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

DEPARTMENT OF HEALTH SERVICES

Medical History Update Form

To be completed by the Physician

(Parents/Guardians: This information will be utilized by the School Health team to provide the prescribed services to your student)

Student's Name_____D.O.B._____

School_____Teacher _____Grade_____

CURRENT DIAGNOSIS / CPT Code and MEDICAL STATUS (additional information may be attached):

_____

_____

_____

Medications: _____

_____

Recommendations for Student Integration Into the school setting:

Activity Restrictions / Limitations _____

_____

Accommodations _____

_____

Nutritional / Dietary _____

_____

Adaptive / Physical Education _____

_____

Physical Therapy _____

_____

Occupational Therapy _____

_____

Special Procedures _____

_____

Return to Clinic _____

Physician's Signature _____ **Date**_____

Physician (Print) _____ **NPI#** _____

Office #_____ **Fax #** _____

FINAL 11/06

EBR Parish School System

STUDENT HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed. Use additional sheets, if necessary, for further explanation.

Name of School:			Grade:	
Student's Name: Last		First		M.I.
Student's Date of Birth:	Sex: ☐ M ☐ F		State or Country of Birth:	
Student's Mailing Address:	City:		State:	Zip Code:
Student's Physical Address:	City:		State:	Zip Code:
Name of Mother or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Name of Father or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Name of child's pediatrician or primary care provider:		Names of medical specialists or special clinics caring for your child:		

_____

Parent or Legal Guardian Signature Date

Please check the type of health insurance your child has: ☐ Private ☐ Medicaid/LaCHIP ☐ None

If your child does not have health insurance, would you like information on no cost health insurance? ☐ Yes ☐ No

In case of emergency—if parent or legal guardian cannot be reached—contact the following:

Name Complete Phone Number ( )

My child has a medical, mental, or behavioral condition that may affect his/her school day: ☐ No ☐ Yes (If yes, please complete Part 2.)

PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent/Legal Guardian is responsible for providing the school with any medication and may be responsible for providing the school with any special food or equipment that the student will require during the school day. Check with the school nurse to obtain correct medication and procedure forms.

❑ ALLERGIES

Allergy Type:

- ☐ Food (list food(s)) _____
- ☐ Insect sting (list insect(s)) _____
- ☐ Medication (list medication(s)) _____
- ☐ Other (list) _____

Reactions: (Date of last occurrence if yes.)

- ☐ Coughing (Date:) ☐ Hives (Date:) ☐ Rash (Date:)
- ☐ Difficulty breathing (Date:) ☐ Local swelling (Date:) ☐ Wheezing (Date:)
- ☐ Generalized swelling (Date:) ☐ Nausea (Date:) ☐ Other _____ (Date:)

Currently prescribed medications and treatments:

☐ Oral antihistamine(Benadryl, etc.) ☐ Epi-pen ☐ Other _____

❑ ASTHMA

Triggers: ☐ Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) _____ ☐ Other (list) _____

Does your child experience asthma symptoms with exercise? ☐ No ☐ Yes

Symptoms:

☐ Chest tightness, discomfort, or pain ☐ Difficulty breathing ☐ Coughing ☐ Wheezing ☐ Other _____

Currently prescribed medications and treatments: _____

_____

Date of last hospitalization related to asthma _____ Date of last emergency room visit related to asthma _____

Does your child have a written asthma management plan? ☐ No ☐ Yes

Is peak flow monitoring used? ☐ No ☐ Yes

Name: _____ DOB: _____

❑ **DIABETES**

Currently prescribed medications and treatments:

- ☐ Insulin: ☐ Syringe ☐ Pen ☐ Pump
- ☐ Blood sugar testing
- ☐ Glucagon
- ☐ Oral medication(s) List medication(s) _____

Is special scheduling of lunch or Physical Education required? ☐ No ☐ Yes

❑ **SEIZURE DISORDER**

Type of seizure:

- ☐ Absence (staring, unresponsive) ☐ Complex Partial ☐ Generalized Tonic-Clonic (Grand Mal/Convulsive)
- ☐ Other (explain) _____

Physical Education Restrictions: ☐ No ☐ Yes

Medication(s): ☐ No ☐ Yes List medication(s) _____

Date of last seizure _____ Length of seizure _____

❑ **OTHER HEALTH CONDITIONS**

- ☐ Anemia ☐ ADD/ADHD ☐ Cancer ☐ Cerebral Palsy ☐ Chicken Pox ☐ Cystic Fibrosis
- ☐ Depression ☐ Digestive disorders ☐ Emotional/Psychological ☐ Juvenile Rheumatoid Arthritis
- ☐ Hemophilia ☐ Heart condition ☐ Physical disability ☐ Sickle Cell Disease ☐ Skin disorders
- ☐ Speech problems ☐ Other (explain)_____

Physical Education Restrictions: ☐ No ☐ Yes (explain): _____

Medication(s): ☐ No ☐ Yes List medication(s) _____

Special procedures required (i.e., catheterization, oxygen, gastrostomy care, tracheostomy care, suctioning): ☐ No ☐ Yes (explain): _____

Special diet required (i.e., blended, soft, low salt, low fat, liquid supplement): ☐ No ☐ Yes (explain): _____

Are there anticipated frequent absences or hospitalizations? No Yes

(explain): _____

❑ **VISION CONDITIONS**

- ☐ Contacts/glasses
- ☐ Other _____

❑ **HEARING CONDITIONS**

- ☐ Hearing aid(s)
- ☐ Other _____

❑ **ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION**

Special school environmental adjustments of the school environment or schedule: ☐ No ☐ Yes (explain): _____

(i.e., seizures, limitations in physical activity, periodic breaks for endurance, part-time schedule, building modifications for access)

Special school environmental adjustments to classroom or school facilities: ☐ No ☐ Yes (explain): _____

(i.e., temperature control, refrigeration/medication storage, availability of running water)

Special safety considerations: ☐ No ☐ Yes (explain): _____

(i.e., special precautions in lifting, positioning, special transportation emergency plan, special safety equipment, special techniques for positioning, feeding)

Special assistance with activities of daily living: ☐ No ☐ Yes (explain): _____

(i.e., eating, toileting, walking)

PART 3: PARENT/GUARDIAN'S TO SIGN if student has a medical condition.

_____ _____

Parent/Guardian's Signature Date

Additional Notes:

RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE

EBRPSS PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

Student: _____ Birthdate: _____ Grade: _____

School: _____ Teacher: _____

Parent/Guardian: _____ Address: _____

Home/Phone: _____ Cell: _____ Work: _____

Other persons to be notified in case of emergency:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Medication to be given at school:

_____

Special Instructions for giving your child this medication: _____

Does your child have any allergies? No □ Yes □ If yes, please list: _____

List any/all medications your child takes at home: _____

The questions below (1-5) must be answered in order for your child to receive medications at school:
All answers must be "Yes" before medication can be administered by trained unlicensed personnel.

1. Have you received and reviewed the EBRP School Board Medication Policy? **Yes□ No□**
2. Do you give permission for the school nurse to share with designated trained unlicensed personnel information about your child relative to medication administration as the nurse deems necessary? **Yes□ No□**
3. Are there any restrictions on this release? __
4. Do you understand that you may retrieve the medication from the school at any time and that the medication will be destroyed after you have been notified if it is not picked up within two weeks following the end of the term or when the medication orders are discontinued? **Yes□ No□**
5. Have you administered the initial dose at home and have you allowed sufficient time (overnight) for observation of adverse reactions before asking school personnel to administer the medication? **Yes□ No□**

For a student who will administer their own medication at school (such as asthma inhaler).
The student will be required to record each dose taken at school (record kept on file in school nurse's office)

- Do you give permission for your child to self-administers medication if the school nurse determines it is safe and appropriate in the school setting? **Yes No**
- Do you believe your child is sufficiently responsible and informed to administer his/her own medication? **Yes No**
- Do you assume responsibility for your child's actions in his/her self-management of medication at school? **Yes No**
- Do you understand that regular medication orders must be provided by a physician for students who self-administer medications at school? **Yes□ No□**

I understand and agree that EBRP School Board and its **employees are not responsible** for any **unintentional mistakes or oversights** in keeping or giving my child medication. I agree to hold the School Board and its trained employees free and harmless from liability for any injuries which might result from the administration of medication to my child.

_____ _____

Parent/ Guardian Signature Date

FINAL 11/06

STATE OF LOUISIANA

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

PART 1: CONTACT INFORMATION

Student's/Child's Legal Name	Date of Birth	Social Security #

Parent/Legal Guardian _____ Telephone # _____

Mailing Address _____

PART 2: RECORD REQUEST

Complete box A **OR** box B below. Both boxes may not be completed on the same form.

A. Specify the records to be released for the treatment date(s) listed below in Part 3:

- ❑ COMPLETE RECORD(S)
- ❑ Discharge Summary
- ☒ History & Physical
- ❑ Operative Report
- ❑ Consultation
- ☒ Progress Notes and School Order(s)
- ❑ Cardiopulmonary **(Indicate EKG, Stress Test, Sleep Study)**
- ❑ Emergency Room
- ❑ Lab
- ❑ Pathology
- ❑ Radiology Results
- ❑ Other _____

_____

B. If initialed below, I specifically authorize release of the following:

Psychotherapy notes and records indicating psychological or psychiatric impairment(s)

_____
Initials of parent/legal guardian

PART 3: AUTHORIZATION

This does not authorize the release of the following: drug and alcohol use counseling and treatment and HIV/AIDS and sexually transmitted disease testing and treatment.

I authorize:

Name: East Baton Rouge Parish School System (School System)

☒ **TO RELEASE Information TO** **AND/OR** ☒ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released AND/OR requested.)

Name: My child's primary care provider and/or specialists (Hospital, Physician, Service Agency, School RN and/or other health provider)

For treatment date(s): current

The information is to be released for the purpose(s) of:

- ❑ Evaluation to determine eligibility or continued eligibility for special education services
- ❑ Providing physical therapy treatment
- ❑ Providing occupational therapy treatment
- ☒ Designing an individual educational program
- ☒ Determining appropriate placement for treatment needs
- ☒ Draft a health care plan and/or emergency plan

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the same medical records department receiving this authorization form. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: 7/1/23.

If I fail to specify an expiration date, event or condition, this authorization will expire in nine (9) months from the date of authorization. An authorization is voluntary. I will not be required to sign an authorization as a condition of receiving treatment services or payment, enrollment, or eligibility for health care services. Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected under the Health Insurance Portability & Accountability Act of 1996.

Signature of Student or Legal Representative (Parent/Legal Guardian must sign if student < 18)	Date	(Relationship to student)

Signature of Witness	Date