The Christian Academy of Louisiana

PHYSICIAN/PARENT REQUEST MEDICATION FORM

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE.

Student's Name _____ Birthdate _____

School _____ Grade _____ Homeroom _____

Parent/Guardian Name (print): _____ Phone Number: _____

Emergency Contact Name: _____ Phone Number: _____

I hereby request that the below ordered medication be administered by school personnel. I give permission for the exchange of information between the prescriber, school staff, and school nurse. I understand that that I must supply the school with no more than a 35 day supply of medication. I understand that this medication will be destroyed, if not picked up within 2 weeks from the last day of school. I have administered the initial dose of medication on: Date: _____ Time: _____.

Parent/Guardian Signature: _____ **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. All medication orders must be renewed each school year.

PART 2: LICENSED PRESCRIBER TO COMPLETE.

1. Student Diagnosis: _____
2. Medication: _____
3. Strength of medication: _____ Dosage (amount to be given): _____

Check Route: ☐ By mouth ☐ By inhalation ☐ Other _____ Time: _____

PRN Frequency (circle appropriate): q 2 hours q 4 hours q 6 hours

Note: The frequency and the time of medication order must be the same as the Rx given. 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
5. Desired Effect: _____
6. Possible side-effects of medication: _____
7. Any contraindications for administering medication: _____

_____

8. Other medications being taken by student when not at school: _____

_____

9. Student's Allergies: _____

Prescriber's Name(Printed): _____

Phone Number: _____ **Fax Number:** _____

Prescriber's Signature: _____ **Date:** _____

PART 3: LICENSED PRESCRIBER/PARENT TO COMPLETE AS APPROPRIATE.

Inhalants/Emergency Drugs Release Form for Students to be Allowed to Carry Medication on Self

1. 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

Prescriber's Signature: _____ **Date:** _____

2. Do you give permission for your child to self-administer the medication at school? ☐ Yes ☐ No
3. Do you assume responsibility for your child's actions in his/her self-management of medication at school? ☐ Yes ☐ No

Parent/Guardian Signature: _____ Date: _____

I understand and agree that TCAL and its employees are nor responsible for any unintentional mistakes or oversights in keeping or giving my child medication. I agree to hold The Christian Academy of Louisiana free and harmless from liability from injuries that might occur as a result of the administration of medications by school employees.

Physician's/Nurse's Signature: _____ **Date:** _____