PHYSICIAN'S AUTHORIZATION FOR SPECIAL HEALTH CARE

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN AND PHYSICIAN

Part 1: CONTACT INFORMATION							
Student Name	Last	First	M.I	Sex ❑M ❑F	DOB	Grade	School Year

I hereby request that the treatment specified below be performed on my child I understand the procedure/treatment may be performed by trained, unlicensed personnel

Parent or Legal Guardian Name (print) ____________ Parent/Legal Guardian's Signature ____________ Date ________

PART 2: PHYSICIAN TO COMPLETE.

PHYSICAL CONDITION FOR WHICH THE STANDARDIZED PROCEDURE IS TO BE PERFORMED:

____

____

NAME OF STANDARDIZED PROCEDURE: Please use a separate form for each procedure.

❑Catheterization Type/Size of Catheter ____________ Lubricant (if any) ____________

Cleaning Solution ____________ ❑Betadine ❑Wipes ❑Other ____________

❑Gastrostomy care Formula ____________ Amount ________ Amount Flush ________

❑Suctioning Type ❑Oral/Pharyngeal ❑Trach

Equipment· ❑Bulb Suction ❑Yankauer ❑Suction Catheter

❑Tracheostomy care Type/Size Trach ____________

❑Oxygen. Amount ________ ❑Nasal Cannula ❑Type Mask ________

❑Blood Glucose Monitoring

❑Other ____________

TIME SCHEDULE AND/OR INDICATION FOR THE PROCEDURE:

____

PRECAUTIONS, POSSIBLE UNTOWARD REACTIONS, AND INTERVENTIONS:

____

____

THE PROCEDURE IS TO BE CONTINUED AS ABOVE UNTIL: ❑End of Session or until ________ (Date)

Physician Name (print) ____________ Physician's Signature ____________ Date ________

Address ____________ Phone ________ Fax ________

RETURN COMPLETED FORM TO SCHOOL NURSE AS SOON AS POSSIBLE

CONFIDENTIAL

INDIVIDUALIZED HEALTHCARE PLAN
IHP
Louisiana Department of Education

Student's Name______________________ Date of Birth ______________ ❑Special Education

School __________________________________ Grade ________ ❑General Education

BACKGROUND INFORMATION/NURSING ASSESSMENT (Complete all applicable sections.)

Brief Medical History/Specific Health Care (Additional information is attached)

Psychosocial Concerns ❑Yes ❑No
(Additional information is attached.)

Family Concerns/Strengths ❑Yes ❑No
(Additional information is attached.)

GOALS AND ACTIONS Individualized Healthcare Plan (IHP) Attach nursing diagnoses, interventions and evaluation, etc

Attach physician's order and other standards for care

1) Procedures and Interventions (student specific)

Procedure	Administered By	Equipment	Maintained By	Authorized/Trained By
(a)				
(b)				
(c)				

2) Medications: ❑No ❑Yes (If yes, attach medication guideline and administration log.

3) Diet: ❑No ❑Yes (If yes, attach description)

4) Special Transportation Needs: ❑No ❑Yes
Additional information is attached

5) Class/School Modifications: ❑No ❑Yes
(If yes, attach additional information)

6) Equipment and Supplies: ❑Parent ❑LEA ❑None

7) Safety Measures: ❑No ❑Yes (If yes, attach description)

8) Student Participation in Procedures ❑No ❑ (If yes, attach description)

CONTINGENCIES
____ Emergency Plan attached
____ Training Plan attached

POSSIBLE ALERTS

AUTHORIZATIONS I have participated in the development of the Health Services Plan and agree with the contents. Please sign and date

Parent//Legal Guardian ____________________ / /
School Nurse ____________________ / /
School Administrator ____________________ / /
Teacher(s)____________________ / /
Other ____________________ / /
Other____________________ / /

Effective Beginning Date__________________ Next Review Date__________________

STATE OF LOUISIANA
MEDICATION ORDER
TO BE COMPLETED BY LA, TX, AR, OR MS LICENSED PRESCRIBER

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE

Student's Name ______________________________

DOB ______________________________

School ______________________________ Grade ____________

Parent or Legal Guardıan Name (prınt)· ______________________________

Parent or Legal Guardıan Signature ______________________________ Date ____________

(Please note A parental/legal guardıan consent form must also be filled out Obtaın from the school nurse)

PART 2: LICENSED PRESCRIBER TO COMPLETE

1 Relevant Dıagnosıs(es) ______________________________
2 Student's General Health Status: ______________________________
3 Medıcatıon. ____________ Strength of medication _Dosage (amount to be gıven) _____

Route ❑By mouth ❑By ınhalatıon ❑Other ________ Frequency ______ Tıme of each dose __________

ALL PRN MEDICATION MUST DENOTE TIME INTERVAL BETWEEN DOSAGE
School medıcatıon orders shall be lımıted to medıcatıon that cannot be admınıstered before or after school hours
Specıal cırcumstances must be approved by school nurse

4 Duratıon of medıcatıon order· ❑Untıl end of school term ❑Other ______________
5 Desıred Effect ______________________________
6 Possıble sıde-effects of medıcatıon ______________________________
7 Any contraindicatıons for admınıstering medıcatıon ______________________________
8 Allergıes to food or medıcıne ınclude ______________________________
9 Other medıcatıons taken at home ______________________________
10 Next vısıt ıs ______________________________

Licensed Prescrıber's Name (Prınted)	Address	Phone/Fax Numbers
Licensed Prescrıber's Sıgnature	Credentıals (ı e , MD, NP, DDS)	APRN # Date

Each medıcatıon order must be written on a separate order form Any future changes ın dırections for medıcatıon ordered require new medıcation orders Orders sent by fax are acceptable Legıbılıty may requıre maılıng orıgınal to the school Orders to dıscontınue also must be wrıtten

PART 3: LICENSED PRESCRIBER TO COMPLETE AS APPROPRIATE

Inhalants / Emergency Drugs

Release Form for Students to be Allowed to Carry Medıcatıon on Hıs/Her Person

Use thıs space only for students who wıll self-admınıster medıcatıon such as asthma ınhaler

1 Is the student a candıdate for self-admınıstratıon? ❑Yes ❑No

2 Has thıs student been adequately ınstructed by you or your staff and demonstrated competence ın self-admınıstration of medıcatıon to the degree that he/she may self-admınıster hıs/her medıcatıon at school, provıded that the school nurse has determined ıt ıs safe and appropnate for thıs student ın his/her partıcular school settıng? ❑Yes ❑No

Licensed Prescrıber's Signature	Credentials (ı e , MD, NP, DDS)	APRN #	Date