

Southeastern Academy Charter School

12251 NC Hwy 41 North
Lumberton, North Carolina 28358
910-738-7828

Date _____

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 given during school hours, including over-the-counter drugs, you have the following options:

- (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. Medication(s) must be brought to school by the parent/guardian in a pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. The medication must be "signed in" at school by the parent/guardian. 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 NCGS §115C-375.2 and G.S. 115C-375.3, 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. In fairness to those giving the medication and to protect the safety of your child, there will be no exceptions to this policy.

If you have questions about the policy, or other issues related to the administration of medication in the schools, please contact the school nurse.

Thank you for your cooperation.

(Revised 7/14)

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12251 NC Hwy 41 North
Lumberton, North Carolina 28358

School Fax: 910-671-8067

To Be Completed By Physician (One medication per form)

Student _____ DOB _____ School _____
Medication _____ Dosage _____
Purpose of Medication _____
Time(s) Medication is to be given _____
Administration Dates: Begin _____ Stop _____
Significant information (include side effects, toxic reactions, omission reactions,
contraindications): _____

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 _____ Telephone _____
- b. Take child immediately to the emergency room at _____
- c. Other _____

FOR SELF-ADMINISTRATION – Please complete this section:

YES NO 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.

MDI (*Metered Dose Inhaler) *MDI with spacer Epi-pen Insulin

*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 (to be completed at school).

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

Physician's Signature _____ Date _____ Telephone _____

Physician's Address _____

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 Southeastern Academy, SeA 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/Guardian Signature _____ Phone Number(s) _____ Date _____

Approved by: _____
Principal's Signature _____ Date _____

Reviewed by: _____
School Nurse's Signature _____ Date _____