SACRED HEART OF JESUS SCHOOL
2251 Main Street • Baton Rouge, Louisiana 70802 • 225-383-7481 • Fax 225-383-1810

MEDICATION ADMINISTRATION ORDER

Request for medication administration at Sacred Heart School is to be completed by a licensed Physician or Dentist, ***One medication order per sheet.*** In some circumstances, medication will be administered by unlicensed, trained school personnel.

STUDENT NAME: _____ GRADE: _____ DOB: _____
STUDENT'S DIAGNOSES (ALL): _____
STUDENT'S GENERAL HEALTH STATUS: _____
ALLERGIES: _____
MEDICATION to be administered: _____
DESIRED EFFECT: _____
DOSE TO BE ADMINISTERED: _____ TIME TO BE GIVEN: _____
ROUTE OF ADMINISTRATION (check one): by mouth: ___, inhalation: ___ injection: ___
Date to begin: _____ Date to end: _____
LIST CONTRAINDICATIONS OR CHILD SPECIFIC POTENTIAL ADVERSE EFFECTS TO MONITOR AT SCHOOL: _____
_____
RESTRICTIONS: _____
NOTIFY MD IF: _____
OTHER MEDICATIONS BEING TAKEN AT HOME BY THIS STUDENT:
_____

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USE THIS SECTION ONLY FOR STUDENTS WHO WILL SELF-ADMINISTER AN INHALER/MEDICATION.

This student has been adequately instructed by me or my staff and demonstrated competence in self-administration of this inhaler/medication to the degree that he/she may self-administer his/her medication at school provided the school nurse has determined it is safe and appropriate for this student at this time.

Yes _____ No _____

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COMMENTS: _____

_____ _____
Date Physician/Dentist Signature

Physician/Dentist Name (Please Print) _____ Office Phone: _____
Office Address: _____

PARENT SIGNATURE:
I request that my child be given the medication ordered above by the physician/dentist. I have reviewed the Sacred Heart School Medication policy found on the back of this form (or on the SHS, website - - Sacredheartbr.com - - Nurses Station-.)

_____
Parent or Guardian signature.