Lake Castle Slidell Private School

"Excellence in Education"
Established 1987

59461 La. Hwy. 433
Slidell, Louisiana 70460
(985) 641-3363
www.lakecastleschool.com

Brian J. Butera
Principal
Susan K. Eckholdt
Assistant Principal

Procedure for Administering Medication at School

It is our foremost recommendation that any medication be administered by a parent at home, or that a parent come to school to administer medication to his/her child. In extraordinary circumstances, medication may need to be administered at school. In that case, our procedure is as follows:

1. No medication shall be administered without an order from a licensed physician, dentist, or other authorized prescriber. The **"Request for Administering Medication at School and Release from Liability"** form shall accompany the order.
2. Our administration will administer ONLY what a parent has brought directly to the office clearly marked with the child's name and specific instructions. These instructions are to be distinctly set forth on the school's **"Request for Administering Medication at School and Release from Liability"** form, which is to be completed, signed, and dated by the parent or guardian of the child, and by the child's physician. This form can be obtained from the school office. **No over-the-counter medication will be administered by the office without a physician's specific authorization set forth on the form.**
3. At NO time shall any child be allowed to have in his/her possession ANY medication whatsoever. This includes throat lozenges, cough drops, eye drops, etc.
4. If a child has any medical condition that arises while at school, such as headache, cramping, earache, itchy skin, etc., the parent will be called and the parent may either pick up the child or come to school to administer the medication.
5. Unless otherwise indicated on the medication form, all medication will be destroyed if it is not picked up within two weeks of the date of the form.

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Request for Administering Medication at School and Release from Liability

This form MUST be completed by the parent and, where indicated, student's physician before ANY medication is administered.

DATE: _____

Name of Student: _____
LAST FIRST MIDDLE NICKNAME

Student's Date of Birth: _____ Sex: M F
(CIRCLE ONE)

Teacher: _____ Grade: _____

Name of Parent/Guardian: _____

Telephone Numbers: Home _____
(INCLUDE AREA CODES)

Work _____ Cell _____

Student Allergies: (list medication, food, etc. to which student is allergic) _____

I, _____, hereby give permission for the
PARENT'S NAME (PRINT)
school administration/teacher, or other unlicensed person to give the following medication to my child (describe in detail):

Prescribed by: _____
PHYSICIAN'S NAME

I give permission to the school administration to share with appropriate school personnel information (such as adverse side effects) relative to the prescribed medication administration as the administrator determines necessary for my child's health and safety. I have administered the initial dose at home and have allowed sufficient time for observation of adverse reactions before asking school personnel to administer the medication.

_____ DATE: _____
SIGNATURE OF PARENT OR GUARDIAN

(THIS FORM CONSISTS OF TWO PAGES—SEE REVERSE)

TO BE COMPLETED BY A LICENSED PHYSICIAN OR DENTIST

STUDENT: _____ Date of Birth: _____

NAME OF LICENSED PRESCRIBER: _____

OFFICE PHONE: (_____)_____ EMERGENCY: (_____)_____

DIAGNOSIS _____

MEDICATION _____ Desired Effects: _____

DOSAGE _____ FREQUENCY _____

Specific Directions or Information for Administration: _____

Date of Order: _____ Discontinuation Date: _____

Contraindications to this Medication or Specific Effects to this Student: _____

Please list other medications taken by this student outside of school: _____

If student will self-administer his/her own medication, such as an asthma inhaler or other emergency medication, 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?

YES _____ NO _____

_____ _____

PHYSICIAN'S SIGNATURE DATE

PARENTAL CONSENT FOR STUDENTS WHO WILL SELF-ADMINISTER HIS/HER OWN MEDICATION, SUCH AS ASTHMA INHALER, INSULIN, OR OTHER EMERGENCY MEDICATION

Do you give permission for your child to self-administer medication? YES _____ NO _____

Do you feel that 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 medication at school? YES _____ NO _____

_____ _____

PARENT'S SIGNATURE DATE