# ZACHARY COMMUNITY SCHOOLS
# MEDICATION PACKET

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

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

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

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

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

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

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

**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**

# Zachary Community Schools

MEDICATION POLICY
ZACHARY COMMUNITY SCHOOL BOARD

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. 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 (thirty school days) of the medication shall be kept at school; the empty bottle will be sent home with the student.
   E. 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.

F. 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.

G. 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.

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

I. 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.

7. A registered nurse and/or licensed medical physician employed by the East Baton Rouge Parish 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

6. 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.

7. 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 on the student's last day of school or when the medication orders are discontinued? ___Yes ____ No
4. 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

*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 HISTORY FORM
# ZACHARY COMMUNITY SCHOOLS

Medical information is needed for the following student to determine if there are health impairments sufficient to warrant special education services. This information will also be utilized by the school nurse to provide health services. This form is to be completed by the Doctor. Please check appropriate behaviors and provide a simple explanation when indicated.

**Name**: ______________________________________________________ DOB: ___________________________

**Name of Parent(s)/Guardian**: ______________________________________________________________________________

**Current Diagnosis, Medical Status, and Current Medication**: ___________________________________________________
______________________________________________________________________________________________________________

**Date Last Seen**: __________________________________ Return **to Clinic Date:** ___________________________________

**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 _______________________________________________________________________________

Special Procedures _______________________________________________________________________________

Speech Therapy ___________________________________________________________________________________

Physical Therapy/ Occupational Therapy/ Adaptive Physical Education _____________________________________

Please check if you agree to your patient receiving OT/PT (will be considered orders for service for one year from date doctor signed)

- ☐ Occupational Therapy
- ☐ Physical Therapy

**Physician's Signature**: ___________________________________ Date: _________________________________

**Print Physician's Name**: __________________________________________________________________________

**Physician's Address**: ____________________________________________________________________________

**Office #**: _______________________________________ **Fax #**: _________________________________________

7/2016

# 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.**

| Student Name: Last | First | M.I. | Sex: M ❑ F ❑ | DOB: | Grade: | School: |
|---|---|---|---|---|---|---|
| Student's Mailing Address: | | | City: | | State: | Zip: |
| Student's Physical Address: | | | City: | | State: | Zip: |
| Name of Mother/Legal Guardian | | Home Phone | Work Phone | | Cell Phone | Employer |
| Name of Father/Legal Guardian | | Home Phone | Work Phone | | Cell Phone | Employer |
| Name of pediatrician/primary care provider | | Phone No | Name of medical specialists/clinics Phone No. | | | |

**Parents: Please notify the school nurse of any changes in the student's 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:**

Name Phone Number Cell 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. **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:___________ ___________________________

**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 ER visit related to asthma _______________

Does your child have a written asthma management plan? ❑ No ❑ Yes Is peak flow monitoring used? ❑ No ❑ Yes

❑ **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) ❑ Generalized Tonic-Clonic (Grand Mal/Convulsive)
❑ Complex Partial ❑ Other (explain) ______________________________
Physical Education Restrictions: ❑ No ❑ Yes
**Medication(s):** ❑ No ❑ Yes List medication(s) ______________________________
Date of last seizure ________________________ Length of seizure ______________________________

❑ **OTHER HEALTH CONDITIONS** **Chicken Pox: Date of disease:** ___________________

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

**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): ______________________________
______________________________

❑ **VISION CONDITIONS**__________________ ❑ Contacts/glasses ❑ Other______________________
❑ **HEARING CONDITIONS**__________________ ❑ Hearing aid(s) ❑ Other: ______________________

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

**Special adjustments of the school environment or schedule needed?** ❑ No ❑ Yes (explain):
*(i.e., seizures, limitations in physical activity, periodic breaks for endurance, part-time schedule, building modifications for access)*

______________________________________________________________________________

__________

**Special adjustments to classroom or school facilities needed?** ❑ No ❑ Yes (explain)
*(i.e., temperature control, refrigeration/medication storage, availability of running water)*

______________________________________________________________________________

__________

**Special safety considerations required:** ❑ 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 needed:** ❑ No ❑ Yes (explain):
(i*.e., eating, toileting,walking)*

______________________________________________________________________________

**Special diet required?** ❑No ❑ Yes (explain)
(i.e., blended, soft, low salt, low fat, liquid supplement):________________________________________

**Are there anticipated frequent absences or hospitalizations?** ❑ No ❑Yes (explain):

______________________________________________________________________________

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

**Nurse Notes**: ________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

____________________________ __________

School Nurse Signature Date

# 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

# ZACHARY COMMUNITY SCHOOLS
## FIELD TRIP PERMISSION

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 "as needed" medications. In most cases, there will not be a nurse available to administer medications on field trips.

Please check the appropriate blank below, so that we know how you would like your child's medication during field trips to be handled.

For **scheduled** medications:

_____ Please withhold scheduled, non-emergency medication during the field trip. *Please be advised that emergency medication must go with the student on all field trips.*

_____ Please send scheduled, non-emergency medication on the field trip.

For **scheduled** and **emergency** medications that must be available on field trips:

_____ I will make every effort to accompany my child or have someone who is not employed by ZCSB accompany my child on school field trips to administer medication to my child. In case I am unable to attend or make arrangements for someone else to attend in my place, I will contact my child's school nurse in an effort to make alternative arrangements for a trained unlicensed ZCSB employee to be available to administer my child's medication.

| ______________________________ | ______________________________ |
| --- | --- |
| Child's Name | Teacher & Grade |
| ______________________________ | ______________________________ |
| Parent Signature | Date |