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): Diabetes Mellitus
2. Student's General Health Status: Good
3. Medication: Glucagon
4. Strength of medication: 1 mg Dosage (amount to be given): Circle Dose ½cc 1cc

   Check Route: ☐ By mouth ☐ By inhalation ☒ Other Injection/intramuscular

   Frequency As needed Time of each dose To be given as needed for low blood sugar and unconsciousness or inability to swallow.

   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: Awake/alert within 4-8 minutes
7. Possible side-effects of medication: Vomiting, pain at injection site
8. Any contraindications for administering medication: If student alert and able to swallow.
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

Licensed Provider's Signature Date

TO PARENTS/LEGAL GUARDIANS:

PLEASE READ THE FOLLOWING INFORMATION REGARDING MEDICATION ADMINISTRATION AT SCHOOL AND SIGN TO

BEFORE ANY MEDICATION CAN BE GIVEN AT SCHOOL I AGREE TO:

1. Provide a signed, fully completed administration form.
2. Make an appointment with the school nurse for an assessment to be performed on the student prior to medication being administered by school personnel.
3. Medication must be brought to by a parent and must be in a container from the pharmacy, properly labeled with the following: name, address and phone number of pharmacy, prescription number, date dispensed, name of student, clear directions for use, drug name and strength, name of pharmacist and physician's name.
4. Over the counter medication must be in the original sealed container and labeled with the student's name.
5. Medication must be counted when delivered to the responsible person at school and the parent must sign an agreement for that count.
6. The initial dose of the medication must be administered at home by the parent or guardian with sufficient time to observe for adverse reactions.
7. No more than a 35 day supply shall be kept at school.
8. A new medication form and medication supply must be provided each school year.
9. At the end of the year or if the medication is discontinued, a parent must pick up the remaining medication within one week. One week following the last day of the school year, any medication left at school will be disposed of.
10. Please list all medications that the student is currently receiving at home and at school:
    1. ______________________________
    2. ______________________________
    3. ______________________________
11. List the names and telephone numbers of persons, in addition to the parent/guardian, to be notified in case of an emergency:
    1. ______________________ ______________________
       Name Phone Number(s)
    2. ______________________ ______________________
       Name Phone Number(s)
    3. ______________________ ______________________
       Name Phone Number(s)

I HAVE READ AND AGRE TO THE ABOVE INFORMATION.

SIGNED: ______________________ ______________________

Name Date