Great Hearts Louisiana, Inc.

MEDICATION ADMINISTRATION POLICY

Approved: September 13, 2023

Our Governing Board of Directors for Great Hearts Louisiana, Inc. has developed and adopted the following policy to ensure the health, safety, and welfare of students who require medications during the school day.

This policy will be reviewed and revised annually as necessary.

Definitions

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 the eyes or ears, and medications applied to the skin. Sunscreen shall be exempt from the definition of medication and may be self-administered by students or voluntarily administered by school employees with written consent from parent/ guardian.

Policy

In accordance with La. R.S. 17:436.1, La. Admin. Code, Title 28 Part CLVII (Louisiana Department of Education (LOE) Bulletin 135-Health and Safety), School-Based Nursing Services in Louisiana Schools (LOE 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:

1. 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.
2. A medical order signed by the treating physician or other authorized healthcare provider prescribing within the scope of their prescriptive authority; a cannot be administered before or after school hours.
3. Written authorization of the student's parent/guardian.

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

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 Board and school nurse.

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. Parents/guardians of a student shall sign a statement acknowledging that the school shall incur no liability and that the parent/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 encouraged to contact the Head of School or school nurse for applicable forms containing detailed information regarding the policies and procedures for self-administration of medication at school.

In no case shall medication be used or administered during school hours or school-related functions without all the following:

1. 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.
2. Signed and written consent of the parent/guardian. (Forms are available at the school)
3. Medication must be provided to the school by the parent/guardian in a container that meets acceptable pharmaceutical standards.
4. 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; the physician, dentist, 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.
5. 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
6. No more than one month's supply (twenty-five school days) of the medication shall be kept at school.

Disposition of Medication at the End of the School Year

Medication shall be picked up by the parent/guardian within 3 days of the end of the academic year. Medication not picked up will be destroyed or otherwise disposed of in accordance with Louisiana law and accepted practice.

Guidelines for Self-Administration of Medications by Student

The governing authority of each public elementary and secondary school shall permit the self-administration of medications by a student with asthma or diabetes or the use of auto-injectable epinephrine by a student at- risk of anaphylaxis, provided that the student's parent/guardian provides the school in which the student is enrolled with the following documentation:

1. Written authorization for the student to carry and self-administer such prescribed medications.
2. Written certification from a licensed medical physician or other authorized prescriber that the student:
    a. Has diabetes, asthma or is at risk of having anaphylaxis.
    b. Has received instruction in the proper method of self-administration of the student's prescribed medications to treat asthma, diabetes or anaphylaxis.
3. A written treatment plan from the student's licensed medical physician or other authorized prescriber for managing diabetes, asthma, or anaphylactic episodes.
4. The treatment plan must be signed by the student, the student's parents/guardians, and the student's licensed medical physician or other authorized prescriber and shall also contain the following information:
    a. The name, purpose, and prescribed dosage of the medications to be self-administered.
    b. The time or times the medications are to be regularly administered and under what additional special circumstances the medications are to be administered.
    c. The length of time for which the medications are prescribed.
5. Any other documentation required by the governing authority of the public elementary or secondary school.
6. Documentation related to the administration of medication shall be kept on file in the office of the school nurse or other designated school official.

The parent/guardian of the 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, diabetes, or anaphylaxis.

A student who has been granted permission to self-administer medication shall be allowed to carry and store with the school RN or other designated school official an inhaler, auto-injectable epinephrine, or the diabetes medication delivery system, at all times.

Permission for the self-administration of asthma or diabetes medications, use of auto-injectable epinephrine by a student shall be effective only for the school year in which permission is granted. Permission for self-administration of asthma or diabetes medications, and/or the use of auto-injectable epinephrine by a student shall be granted each subsequent school year, provided all of the requirements stated above are fulfilled.

Upon obtaining permission to self-administer asthma or diabetes medication and/or auto-injectable epinephrine pursuant to this section, a student shall be permitted to possess and self-administer such prescribed medication at any time while on school property or while attending a school-sponsored activity.

A student who uses any medication permitted in a manner other than as prescribed shall be subject to disciplinary action; however, such disciplinary action shall not limit or restrict such student's immediate access to such prescribed medication.

Students with diabetes shall be permitted to attend to the self-management, administration of medications, treatment and documentation as outlined in his/her Diabetes Management and Treatment Plan on file at the school in which the student is enrolled.

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

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A NOTE FROM THE SCHOOL NURSE

Dear Parent(s)/Guardian(s):

Great Hearts Harveston would like to inform you of the school policies that have been put in place to ensure the health, safety, and welfare of students who require medications during the school day.

Great Hearts Harveston in accordance with Louisiana State Board of Education, Louisiana State Board of Nursing, and East Baton Rouge Parish public schools requires that the following forms must be on file in your student's health record before we can begin to give any medications:

1. Signed consent by the parent/guardian to give the medication. Please complete the enclosed consent form and give it to the school nurse.
2. Signed medication order. The written medication order form should be taken to your student's licensed prescriber (physician, dentist, nurse practitioner, etc.) for completion and be returned to the school nurse. This order must be renewed as needed and 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 25) day supply of the medication should be delivered to the school.

When your student needs medication that is prescribed to be given during the school hours of 9:00 a.m. and 2:00 p.m., please act quickly to follow these policies so that the school can give the medication as soon as possible.

If you have any questions, please call the school at (225)416-7611 leave your name and phone number and the school nurse will return your call.

Thanks for your Consideration,

School Nurse

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PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

(Please Print)

Student: _____ Birthdate: _____ Parent/Guardian: _____

School: _____ Grade: _____ Teacher. _____

Address: _____Home/Cell Phone: _____ Business Phone: _____

Persons to be notified in case of emergency:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Medication to be given at school:

Special Instructions:

List all allergies:

List of medications taken at home:

The following questions must be answered yes to allow your child to receive medications at school via the school nurse or trained school employee.

1. Have you received and reviewed the Great Hearts Academy of Louisiana Medication Policy? Yes___ No____
2. Do you give permission for the school nurse to share with designated trained unlicensed personnel information about your student relative to medication administration as the nurse deems necessary? Yes___ No____
3. Are there any restrictions on the release of medical information?
   _____
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 3 days following the end of term or when medication orders have been discontinued? Yes___ No____
5. Have you administered the initial dose at home and allowed for sufficient time (1-2 weeks) for observation of adverse reactions before asking school personnel to administer the medication? Yes___ No___

Answer the questions listed below only if your student has medication orders from their ordering prescriber to self-administer their own medication, such as an asthma inhaler or EpiPen.

1. Do you give permission to your student to self-administer medication if the school nurse determines it is safe and appropriate in the school setting? Yes____ No____
2. Do you believe that your student is sufficiently responsible and self- aware to administer their own medication? Yes____ No ____
3. Do you assume responsibility for your student's actions in their management of their medication while at school? Yes____ No____
4. Do you understand that regular medication orders must be provided with an ordering prescriber specifically stating that a student can self- administer medication while at school? Yes___ No____

I understand that, in accordance with Louisiana State Board of Education, Louisiana State Board of Nursing, East Baton Rouge Parish School System, and Great Hearts Academy of Louisiana: Great Hearts Academy of Louisiana's school nurse and or employees are not responsible for any unintentional mistakes or oversights in keeping or giving my child medication. I agree to hold the East Baton Rouge Parish School Board and Greats Hearts Academy of Louisiana from liability from injuries which might occur as a result of the administration of medications by school employees.

_____	_____	_____
Parent/Guardian Name	Parent/Guardian signature	Date

FINAL 11/06

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

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 #

Parent/Legal Guardian _____ Telephone # _____

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 _____

_____

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: _____ (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
- ❑ _____

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