Central Private Schools, Inc.
Parent/Guardian Consent for Medication Administration

(Please print all information)
Student: _____ D.O.B:_____ Grade: _____
Homeroom Teacher: _____
Parent/Guardian: _____ Home Phone: _____
Address: _____
Business phone: _____ Other phone (pager, cellular): _____
Other persons to be notified in case of emergency:
Name: _____Relationship: _____ Phone: _____
Name: _____Relationship: _____ Phone: _____

Medication you wish for school personnel to administer to your child at school: _____
_____ Prescription #: _____
(only medications labeled by a licensed pharmacist will be administered via this consent)
List any allergies: _____
Instructions for administering this medication(s): _____
_____
List medications student receives at home: _____
_____

Have you received a copy of Central Private Schools, Inc. Medication Policy? Yes _____ No_____

Do you give permission for designated, unlicensed personnel to receive information about your child relative to medication administration as the administration deems necessary? Yes _____ No_____
Are there any restrictions on this release? _____
_____

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_____

Have you administered the first dose at home and have you allowed enough time (at least overnight) for observation of adverse reactions before asking school personnel to administer the medication?
Yes_____ No_____

(All above answers must be "yes" before the medication will be administered at school)

NOTE: This document has two pages, both of which must be completed by the parent/guardian.

The following are for students who will ADMINISTER THEIR OWN MEDICATIONS

Do you give permission for your child to self administer medication if the school personnel determine 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 understand that medication orders (from a licensed physician) must be provided for students who self-administer medications at school? Yes_____ No_____

Do you understand that the student will be required to record each dose with the designated personnel? Yes_____ No_____

I understand and agree that Central Private Schools, Inc. and its employees are not responsible for any unintentional mistakes or oversights in keeping the medication or in giving my child the medication. I agree to hold Central Private Schools, Inc., its employees and board of directors free and harmless from liability from injuries that might occur as a result of the administration of medications by school employees.

_____ _____

Date Parent/Guardian's Signature

FINAL 11/06

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 ❑ 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