEN ________ ☐ AM ☐ PM ☐ AS NEEDED ROUTE ________ MEDICATION ALLERGIES ______________

"AS NEEDED" MEDICATION TO BE GIVEN IF THESE SYMPTOMS ARE PRESENT: ______________ SPECIFIC DIRECTIONS (if any) FOR ADMINISTRATION: ______________

- I request the above medication to be given to my child at school as prescribed by my physician, healthcare provider, or dentist. (see back side)
- I give my consent for this information to be shared with my child's teachers and related school staff.
- I understand this form expires at the end of the school year, or at an earlier date if designated by the licensed medical prescriber.
- I acknowledge that Lincoln Parish School Board and its employees will not be held liable if my child self-admiinisters medication at school.
- I am responsible for notifying the school if any changes in medication occur and if any changes in phone numbers occur.

PARENT / GUARDIAN SIGNATURE ______________ **DATE** ________ **HOME PH. #** ________ **WORK PH. #** ________ **CELL PH. #** ________ **OTHER #** ________

MEDICATION TO BE KEPT: ☐ office ☐ special ed. room ☐ ______________ ☐ self-administered (ordered by prescriber)

NURSE'S INITIALS: ________ Counseling / Instruction ______________ POISON CONTROL: 1-800-256-9822

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

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Licensed Provider's Signature Date