



Letter to Parent Regarding Administration of Medication in School

Dear Parent/Guardian,

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 the medication form from the school nurse or school receptionist or print page 2 of this document. 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. New authorization forms are required at the beginning of every school year, when the dose or directions change, and when a new medication is prescribed. Parents/guardians must supply the medications.
- 3) 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.
- 4) Please discuss with you doctor an alternative schedule for administering the medication (i.e. outside of school hours).
- 5) Self-medication: In accordance with G.S. 115C-375.2, 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 self-carry medications. Students who self-carry medication must read and sign page 3 of this document and submit it with the physician's form.
- 6) Please have physician fill out an emergency action plan for children needing an epi-pen, asthma medications, or seizure medications. We also need a plan of care for children with diabetes signed by the physician. You can find copies of these forms on our website <https://www.ciscomets.com/forms-policies>
- 7) When a student self-administers an OTC medication (Tylenol, Advil, Pamprin, etc) without school staff support, the drug must be sent in the original container with only 1or 2 doses with a written authorization signed by the parent and attached to the container.

School personnel **will not** administer any medication to 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 any questions about the policy, or other issues related to the administration of mediation in the schools, please contact the school nurse at rosannachristian@ciscomets.com

Thank you for your cooperation,

Rosanna Christian, RN
School Nurse
Carolina International School



CAROLINA International School

“The World Is Our Family”
A North Carolina Public Charter School

9545 Poplar Tent Road, Concord, NC 28027
704.455.3847 (phone) | 704.455.4672 (fax)
School Nurse: Extension 9514

Student's Name: _____ Birth Date: _____
School Year: _____ Grade: _____

Only one medication on each authorization form

Name of Medication: _____

Circle One: Tablet Capsule Liquid Inhaler Patch Drops Injection Rectal Other: _____

Diagnosis for which medication has been prescribed (IF ALLERGY, LIST ALLERGEN(S): _____

Dosage (amount to be given) _____

Time/Frequency: _____ A.M. _____ P.M. or As Needed every _____

Reason for Medication: _____

Side Effects (expected or predictable): _____

Termination Date: _____ (All medication orders expire at the end of the school year unless otherwise stated.)

Physician's Signature: _____ Date: _____

Physician's Name Printed _____ Telephone #: _____

Parent Authorization: Please sign the authorization below that applies to your child. If medication will be SELF-ADMINISTERED by your child please complete page 2 also. Self-carry and administration allowed ONLY for emergency use medications.

Parent permission for routine or emergency medication to be administered BY THE SCHOOL NURSE/STAFF:

- I hereby give my permission for my child (named above) to receive medication during school hours.
- Medication will be kept in the nurse's office.
- 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.
- I have read and understood the Letter to Parent Regarding Administration of Medication in School"
- 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).

Parent/Guardian Signature: _____ Phone: _____ Date: _____

Parent Permission for emergency medication to be CARRIED & SELF-ADMINISTERED BY THEIR CHILD (K-5 consult with School Nurse):

- I agree to the Medication authorization as written by the above medical provider.
- I hereby request that my child be allowed to carry and self-administer the medication at school as prescribed by my child's licensed health care provider. I understand my child must carry this medication at all times in school or he/she will lose the right to carry it. I further understand that the school undertakes no responsibility for the administration of the medication. I hereby release the School Board, its agents and employees, from any and all liability that may result from my child taking this medication.
- My child is knowledgeable about this medication and how to self-administer it.
- I agree to ensure that the medication will have a pharmacy label with my child's name.

Parent/Guardian Signature: _____ Phone: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____



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School Nurse: Extension 9514

Student's Name: _____

Student Contract for Self-Administered Medication

Student Responsibilities:

- I plan to keep my inhaler, equipment, Epi-pen or other medication with me at school rather than in the school nurse's office.
- I agree to use my inhaler, equipment, Epi-pen or other medication in a responsible manner, in accordance with my licensed health care provider's orders.
- I will notify the school health office or main office if I am having more difficulty than usual with my health condition.
- I will not allow any other person to use my inhaler, equipment, Epi-pen or other medication.
- I will carry the least amount of medication possible in its original container.

Student's Signature: _____ **Date:** _____

School Nurses Responsibilities:

- Emergency Action Plan complete and on file at school
- Demonstrates correct use/administration
- Recognizes proper and prescribed timing for medication
- Agrees to carry medication or keep in an established location
- Knows health condition well
- Will not share medication or equipment with others.

Comments: _____

Parent/Guardian Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____

In order to keep this student in optimum health, help maintain maximum school performance and sustain attendance, it is necessary that medication be given during school hours.