Includes in this packet:

- Medication Orders
- Parental Consent Forms
- Health Update Form
- Medication Policy

Forms must be completed and brought to school by parent with the medication. A parent will need to sign the medication in with a nurse or secretary in the office.

**STUDENTS MAY NOT BRING THE MEDICATION TO SCHOOL.**

Any student possessing medication while at school without prior authorization will be subject to disciplinary action.

Your child’s physician may fax the order to the appropriate school, to the attention of ‘School Nurse’. However, the original must be sent to the school as soon as possible:

Zachary High School  
Fax: 658-0010  
Phone: 654-2776

Port Hudson Career Academy  
Fax: 658-7385  
Phone: 658-7381

Northwestern Middle School  
Fax: 658-2025  
Phone#: 654-9201

Copper Mill Elementary School  
Fax: 658-1298  
PHONE: 658-1288

Zachary Elementary School  
Fax: 654-8746  
Phone: 654-4036

Northwestern Elementary School  
Fax: 654-6613  
Phone: 654-2786

Zachary Early Learning Center  
Fax: 654-6392  
Phone: 654-6011

Rollins Place Elementary School  
Fax: 658-8207  
Phone: 658-1940

Please carefully read our medication policy. Any medication not picked up at the end of the school year will be disposed of.

THANK YOU,

ZACHARY COMMUNITY SCHOOLS NURSE DEPARTMENT
1. As a general principle, medication shall not be given at school unless it is certified in writing by the attending physician that such medication cannot be administered before or after school hours.

2. Possible exceptions to the general principle:
   A. Medication for behavior modification (e.g. Ritalin)
   B. Insect sting allergy-- Must have a note from the physician with specific instructions.
   C. Anticonvulsant medications (e.g., Dilantin, Phenobarbital)
   D. Medication for asthmatic conditions
   E. Extenuating circumstances--These will be assessed on an individual basis, e.g. field trips, chronic disorders, i.e. migraine headaches, arthritis, Sickle Cell Anemia, etc.

3. Antibiotics and other short term medications, including non-prescription medication, shall not be given at school.

4. Children shall not be allowed to have medications in their possession on the school grounds. Possession of prescription and/or non-prescription medication without evidence of a physician’s order is an offense that is subject to disciplinary action and may result in suspension or expulsion. Teachers and principals have the right to take the medication from the child and contact the parents for appropriate information. Exception: see Self Administration of Medication

5. Prior to the administering of medications during school hours, the following will be required:
   A. Medication shall not be administered to any student without an order from a physician or dentist licensed in the states of Louisiana, Texas, Arkansas and Mississippi and written parental consent.
   B. Medication must be brought to the school by the parent or guardian in the container that meets acceptable pharmaceutical standards.
   C. Both the consent letter from the parent or guardian and the medication container shall contain clear instructions identifying the student's name, prescription numbers if any, date, frequency, name of the medication, dosage, route, and physician's or dentist's name.
   D. No more than one month's supply (twenty-five school days) of the medication shall be kept at school; the empty bottle will be sent home with the student.
   E. The initial dose of a medication shall be administered by the student’s parent/guardian outside the school jurisdiction with sufficient time for observation for adverse reactions (24 hours preferably unless otherwise deemed and documented by the prescribing physician). *This guideline applies to any and all medication being given, including medication administered at home only, as well, to ensure your child’s safety while at school.
F. If a student is to receive a fraction of a tablet, for example: 1/2 tablet, the parent is responsible for scoring (breaking) the tablets. Fractional doses are not exact; therefore, unlicensed personnel are not allowed to break tablets.

G. At the beginning of each school year and anytime there is a change in medication a new form from the physician must accompany the new prescription.

H. All medication must be recorded daily on the Medication Log. The Parental Consent and the Physician's Order Form will be kept with the Medication Log and a copy of each form will be placed in the cumulative folder.

I. Because of potential danger, medication must be kept under lock and key in a secure, central location.

J. The principal shall designate at least two employees to administer medications in each school. Designated employees must receive the required training for medication administration in the schools.

6. A registered nurse and/or licensed medical physician employed by the Zachary Community School Board shall review the physician's or dentist's order and the Parent/Guardian Consent for Medication Administration. The nurse shall assess the health status of the specific child in his specific educational setting. The nurse shall determine that, according to the legal standards of the respective licensed health professional when performing such procedure, the administration of medication can be safely performed by and delegated to someone who has received documented training with documented competence other than a licensed health professional.

7. Self Administration of Medication

Self administration of medication by a student may be permitted under the following conditions:

A. The completed Parental Consent and Physician's Order Form have been brought to the school.

B. The school nurse has evaluated the situation and deemed it to be safe and appropriate; has documented this on the student's cumulative health record; and has developed a plan for general supervision. The plan may include observation of the procedure, student health counseling and health instruction regarding the principles of self-care.

C. The principal and appropriate staff are informed in writing that the student is self administering prescribed medication.

D. The medication is handled in a safe, appropriate manner.

8. The School Board and its employees are not responsible for any unintentional mistakes or oversight in keeping or giving the student's medication.

This policy is in compliance with Act No. 87 of 1993 and the Joint Policy of LSBN (Louisiana State Board of Nursing) and SBESE (State Board of Elementary and Secondary Education).
ZACHARY COMMUNITY SCHOOLS

ZCSB PARENT/GUARDIAN CONSENT FOR MEDICAL ADMINISTRATION

Name: ___________________________________ DOB: _________________________ Grade ___________

School: __________________________________ Teacher: ____________________________

Parent/Guardian: __________________________  Address: ________________________________________

Home Phone: _____________________________ Business Phone: _____________________________

Other persons to be notified in case of emergency:
Name: ___________________________ Relationship: ______________________ Phone: ________________
Name: ___________________________ Relationship: ______________________ Phone: ________________

Medication Name: ___________________________________ Prescription #: __________________________

List any allergies: __________________________________________________________________________

Are there any special instructions for giving your child this medication? _______________________________

_________________________________________________________________________________________

List medications student receives at home: _______________________________________________________

1. Have you received and reviewed the ZCSB 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. Are there any restrictions on this release? ______________________________________

3. 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

4. Have you administered the initial dose at home and have you allowed sufficient time for observation
   of adverse reactions before asking school personnel to administer the medication? ____ Yes ____ No

All of the above answers must be yes before the medication can be administered at school by unlicensed
untrained personnel.

Use this box only for a student who will administer his/her own medication, such as an
asthma inhaler. The student will be required to record each dose.

Do you give permission for your child to self-administer 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 for students who self-
administer medications at school? _____ Yes _____ No

I understand and agree that Zachary Community 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
free and harmless from liability from injuries, which might occur as a result of the administration of
medications by school employees.

________________________________________  _______________________________________
Date                          Parent/Guardian Signature
Medical information is needed for the following student in order to determine if there are health impairments sufficient to warrant special education services and will also be utilized by the school nurse to provide health services to students. Please check appropriate behaviors and provide a simple explanation when indicated: Please return this completed form to the school nurse at your child's school.

Name: ____________________________________________ DOB: _______________________

Name of Parent(s)/Guardian: ___________________________________________________________________

CURRENT DIAGNOSIS, MEDICAL STATUS, AND CURRENT MEDICATIONS:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Date Last Seen: _______________ Severity of Illness: [ ] Mild [ ] Moderate [ ] Severe

Condition Causes:
[ ] temporary or chronic lack of strength
[ ] temporary or chronic lack of vitality
[ ] temporary lack of alertness
[ ] reduced efficiency in school work because of ______________________________

Student is substantially limited in the following major life activity/activities: [ ] caring for one’s self
[ ] seeing  [ ] working  [ ] hearing  [ ] walking  [ ] performing manual tasks  [ ] breathing
[ ] speaking  [ ] learning  [ ] other major life activity (describe): _____________________________

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’s Name Printed: __________________________________________________________________

Physician’s Address: ______________________________________________________________________

Office #: ______________________ Fax #: ______________________
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: __________________

Should the student’s medication be given or omitted on early dismissal days? Circle one

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 _______

   Indications for PRN meds and/or specific directions:

   ALL PRN MEDICATION MUST DENOTE TIME INTERVAL BETWEEN DOSAGE

   Employees are not allowed to administer medications that exceed the recommended 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. Can this medication be delayed until the student returns to school from a field trip?
   ☐ Yes ☐ No ☐ If yes, please indicate the length of time dose can be delayed: __________

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. Allergies to food or medicine include: _____________________________________________

10. Other medications taken at home: ________________________________________________

11. Next visit is: _____________________________________________________________________

Licensed Prescriber’s Name (Printed) Address Phone and Fax Numbers

Licensed Prescriber’s Signature Credential (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 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

Licensed Prescriber’s Signature Credential (i.e., MD, NP, DDS) APRN # Date
STATE OF LOUISIANA
HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

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.

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Last</th>
<th>First</th>
<th>M.I.</th>
<th>Sex:</th>
<th>DOB:</th>
<th>Grade:</th>
<th>School:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student’s Mailing Address:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
<td>Zip:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student’s Physical Address:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
<td>Zip:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Mother/Legal Guardian</td>
<td>Home Phone</td>
<td>Work Phone</td>
<td>Cell Phone</td>
<td>Employer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Father/Legal Guardian</td>
<td>Home Phone</td>
<td>Work Phone</td>
<td>Cell Phone</td>
<td>Employer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of pediatrician/primary care provider</td>
<td>Phone No</td>
<td>Name of medical specialists/clinics</td>
<td>Phone No.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Parents: Please notify the school nurse of any changes in the students medical condition.

Parent/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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
<th>Cell Phone Number</th>
</tr>
</thead>
</table>

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. Parents are responsible to keep the school nurse informed regarding their child’s health status.

❑ ALLERGIES

Allergy Type:
❑ Food (list food(s) ____________________________  ❑ Medication (list medication(s)) ____________________________
❑ Insect sting (list insect(s)) ____________________________  ❑ Other (list) ____________________________

Reactions: (Date of last occurrence)
❑ Coughing (Date: ____________)  ❑ Swelling (Date: ____________)  ❑ Rash (Date: ____________)
❑ Difficulty breathing (Date: ____________)  ❑ Nausea (Date: ____________)  ❑ Other ____________________________
❑ Hives (Date: ____________)  ❑ Wheezing (Date: ____________)  (Date: ____________)

Currently prescribed medications and treatments:
❑ Oral antihistamine (Benadryl, etc.)  ❑ Epi-pen  ❑ Other ____________________________

❑ ASTHMA

Triggers (i.e., tobacco, dust, pets, pollen, etc.) (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
- 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)
- Generalized Tonic-Clonic (Grand Mal/Convulsive)
- Complex Partial
- Other (explain)

Physical Education Restrictions:  No  Yes
Medication(s):  No  Yes (explain): 
Date of last seizure  Length of seizure

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

Physical Education Restrictions:  No  Yes (explain): 
Medication(s):  No  Yes (explain): 

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., precautions in lifting or positioning, transportation emergency plan, safety equipment, techniques for positioning or feeding)

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

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

PART 3: SCHOOL NURSE TO REVIEW if parent/legal guardian indicates medical condition.

Nurse Notes:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

School Nurse Signature ____________________________________________ Date ______

RETURN COMPLETED FORM TO SCHOOL NURSE AS SOON AS POSSIBLE
Dear Parent/Guardian:

The medication law, Act 87 of 1993, requires medication to be administered by either a licensed or trained unlicensed school board employee. However, a parent may delegate this responsibility to a volunteer who is not employed by the school board. This law is strictly enforced by the school board administration.

On class field trips, the class may not be at school for scheduled medication, or PRN as needed medications. In most cases there may not be a trained unlicensed person to administer medications on field trips.

A volunteer, (a parent or teacher), will give your child the needed medication. Please check the appropriate blank below, so that we know how you would like medication administration during field trips to be handled.

_____ Yes, the volunteer may administer my child’s medication during the field trip.
_____ No, my child may not receive medication from a volunteer. Please withhold the dose during the field trip. (Please be advised that emergency medication must go with the student on all field trips. Contact your school nurse.)
_____ I will be going on the field trip and will administer medication to my child.

___________________________                  _________________________
Child’s Name                                                  Teacher & Grade

___________________________                  _________________________
Parent Signature                                                      Date