Kestrel Heights School

4700 S. Alston Avenue, Durham, NC 27713
Phone 919-484-1300 Fax 919-572-2409
www.kestrelheights.org

Dr. Mark Tracy, Executive Director
Dr. Kimberly Yates, High School Principal
April Goff, Middle School Principal
Dr. Renita Webb, Elementary Principal

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 a medication form 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 and will be administered according to the doctor's written instructions.
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.

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 questions about the policy, or other issues related to the administration of medication in the schools, please contact Ms. Vargas at Vargas@kestrelheights.org

Thank you for your cooperation.

Ms. Suzanne Vargas
Admissions
Kestrel Heights School

Student Agreement for Self-Carried Medication

Student: ____ Grade: _____________

Parent: ____________________________________ Telephone Number: _______________

Licensed Health Care Provider: ____
Telephone Number: ____

Medication: ____
Dose: ______________________________ Time: _________________________

Medication is permitted in accord 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.

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RESPONSIBILITIES

- I plan to keep my inhaler, equipment, and/or Epinephrine auto injector with me at school.
- I agree to use my 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 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: ___________________

_____ 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
_____ Will not share medication or equipment with others

Comments:

Administrative Signature: ____________________________ Date:________________________

Request for Medication Administration in School
<u>To be completed by physician</u>

Name of Student: ________________________________

Medication: ______________________________________ Dosage: ____________________________

Time(s) medication is to be given:
a.m.________ p.m.__________ To be given from: (date) ______________ 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-ADMINSTRATION -
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 must provide an extra inhaler to be kept at school in case of emergency

-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

-Student must have a self-medication treatment contract.

-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).

____ 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 Telephone Number Date