

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 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: 658-0664
Phone: 654-2786

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 (twenty-five 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 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 (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

ZACHARY COMMUNITY SCHOOL SYSTEM

MEDICAL HISTORY UPDATE FORM

(To be completed by student's physician)

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

HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

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.				
Name of School:			Grade:	
Student's Name: Last		First		M.I.
Student's Date of Birth:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	State or Country of Birth:	
Student's Mailing Address:		City:	State:	Zip Code:
Student's Physical Address:		City:	State:	Zip Code:
Name of Mother or Legal Guardian:	Home Phone: ()	Work Phone: ()	Cell Phone: ()	Employer:
Name of Father or Legal Guardian:	Home Phone: ()	Work Phone: ()	Cell Phone: ()	Employer:
Name of child's pediatrician or primary care provider:		Names of medical specialists or special clinics caring for your child:		
Parent or Legal Guardian Signature				Date
Please check the type of health insurance your child has: <input type="checkbox"/> Private <input type="checkbox"/> Medicaid/LaCHIP <input type="checkbox"/> None				
If your child does not have health insurance, would you like information on no cost health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
In case of emergency—if parent or legal guardian cannot be reached—contact the following:				
Name		Complete Phone Number ()		
My child has a medical, mental, or behavioral condition that may affect his/her school day: <input type="checkbox"/> No <input type="checkbox"/> 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.				
<input type="checkbox"/> ALLERGIES				
Allergy Type:				
<input type="checkbox"/> Food (list food(s)) _____				
<input type="checkbox"/> Insect sting (list insect(s)) _____				
<input type="checkbox"/> Medication (list medication(s)) _____				
<input type="checkbox"/> Other (list) _____				
Reactions: (Date of last occurrence if yes.)				
<input type="checkbox"/> Coughing (Date: _____)		<input type="checkbox"/> Hives (Date: _____)		<input type="checkbox"/> Rash (Date: _____)
<input type="checkbox"/> Difficulty breathing (Date: _____)		<input type="checkbox"/> Local swelling (Date: _____)		<input type="checkbox"/> Wheezing (Date: _____)
<input type="checkbox"/> Generalized swelling (Date: _____)		<input type="checkbox"/> Nausea (Date: _____)		<input type="checkbox"/> Other _____ (Date: _____)
Currently prescribed medications and treatments:				
<input type="checkbox"/> Oral antihistamine (Benadryl, etc.)		<input type="checkbox"/> Epi-pen		<input type="checkbox"/> Other _____
<input type="checkbox"/> ASTHMA				
Triggers: <input type="checkbox"/> Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) _____ <input type="checkbox"/> Other (list) _____				
Does your child experience asthma symptoms with exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Symptoms:				
<input type="checkbox"/> Chest tightness, discomfort, or pain <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Coughing <input type="checkbox"/> Wheezing <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Is peak flow monitoring used? <input type="checkbox"/> No <input type="checkbox"/> 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) Complex Partial Generalized Tonic-Clonic (Grand Mal/Convulsive)
 Other (explain) _____

Physical Education Restrictions: No Yes

Medication(s): No Yes List medication(s) _____

Date of last seizure _____ Length of seizure _____

OTHER HEALTH CONDITIONS

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

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): _____

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

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

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

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

 School Nurse Signature

 Date

Notes:

RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE

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 No2. 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 No3. If training has not occurred, may the school nurse conduct a training program? Yes No_____
Licensed Provider's Signature _____ Date _____

ZACHARY COMMUNITY SCHOOLS

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