

St. Tammany Parish School Board School Nurse Program

COVINGTON ANNEX
STUDENT HEALTH SERVICES

898-3375 * FAX 898-3377
646-4913 * FAX 646-4944

Dear Parent/Guardian:

In accordance with LA R.S. 17:436.1, the St. Tammany Parish School Board has formulated the following guidelines to be used when a student has to receive medication during schools hours:

1. No medication shall be administered or self-administered by a student without an order from a licensed physician, dentist or any other authorized prescriber who is licensed in the state of Louisiana or an adjacent state. A letter of request and authorization from the student's parent or guardian is required. All medication orders must be renewed at the beginning of each school year.
2. No medication shall be administered or self-administered by a student unless the initial dose has been administered at home and sufficient time has been allowed for observation of adverse reactions before asking school personnel to administer the medication.
3. No medication shall be administered or self-administered by a student unless it is provided to the school in a container labeled by a registered pharmacist with the time and dosage that corresponds to the prescriber's order.
4. A registered nurse employed by the St. Tammany Parish School Board will review the prescriptive order and the parent's request. The registered nurse will determine if delegation of administration of the medication by the trained unlicensed school personnel is appropriate.
5. In order to ensure proper identification of students receiving medication, it is recommended that the parent submit a recent photo of the student to attach to the medication folder.
6. Medication must be brought to school and retrieved by a responsible adult. No medication will be received at school or sent home via a student. Medication will be destroyed if it is not picked up within two weeks following termination of the order or two weeks beyond the end of the current school year.

If your child requires medication for an acute illness, we encourage you to work with your physician to schedule doses that can be given at home. Long-term illness and medication may require administration during school hours. **ONLY ORAL, INHALANT BY PRE-MEASURED AEROSOL, TOPICAL OINTMENT FOR DIAPER RASH, AND EMERGENCY MEDICATIONS MAY BE GIVEN AT SCHOOL BY UNLICENSED PERSONNEL TRAINED TO GIVE MEDICATION AT SCHOOL.**

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PARENTAL REQUEST FOR ADMINISTERING MEDICATION AT SCHOOL AND RELEASE FROM LIABILITY

NAME OF STUDENT: _____ D.O.B.: _____
SCHOOL: _____ GRADE: _____ TEACHER: _____
NAME OF PARENT/GUARDIAN: _____ HOME PHONE: _____
WORK NUMBER: _____ CELL NUMBER: _____

1. I hereby give permission for the school nurse or the designated unlicensed person, trained to administer medication at school, to give the following medication ordered by the physician. YES ___ NO ___
2. I have administered the initial dose ordered at home and have allowed sufficient time for observation of adverse reactions before asking school personnel to administer the medication. YES ___ NO ___
3. My child has permission to carry and self-administer his/her inhaler/emergency medication **if ordered by the prescriber** and in concurrence with the school nurse assessment. YES ___ NO ___
4. Do you assume responsibility for your child's actions in his/her self-management of medication at school? YES ___ NO ___

I give permission to the school nurse to share with appropriate school personnel information (such as adverse side effects) relative to the prescribed medication administration as the nurse determines necessary for my son's/daughter's health and safety.

Yes: ___ Restrictions on release: _____

Medication must be brought to school and retrieved by a responsible adult. Medication will be destroyed if it is not picked up within two weeks following termination of the order or two weeks beyond the end of the current school year.

Printed Name of Parent/Guardian Signature of Parent/Guardian DATE: _____

PHYSICIAN, DENTIST OR OTHER AUTHORIZED PRESCRIBER: LOUISIANA OR ADJACENT STATE

In most instances, the medication will be administered by unlicensed, trained, school personnel. Please make the following orders clear enough for them to understand.

DIAGNOSIS: _____

DESIRED EFFECT: _____

MEDICATION: _____ DOSAGE: _____

DISCONTINUE DATE: _____ AT STUDENT'S LUNCH TIME: YES ___ NO ___
IF NOT, SPECIFY TIME: _____

Possible Side Effects/Contraindications/Adverse Reactions: _____

Please list other medications being taken by this student outside of school: _____

STUDENT ALLERGIES: _____

NOTICE: USE THIS SECTION ONLY FOR A STUDENT WHO WILL SELF-ADMINISTER HIS/HER OWN MEDICATION, SUCH AS AN ASTHMA INHALER OR OTHER EMERGENCY MEDICATION.

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 is safe and appropriate for this student in the particular school setting? YES ___ NO ___

Do you give authorization for this student to carry his/her own medication, if it is requested by the parent and the school nurse has determined it safe and appropriate? YES ___ NO ___

PHYSICIAN'S NAME (PLEASE PRINT): _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

ADDRESS: _____ PHONE: _____