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.

**<u>STUDENTS MAY NOT BRING THE MEDICATION TO SCHOOL.</u> **
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: 654-6392
Fax: 654-6011

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

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

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

Rollins Place Elementary
Phone: 654- 8207
Fax: 658-1940

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

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

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 in order 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 #**: _____

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

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