Health Centers in Schools
A Partner of OUR LADY OF THE LAKE CHILDREN'S HEALTH

Dear Parent(s)/Guardian(s)

We would like to inform you of the school policies that have been put in place to ensure the health, safety and welfare of children who need medications during the school day. Also the policy for students who have been diagnosed with a disease process that do not require medication at school and those who have allergies to medications, food, substances and insects.

Students who have been diagnosed with a disease process must be identified at the beginning of the school year, so that procedures can be put in place to accommodate there special needs. This includes completion of health plans, special diet request forms, consents, authorizations and medication order.

Our school board requires that the following forms must be on file in your child's health record before we can begin to give any medications:

1. Signed consent by the parent or guardian to give the medication. Please complete the enclosed consent form and give it to your school nurse.

2. Signed medication order. The written medication order form should be taken to your child's licensed prescriber (physician, dentist, nurse practitioner etc,) for completion and return to the school nurse. This order must be renewed as needed and also at the beginning of each school year

3. Signed and completed authorization for release of information.

Medication should be delivered to the school nurse, or designated person, in a container with a label from the pharmacy by either you or a responsible adult whom you designate. Please ask your pharmacy to provide separate bottles for school and home use. No more than one month's supply (twenty-five school days) of the medication shall be kept at the school. Medications can only be kept in backpack by students who have a release forms and consents on file to carry and administer his/her medication.

When your child needs medication to be given during the school day, please act quickly to follow these policies so that we can give the medication as soon as possible.

If you have any questions please call the school at _____ leave your name and phone number and the school nurse will return your call.

Thank you for your cooperation.

Sincerely yours,

School Nurse _____ Fax#: 225-343-9141

EAST BATON ROUGE PARISH SCHOOL MEDICATION POLICY

SECTION TWENTY-FIVE – MEDICATION

1. In accordance with La. R.S. 17:436.1, La. Admin. Code, Title 28 Part CLVII (Louisiana Department of Education (LDE) Bulletin 135—Health and Safety), School-Based Nursing Services in Louisiana Schools (LDE 2015), and School Board policy, medication shall not be taken or given at school or school-related functions when other reasonable options exist. When no reasonable alternative exists due to the student's specific health needs, the parent/guardian may request in writing that medication be administered during the school day. The written request must include:

a. Certification by the student's attending physician or other authorized healthcare professional licensed in Louisiana or adjacent state that administration of the medication to the student during the school day is medically necessary and cannot be administered before or after school hours; and

b. A medical order signed by the treating physician or other authorized healthcare provider prescribing within the scope of his or her prescriptive authority; and

c. Written authorization of the student's parent or guardian.

2. For purposes of this policy, the term "medication" means all medicines including those prescribed by a licensed health care provider and any non-prescription (over-the-counter) drugs, preparations, and/or remedies, including those taken by mouth, inhaler, those that are injectable, and those applied as drops to eyes, nose, or medications applied to the skin. Sunscreen shall be exempt from the definition of medication and may be self-administered by students or voluntarily applied by school employees with written consent of a parent/guardian.

3. Students shall not be allowed to have medications in their possession on the school grounds or at school-related functions, except as provided in paragraph 4, below.

4. The possession, use, or sale of prescription or non-prescription medication by a student or the giving of, any type of medication to another student at school, on the school bus, or other school function is strictly prohibited and subject to disciplinary action, except that students with asthma and those at risk of anaphylaxis shall be allowed to carry, possess, and self-administer prescribed pre-measured medications (e.g., inhalers land auto-injectable epinephrine "EpiPen") in accordance with physician's orders and specific procedures established by the School Board.

The school and its employees shall incur no liability because of any injury sustained by the student from self-administration of medications used to treat asthma or anaphylaxis. The parent or other legal guardian of a student shall sign a statement acknowledging that the school shall incur no liability and that the parent or other legal guardian shall indemnify and hold harmless the school and its employees against any claims that may arise relating to the self-administration of medications used to treat asthma and anaphylaxis. Interested parties are urged to contact the school principal or school nurse for applicable forms and detailed information regarding the procedural requirements for obtaining authorization for self-administration of medication at school.

5. In no case shall medication be used or administered during school hours or school-related functions without all the following:
a. An order from a licensed medical physician or other authorized prescriber in Louisiana or adjacent state which includes the student's name; name, signature, business address, office phone number, and emergency phone numbers of the physician or other authorized healthcare prescriber; the frequency and time of the medication; the route and dosage of the medication; and a written statement of the desired effects and any student-specific potential for adverse effects;

b. Signed, written consent of the parent or legal guardian. (Forms are available at each school);

c. Medication must be provided to the school by the parent or guardian in the container that meets acceptable pharmaceutical standards;

d. The medication container shall contain clear instructions identifying the student's name; name, address, and telephone number of the pharmacy; prescription numbers; date dispensed; clear instructions for use; drug name and strength; last name and initial of pharmacist; cautionary auxiliary labels, if applicable; physician's dentist's, or other authorized healthcare prescriber's name. Labels of prepackaged medications shall contain the medication name; dosage form; strength; quantity; name of manufacturer or distributor; and manufacturer's lot or batch numbered;

e. At the beginning of each school year and anytime there is a change in medication, a new form from the physician or other licensed prescriber licensed in Louisiana must accompany the new prescription; and

f. No more than one month's supply (twenty-five school days) of the medication shall be kept at school.

6. Disposition of medication at the end of the school year. Medication shall be picked up by the parent/guardian within 5 days of the end of the academic year. Medication not picked up will be destroyed or otherwise disposed of in accordance with the law and accepted practice.

7. A school nurse or trained school employee shall be authorized to administer auto-injectable epinephrine as defined in La. R.S. 17:436.1(J)(4)(a) to a student who the school nurse or trained school employee, in good faith, professionally believes is having an anaphylactic reaction, whether such student has a prescription for epinephrine.

Parents are urged to notify the student's teacher and principal, in writing, in the event the student has an allergy or other condition which may put the student at risk of anaphylaxis.

**** This section provides a basic summary of procedures for medication administration and use in the school environment. Please contact the school principal or school nurse for procedures applicable to medication administration for specific diseases, conditions, and treatments. Parents/guardians and majority-aged students are urged to notify school authorities about their medical circumstances so that appropriate supports can be made available.**

SECTION TWENTY-SIX - COMMUNICABLE DISEASE CONTROL POLICY

Current and satisfactory evidence of immunization against vaccine-preventable diseases (e.g., immunization records) is required for all students entering school for the first time (including pre-kindergarten and kindergarten), for students transferring from another school system, and for all students entering the sixth grade. Such evidence shall be in compliance with the immunization schedules established by the Office of Public Health, Louisiana Department of Health, unless compliance is waived pursuant to Louisiana law.

School personnel shall cooperate with public health personnel in completing and coordinating all immunization data, waivers and exclusions, including the forms required by the Louisiana Department of Health to facilitate control of preventable communicable diseases.

In the event of an outbreak of a vaccine-preventable disease at school system facility, the EBRPSS administration may, upon the recommendation of the office of public health, exclude from attendance unimmunized students until the appropriate disease incubation period has expired or the unimmunized student presents evidence of immunization.

If the student's physical condition indicates that the health of the student does not safely allow his/her continued attendance at school, the student will remain away from school until the student's physician and/or a physician of the School Board's choice verifies that the student can safely return to the regular school environment.

Infected students shall inform appropriate school officials of the infection so that proper precautions for the protection of the other students, employees, and the infected student can be taken.

If the student's physician's and/or a School Board-selected physician indicates that the health of the student does not allow his continued attendance in the regular education program, education services will be provided in a setting that is appropriate to the health status of the child.

The identity of an infected individual, or an individual who there is reasonable cause to believe is an infected individual, shall be revealed only to those who have a need to know. If an infected individual is permitted to remain in the school setting after a determination has been made, employees who will have regular personal contact with the individual shall be informed of information as to the individual's medical condition.
Persons informed of the identity of an infected person shall not disclose such information to others except as authorized under this policy.

The determination of whether an infected student shall be permitted to remain in school in a capacity that involves contact with students or employees shall be made on a case-by-case basis as determined by the Superintendent and appropriate staff.

SECTION TWENTY-SEVEN – STUDENTS WITH DIABETES

For parents of a student with diabetes who seeks care for the student's diabetes while at school or while participating in a school related activity, the parents shall submit a diabetes management and treatment plan, which plan must be updated on an annual basis. Such plan shall be developed by a physician or other licensed health provided recognized by the Centers for Medicare and Medicaid services who is selected by the parent or guardian to be responsible for such students and diabetes treatment and a current copy of such plan shall be kept on file at the school in which the student is enrolled.

A student diabetes management and treatment plan shall contain:
(1) an evaluation of the student's level of understanding of its conditions and its ability to manage his diabetes.

(2) the diabetes related healthcare services the student may receive or self-administer at school or during a school related activity.

(3) A time table, including dosage instructions, of any type of diabetes medication to be administered to the student or self-administered by the student.

(4) the signature of the student, the student's parents or legal guardian and the physician responsible for the student's diabetes treatment.

The school nurse shall provide care to the student with diabetes or assist the student with self-care of his or her diabetes, in accordance with the student's diabetes management and treatment plan on file with the school. If the school nurse is unavailable, an unlicensed diabetes care assistant may provide care to a student with diabetes or assist a student with self-care of his or her diabetes. "Unlicensed diabetes care assistant "shall mean as such a school employee who volunteers and is trained in accordance with provisions of

La. R.S.17:436.3(C)(1) or also an employee of an entity that contracts with the school or school system to provide school nurses who are responsible for providing healthcare services required by law or Department of Education regulation. (La. R. S. 17:436.3(C)(1)).

The East Baton Rouge Parish School System and all of its entities (including Career and Technical Education Programs) does not discriminate on the basis of age, race, religion, national origin, disability or gender in its educational programs and activities (including employment and application for employment), and it is prohibited from discriminating on the basis of gender by Title IX (20 USC 168) and on the basis of disability by Section 504 (42 USC 794). The Title IX Coordinator is Andrew Davis (ADavis6@ebrschools.org), Director of Risk Management - phone (225)929-8705; and the Director of Exceptional Student Services is Elizabeth Taylor Chapman (ETaylor@ebrschools.org) – phone (225)929-8600.

FINAL 11/06

OUR LADY OF THE LAKE CHILDREN'S HEALTH

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

EBRP PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

(Please Print)

Student: _____ Birthdate: _____ Grade: _____

School: _____ Teacher: _____

Parent/Guardian: _____ Address: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Other persons to be notified in case of emergency:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Medication to be given at school: _____

Special Instructions for giving your child this medication: _____

List all allergies: _____

List all medications student takes at home: _____

The following questions must be answered in order for your child to receive medications at school; all answers must be "Yes" before the medication can be administered at school by unlicensed trained personnel.

1. Have you received and reviewed the EBRP School Board 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__**
3. Are there any restrictions on this release? _____
4. 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__**
5. 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__** (with the exception of epinephrine)

Use this box ONLY for a student who will administer his/her own medication, such as asthma inhaler. The student will be required to record each dose.

1. Do you give permission for your child to self administers medication if the school nurse determines it is safe and appropriate in the school setting? **Yes__ No__**
2. Do you believe your child is sufficiently responsible and informed to administer his/her own medication? **Yes__ No__**
3. Do you assume responsibility for your child's actions in his/her self management of medication at school? **Yes__ No__**
4. Do you understand that regular medication orders must be provided by a physician for students who self administer medications at school? **Yes__ No__**

Authorization for release of information completed? Yes ____ No ____

I understand and agree that EBRP 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.

_____ _____

Parent/ Guardian Signature Date

OUR LADY OF THE LAKE CHILDREN'S HEALTH

FINAL 11/06

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 #
X	X	N/A

Parent/Legal Guardian X Telephone # X

Mailing Address _____

PART 2: RECORD REQUEST

Complete 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 Medical History Update

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

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: HCS School Nurse / OLOL FMOLHS (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: (Physician name) X (Hospital, Physician, Service Agency, School RN and/or other health provider)

For treatment date(s): Current

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
- ☒ To design and implement an Individual School Health Plan

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.

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

X	X
Signature of Witness	Date

Health Centers in Schools
A Partner of OUR LADY OF THE LAKE CHILDREN'S HEALTH

MEDICAL HISTORY UPDATE FORM

To Be Completed By Doctor

(This information will be utilized by the School Nurse to provide health services to students)

Student's Name_____ **D.O.B.**_____

School_____ **Teacher/Grade**_____ **School Nurse**_____

CURRENT DIAGNOSIS & MEDICAL STATUS (*additional information may be attached)*

_____

_____

_____

MEDICATIONS:_____

_____

Allergies:_____

Recommendations For Student Integration Into The School Setting

*ActivityRestrictions/Limitations*_____

_____

_____

*Accommodations*_____

_____

_____

*Nutritional /Dietary*_____

_____

_____

*AdaptivePhysicalEducation*_____

_____

_____

*PhysicalTherapy*_____

_____

_____

*OccupationalTherapy*_____

_____

_____

*SpecialProcedures*_____

_____

_____

_____

*Return To Clinic*_____

Physician's Signature_____ ***Date***_____

Printed Physician's Name or Stamp_____

Phone#_____ ***Fax#***_____