KESTREL HEIGHTS CHARTER SCHOOL

Dear Parent/Legal Guardian:

Our school has a written policy to assure the safe administration of medication to our students during the school day. If your child requires medication of any type, including over-the-counter drugs given during school hours, you have the following options:

- You may come to school and administer medication to your child at the appropriate time(s).
- You may obtain a copy of a medication form from the main office or on our website.
- Take the form to your child's doctor and have him/her complete the form by listing the medication(s) needed, dosage, and number of times per day the medication is to be administered. This form must be completed by the physician for both prescription and over-the-counter drugs. The form must be signed by the doctor and by you, the parent/ legal guardian. Prescription medicines must be brought to school in a pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. Over-the-counter drugs must be received in the original container and will be administered according to the doctor's written instructions.
- You may discuss an alternative schedule with your physician for administering medication (i.e., outside of school hours).
- Self-medication: In accordance with G.S. 115C-375.2 and G.S. 115C-47, students requiring medication for asthma, anaphylactic reactions, or both, and diabetes may self-medicate with physician authorization, parent permission, and a student agreement for self-carried medication.

- All medication must be picked up by the parent/legal guardian within fourteen days from the last day of the school year. Any medication not picked up will be properly disposed.

School personnel will not administer any medication to students unless they have received a completed medication form, signed by both the physician and parent/legal guardian, and the medication has been received in an appropriately labeled container.

Sincerely,

Ms. Suzanne Vargas

Admissions/LEA Data Coordinator

Kestrel Heights School

KESTREL HEIGHTS CHARTER SCHOOL

Student Agreement for Self-Carried Medication (Inhalers, Epi Pens and Insulin)

Student: _____ Grade: _____

Parent: _____ Telephone: _____

Health Care Provider: _____ Telephone: _____

Medication: _____

Dose: _____ Time: _____

Medication is permitted in accordance with state laws and district policy. Both student's health care provider and parent/guardian must complete Medication Authorization Form. Student's name must appear on inhaler/container.

RESPONSIBILITIES

- I plan to keep my insulin, inhaler, equipment, and/or Epinephrine auto injector with me at school.
- I agree to use my insulin, inhaler, equipment, and/or Epinephrine auto injector in a responsible manner, in accordance with my licensed health care provider's orders.
- I will notify the school staff (i.e., teacher, nurse) if I am having more difficulty than usual with my health condition.
- I will not allow any other person to use my insulin, inhaler, equipment, and/or Epinephrine auto injector.
- If I use the medication in a manner other than as prescribed, the school may impose disciplinary action according to the school's disciplinary policy.

Student's signature: _____ Date: _____

Parent signature: _____ Date: _____

For school officials:

❒ *Written statement, treatment plan and emergency action plan completed by the health care provider and on file at a location that is easily accessible*
❒ *Demonstrates correct use/administration.*
❒ *Recognizes proper and prescribed timing for medication.*
❒ *Agrees to carry medication.*
❒ *Knows health condition well*
❒*Keeps a second labeled container in health office or main office per G.S. 115C-375.2*

Administrative Signature: _____ *Date:* _____

KESTREL HEIGHTS CHARTER SCHOOL

Request for Any Medication Administration in School
To be completed by physician

Student: _____ Grade: _____

Medication: _____ Dosage: _____

Time(s) medication is to be given: a.m._____ p.m._____ Dates to be given: _____ to_____

Significant Information (include side effects, toxic reactions, and omission reactions):

_____

_____

Contraindications for Administration:

_____

_____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

a. Contact me at my office at telephone_____

b. Take child immediately to the emergency room at_____

FOR SELF-ADMINISTRATION -

❒ Student has demonstrated understanding of and ability to self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions and may carry and self-administer as prescribed.

❒ Parent/guardian should provide an extra inhaler to be kept at school in case of emergency

❒ All prescription medication for use at school will be furnished by parent or guardian in a container properly labeled by a pharmacist and over the counter medicine must be in the original container. All medicines must have identifying information, (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany this authorization form in accordance with the requirements stated in G.S. 115C –375.2

_____ Date_____

Physician's Signature

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for the school year, unless revoked.

_____ _____

Parent or Guardian's Signature Date