LSDVI STUDENT HEALTH CENTER

MEDICATION ORDER

TO BE COMPLETED BY LA, TX, AR, OR MS LICENSED PRESCRIBER

(In some instances, medications will be administered by unlicensed trained school personnel.)

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE

Student's Name:	Birthdate:
School:	Grade:

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):

   Check Route: ☐ By mouth ☐ Inhaled ☐ Topical ☐ Subcutaneous ☐ Intramuscular ☐ 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.

4. Duration of medication order: ☐ Until the end of school term ☐ Other:
5. Desired Effect:
6. Possible side effects of medication:
7. Any contraindications for administering medication:
8. Other medications being taken by student when not at school:
9. Next visit with prescribing provider:
10. Is this medication necessary on school field trips: ☐ **yes** ☐ **no**

    (which may include overnight field trips for consecutive days and weekends)

Prescriber's Name (printed) Address Phone and Fax numbers

Prescriber's Signature Credentials (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 medication orders. Orders sent by fax are acceptable. Legibility may require mailing original to the school. Orders to discontinue also must be written.

PLEASE NOTE: A copy of an emergency action plan is needed for any prescribed emergency medications.*

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

School Use Only: Entered into JCAMPUS on ____/____/____ by _____ Witnessed by _____ Revised 5/2016