

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 ☐ 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
3. If training has not occurred, may the school nurse conduct a training program? ☐ Yes ☐ No

Licensed Provider's Signature_____
Date

Parental Consent for Administration of Medication

I, the undersigned parent/guardian of the minor child, _____, a student at
Student's Name

MAX Charter School, hereby request the MAX Charter School to administer _____
Name of Medication

as prescribed by _____ from _____ to _____ under
Prescribing Doctor Start Date End Date

the supervision of the nurse or designated, unlicensed, trained school personnel.

The medication is to be furnished by me and labeled as detailed in the medication administration policy. I assume all responsibility for mistakenly furnishing incorrect dosage. I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if not picked up following termination of the order or end of the school year. I hereby relieve and discharge the MAX Charter School Board, and/or any of its agents or employees from any and all liability for any injury or damage to the health of said child arising out of, or resulting from the necessity of said child having to take medication during school hours. I give permission to the school nurse to share with appropriate school personnel information relative to the medication necessary for my child's health and safety.

_____	Yes	_____	No	I give permission to the school nurse to share with appropriate school personnel information relative to the medication necessary for my child's health and safety.
_____	Yes	_____	No	I have administered the initial dose at home and have allowed sufficient time to observe for adverse reactions.
_____	Yes	_____	No	I have received a copy of the medication administration policy, which can be found on MAX Charter School's website.

NOTICE: This section to be completed only for students who will administer his/her own medication.

_____	Yes	_____	No	I give permission for my child to self-administer medication if the school nurse determines it is safe and appropriate.
_____	Yes	_____	No	My child is sufficiently responsible and informed to administer his/her own medication.
_____	Yes	_____	No	I assume responsibility for my child's actions in his/her self-management of medication at school.
_____	Yes	_____	No	I understand that medication orders must be provided for students who self-administer medication at school, including when there is a medication change.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____

Best Phone # in case of Emergency: _____

STATE OF LOUISIANA

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

PART 1: CONTACT INFORMATION

Student's/Child's Legal Name	Date of Birth	Social Security #
Parent/Legal Guardian _____		Telephone # _____
Mailing Address _____		

PART 2: RECORD REQUESTComplete box A **OR** box B below. Both boxes may not be completed on the same form.

A. Specify the records to be released for the treatment date(s) listed below in Part 3: ☐ COMPLETE RECORD(S) ☐ Discharge Summary ☒ History & Physical ☐ Operative Report ☒ Consultation ☒ Progress Notes ☐ Cardiopulmonary (Indicate EKG, Stress Test, Sleep Study) ☐ Emergency Room ☐ Lab ☐ Pathology ☐ Radiology Results ☐ Other _____	B. If initialed below, I specifically authorize release of the following: Psychotherapy notes and records indicating psychological or psychiatric impairment(s) _____ Initials of parent/legal guardian
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PART 3: AUTHORIZATION

This does not authorize the release of the following: drug and alcohol use counseling and treatment and HIV/AIDS and sexually transmitted disease testing and treatment.

I authorize:

Name: _____ The MAX Academy _____ (School System)

☐ TO RELEASE Information TO AND/OR ☒ TO OBTAIN Information FROM
 (Place an "X" in the box that indicates if the information is being released AND/OR requested.)

Name: _____ (Hospital, Physician, Service Agency, School RN and/or other health provider)

For treatment date(s): _____

The information is to be released for the purpose(s) of:

- | | |
|--|--|
| ☐ Evaluation to determine eligibility or continued eligibility for special education services
☐ Providing physical therapy treatment
☐ Providing occupational therapy treatment | ☐ Designing an individual educational program
☐ Determining appropriate placement for treatment needs
☒ <u>Development of Individualized Healthcare Plan</u> |
|--|--|

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the same medical records department receiving this authorization form. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.

If I fail to specify an expiration date, event or condition, this authorization will expire in nine (9) months from the date of authorization. An authorization is voluntary. I will not be required to sign an authorization as a condition of receiving treatment services or payment, enrollment, or eligibility for health care services. Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected under the Health Insurance Portability & Accountability Act of 1996.

 Signature of Student or Legal Representative
 (Parent/Legal Guardian must sign if student < 18)

 Date

 (Relationship to student)

 Signature of Witness

 Date