BONNIE CONE CLASSICAL ACADEMY

# Letter to Parent Regarding Administration of Medication in School

Dear Parent:

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

1. You may come to school and give the medication to your child at the appropriate time(s).
2. You may obtain a copy of a medication form ***(Request for Medication Administration in School)*** from the school nurse or school secretary. 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 or 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, labeled with your child's name, and will be administered according to the doctor's written instructions.
   ***(Please see and sign page 2, Parent/Guardian responsibilities)***
3. You may discuss with your doctor an alternative schedule for administering medication (i.e. outside of school hours)
4. 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. Students must demonstrate the necessary knowledge and developmental maturity to safely assume responsibility for and management of self-carry medications.

School personnel will not administer any medication to the students unless they have received a medication form properly completed and signed by both doctor and parent/guardian, and the medication has been received in an appropriately labeled container. If you have questions about the policy, or other issues related to the administration of medication at schools, please contact the school nurse at the following number: _____.

Thank you for your cooperation,

_____

School Nurse Date

_____

Director Date

10700 Asbury Chapel Rd, Huntersville, NC 28078
(704) 948-4439

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# The Responsibility of the Parent or Legal Guardian

1. Limit the medications that must be given during the school day to those necessary in order to maintain the child at school.
2. Provide a written request for school personnel to administer the medication. This should be in the form of a request/permission form (Request for Medication to be given during School Hours form). Return completed form to school. A separate parent request/permission form must be completed for each medication given at school.
3. Parents may choose to administer the medication at school themselves.
4. Complete an Authorization form, signed by a health care provider licensed to prescribe medications, which includes the following:
    a. Name of child
    b. Name of medication
    c. Date it was prescribed
    d. Dosage
    e. How the medicine is to be given at school
    f. When the medicine will be given at school
    g. Special instructions about the child receiving the medication or about the medicine itself.
    h. Until what date the medicine is to be given at school
    i. Possible side effects of the medication
    j. Possible adverse reactions to the medication
    k. Name of the health care provider and how to locate or communicate with him or her if necessary
5. Provide each medication in a separate pharmacy-labeled container that includes the child's name, name of the medication, the exact dose to be given, the number of doses in the original container, the time the medication is to be given, how it is to be administered, and the expiration date of the medication.

    Note: The parent should request of the pharmacist to provide two labeled containers – one for home use and one for school use – if child needs to be given medication both at home and at school.

6. Over the counter medications administered at school should be provided in their original packaging labeled with the student's name.
7. Provide the school with new, labeled containers when dosage or medication changes are prescribed.
8. Retrieve all unused medications from school when medications are discontinued, and /or at end of school year (according to local written policy)
9. Maintain communication with the school staff regarding any changes in the medical treatment and child's need at school.

_____

Parent Signature Date

_____

Health Office Representative Date

10700 Asbury Chapel Rd, Huntersville, NC 28078
(704) 948-4439

BONNIE CONE CLASSICAL ACADEMY

# Request for Medication Administration in School

To be completed by physician

Name of Student: _____

School: _____

Medication: (each medication is to be listed on a separate form) _____

Dosage and Route: _____

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

Significant Information (include side effects, toxic reactions, reactions if omitted, etc.)

_____

Contraindications to administration: _____

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

a. Contact me at my office, Phone: _____

b. Take child immediately to the emergency room at: _____

## FOR SELF-ADMINISTRATION

☐ **Student has demonstrated ability and understands the use of and may carry and self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions only.**

**Asthma/allergic reaction____ MDI (Metered Dose Inhaler) ___MDI with spacer**
**Diabetes ____ Insulin ____ Glucose ____Epinephrine ____**

***Parent/guardian must provide an extra inhaler/epinephrine injector/source of glucose to be kept at school in case of emergency and that will be replaced when it expires.**

*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 requirements stated in G.S. 115C-375.2 The student also must have a self-medication agreement on file.*

Physician's Signature: _____ Date: _____

(over)

# Bonnie Cone Classical Academy

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.

I will furnish all medication for use at school in a container properly labeled by a pharmacist with identifying information (name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken) and replace the medication when it expires.

Parent or Guardian's Signature: _____

Telephone Number _____ Date: _____

_____

*(School use only)*

Name and title of person to administer medication (unless self-administered) _____

Approved by: _____ Date: _____

Reviewed by: _____Date: _____

10700 Asbury Chapel Rd, Huntersville, NC 28078
(704) 948-4439

BONNIE CONE CLASSICAL ACADEMY

**Student Agreement for Self-Carried Medication**

**Student: _____Grade: _____**

**Campus: _____**

**Parent(s) Printed name: _____**

**Parent(s) Contact Numbers: _____**

**Health Care Provider: _____Phone Number : _____**

**Medication: _____ Dose and Time: _____**

Medication is permitted in accordance with state laws and district policy, both student's health care provider and parent guardian must complete Medication Authorizations Form. Students name must appear on medications and devices.

**Student Responsibilities**

- *I will keep my inhaler/equipment, Epinephrine Auto Injector, or diabetes medication/equipment with me at school.*
- *I agree to use my inhaler/equipment, Epinephrine Auto-Injector, or diabetes medication/equipment in a responsible manner, in accordance with my licensed health care providers 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 medication or equipment.*

**Student Signature: _____Date: _____**

___ Emergency Action Plan complete and on file at school
___ Demonstrates correct use/administration
___Verbalizes proper and prescribed timing for medication
___Agrees to carry medication
___Can describe own health condition well
___Keeps a second labeled container in health office or main office
___Will not share medication or equipment with others

As the parent/guardian of the above-named student, I acknowledge that Bonnie Cone Classical Academy, its employees, or agents shall incur no liability as a result of any injury arising from the self-administration or misuse of the above-named medication by the above-named student; or if the above named-student does not have the medication with them when needed; or if the medication carried by the above-named student has passed its expiration date. I agree to hold harmless the school and its employees or agents against any claims arising out of such self-administration.

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Director Signature: _____ Date: _____

Physician Signature: _____ Date: _____