

## 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  No2. 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  No3. If training has not occurred, may the school nurse conduct a training program?  Yes  No\_\_\_\_\_  
Licensed Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_