PHYSICIAN MEDICATION FORM

(Request for medication administration at school to be completed by Louisiana licensed Physician or dentist.)
In most instances, medication will be administered by unlicensed trained school personnel.

STUDENT: ______________________ DOB: __________ SCHOOL: ______________________

STUDENTS DIAGNOSES (all): ______________________

MEDICATION: ______________________ GENERIC: ______________________

STRENGTH: ______________________

AMOUNT PER DOSE: ______________________ TIME OF EACH DOSE: ______________________

(Whenever possible, medication should be scheduled at times other than school hours)

CHECK BELOW WHICH ROUTE:

Oral: __________ Premeasured aerosol inhalation: __________ Topical: __________
(Only Ointments for diaper rash accepted)

GIVE MEDICATION: (1) Until end of school term: __________
(2) Other ______________________
(give dates)

WATCH FOR AT SCHOOL ______________________

Use this section only for students who will carry and administer their own medication; such as students using an inhaler.
Has this student been adequately instructed by you or your staff and demonstrated competence in self-administration of this medication to the degree that he/she may self-administer his/her medication at school.
YES __________ **NO** __________

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PHYSICIAN/DENTIST SIGNATURE

____
DATE

PHYSICIAN'S NAME: ______________________ TITLE: ______________________

ADDRESS: ______________________ TELEPHONE # ______________________

Note: Any future change in directions for this medication requires new medication orders.
Each medication ordered must be written on a separate order form.
Orders sent by fax are acceptable.