

## 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.*