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**Appendices**

See individual Appendices:

*Appendix I: Resources, References, Resolutions and Position Statements*

*Appendix II: General Statutes, State Policies and Administrative Code*

*Appendix III: State – Generated Forms*
North Carolina School Health Program Manual

Foreword

The purpose of this manual is to assist school administrators, school nurses, and other health professionals in planning and implementing coordinated school health programs based on local needs and resources. Effective programs place emphasis on prevention, case finding, early intervention, and remediation of health problems. Of equal importance is the focus on health promotion through individual and group education, health counseling for identified behavioral risk, and efforts to assure that students benefit from a safe environment.

The overall goal of a coordinated school health program is to help each child achieve and maintain optimum health, so that maximum physical, emotional, and intellectual growth can occur. This type of program helps meet the needs of students, parents, the school, and the community, thus facilitating effective education and positive student outcomes.

A coordinated health program model consists of:

1) health services;
2) health instruction;
3) a safe, healthy school environment;
4) physical education;
5) psychological and social services;
6) nutrition services;
7) school site health promotion for staff, and
8) family and community involvement in school health.

This manual provides direction for the standardization of health services in North Carolina schools. Guidelines for developing local policies, procedures, and activities are included as a basis for assuring quality of services across the state. The benefits to the school district will become apparent as parents and members of the community become familiar with a basic and consistent standard of school health services that they can expect to receive in North Carolina schools. Most important are the benefits to children. This manual focuses on their needs from both health and educational perspectives.

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Introduction

North Carolina takes the position that health and education are interdependent; therefore, the identification of health related barriers to learning are crucial to the provision of an appropriate educational plan for every student. To meet that objective, North Carolina has instituted comprehensive school health services in every school district. Through the work of the North Carolina Division of Public Health, the North Carolina Department of Public Instruction, local health departments, and local education agencies, the state makes comprehensive school health services a priority.

The first school nurses in the United States

School nursing in North Carolina has evolved along the same path created by the public health nurses in New York City, credited as being the first school nurses in this country. From the early days of school nursing in the United States, the school health program has been part of public health nursing, and the history of school nursing in North Carolina reflects that partnership.

The early history of public health in North Carolina

During the 1870s, a typhoid epidemic swept the country. State boards of health were created to limit the destruction of lives that the epidemic created. Through efforts of Dr. Thomas Fanning Wood of Wilmington, the North Carolina Legislature passed a law in 1877 creating the North Carolina State Board of Health. By 1909, one of its divisions was Preventive Medicine and Hygiene. In 1915, Dr. George M. Cooper of Clinton was appointed Director of the Bureau of Rural Sanitation on the executive staff of the State Board of Health, a position that led to his later becoming Director of the Division of Preventive Medicine and Hygiene.

Dr. Cooper realized the need for a system of medical inspection of school children in elementary grades. He arranged to have these inspections done during the school term
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with funds obtained from county authorities, private donations and social agencies. He wrote the law, enacted by the legislature in 1919, providing for periodic inspection of school children and an appropriation for the salaries of “agents.” The term “agent” applied to physicians, dentists, teachers, and nurses. Dr. Cooper’s idea was to appoint capable, well-trained graduate nurses for the work of school inspections, because they could reach mothers and teachers and would cooperate with physicians in private practice.

The first school nurses in North Carolina

As early as 1772, a North Carolina city, Salem, delivered public health services through a city health department, with a physician, midwife and nurses. Greensboro, in Guilford County, holds the distinction of having established the first county health department in the United States in 1911. In 1919, only 20 counties in the state had either a city or county health department. North Carolina’s local health department system was similar to that in other cities and counties across the nation.

The first recorded school nursing in the state was offered by the Wayside Workers of the Home Moravian Church in East and West Salem Schools in 1911. This began a movement whereby various benevolent societies, civic organizations and public-spirited citizens marshaled forces to provide services for school-aged children. In 1915, the Durham City School Board employed a nurse, and in 1919, Guilford County hired two nurses, one of each race, to work in schools to improve management of contagious diseases.

Six nurses who were hired to work in the School Health Supervision Subdivision of the North Carolina Division of Preventive Medicine and Hygiene in 1919 are recognized as being the forerunners of school nurses in North Carolina. The school nurse movement in North Carolina was largely due to the splendid efforts of the first six nurses. “They traveled on foot, horseback, on rafts, by boat, tram cars, ox-carts-any way to reach the ‘forgotten’ child.”1 They worked in practically every county in the state, performing common health functions of the day: weighing and measuring children, testing vision and hearing, examining teeth and throats, taking family and child histories relative to immunization status, and assessing for the presence of communicable diseases.

By 1922, school health efforts turned to correcting identified defects. Dr. Cooper instituted two new programs: teaching oral hygiene and organizing tonsil and adenoid

clinics. Six dentists gave demonstrations throughout the counties, using portable equipment to teach oral hygiene to school children. These efforts provided the impetus for the later development of a Dental Health Section in the State Board of Health. The nurses were instrumental in organizing the tonsil and adenoid clinics under the directions of eye, ear, nose and throat specialists. This clinic service continued for 12 years.

The first coordinated school health program

During Dr. Cooper’s tenure, the State Department of Public Instruction and the State Board of Health cooperated on behalf of school children. Not until Charles E. Spencer was hired by the Department of Public Instruction in 1938, however, was serious concern and planning for health and physical education manifested. A $50,000 Rockefeller Board grant in 1939 funded the North Carolina School Health Coordinating Services, an advisory committee, to organize the school health program. Field work was initiated, and additional grants made workshops and consultants a reality. In 1947, the school health program expanded statewide and involved health and physical education, concern for a healthy environment, and health services. The School Health Coordinating Service Committee also produced and distributed curriculum guides to schools.

Additional impetus was given to the development of the School Health Program in 1949 by a General Assembly appropriation of $55,000 for each year of the biennium to establish a Joint School Health Service Program of the State Board of Education and the State Board of Health. The School Health Coordinating Service Committee served as the designated administrative unit for the two departments in the Joint School Health Plan developed by the two agencies in 1949.

From 1949 on, the General Assembly appropriated funds (“School Health Funds”) annually to the State Board of Education to be allocated to local school administrative units for school health services. In the early years of the School Health Coordinating Service Committee, the funds were used for public health nurse salaries, physician services for health assessment, and treatment for the correcting of chronic remediable defects. However, the Budget Appropriation Act for the Biennium 1957-59 stipulated that “not less than 90 percent of the expenditures out of the appropriations for each year made to the State Board of Education under Nine Months School Fund for Child Health Program shall be expended for diagnosis and the correction of chronic remediable physical defects of public school children. An amount not in excess of ten percent of the appropriation for each year may be expended for case finding, health education, and intensive follow-up services.”
This legislation affected the existing pattern of school health service delivery in North Carolina because the “Fund” could no longer be used to subsidize nurse salaries for needed case finding and follow-up services. Nursing was a necessary component of the Child Health Program for the Board of Education. The health service program, financed by school health funds, constituted only a small part of the total school health program carried on by schools and health departments in 1957.

Between 1949 and 1957, the General Assembly did not appropriate monies requested for the State Board of Health’s general fund for aid to local health departments. However, the State Board of Health allocated about $330,000 for school health services each year.

The effect of special education of children on school health programs

In 1963, the School Health Coordinating Service Committee published a guide for planning a total school health program entitled “Health Services in Our Public Schools.” Its contents indicated that the State Board of Education and the State Board of Health were still planning together to provide for a school health program. Within five years, however, this committee was dissolved.

This may have been partially due to new directions of federal legislation and federal funding for school health services directed to Boards of Education. For example, the Elementary and Secondary Education Act (ESEA) was passed in 1965 and was implemented in North Carolina in 1966. The act provided funds for nurses and other educational support service professionals to work with educationally and emotionally deprived children of school age. This included Indian and migrant children who were considered to have special educational needs. The act also provided funding for the support of instructional activities for the children identified as educationally disadvantaged. Under Title VI-B of ESEA, “funds were provided for initiation, expansion and improvement of programs and services for physically and mentally handicapped children at the preschool and elementary level.” The Education of the Handicapped Act (PL. 94-142) incorporated Title VI-B of ESEA and broadened as well as strengthened the mandates of Boards of Education for implementation.

During the 1973 session of the North Carolina General Assembly (2nd session 1974), legislators ratified “An Act to Establish Equal Educational Opportunities in the Public School; and For Other Purposes.” This bill transferred administration of the School Health Fund from the Department of Public Instruction to the Department of Human Resources. From July of 1974 until September 1999, the School Health Fund was used for the prevention, as well as the diagnosis and correction, of chronic, remediable
physical defects of public school children. Provision was made for the purchase of medications for eligible children when there was no other funding resource. The School Health Fund was not used for personnel salaries.

In 1977 the General Assembly enacted legislation that became the framework for the development of a North Carolina State Plan for the implementation of PL 94-142. The bill defined the exceptional child, provided funding for educational support services personnel, spelled out protocols for identification and placement in the development of the educational placement plan, and called for parent involvement in the development of the educational placement plan. Rules were developed by the North Carolina Department of Public Instruction’s Division for Exceptional Children. The rules called for the identification of these children through a community “Child Find” and referral mechanism.

In 1986, the United States Congress passed the “Amendments to the Equal Education of the Handicapped Act” (PL 99-457) and additional amendments in 1991 through, the “Individuals with Disabilities Education Act” (IDEA) (PL 102-119). This new law reaffirmed all of the special education entitlement of the PL 94-142 passed in 1976, but extended age eligibility down to birth. Two new programs emerged: The Infant and Toddler Grant Program (Part C), serving children birth to three years; and the Preschool Grant Program (Part B), serving children three to five. The Department of Public Instruction was chosen as the lead agency for The Preschool Grant Program (Part B) of Public Law 99-457 and implemented it in the 1991-92 school year. This program provides non-discriminatory testing, placement in the least restrictive environment, individualized education programs, related support services, and procedures for due process for children aged three to five.

Other developments in the progress of school health programs in North Carolina

In 1978, North Carolina General Assembly ratified “An Act to Establish a Statewide School Health Education Program Over a Ten-year Period of Time.” This bill defined what was meant by “comprehensive school health education” and assigned responsibilities to the State Board of Education, the State Department of Public Instruction, and local educational administrative units for the development of a health education program for kindergarten through ninth grade. It called for the creation of a State School Health Education Advisory Committee and local school health education coordinators for each county.
The following year, on February 16, 1979, the General Assembly ratified “An Act to Rewrite the Immunization Law.” This bill listed immunizations required by the Commission for Health Services and assigned responsibility for the enforcement of the rules to the Department of Human Resources. The bill also required that a certificate of immunizations indicating that the child had received all of the immunizations required by the General Statute 130-87 be presented to day-care facilities or schools as a condition for school attendance (K-12) by the 1980-81 school year.

During 1979, state legislators passed several other bills with implications for school health:

- **“An Act to Provide Sports Medicine and Emergency Paramedical Services and Emergency Life Saving Skills to Students in the Public Schools.”**
  
  This bill:
  
  - appropriated monies for the provision of sports medicine and paramedical life-saving services
  - appropriated monies for the in-service educational training of public school personnel for the development of sports medicine and emergency paramedical skills.

- **“An Act for the Defense of Certain Public School Employees.”** This bill:
  
  - defined the scope of duty of teachers to provide some medical care
  - provided for legal defense mechanisms for public school employees against whom claims or civil actions are commenced for personal injury on account of an act done or omission made in the course of duties under General Statute 115C-307;
  - enabled public school employees when given such authority by the Board of Education or its designee, to:
    - administer drugs or medications prescribed by a doctor upon written request of parents;
    - give emergency health care when circumstances indicate that delay might seriously worsen the physical condition or endanger the life of the pupil; and
    - perform any other first aid or life saving techniques in which the employee has been trained in a program approved by the State Board of Education.

The **Basic Education Plan (BEP),** enacted by the legislature in 1985, made sweeping changes in North Carolina’s education program. The plan spelled out the education that was to be available to every student in the state. The BEP described a program of instruction that included traditional curricula as well as “healthful living.” The program
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included support services such as guidance, health and psychological services; staff ratios; staff development; and facilities standards. The plan set a state-funding ratio for student support service positions, which included nurses. According to the BEP formula, there was to be one school nurse per 3,000 average daily membership (ADM) with at least one nurse per county funded by the state. The BEP formula for school nurses has not been changed since its enactment.

A Kindergarten Health Assessment bill was ratified on May 1, 1987 with an effective date of January 1, 1988. That Legislation, still in effect, states that every child who enters kindergarten in the public schools is required to have a health assessment, the results of which are sent to the school. Principals are responsible for reporting to the State the number of kindergarten students meeting (or not meeting) this requirement. Students are to be excluded from school when they have not received a health assessment within the designated time frame.

In the fall of 1991, the North Carolina State Board of Education adopted a policy requiring all newly employed school nurses to hold national school nurse certification through either the American Nurses Association or the National Association of School Nurses. The policy became effective July 1, 1993. The policy allows local education agencies to employ, if necessary, uncertified nurses; however, they must be hired with the stipulation that they become nationally certified within three years of their hire date. (Note: As of 2010, national certification for school nurses is available through the American Nurses Credentialing Center [ANCC] for renewals only and the National Board for Certification of School Nurses [NBCSN] for both renewals and new certification.)

A state salary schedule acknowledging both national certification and years of nursing experience was implemented in 1993. Beginning with the 1998-99 school year, certified school nurses employed by the public schools were paid on the “G” salary schedule. Until national certification is attained, the nurse’s salary is assigned according to the non-certified nurse schedule. During the 2001 Session the General Assembly changed the requirements for the national certification of school nurses. The language allowed school nurses employed in the public schools prior to July 1, 1998 to avoid requirement for national certification in order to continue employment. “School nurses not certified by the American Nurses Credentialing Center or the National Board for Certification of School Nurses shall continue to be paid based on the non-certified nurse salary range as established by the State Board of Education.”

By 1992, there was sufficient interest among nurses employed in school nursing to form an organization that would advance the goals of school health in North Carolina. The
School Nurse Association of North Carolina (SNANC) was organized in that year to provide an opportunity for school nurses to:

- network with other school nurses;
- obtain professional resources, including continuing education; and
- advocate for quality school health services.

The members later formed regional groups to provide local networking. They also created a link between the SNANC Executive Board and the ANANC (American Nurses Association of NC) and to the National Association of School Nurses (NASN).

The number of students with special health care needs, including those who are technology dependent, has increased over the past several years. On July 1, 1995 the North Carolina State Board of Education adopted a policy entitled “Special Health Care Services” that requires each local school district to make a registered nurse available for assessment, care planning, and on going evaluation of students with special health care services in the school setting. This policy may be found in Appendix B of this manual.

In 1995, the state agency then known as the North Carolina Department of Environment, Health and Natural Resources (DEHNR) established regional school nurse consultant positions in addition to the central office state school nurse consultant. These regional consultants were placed in four DEHNR regions across the state. They were added to expand professional school nurse technical assistance to local health departments and local education agencies and to augment the consultation provided by the state school nurse consultant. Two additional positions were added in the spring of 1997.

In 1992, the General Assembly appropriated funds for Comprehensive Adolescent Health Care Projects in the form of school-based and school-linked health centers. These health centers are located on a school campus (school-based) or affiliated with schools in the community (school-linked). They employ a variety of professional health care providers to increase adolescents’ accessibility to primary care, mental health, nutrition, health risk education counseling and preventive health services. Most are sponsored by a health care organization. The health centers in schools are established after broad-based community planning and endorsement and require informed, written parent permission prior to a student’s participation. By the end of 2008, there were more than 50 school-based and school-linked health centers located across the state.

In 1996 after a major organizational downsizing and restructuring, the North Carolina Department of Public Instruction changed its name to Public Schools of North Carolina. The Department of Environment, Health and Natural Resources underwent a change, as
well, with the personal services programs of public health becoming a part of a newly
organized Department of Health and Human Services. In 1999, the Division of Public
Health, which includes the school health services programs of the Women’s and
Children’s Health Section, was established, and is where the School Health Unit, which is
responsible for this manual, resides.

In order to further promote the concept and work of coordinated school health services,
North Carolina sought and received a grant from the Centers for Disease Control and
Prevention (CDC) in 1998. Awarded to the Department of Public Instruction, the
program, called NC Healthy Schools, supports the development of a planned and
coordinated school health program. The program consists of eight components
including healthful school environment; health services; health education; physical
education; counseling, psychological and social services; nutrition services; family and
community involvement; and health promotion for staff. All of these components are
represented to some extent in the state education agency, state health agency, and in local
school districts. The program’s design assists in the development of an infrastructure
(system of supports) at the state level that supports the prevention and reduction of health
risks statewide through the establishment of coordinated school health programs at the
local level. The five-year grant has been renewed twice, most recently in March 2008.

In 1998, the General Assembly enacted historic legislation to help thousands of uninsured
children and adolescents get health insurance under the North Carolina Health Choice
for Children program. Funded by the federal government and the state, this program
provides free or low-cost health insurance to children whose families cannot pay for
private insurance and who do not qualify for Medicaid. The legislation also provided for
revision of the state’s School Health Fund guidelines. The new funding priorities
included: 1) base-funding for school-based and school-linked health centers, 2) provision
of funds for emergency dental services, and 3) purchase of bulk medications.

In September 2002, a new law addressing the care of school children with diabetes was
passed by the General Assembly. It required the State Board of Education to adopt
guidelines for the development and implementation of individual diabetes care plans. The
guidelines, written in consultation with the North Carolina Diabetes Advisory Council,
reflect reference to the American Diabetes Association for the Management of Children
with Diabetes in the School and Day Care Setting and include the following:

- procedures for the development of an individual diabetes care plan at the written
  request of the student’s parent/guardian;
- procedures for the regular review of an individual care plan;
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- information to be included in a diabetes care plan, including the responsibilities and appropriate staff development for teachers and other school personnel;
- an emergency care plan, the identification of allowable actions to be taken,
- the extent to which the student is able to participate in the student’s diabetes care and management
- other information necessary for teachers and other school personnel in order to offer appropriate assistance and support to the student; and
- information and staff development to be made available to teachers and other school personnel in order to appropriately support and assist students with diabetes.

The new legislation requires that all school staff members complete a basic training to become familiar with the law; the needs of children with diabetes; and the symptoms and treatment of hyperglycemia (high blood sugar), hypoglycemia (low blood sugar) and other diabetes emergency procedures. At least two volunteer staff members are to be intensively trained in the care for students with diabetes and in responding to emergencies.

In January, 2003, the State Board of Education adopted the “Healthy Active Children” policy (HSP-5-000). In order for the policy to be fully implemented as required by the 2006-07 school year, schools were expected to:

- conduct a needs assessment on health services and programs;
- provide an action plan to the North Carolina Department of Public Instructions by July 15, 2004; and
- provide progress reports by July 15, 2005 and 2006.

In addition, an annual report will contain the number of minutes provided for children in physical education and in physical activity yearly.

The policy’s support for improved/increased physical activity for students in pre-kindergarten, kindergarten and grades up to middle school is evidenced by the following:

- Elementary schools should consider the benefits of having 150 minutes per week and secondary schools should consider the benefits of having 225 minutes per week of physical activity that will include a minimum of every other day of physical education throughout the 180-day school year.
- The physical education course is defined and should be the same class size as other regular classes.
- Appropriate amounts of recess and physical activity will be provided for students and for duration sufficient to provide a significant health benefit to students.
An important component of the policy is that structured recess is not to be denied or withheld as a form of punishment.

In February, 2003 the rule was changed regarding the emergency administration of epinephrine to persons suffering an adverse reaction to agents that might cause anaphylaxis. While previous legislation had limited the administration of emergency epinephrine to persons suffering an adverse reaction to insect stings, the rule change expanded the causes of anaphylaxis in persons who could be eligible to receive emergency treatment. The revised rule continues to allow a physician to authorize other practitioners to train persons to administer epinephrine and the physician doing so is responsible for signing the application forms of these trained persons, prior to sending them to the North Carolina Office of Emergency Medical Services (OEMS).

Dr. Leah Devlin, (the state health director at the time) created a School Health Matrix Team in 2002 to bring together all the Division of Public Health’s resources dedicated to the health of students. The School Health Matrix Team formalizes a system by which all of the Division’s “school health players” could work together around the CDC’s eight-component model of coordinated school health to improve the health status of students. In close collaboration with the Department of Public Instruction, The Matrix Team seeks to improve the health and academic achievement of students through strengthened school health programs and policies.

Major changes in recent years have dramatically affected the delivery of school health services. These include:

1) an increase in the number and severity of illnesses in students who attend school;
2) the marked increase of social morbidities such as substance abuse, homicide, suicide, child abuse and neglect, and violence;
3) psychosocial and developmental problems, such as Attention Deficit/Hyperactivity Disorder (ADHD), depression, eating disorders;
4) the impact of immigration, homelessness, and diverse cultural and linguistic groups;
5) changes in the family structure (divorce, remarriage, working parents); and
6) threats of bioterrorism.

North Carolina has tried to improve support resources to students, including a number of attempts to improve the school nurse-to-students ratio. In 2003, the N.C. General Assembly requested a formal study regarding school health needs. A special provision was added to the budget that required the State Board of Education to review the standards for the number of school nurses recommended in the Basic Education Program and to determine whether these standards were being met by the local school
administrative units. The State Board was also asked to compare the current standards with standards recommended by national health organizations to determine whether the current standards are adequate to meet the changing needs and demands for health services of the current and projected school populations. The State Board of Education made the following recommendations to the Joint Legislative Education Oversight Committee in February 2004:

- Expansion of school nurse services in order to reach a 1:750 ratio by the year 2014;
- Provide a process for lead health officials of NC DPI and NC DHHS to collaborate and coordinate the successful planning and implementation of the recommendations for increased school nurse-to-students ratio;
- Sustain current DPI standards and definitions of school nursing; and
- Encourage ongoing dialogue with Joint Legislative Education Oversight Committee to identify sources of revenue for expanded school nurse services funding.

That spring, in 2004, the legislature appropriated funds for a School Nurse Funding Initiative (SNFI). The funds provided 65 time-limited school nurse positions over a two-year period and 80 permanent school nurse positions. In July 2006, the General Assembly assured that the 65 time limited position would be permanent, and appropriated funding bring the total to 145 full time school nurse positions supported through the School Nurse Funding Initiative. In July 2007, additional funds were appropriated for an additional 66 school nurse positions.

The budget stated that DHHS/DPH and DPI “shall provide funds to communities to hire school nurses” and that criteria for the awarding of funds would include determining areas of greatest need and greatest inability to pay for school nurses. The budget specified that the following would be part of the criteria:

1) current school nurse-to-students ratio;
2) economic status of the community; and
3) health needs of area children.

All funds were to be expended for salary, fringe benefits, and training for direct school nurse services. The allocation of the positions according to the criteria developed by DHHS/DPH and DPI increased the number of LEAs meeting the recommended ratio of one nurse to no more than 750 students from 10 in the 2003-2004 school year to 39 by end of 2007-2008. Since initiation, the program has helped reduce the average school nurse to students ratio from 1:1,897 to 1:1,225.
In April 2005, a new law addressing the care of school children with asthma or students subject to anaphylactic reactions was passed by the General Assembly. It required the local boards of education to adopt a policy authorizing a student with asthma or a student subject to anaphylactic reactions, or both, to possess and self-administer asthma medication on school property during the school day, at school-sponsored activities, or while in transit to or from school or school-sponsored events. As used in this section, “asthma medication” means a medicine prescribed for the treatment of asthma or anaphylactic reactions and includes a prescribed asthma inhaler or epinephrine auto-injector. The policy shall include a requirement that the student’s parent or guardian provide to the school:

- Written authorization from the student’s parent
- Written statement from the student’s health care practitioner verifying that the student has asthma or an allergy that could result in an anaphylactic reaction
- Written prescription from the health care practitioner
- Written statement from the student’s health care practitioner that the student understands, has been instructed in self-administration for the asthma medication, and has demonstrated the skill level necessary to use the asthma medication and delivery device.
- A written treatment plan and written emergency protocol formulated by the health care practitioner who prescribed the medicine for managing the student's asthma or anaphylaxis episodes and for medication use by the student.
- A statement provided by the school and signed by the student's parent or guardian acknowledging that the local school administrative unit and its employees and agents are not liable for an injury arising from a student's possession and self-administration of asthma medication.

Other requirements necessary to comply with state and federal laws related to asthma and anaphylaxis medications can be found in Section Five of this manual.

More school nurses were provided by the State of North Carolina in 2006, when then-Governor Michael Easley added 100 school nurses as part of Child and Family Support Teams in the schools. The initiative provided recurring state funds to team 100 school nurse positions with an equal number of school social workers at 103 schools in 21 school districts across the state. The purpose of the program was to provide school based professionals to screen, identify and intervene for children who are potentially at risk of academic failure or out-of-home placement due to physical, social, legal, emotional, or developmental factors.
The Child and Family Support Teams and the School Nurse Funding Initiative programs together provided for 311 school nurse positions funded by state money.

In June 2006, Kate B. Reynolds Charitable Trust funded a **School Based Case Management Project**. The goals of the project are: (1) Improve academic and health outcomes for children with chronic illness enrolled in a school based case management program, and (2) Evaluate research findings in relation to the role of the school nurse providing school based case management.

The project was initially conducted in five northeastern North Carolina counties (Dare, Pamlico, Perquimans, Pitt, and Washington) in collaboration with East Carolina University College of Nursing and the Department of Health and Human Services, Children and Youth Branch. The study began during the 2006/07 academic year. Its work has been chronicled in the *Journal of School Nursing* and has led to additional funding for three years, to implement similar work in an additional number of counties throughout the state.

In July 2007, North Carolina joined the majority of states in enacting **tobacco-free policies** in schools and on school grounds. The new law required local boards of education to adopt, implement, and enforce a written policy prohibiting at all times the use of any tobacco product by any person in school buildings, in school facilities, on school campuses, and in or on any other school property owned or operated by the local school administrative unit by August 1, 2008.
Child Abuse and Neglect

Children are reported as abused, neglected or dependent in North Carolina each year. The primary source of these reports is educational personnel. While the number of reports is increasing annually, so is public awareness and understanding about the responsibility to report. Educators are in a key position to identify and respond to child abuse and neglect. They have a legal mandate to report suspected cases to the local department of social services; they have a professional responsibility to keep children from harm; and they have a deep personal commitment to the children with whom they work. In addition, the school is frequently a focal point in the community, offering a variety of support services to children and families. The school community is in a good position to promote child abuse prevention programs and services.

Facts regarding child abuse and neglect:

- Any person or institution who has cause to suspect that any juvenile is abused or neglected must report the case to the local department of social services where the juvenile resides or is found.

- Most school districts in North Carolina have adopted a Board of Education policy and administrative procedure for the reporting of suspected child abuse or neglect cases by school personnel. A copy of the documents should be reviewed by all personnel prior to an incident of suspected abuse or neglect. Review of these documents should be standard policy for all personnel. In some instances, a written administrative procedure has not been adopted. In these situations, a process that is consistent with state law should be agreed upon in each school building and shared with all staff. It is most desirable for the person who has the initial suspicion to make the report to the local department of social services using support personnel as resource people if necessary. The school administration should be notified immediately of the action being taken.

- It is presumed that persons who are mandated by law to report do so in good faith and are, therefore, immune from any civil or criminal liability. However, personal concerns of educators regarding the repercussions of making a report can be significantly diminished by a clear policy and supportive environment.

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1 The remainder of this chapter was prepared jointly by the Work First / Child Protective Services Policy Unit, North Carolina Division of Social Services, and the Division of Public Health, June 2008
According to the statute, reports may be made in person, by telephone, or in writing to the local department of social services. Usually, reports from schools are made by telephone. Written documentation of the report may be kept on file by the school administration if required by school policy.

All information that may be helpful to the social worker in making the investigation should be reported. Include as much of the following information as possible:

- Name, address, age or birth date of the child;
- Name, address, and telephone number of the child's parent, guardian or caretaker;
- Parent's place of employment, address and hours of work (if known);
- Present whereabouts of the child;
- Names and ages of siblings;
- Nature and extent of the injury or condition observed and any other information that the person making the report believes might be helpful in establishing the need for protective services;
- Reporter's name, address and telephone number, and
- Name and address of the suspected perpetrator if not the parent.

The report should be made regardless of the amount of this information that is available.

The law requires the reporting of a suspicion of child abuse or neglect. The responsibility for investigation and substantiation lies with the department of social services. The individual filing the report should gather enough information from the child to affirm his or her suspicion that the child has been non-accidentally injured by the parent or caregiver. It is not necessary or desirable to get all the details of the situation. The child most likely will have to recount the incident a number of times during the investigation and it is important not to breach the privacy of the child and family.

The child should receive the same caring, supportive response that would be afforded any child suffering pain or injury. Because a child's disclosure may not be intentional, it is important to respond sensitively.

- Believe the child and take him or her seriously.
- Use words the child understands and allow the child to describe the situation in his or her own language.
- Reassure the child that what happened was not his or her fault and let the child know you are sorry for what happened. Do not let the child feel that he or she is "in trouble" for disclosing.
North Carolina School Health Program Manual

Section B                    Chapter 1
Students at Risk                                          Child Abuse and Neglect

▪ Respond evenly and confidently without disclosing feelings of shock, repugnance, anger or fear.
▪ Tell the child that some future action is required. Do not make promises you can not keep. Reporting is necessary to help the family and to keep the child safe, although reporting may escalate the problem at first.

▪ The department of social services will begin an investigation to ascertain the facts in cases of abuse within 24 hours and in cases of neglect within 72 hours. The department of social services will determine whether immediate removal of the child or other children from the home is necessary for their protection, whether continued protective services should be provided for the family, and whether the court should become involved.

▪ Unless a court petition is filed within five (5) working days of receipt of the report, the person making the report will receive written notice of the action being taken by the department of social services. If the person making the report is not satisfied with the action being taken, he or she may request review of the decision by the prosecutor within five working days of the receipt.

▪ Err on the side of the child. Most caseworkers in departments of social services encourage individuals to call and discuss situations about which they are concerned.

An Overview of Child Protective Services

In North Carolina, each county department of social services has the legal responsibility and authority to assess reports of suspected child abuse, neglect, and dependency. Sometimes people see situations that might be abusive or neglectful, but they are afraid that they could be wrong. They don’t want to “cause trouble” for the family. On the other hand, if the person is right, this might be the child’s only chance to have the abuse and/or neglect stopped. Because of that report, the family may get the help they need.

If you think that a child is being abused or neglected, or if there is no responsible adult providing care for the child, you have the legal responsibility to report your suspicions to the local department of social services. You do not have to tell the family that you are making a report. However, if you are working with the family, you are encouraged to talk with them about your concerns, explain your legal obligation to report, and ask them to make the report with you. You do not have to give your name to social services, but providing your name may be helpful to the Child Protective Services (CPS) assessment.

After you have made a child protective services report, the county department of social services will decide whether or not to conduct a CPS assessment based on North Carolina law. This decision is reviewed by a supervisor to make sure that no child goes unprotected if the report meets the legal definition of abuse, neglect, or dependency. If you gave your name and address when you made the report, you will be told if the agency conducts a CPS assessment or not. If the agency does not accept the report for assessment, you will be told why the agency did not accept the report. You can ask for a review if you disagree with that decision.

You may see some situations that concern you, but are not situations that the department of social services can or will assess. In order for a CPS assessment to occur, three things must be true:

- The victim must be an un-emancipated child whose age is between birth and 18 years of age. Departments of social services cannot provide child protective services to unborn children, nor to children who have been legally emancipated (by marriage or court order).
- The report must meet the legal definitions of abuse, neglect or dependency as set forth in law.
- The maltreatment must have been the result of action or inaction on the part of a parent, guardian, custodian or caretaker (see p. 2 [5] of Selected Statutes from the North Carolina Juvenile Code). If someone other than these people

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2 Prepared jointly by the Work First / Child Protective Services Policy Unit, North Carolina Division of Health and Human Services, and the Division of Public Health, June 2008
School Health Program Manual – January 2010
N.C. Division of Public Health – Children & Youth Branch – School Health Unit
with a child. Emotional abuse involves causing or allowing serious emotional damage to a child. Moral turpitude involves encouraging, allowing or approving delinquent acts by a juvenile.

You should report child abuse if you know or have cause to suspect that a child has been mistreated by a parent, guardian, or caretaker who committed an act that would meet the above definitions. “Cause to suspect” could occur if the child or another person likely to know about the situation stated that the parent, guardian, or caretaker either committed the act or knowingly allowed the act. If you see suspicious bruises, marks, burns or behavior and the explanation does not “fit” what you are seeing, that too is cause to suspect. Some indicators of abuse may include:

- **Self**-destructive behavior by the child
- Human bites
- Unexplained bruises in different stages of healing or bruises that look like the imprint of a hand or implement. Burns, especially cigarette burns or burns that surround a body part.
- Child is wary of physical contact; may flinch when you approach.
- Child is frightened of parent or caretaker.
- Child is extremely shy, withdrawn or passive.
- Child is unresponsive to pain.
- Child exhibits inappropriate sexual behaviors.

**Reports of Neglect**

In North Carolina, a neglected juvenile is one who:

- does not receive proper care, supervision, or discipline from the parent, guardian, or caretaker;
- has been abandoned;
- has not been provided necessary medical care;
- lives in an environment injurious to his/her welfare; or
- has been placed for adoption or care in violation of the law.

This definition is vague, because there are a variety of culturally acceptable child rearing practices that would make it impossible to be more specific. If the level of care provided to the child is harming the child’s growth or development, and the parent, guardian, or caretaker has the means to provide for the child, it is considered to be neglectful. If the family does not have the money to provide adequate physical or medical care, social services can help them find resources to provide for their children.

Regardless of the family’s circumstances, it is the school employee’s responsibility to report any suspected neglect to Child Protective Services in the local department of social services. Some indicators of neglect are:
• Abandonment of a child by the parent, guardian, custodian or caretaker.

• Unattended medical problems, including illness and physical conditions that can be treated or cured with appropriate therapy.

• Consistent lack of supervision or inappropriate supervision by the parent, guardian, custodian or caretaker.

• Ongoing drug or alcohol abuse by mother that results in a positive drug screen on a newborn and/or interferes with her ability to provide supervision and care.

• Consistent hunger resulting in malnourishment.

• Clothing inappropriate to extreme weather conditions, or poor hygiene.

• Distended stomach.

• Indiscriminate affection.

• Extreme tiredness or sleepiness on a regular or frequent basis.

• Unexplained delays in intellectual, social or physical development.

• Dangerous physical or social environment.

**Reports of Dependency**

A dependent child is a juvenile in need of assistance because the child either has no parent, guardian or caretaker responsible for his care or supervision or because the parent, guardian or caretaker is unable to provide for care or supervision because of some physical or mental incapacity and has not made arrangements for the child.

**What One Can Expect From Child Protective Services**

If the county department of social services accepts the report for a CPS assessment, someone must see the child within 24 hours if the allegation is abuse, or within 72 hours if the allegation is neglect or dependency, or immediately depending on the circumstances. Your identity as reporter is protected and is not released to the family unless ordered by a court (a very rare occurrence). If a criminal investigation is necessary, your name may be given to the law enforcement officer conducting the investigation so that he or she can talk further with you.
If you give your name and address, the following written notices will be sent to you unless you ask not to have them sent:

- A notice within five working days of your report as to whether or not the report was accepted for a CPS assessment and whether the report was referred to state or local law enforcement; and
- A notice within five working days of the case decision following the CPS assessment regarding the agency’s findings and actions, along with your rights to have this decision not to file a petition, reviewed by the District Attorney.

In most cases, the agency will work with the family to try to solve the problems without removing children from the home. Children are removed from their homes only when absolutely necessary to protect their safety. You may be asked to be a part of a Child and Family Team (CFT) meeting when the county department of social services is involved with the family on an ongoing basis. Your role as a service provider for the child and family may be extremely important as a part of the CFT meeting process.

The confidentiality of the contents of Child Protective Services records is given special protection. Information from the record is released only when doing so will benefit the child, such as to community agencies providing services to the child. Access to the record itself is limited even further.
Indicators of Possible Child Abuse and Neglect

**Physical Abuse**

Physical abuse of children means non-accidental physical injury caused, or allowed to be caused, by the child’s caretaker. It is an act of commission that may include burning, beating, branding, punching, etc. While the injury is not an accident, it is not necessarily deliberate or willful on the part of the child’s caretaker. Abuse may occur as a result of over-discipline or from punishment which is inappropriate for the child’s age or condition.

**Physical Indicators**

Unexplained bruises and welts:
- on face, lips, mouth
- on torso, back, buttocks, thighs
- in various stages of healing
- clustered, forming regular patterns
- reflecting shape of article used to inflict (electric cord, belt buckle)
- on several different surface areas
- regularly appear after absence, weekends or vacation

Unexplained burns:
- cigar or cigarette burns, especially on soles, palms, back or buttocks
- immersion burns (sock-like, glove-like, doughnut-shaped on buttocks or genitals)
- patterned, like electric burner, iron, etc.
- rope burns on arms, legs, neck or torso

Unexplained fractures:
- to skull, nose, facial structure
- in various stages of healing
- multiple or spiral fractures

Unexplained lacerations or abrasions:
- to mouth, lips, gums, eyes
- to external genitals

**Behavioral Indicators**

- Wary of adult contacts
- Apprehensive when other children cry
- Behavioral extremes:
  - aggressiveness, or withdrawal
- frightened of parents
- afraid to go home
- Reports injury by parents
Neglect

Neglect means depriving a child of living conditions which provide the minimally needed physical and emotional requirements of life, growth and development; (e.g., lack of food, inadequate housing and clothing, lack of needed medical attention, abandonment, lack of supervision or guidance, unmet educational needs).

**Physical Indicators**

- Consistent hunger, poor hygiene
- Inadequate or inappropriate dress
- Consistent lack of supervision, especially in dangerous activities or for long periods
- Unattended physical problems or needs

**Behavioral Indicators**

- Begging, stealing food
- Extended stays at school (early arrival and late departures)
- Constant fatigue, listlessness, or falling asleep in class
- Alcohol or drug abuse
- Delinquency (e.g., thefts, rule violations)
- States there is no caretaker
Sexual Abuse

Sexual abuse usually is not identified through physical indicators alone. Frequently a child’s behavior may indicate that he or she has been sexually assaulted or involved in sexual activity. The child may also confide in someone about the sexual assault or sexual activity. Possible indicators of sexual abuse are:

**Physical indicators**

- Difficulty in walking or sitting
- Bruises or bleeding in external genitalia, vaginal or anal areas
- Sexually-transmitted infections, especially in pre-teens
- Pregnancy, especially in early adolescence

**Behavioral indicators**

- Unwilling to change for gym or participate in physical education class
- Torn, stained or bloody underclothing
- Withdrawal, fantasy, or infantile behavior
- Pain or itching in genital area
- Poor peer relationships
- Bizarre, sophisticated, or unusual sexual behavior or knowledge
- Delinquency or running away
- Reports sexual assault by caretaker
Emotional Abuse

Emotional abuse of children includes consistently blaming, belittling or rejecting a child; consistently singling out one child for negative treatment; and persistently creating public humiliation of the child. Emotional abuse is rarely manifested through physical indicators. More often it is observed through behavioral indicators, which show that the child is not functioning at his/her usual intellectual or behavioral level. Emotional abuse is the most difficult to substantiate. It must be shown that serious emotional damage was caused by the parent and that the parent refuses to permit, provide for, or participate in treatment.

Physical Indicators

- Speech disorders
- Failure to thrive

Behavioral Indicators

- Habit disorders (sucking, biting, rocking, etc.)
- Conduct disorders (antisocial, destructive, etc.)
- Neurotic traits (sleep disorders, inhibition of play)
- Psychoneurotic reactions (hysteria, obsession, compulsion, phobias, hypochondria)
- Behavior extremes:
  - compliant, passive
  - aggressive, demanding
  - inappropriately adult (parenting other children)
  - inappropriately infantile (head banging, rocking, thumb-sucking)
  - developmental lags (physical, emotional, intellectual)
  - attempted suicide

References:
Prevent Child Abuse North Carolina [www.preventchildabusenc.org](http://www.preventchildabusenc.org)

North Carolina Department of Health & Human Resources, Division of Social Services [www.dhhs.state.nc.us/dss/](http://www.dhhs.state.nc.us/dss/)
Child Abuse and Neglect

(Sample Policy)

Any school employee who suspects that a child’s physical or mental health or welfare may be adversely affected by abuse or neglect will report to the county department of social services. (It may also be part of school policy that the person reporting to the county department of social services will also report to the principal). The schools will cooperate fully with the department of social services Child Protection Services staff who are assessing alleged cases of child abuse and neglect.

It is the responsibility of the Child Protection Services of the department of social services to assess and determine the allegation of abuse or neglect. Anyone making a report of abuse or neglect, in good faith for concern of the child, “shall be immune from any civil or criminal liability that might otherwise be incurred or imposed for complying with the requirements of this statute.” (G.S. 118-118C)

Historical Authority: North Carolina law (G.S. 110-118) requires professional staff (e.g., nurses, social workers, psychologists, school teachers, principals, school attendance counselors) to report a suspected abused or neglected child to the director of social services (or his designee) in the county where the child resides or is found.

(See Appendix II for relevant North Carolina statutes.)
Child Abuse and Neglect Documentation
For School Internal Use

*(Sample Form)*

<table>
<thead>
<tr>
<th>Name of Student</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>School Phone</td>
</tr>
<tr>
<td>Name of Parent or Guardian</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>Home Phone</td>
</tr>
<tr>
<td>Employer</td>
<td>Work Phone</td>
</tr>
</tbody>
</table>

**Incident Requiring Report**

__________________________

**Reported by**

__________________________

**Date of Report**

__________________________

**Result of CPS Assessment:**

- [ ] Substantiated
- [ ] Unsubstantiated
- [ ] Under Investigation

**Case Worker**

__________________________

**Date**

__________________________

**NOTES:**

__________________________

__________________________
Students With Special Needs

I. Exceptional Children’s Services

All students, including students with special needs, have a right to access a free, appropriate public education. Federal and state laws and regulations assure that students with special needs receive the education they need, including special education and related services, if needed. Special needs include mental, physical or emotional disabilities.

Many students with special needs do not need special education and related services; they are educated in regular education programs without their educational performance being adversely affected. Some of these students may have specialized health care needs that require the involvement of nursing, medical and/or allied health personnel but do not qualify for special education and related services. These services should be provided as part of the local educational agency’s (LEA) general school health program, in cooperation with the student’s family and primary health care provider.

When a student’s educational needs cannot be met in existing regular education programs, he/she can be referred for consideration to be served within a special education placement.

When a school nurse suspects that a student’s educational needs are not being met because of the adverse effects of some health need or problem, a written referral should be given to the principal or Exceptional Children (EC) chairperson, outlining this concern. Following the referral, the procedures for developing and managing services and programs for the student with special needs, as outlined in Policies Governing Services for Children with Disabilities (2007)¹ must be followed.

Role of the School Nurse

School nurses work closely with students, families and school staff when a student also has health related problems that impact education. Those students may be served by the special education process or through section 504 accommodations. The parameters of the nurse’s role are discussed in Section B, Chapter 3, “Students Assisted by Medical Technology.” The reader is also referred to two issue briefs by the National Association of School Nurses: 1) School Health Nursing Services Role in Health Care: Section 504

¹ NC Department of Public Instruction, Exceptional Children Division.
Legislative Requirements

The Individuals with Disabilities Education Act (IDEA) mandates that all children with disabilities, aged three through 21, be provided a free, appropriate public education. This legislation makes federal funds available to assist state and local education agencies in meeting the educational needs of students with certain special needs and/or disabilities. The act requires: (1) a comprehensive evaluation prior to consideration for placement in a special education program; (2) development of an individualized education program (IEP) before placement; (3) education in the least restrictive environment; (4) due process procedures; and (5) opportunities for parent participation. In North Carolina, the following definition applies.

Children with Disabilities: The term “child with a disability” means a child evaluated in accordance with North Carolina law as having autism, deaf-blindness, deafness, developmental delay (applicable only to children ages three through seven), hearing impairment, intellectual disability, multiple disabilities, orthopedic impairment, other health impairment, serious emotional disability, specific learning disability, speech or language impairment, traumatic brain injury, or visual impairment (including blindness) and who, by reason of the disability, needs special education and related services.²

Special education: Specially-designed instruction, at no cost to parents or guardians, to meet the unique needs of a child with a disability, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions. (20 U.S.C. 1401(c)(16)).

Related services: Transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, school nursing, psychological services, occupational and physical therapy, recreation, rehabilitation counseling, social work services, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a child with a disability to benefit from special education, and includes the early identification and assessment of handicapping conditions in children.

This legislation followed Section 504 of the Rehabilitation Act of 1973, a civil rights statute prohibiting discrimination against individuals solely because of their disabilities. While it contains no authorization for funds, Section 504 prohibits acts of discrimination by any agency, organization or program receiving federal financial assistance against people with handicaps, regardless of age. Section 504 and IDEA augment each other and assure that children with disabilities receive an appropriate education and are not discriminated against by public agencies.

Public Law 99-457, the Preschool Program for Children with Disabilities, Part B, extends special education and related services to preschool children with disabilities, three to five years of age. Part C, the Program for Infants and Toddlers with Disabilities, is for disabled and at-risk children from birth to age three and for their families. Part C lists special education, audiology, speech and language therapy, psychology, occupational and physical therapy, social work, nursing, nutrition, and medicine as care components of early intervention programs. This legislation recognizes the important role of parents and provides for services that assist them in developing knowledge and skills to perform their role.

In June 1997, amendments to IDEA were approved. The amendments addressed major changes in:
- requirements for progress reports to parents;
- provision for students with disabilities to access the general curriculum, just as other students;
- mediation;
- disciplinary action through manifestation determination, and;
- a new process for re-evaluations.

North Carolina’s response to the need to provide appropriate educational services for children with disabilities is included in Article 9 of the Public School Laws of North Carolina. While state laws may expand the services provided beyond those included in federal laws, they may not do less.
North Carolina State Board of Education Regulations

In the Public Schools of North Carolina publication, *Policies Governing Services for Children with Disabilities* (2007), the terms used in the definition of children with special needs are further defined as follows:

1. **Autism (sometimes called autism spectrum disorder)** means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, which adversely affects the child’s educational performance.

2. **Deaf-blindness** means hearing and visual impairments that occur together, the combination of which causes such severe communication and other developmental and educational needs that they cannot be accommodated in special education programs solely for children with deafness or children with blindness.

3. **Deafness** means a hearing impairment that is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, which adversely affects the child’s educational performance.

4. **Developmental delay** means a child aged three through seven, whose development and/or behavior is delayed or atypical, as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas: physical development, cognitive development, communication development, social or emotional development, or adaptive development, and who, by reason of the delay, needs special education and related services.

5. **Serious emotional disability** (hereafter referred to as emotional disability) means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance:
   - Inability to achieve adequate academic progress that cannot be explained by intellectual, sensory, or health factors
   - Inability to maintain satisfactory interpersonal and/or intrapersonal relationships with peers and teachers.
   - Inappropriate types of behavior or feelings under normal circumstances.
   - A general pervasive mood of unhappiness or depression.
- A tendency to develop physical symptoms or fears associated with personal or school problems.

Serious emotional disability includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance that is an inability to build or maintain satisfactory interpersonal and/or intrapersonal relationships with peers and teachers.

6. **Hearing Impairment** means impairment in hearing, whether permanent or fluctuating, that adversely affects a child’s educational performance but that is not included under the definition of deafness.

7. **Intellectual disability** means significantly subaverage general intellectual functioning that adversely affects a child’s educational performance existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

8. **Multiple disabilities** means two or more disabilities occurring together, the combination of which causes such severe educational needs that they cannot be accommodated in special educational programs solely for one of the impairments. Multiple disabilities does not include deaf-blindness.

9. **Orthopedic Impairment** means a severe physical impairment that adversely affects educational performance. The term includes impairments resulting from congenital abnormalities, as well as impairments from other causes.

10. **Other-Health Impairment** means having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that –

    - Is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, and Tourette’s Syndrome, etc, ; and

    - Adversely affects a child’s educational performance.

11. **Specific Learning Disability**

    - General – means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or
written, that may manifest itself in the impaired ability to listen, think, speak, read, write, spell, or to do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia.

- Disorders not included – specific learning disability does not include learning problems that are primarily the result of visual, hearing, or motor disabilities, of mental retardation, of serious emotional disturbance, or of environmental, cultural, or economic disadvantage.

12. **Speech or Language Impairment**

- A communication disorder, such as an impairment in fluency, articulation, language, or voice/resonance that adversely affects a child’s educational performance.
- Language may include function of language (phonologic, morphologic, and syntactic systems)
- A speech or language impairment may result in a primary disability or it may be secondary to other disabilities.

13. **Traumatic Brain Injury** means an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child’s educational performance. Traumatic brain injury applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing and speech. Traumatic brain injury does not apply to brain injuries that are congenital or degenerative or brain injuries induced by birth trauma.

14. **Visual Impairment, including blindness** means an impairment in vision that, even with correction, adversely affects a child’s educational performance. The term includes both partial sight and blindness. A visual impairment is the result of a diagnosed ocular or cortical pathology.
Identification and Placement

The process of identification and placement in appropriate special education and related services for a student with special needs involves several essential steps.

- **Observe or Recognize a Problem**
  
  If a parent, teacher or other school personnel (school nurse is included in this category) recognizes that the regular education program may not be meeting a student’s needs, the student should be observed in the educational setting by the principal, a teacher or director of exceptional children or appropriate support services personnel. A written description of the student’s behavior and academic skills should be completed. This step may be eliminated if there is adequate documentation of the student’s problem without it.

- **Conduct an Initial Conference Prior to School-Based Committee Referral**
  
  The student’s teacher, the local chairperson or director of exceptional children programs and the principal may review the information related to the focus of concern to determine if special education services or placement seem to be indicated. If it is felt that a special program or service may be needed, parents are notified and the observation report and initial conference report are sent to the school-based committee.

- **Submit a Written Response to the Principal**
  
  This communication includes the reason for referral, the specific presenting problems and the student’s current strengths and weaknesses.

- **Review Referral Information by the School Based Committee**
  
  Involve parents in the planning process; obtain parental permission for assessment; arrange an evaluation by a multi-disciplinary team; review the evaluation results; and see that an individualized education program (IEP) is developed and reviewed annually. The school-based committee is responsible for writing a brief summary of each evaluation.

- **Develop Individualized Education Program**
  
  - Detailed information on the referral, identification, screening, evaluation and placement process of students with special needs is found in the publication Policies Governing Services for Children with Disabilities. The publication is available from the Exceptional Children’s Division, Public Schools of North Carolina, 2007 Edition. The Director of Programs for Exceptional Children in each local school system has a copy of this publication.
  - To review or download this publication, go to: http://www.ncpublicschools.org/docs/ec/policy/policies/2007policies.pdf
Individualized Education Program (IEP)

The placement of a student with special needs must be based on the individualized education program (IEP) for that student. The IEP committee works as a team to develop the IEP document to address the special needs of the student. The individuals specified in the regulations to be part of the IEP committee are:

1. The teacher or teachers responsible for implementing the IEP, including a regular education teacher.

2. A representative of the local educational agency other than the student’s teacher, who is qualified to provide or supervise the provision of specially-designed instruction to meet the unique needs of the student, and regular education activities, including positive behavioral strategies.

3. The parent(s) or guardian(s)

4. The student, when appropriate.

5. Other individuals at the discretion of the agency or the parent, such as professionals from other agencies or from the private sector who have been involved in evaluation or treatment of the student. The school nurse could participate as a member of the IEP Committee.

6. A person who can interpret evaluation results and impact on the student. (A school nurse should assist if health related issues.)

7. If the student has been evaluated for the first time, the local educational agency shall have:
   
   • A member of the evaluation team participate in the IEP meeting

   --OR--

   • A representative of the local educational agency, the student’s teacher, or some other person present at the meeting who is knowledgeable about the evaluation procedures used with the student and who is familiar with the results of the evaluation.
Contents of the Individualized Education Program (IEP) \(^3\)

The individualized education program for each child must include:

1. A statement of the child’s present levels of educational performance
2. A statement of measurable annual goals.
3. A statement of short-term objectives or benchmarks.
4. A statement of special education and related services and supplementary aids and services to be provided for the child.
5. A statement of the program modifications or supports for school personnel that will be provided for the child.
6. An explanation of the extent, if any, to which the child will not participate with nondisabled children in regular class.
7. A statement of any individual modifications in the administration of state or district-wide assessments of student achievement that are needed in order for the child to participate.
8. The projected date for the beginning of the services/modifications.
9. A statement of how the child’s progress will be measured and how the child’s parents will be regularly informed of the process.
10. Transition services, as applicable.


\(^3\) Reference: 34 CFR 300.347
II. An Overview of Section 504 of the Rehabilitation Act of 1973  
(Educational Component)

A. Introduction

Section 504 of the Rehabilitation Act of 1973 is a federal civil rights law protecting the rights of individuals with handicaps. Section 504 requires that “no otherwise qualified individual with handicaps in the United States shall, solely by reason of handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”

There are seven subparts of Section 504 including employment and program accessibility. The part on Preschool, Elementary and Secondary Education has significant impact on the school district’s responsibilities to provide a free and appropriate education for all students with disabilities.

Section 504 is not new legislation; however, within the last several years, the Office of Civil Rights has become proactive in addressing the educational needs of handicapped students with disabilities.

School personnel are already familiar with the Individuals with Disabilities Education Act (IDEA), which addresses educational needs of children who require special education and related services and who meet eligibility criteria in at least one of the categories of disabilities. All students who are disabled under IDEA are considered to be disabled under Section 504. However, some students determined to be disabled under Section 504 may not be eligible for special education services under IDEA. These children are entitled to an appropriate response from regular education. School personnel must be aware that children identified under Section 504 may require accommodations in regular education and related services even though special education services are not required.

Under Section 504, the definition of disabled individuals is much broader than under IDEA provisions, in that persons may be considered disabled if they have a physical or mental impairment which significantly restricts them from performing a major life activity such as learning. Under the definition, a person may also be considered disabled if there is a record of such impairment or the person is perceived as having an impairment.
Physical or mental impairment is interpreted to mean:

1. Any physiological disorder or condition, cosmetic disfigurement or anatomical loss.
2. Any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness and specific learning disabilities.

There is no inclusive list of specific diseases and conditions that qualify. Examples that may be considered are attention deficit disorder, sickle cell disease, brittle diabetes, and/or uncontrolled asthma.

B. Implementation

If school personnel have reason to believe that a student has a disabling condition as defined under Section 504, the student must be evaluated. A parent may also initiate a referral for evaluation. The parent must be notified of evaluation procedures.

Guidelines for evaluating and determining a disability under Section 504 dictate use of a multi-disciplinary team that includes persons knowledgeable about the student’s suspected disability. Information from a variety of sources should be used. The evaluation must accurately and thoroughly assess the nature and extent of the disability and focus on specific areas of educational deficit.

The specific evaluation procedures employed are determined by the type of disability suspected and the type of services that may be needed. In some cases, the evaluation may be handled solely by a school-based assistance team. An assistance team, in cooperation with parents, could appropriately access existing evaluation data, review school records and obtain observation data, determine a disabling condition under Section 504, and recommend programming within regular education. An example would be a child who enters school with medical documentation of sickle cell anemia. The assistance team might collect observation data indicating that the child has limited stamina. Appropriate services might include giving modified assignments due to the child’s limited stamina and assisting the parents with giving feedback to medical personnel.

In cases where comprehensive evaluation is needed and/or the child demonstrates characteristics of a disability under IDEA, a referral to the school-based committee is warranted. The school-based committee should then follow appropriate evaluation procedures as specified in the current edition of Policies Governing Services for Children with Disabilities. To review or download this publication, go to:

## Components of IDEA and Section 504

<table>
<thead>
<tr>
<th>COMPONENTS</th>
<th>IDEA</th>
<th>SECTION 504</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedural Safeguards</td>
<td>Both require <em>notice</em> to the parent or guardian with respect to identification, evaluation and/or placement.</td>
<td>Does not require <em>written</em> notice, but a district would be wise to do.</td>
</tr>
<tr>
<td></td>
<td>Requires <em>written</em> notice</td>
<td>Does not require written notice, but a district would be wise to do.</td>
</tr>
<tr>
<td></td>
<td>Delineates required components of written notice.</td>
<td>Not required</td>
</tr>
<tr>
<td></td>
<td>Requires <em>written</em> notice prior to any change in placement.</td>
<td>Requires notice only before a “significant change” in placement.</td>
</tr>
<tr>
<td>Evaluations</td>
<td>Requires consent before an initial evaluation is conducted.</td>
<td>Does not require consent, only notice.</td>
</tr>
<tr>
<td></td>
<td>Requires re-evaluations to be conducted at least every three years.</td>
<td>Requires periodic re-evaluations.</td>
</tr>
<tr>
<td></td>
<td>Information gathered from - variety of Sources</td>
<td>Information gathered from - variety of sources</td>
</tr>
<tr>
<td></td>
<td>Requires an update and/or review before any change in placement.</td>
<td>Re-evaluation is required before a significant change in placement.</td>
</tr>
<tr>
<td>Grievance Procedure</td>
<td>Does not require a grievance procedure, nor a compliance officer.</td>
<td>Requires districts with more than 15 employees to designate an employee to be responsible for assuring district compliance with Section 504 and provide a grievance procedure.</td>
</tr>
</tbody>
</table>

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4 This chart reflects guidelines from references in N.C. Department of Public Instruction, U.S. Department of Education, U.S. Office of Civil Rights; reviewed by James F. McKethan, LLC, Fayetteville, NC.
<table>
<thead>
<tr>
<th>COMPONENTS</th>
<th>IDEA</th>
<th>SECTION 504</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due Process</td>
<td>Both statutes require districts to provide impartial hearings for</td>
<td>Requires that the parent have an opportunity to participate and be</td>
</tr>
<tr>
<td></td>
<td>parents or guardians who disagree with the identification, evaluation</td>
<td>represented by counsel. Other details are left to the discretion of the</td>
</tr>
<tr>
<td></td>
<td>or placement of a student with disabilities.</td>
<td>local school district. These should be covered in School District Policy.</td>
</tr>
<tr>
<td></td>
<td>Independent Ed. Eval</td>
<td>Not required.</td>
</tr>
<tr>
<td></td>
<td>Stay Put</td>
<td>Not Required.</td>
</tr>
<tr>
<td></td>
<td>Attorney Fees</td>
<td>Attorney Fees</td>
</tr>
<tr>
<td>Exhaustion</td>
<td>Requires the parent or guardian to pursue administrative hearing</td>
<td>Not required.</td>
</tr>
<tr>
<td></td>
<td>before seeking redress in the courts.</td>
<td></td>
</tr>
<tr>
<td>Enforcement</td>
<td>Enforced by Exceptional Children’s Division, Public Schools of North</td>
<td>Enforced by the U.S. Office of Civil Rights</td>
</tr>
<tr>
<td></td>
<td>Carolina</td>
<td></td>
</tr>
<tr>
<td>Discipline</td>
<td>If action is contemplated to remove child with disability due to</td>
<td>Section 504 will follow IDEA with the exception of “no manifestation” in</td>
</tr>
<tr>
<td></td>
<td>school code violation, a review to determine whether the behavior</td>
<td>which case services do not have to be provided. Manifestation not required</td>
</tr>
<tr>
<td></td>
<td>was a “manifestation” of the child’s disability, will be done.</td>
<td>for alcohol &amp; drug Violations.</td>
</tr>
<tr>
<td></td>
<td>If “Yes: – May be placed in other situation WITH services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If “No” – Relevant disciplinary procedures applicable as with</td>
<td></td>
</tr>
<tr>
<td></td>
<td>children without disabilities, WITH services.</td>
<td></td>
</tr>
</tbody>
</table>
Side by Side: IDEA and 504

The comparison chart on the following pages is reproduced by permission from:

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jmckethan@microscribepub.com
Permission obtained 2/15/10
### Side-by-Side: IDEA and §504

<table>
<thead>
<tr>
<th>IDEA</th>
<th>SECTION 504</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Funding statute</td>
<td>• Non-funding statute</td>
</tr>
<tr>
<td>• Discrete categories of disabilities</td>
<td>• Broadly defines disabled children</td>
</tr>
<tr>
<td>• Procedural due process</td>
<td>• Procedural due process</td>
</tr>
<tr>
<td>• “Pure” Section 504 children are not covered under IDEA</td>
<td>• All IDEA children are covered by Section 504</td>
</tr>
<tr>
<td>• IEP’s reasonably calculated to convey educational benefit</td>
<td>• meet the needs of disabled students as adequately as the needs of non-disabled are met</td>
</tr>
<tr>
<td>• Child find</td>
<td>• Child find</td>
</tr>
<tr>
<td>• Consent for evaluation</td>
<td>• Consent for evaluation</td>
</tr>
</tbody>
</table>

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SIDE-BY-SIDE: IDEA AND §504

IDEA

- Evaluation
- Eligibility – adversely affects
- Annual review
- Re-evaluations
- LRE
- Consent for placement
- Special education
- Culture, economic & environment
- Discipline – manifestation

SECTION 504

- Evaluation
- Eligibility – substantial limitation
- No annual review
- Re-evaluation
- Educational setting (LRE)
- Consent for placement\(^1\)
- Special education
- Culture, economic & environment
- Discipline-manifestation

\(^1\) Consent implied, OCR On-line Q & A, #43.
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Students Assisted by Medical Technology:
A Procedure for Entrance into an Educational Setting

The entry of a child assisted by medical technology into the school setting presents a challenge to the family, student and school staff. A medically-safe and educationally-sound program, accomplished by a collaborative effort, should create an environment that fosters academic success and social competence.

For a smooth transition into the educational setting, an organized planning process must be followed. This section outlines the steps and roles of personnel needed to facilitate this process.

Early Notification

Time is needed to properly plan, prepare and train school staff to meet the needs of a prospective student with special health care needs. Sufficient time is minimally defined as 10 school days; the U.S. Office of Civil Rights (OCR) in a decision in 1999, ruled that a school may exclude a student with special health care needs for no more than 10 school days if needed for proper planning or to hire/train school staff. However, it is preferable that the educational setting be notified about a prospective student with special health care needs two months before school entrance, if possible, in order for thorough planning and preparation. Notification of a student’s pending admission or return to school usually comes from the parent; in the case of the child assisted by medical technology, the child’s health care provider should also notify the education system as soon as the child is ready to leave the hospital or chronic care facility. Depending on the education system, different personnel may receive the notification, including the district superintendent, the principal, and the director of the Exceptional Children’s Program. School health professionals, such as the school nurse and school physician, should also be notified, as their input is essential in planning for placement.

Once the child is out of the hospital, other sources of referral to the education system may include case managers, the primary pediatrician, visiting nurses, and other home care providers. Staff from any public or private developmental or education program in which the child may be currently enrolled should also initiate a timely referral to the new program.

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Administrative Responsibility

The director of the Exceptional Children’s (EC) Program or principal, in collaboration with the school nurse, oversees the admission process to ensure that the needs of the child in the school setting are met. The determination of these requirements must be based on appropriate health and education assessments. Confidentiality and privacy must be respected and preserved.

The EC director also has the responsibility to provide adequate staff to meet the student’s education, transportation and health care needs. The appropriate staff should attend the planning and training meetings. Also, the health care plan and emergency plan should be reviewed by the EC director. The Exceptional Children’s Program Director is also responsible for arranging adequate insurance, as required by state law, to cover the liability issues involved when children assisted by medical technology attend school.

Role of the Parent or Guardian

Due to the parent’s or guardian’s unique understanding of the child’s needs and abilities, they should have an integral role in the planning process. They are the ultimate source of information and resources. Their role will include:

- Advocating on behalf of the child.
- Providing access to health care providers.
- Participating in planning and training meetings.
- Collaborating in the development of health care and emergency plans.
- Notifying the coordinator of school health services of changes in the student’s condition or health care requirements.
- Serving as a source of child-specific information.
Role of the Registered Nurse (School Nurse)

This person will serve as a liaison among family, community health providers, and educators to assure that the special health care needs of the student are addressed in the school. In most cases, the registered nurse (school nurse) assigned to the school where the student is enrolled is the appropriate person for this role.

The nurse is responsible for:

- Generating a nursing assessment of the child;
- Obtaining pertinent medical and psychosocial information;
- Developing a health care plan for the student in collaboration with the family, student and physician;
- Ensuring that a child-specific emergency plan is in place. This should be developed in collaboration with the school administration, community emergency personnel and the family;
- Attending the education planning meeting, reviewing the health care plan, and making recommendations for placement, staffing and training based on the student’s health care needs;
- Coordinating the student’s in-school health care as specified in the health care plan;
- Ensuring that care givers in the school have received competency-based training in appropriate child-specific techniques and problem management;
- Providing information for other personnel and students in the education setting about the special medical needs of the student, when appropriate;
- Maintaining appropriate documentation; and,
- Regularly reviewing and updating the health care plan and training for care givers, based on the student’s condition.
Pre-Planning Meeting

After the school has been notified about a prospective student with specialized medical needs, the school will arrange a meeting with an administrative designee (principal or director of the Exceptional Children’s Program), the parents/guardian and the student (if appropriate), and the school nurse.

Planning Meeting

The parents and student, registered nurse (school nurse), members of the education evaluation team, and the education and administrative staff will meet to discuss safe and appropriate classroom placement, and services and personnel necessary for the child to attend school in the least restrictive environment. This meeting should be held for every student assisted by medical technology, regardless of the child’s need for special education. If the student is to receive special education services, the health care plan could be incorporated into the Individualized Education Program (IEP), or attached to the IEP.

Training

Training of staff and caregivers is key to assuring the ability of the education setting to accommodate the student as safely as possible. Training should occur on several different levels, from general information to school staff to child-specific techniques for direct caregivers. This process does not end with the child’s entrance into school. Regular review and update of skills should occur as well as ongoing evaluation of student’s response to care.

Information Meeting

Once appropriate placement and services have been designated for the prospective student, the registered nurse (school nurse) should organize a meeting (or series of meetings) to educate the school staff about the student’s condition and specialized medical needs. The meeting(s) should address any concerns and questions of the school personnel, such as liability, roles and responsibilities of staff members. In addition, a general overview of the student’s health care plan should be presented. All school staff who will interact with the student should attend. The parent and student may or may not participate in these meetings.
General Staff Training

The registered nurse (school nurse) must provide a general overview of the student’s condition and health care needs. This should be done in conjunction with the family and other consultants such as the physician, home care provider, or specialists from the child’s medical center. Personnel who should attend this general staff training session include teachers, the principal and/or special education director, community emergency personnel, and other staff who will be in contact with the student, such as the bus driver, occupational therapist and physical therapist.

Topics that should be covered in the general staff training include:

- An overview of the child’s condition and specialized health care needs;
- A detailed review of the student’s health care plan;
- A basic overview of pertinent anatomy and physiology;
- The different staff member roles and responsibilities in the daily and emergency care of the student in school;
- Transportation issues and personnel, and
- Emergency plan and procedures.

Staff education can be accomplished through formal didactic sessions, “hands-on” introduction to equipment, use of audio-visual aids, and other pertinent teaching tools. Staff members should be encouraged to express their questions regarding the student’s needs and care in the training sessions. Staff training should be updated yearly and/or with any change in the student’s condition or placement in the school.

Child-Specific Technical Training

The essential and back-up care givers who will be responsible for providing direct care for the student during the school day must receive training in child-specific procedures. The school nurse is responsible for providing/coordinating training based on the child’s medical and other care needs. When necessary, additional training in child-specific skills may be obtained from a local medical center, home care provider, or other health care professional with clinical expertise in pediatric care. The school nurse coordinates such additional training consistent with N.C. Board of Nursing guidelines on delegation. (See Section D Chapter 6). A checklist for technical skills for each procedure is included at the end of the manual entitled Children and Youth Assisted by Medical Technology in Educational Settings, Guidelines for Care, Second Edition. Each list can be used as a

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2 Available from Brooks Publishing Co., P.O. Box 10624, Baltimore, MD 21285 (1-800-638-3775)
foundation for competency-based training in appropriate techniques and problem management. Specific procedures are outlined step-by-step. The school nurse providing the training is responsible for documenting acquisition of skills by completing the checklist as each technique is mastered.

In addition, the documentation should include comments regarding the caregiver’s strengths and weaknesses, as well as recommendations for further training and periodic skill review.

Monitoring and oversight of training should occur whenever there has been a change in the student’s status, when an emergency has occurred, and as needed. Training and review processes should be documented by the school nurse.

**Follow-up and Training**

Once the initial phase of training and planning is completed, regular evaluation of the health care plan and caregivers’ skills is necessary. The Individualized Education Program and the health care plan should be reviewed yearly. Based on the child’s condition, the reassessment of the health care plan may need to be done more frequently. After one month, it is important to assess the child’s adaptation to school and the school’s accommodation to the child.

**Home/Hospital Arrangements**

Occasionally it may not be in the student’s best interest to be in a group setting such as school. A child assisted by medical technology may be unstable or have serious medical conditions. In such a case, decisions regarding school attendance should be made by a team consisting of the child’s parents/guardian, primary care physician, medical specialists, the coordinator of school health and the educational coordinator.

If it is recommended that the child not attend school at this time, every effort should be made to continue the child’s educational services in an alternate setting (home or hospital) at the level the child can tolerate. Contact with other children through visits and telephone calls should be encouraged. The child’s status must be regularly reassessed and school attendance reconsidered if appropriate.

Resource:
North Carolina State Board of Education, [http://sbepolicy.dpi.state.nc.us/](http://sbepolicy.dpi.state.nc.us/)
Special Health Care Services
State Board of Education Policy - GCS-G-006

Policy designating special health care services to be provided under Basic Education Plan

SPECIAL HEALTH CARE SERVICES

(a) Each LEA shall make available a registered nurse for assessment, care planning, and on-going evaluation of students with special health care service needs in the school setting. Special health care services include procedures that are invasive, carry reasonable risk of harm if not performed correctly, may not have a predictable outcome, or may require additional action based on results of testing or monitoring.

(b) Care planning includes but is not limited to:

   (1) identification of appropriate person(s) to perform the procedure;

   (2) teaching those persons to perform the procedure; and

   (3) identification of a mechanism for registered nurses to provide ongoing supervision to ensure the procedure is performed appropriately and monitoring the student's response to care provided in the school setting.

(c) To assure that these services are provided, LEAs have the flexibility to hire registered nurses, to contract with individual registered nurses, to contract for nursing services through local health departments, home care organizations, hospitals and other providers, or to negotiate coverage for planning and implementing these services with the licensed physician, nurse practitioner, or physician assistant prescribing the health care procedure.

(d) LEAs shall implement this rule in compliance with the provisions of G.S. 115C-307(c).

1 Policy Identification: Title: 16 NCAC 6D.0402 Policy designating special health care services to be provided under BEP support services; Priority: Globally Competitive Students; Category: Basic Education Plan; Policy ID Number: GCS-G-006; Current Policy Date: 04/06/1995; Statutory Reference: GS 115c-12(9)c; GS 115C-81; GS 115C-307(c)
Students with Special Health Care Needs

(Sample Policy)

Consistent with the State Board of Education Policy GCS-G-006, the local LEA will make available a registered nurse for assessment, care planning, and ongoing evaluation of students with special health care service needs in the school setting. The school nurse shall determine the level of personnel (licensed or unlicensed) needed to perform the care at school and, with the school administrator(s), will identify appropriate persons to provide care. The school nurse shall delegate health care tasks and procedures according to his/her professional judgment in compliance with the North Carolina Nursing Practice Act.

(Sample Procedure)

1. Students with special health care needs, including those who are technology dependent, shall be referred to the school nurse. Parents, teachers, and administrators are responsible for notifying the school nurse when students with special health care needs enroll in school. At this time the school nurse shall obtain information to determine health needs that may occur at school. The school nurse shall determine, in collaboration with school administrators, parents, and providers, when the student may safely begin attending school. A student may be excluded from school for up to 10 school days if needed to properly plan for and train school staff.

2. The school nurse, as the school staff member with the knowledge and expertise in health care management at school, shall develop a plan of care. This plan of care will describe the care that is needed to safely care for the student at school and will be based upon consultation with the student’s medical care provider(s), parents/guardians, and the student when applicable.

3. The school nurse will be responsible for teaching and monitoring procedures performed and for evaluating the student’s response to care. The nurse will develop a system of documentation validating training, performance, and ongoing supervision of designated personnel. Designated school personnel shall document daily the care given and student’s response to care.

4. Students shall be instructed in self care when appropriate to do so.
5. School personnel shall be made aware of the existence of health problems for purposes of emergency care as well as for daily programming. In-service training shall be provided to teachers and other school personnel as necessary to instruct them in types of emergency care that might be needed (e.g., what to do during a seizure, how to recognize signs of insulin shock or diabetic coma, or how to move students to and from wheelchairs). Underlying this involvement of the regular education personnel shall be an understanding of their informed choice to participate and related release from liability offered by school law.

6. A student’s physicians’ written requests for adaptive health care or limited activities for students should be reviewed for appropriateness to the school setting and incorporated accordingly.

7. The school nurse shall assist in coordinating services by acting as a liaison with the health care provider, students, family, and school.
Physician and Parent Authorization to Provide Specialized Health Care Procedure
(Sample Form)

Return completed form to:
School Nurse
School

Name of Student: ____________________________ Birth Date______________________
Address____________________________________________ ___________________________

1. Physical condition for which the specialized health care procedure is to be performed:

2. Name of procedures (e.g., catheterization, gastrostomy feeding; suctioning) to be provided:

3. Precautions, possible untoward reactions, and interventions:

4. Time schedule and/or indication for the procedure:

5. The procedure is to be continued as above until: __________________________

6. __________________________

Physician’s Signature
Date

7. I hereby request school staff to perform the above procedure on or for the above-named student:

______________________________
Parent/Guardian’s Signature
Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize (name of physician) __________________________
to release to the school nurse or principal specific, confidential, medical information contained in
the medical record about my child. I understand that this information will be kept confidential
and used by school staff to deliver health care services to my child in school.

______________________________
Child’s Name
Birth Date

To: (name of school) __________________________

(Parent/Guardian’s Signature)
When A Student Needs Continuous, One-on-One Care at School: Guidelines for School Nurses

Continuous, One-on-One “Private Duty” Care is a Related Service

When the U.S. Supreme Court ruled on the issue of whether or not “private duty” nursing services are Related Services under IDEA, (Cedar Rapids Community School District v. Garret F. [119SCt.992] March 1999), its ruling became binding on all federal district courts in all states. The Court ruled that continuous, private duty care that can be given by a qualified nurse or other qualified person (other than a physician) is a related service and required by IDEA.

Relationship with the School Nurse

Frequently, the school nurse does not have direct supervisory responsibility for a private duty nurse or caregiver that is hired by an outside agency. Regardless, the school nurse has a duty to assure the proper care of any student in his or her school. A collaborative relationship with other health care professionals who provide care for the student is essential in order for that to occur. If any nurse suspects misconduct or incapacity of another nurse, or has reasonable cause to suspect that any person is in violation of the N.C. Nurse Practice Act, the nurse is responsible for reporting those facts to the N.C. Board of Nursing. The nurse is immune from liability resulting from the report if he or she has reason to believe that the report is true. Using his or her professional judgment, the school nurse may also choose to speak directly with the nurse involved, the nurse’s hiring agency, and/or school administration.

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1 Developed by R. Piche, 10/01; revised by N.C. School Nurse Consultants 6/08
2 www.ncbon.com, Nurse Practice Act, August 2009 (Article 9 of Chapter 90 of the N.C. General Statutes, Article 9A, Nursing Practice Act).
North Carolina Special Health Care Services
Students who need special health care and procedures at school (especially those that are imperative for survival or those that would cause great harm if performed incorrectly) must be assessed by a Registered Nurse (RN). That RN is the School Nurse in many school districts. Refer to “Special Health Care Services,” Section B Chapter 4. The nurse must assess the student’s needs and make recommendations about the appropriate person to perform the care, i.e., a licensed professional nurse or other competent caretaker.

The school nurse:

1. Collaborates with parents, physicians, and other community resource specialists to complete the student’s needs assessment.
2. Determines the level of care provider and level of services that the student will need at school.
3. Brings the findings and recommendation to the IEP team for further collaboration and input.
4. Perhaps assists the IEP team and school administration to secure the “private duty” caregiver through direct hiring, or by contracting through a community agency.
5. Develops or assists in the development of the job duties of the caregiver and assists in completing a written agreement with the caregiver or hiring agency. (For a sample see “Written Agreement for Private Duty Care at School”)
6. Directs the caregiver or the employing agency supervisor in documenting any required school records for daily care. (Examples: daily medication administration forms, procedure logs)
7. Provides ongoing, periodic coordination and communication with the caregiver to proactively anticipate changes in student needs.
Written Agreement for
Private Duty Care at School

Name of Student:_______________________Date of Birth:_______________________
Name of School:____________________ School District:_________________________
Date this agreement is effective:________Date this agreement expires:_______________
  Date & Signature of principal:____________________ ____________________
  Date & Signature of parent: ______________________ ____________________
  Date & Signature of school nurse: ________________ _____________________
  Date & Signature of care-giver’s agency supervisor:_______________________
  Date & Signature of “private-duty” one-to-one care-giver:__________________
  Date & Signature of classroom teacher:____________________________________

Duties of School Principal/School Nurse Supervisor/or LEA Administrator

1. Coordinate and manage written contract agreement between parent, one-to-one
caregiver agency and school, (including financial reimbursements). Keep parent
informed of contract agreement items as needed.

2. Include in contract agreement a plan with parent about attending (or not
attending) school if conditions of health care plan are temporarily not available –
example: if agency or parent does not supply a competent substitute for one-on-
one caregiver on any school day as originally agreed upon.

3. Support and collaborate with teacher, school nurse, parent, private duty caregiver
and employment agency in implementing overall student health care plan. This
includes regular school hours, field trips, school-sponsored “after-hour”
activities, and school bus transportation.

4. Inform parent and other school staff of school changes that occur that may affect
student’s care.

5. Assure all district school policies are implemented and keep central office
administrators informed as needed.

6. Assure environmental safety improvements, handicapped accessibility, and
building and classroom modifications that student requires.

7. Specify other duties:_____________________________________________________

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3 This sample agreement contains job duties only and does not replace the financial agreement between the
LEA and the health care agency. For another sample, see Appendix J “Private Duty Nurse Contract” in
Duties of Parents(s)

1. Keep school nurse, school staff and one-to-one care provider informed of any revised health information or revised doctor’s orders.
2. Provide medical equipment, supplies and all medications for school use.
3. Be available, at least by telephone, to school if student becomes sick, injured or requires emergency care. Complete all written information and records required at school.
4. Be available for meetings and conferences at school regarding student’s continuing care plan.
5. Collaborate with school personnel in development of individualized education and health care plan to be implemented at school.
6. Specify other duties: ______________________________________

Duties of Daily Caregiver’s Employing Agency (RN supervisor)

1. Collaborate with school nurse to assess student’s overall school care needs by gathering information from attending physicians, health care specialists, parents, teachers, and any other significant providers.
2. With input from the school nurse, physicians, and parent, initiate and complete in writing: a.) the daily student health care plan; b.) emergency action care plan; and c.) specific job duties for the one-on-one “private duty” caregiver.
3. If required by the LEA, maintain school record documentation of all medications, and procedures provided at school or throughout the school day, including off-campus time such as bus transportation and field trips.
4. Provide periodic on-site, direct supervision of the caregiver in accordance with the N.C. Nurse Practice Act to assure safe and appropriate patient care.
5. Provide a substitute caregiver at school when the regularly assigned caregiver cannot be available.
6. Specify other duties: ______________________________________
Duties of the School Nurse

1. If appropriate, provide input to the agency RN supervisor and caregiver in developing the student’s daily care plan and emergency action plan for use at school.
2. Help classroom teacher to maintain a safe environment for student including reporting any deficiencies to principal, teacher, caregiver, caregiver’s supervisor, and/or parent.
3. Maintain current knowledge of child’s health condition and help to assure that child’s health and safety needs at school are being met.
4. Monitor student’s condition at regular intervals. Notify principal, parent and other appropriate persons regarding any needed improvements or any problems.
5. Help assure that school district policies and content of this agreement are being met.
6. Specify other duties:____________________________________________________
Description

A coordinated school health program promotes the maximum physical, social, emotional, and educational growth of children. Reports show that school absenteeism and dropping out of school are areas of concern in North Carolina. The incidence of chronic health conditions and special health care needs, teenage pregnancies, child abuse and neglect, motor vehicle and other injuries, homicide and suicide demonstrate that health-related support services and health education are needed.

Recognizing the necessity for a coordinated school health program that addresses the present and future health needs of children and adolescents, the Centers for Disease Control and Prevention, the American School Health Association and other organizations concerned with student health endorse an interactive, eight-component model. The model has interlocking physical, mental, social, emotional, and intellectual aspects that are addressed by a systematic, planned approach. Although the school nurse can provide leadership for the team, he or she may also play a role in each of the eight components. ¹

The eight components are:

1. **Health Services** - These are activities aimed at determining the individual health status of students and school staff, referral for personal health services and correction measures, individual protective services such as emergency first aid and immunization programs, and health promotion. School nurses play a prominent role in planning and providing health promotion and early intervention.
   
   **School Nurse Role:** Assessing student health status, providing emergency care, ensuring access to health care, and identifying and managing health-related barriers to student learning.

2. **Comprehensive Health Education** - School health education is a multidimensional process associated with health activities designed to favorably influence the health knowledge, attitudes, and behaviors of individuals in school settings. It addresses the physical, emotional, mental and social aspects of health. The education is designed to help students improve health, prevent illness and reduce risky behaviors, thus influencing students' present and future health needs.
   
   **School Nurse Role:** Providing resources and expertise in developing health curricula and providing health information.

¹NASN 2001b, and, School Nursing: A Comprehensive Text, chapter 3
3. **Healthy School Environment** - The health of the students and school personnel is affected by the environment in which they work and play. Because the environment influences the habits, health, attitudes, comfort, safety and working efficiency of both students and staff, it needs to be and feel physically and emotionally safe. Creating and maintaining this supportive environment for learning is the responsibility of the school administration, with the help of all school personnel. Inspecting for environmental deficiencies is the statutory responsibility of the local department of health. (See Section C, Chapter 8)

   *School Nurse Role:* Monitoring, reporting, and intervening to correct hazards, collaborating to develop a crisis intervention plan, and providing adaptations for students with special needs.

4. **Physical Education** - The physical education program stresses regular and frequent fitness activities that promote the development of lifelong fitness habits. Students learn to assess their fitness status, set goals, and design personal activities.

   *School Nurse Role:* Collaborating with physical educators to meet physical education goals, providing information to students about physical activity, and helping to design appropriate programs for students with special health concerns.

5. **School Counseling / Psychological and Social Services** - Counselors, psychologists and social workers are an important link in the school-site health promotion program, providing individual and group assessments, interventions, and referrals. The goal is to prevent problems early and enhance healthy development.

   *School Nurse Role:* Collaborating with counseling staff to identify student psychosocial problems and to provide input and intervention.

6. **Nutrition Services** - School food services provide healthy, nutritious meals and snacks that reinforce the message students receive through health instruction.

   *School Nurse Role:* Providing education about nutritious foods, monitoring menus and food preparation, and encouraging the inclusion of healthy foods on menus, in vending machines, and for classroom snacks.

7. **School Site Health Promotion for Faculty and Staff** - School personnel organize and implement a wide variety of health and wellness activities. Faculty and staff involvement in health promotion activities provides positive role models, reinforces the school health message, and increases job satisfaction.

   *School Nurse Role:* Providing health information and health promotion activities, monitoring chronic conditions, and maintaining records.
8. **Family and Community Involvement in Schools** - The success of the school health program depends upon the support of the community. Joint school and community partnerships use community resources for health instruction, school-site health promotion programs, health services and referrals. They seek to involve parents, health professionals, and a cross-section of the community in decisions regarding coordinated school health programs.

*School Nurse Role:* Taking a leadership role in collaborating with community agencies to identify and provide programs to meet the physical and mental health needs of children and families.

Many people are involved in planning, implementing and evaluating a school health program. They include school personnel: school administrators, teachers, school nurses, physical educators, health educators, school social workers, guidance counselors, psychologists, health and teacher aides, and parents and students. They also include community professionals, such as:

- local health department administrators
- sanitarians
- physicians
- dentists and registered dental hygienists

Also involved are specialists in educational support services such as audiologists, physical therapists, rehabilitation and occupational therapists.

Resources:

[http://www.cdc.gov/HealthyYouth/CSHP/](http://www.cdc.gov/HealthyYouth/CSHP/)


NASN (2001b) *Position Statement: Coordinated School Health Programs*
Framework Guidelines

The framework of a school health program is comprised of the following suggested components for a well-coordinated school health program:

I. A philosophy
II. A purpose
III. Goals
IV. Policies and procedures
V. A plan for implementing and evaluating the program
VI. A School Health Advisory Council

Each element of the framework should build and gain impetus from the other, yet be an understandable entity.

I. A Philosophy

A program's philosophy is the cornerstone or foundation of its existence. The philosophy provides a point of view, a statement of values, an aspiration for ideal possibilities, and the significance or relationship of concepts pertaining to a school health program. The philosophy answers the question of why a health program exists and also queries its worth. It lends direction for a program's purpose, goals, and objectives.

A philosophy should be developed jointly by school health staff and administrators and should contain emerging concepts that are important to the local district, personnel, and the health program. Constructs that may be addressed in a school health program philosophy are: the student, health, nursing, health services, and the school. A sample school health program statement of philosophy follows this page.
School Health Program Philosophy

Sample

HEALTHY INDEPENDENT SCHOOL DISTRICT
Healthy, NC

The faculty members support the school health program philosophy of Healthy Independent School District. In accordance with this philosophy, we believe in the holistic student, affirmed as having inalienable rights, intrinsic value, dignity, and responsibility. The student is accepted without prejudice in terms of biological, socioeconomic, political, cultural, religious, and emotional complexities.

Health is recognized not exclusively as the absence of illness or disease, but as the most desirable level of physiological, psychological, and emotional well-being. We believe that all students have the right to learn how health may better be achieved.

School nursing is acknowledged as being a helping profession. School nurses are student advocates and liaisons among the student, school, community, and home.

The school health program is a vehicle in the advancement of student, staff, and community health and wellness. The program provides assistance in the discovery of barriers that may be hindrances to student learning.

One of the major principles of education has been the achievement and maintenance of good health. The school is an avenue through which meaningful preventive health measures may be initiated. The school setting has a unique advantage in: the promotion of health education; the development of positive healthful attitudes; the maintenance of an environment conducive to optimal health, growth, and learning; and the meeting of needs of school students and school personnel.
II. A Purpose

The purpose of the school health program should be agreed upon and stated by school administrators and school nursing personnel. A program purpose is a continuum of the philosophy; it provides direction and information regarding the aim and intent of the school health program. A sample statement of school health program purpose follows this page.

To provide coordinated school health and health maintenance services that comply with the accreditation standards, a school district must carefully plan, efficiently develop, and thoroughly evaluate the program. The school health program should be based upon an annual needs assessment. The program plan should address (short-and long-term) goals and objectives.

Once the annual projection of student needs is made, the district should identify the resources for provision of the school health program. A realistic school nurse/student ratio should be established. (The North Carolina Division of Public Health, and a number of national groups, including the Centers for Disease Control and Prevention, American Nurses Association, American School Health Association, and National Association of School Nurses, recommend a school nurse to students ratio of 1:750 for general populations; 1:225 in the student populations that may require daily professional school nursing services or interventions; and 1:125 in student populations with complex health care needs. A 1:1 ratio may be necessary for individual students who require daily and continuous professional nursing services.) In arriving at the nurse to students ratio, consideration should be given to students’ needs and school health services planned. The goals and objectives of a school health program should be measurable, attainable, realistic, and time specific. They should be reviewed at regular intervals for relevance and applicability to the individual school district.

The implementation of a school health program focuses on what services will be provided, who will receive the services, how services will be provided and who will provide the services.

Districts must establish priorities for student services and organize time frames for screening schedules, referrals and follow-up procedures. Resources to assist in resolving health problems identified at school should be located and developed. Recognition must be made for time allotment for school nurses to prepare for student emergencies and illness, health counseling, health teaching and health appraisals.

An annual evaluation of the school health program serves two purposes: to provide a summation of the health program outcomes and to point out areas where change is needed. An evaluation reveals strong and weak points. Evaluation results are helpful in planning
continuing education or in-service programs, as well as providing a basis for planning the next year’s program.
School Health Program Purpose

Sample

HEALTHY INDEPENDENT SCHOOL DISTRICT
Healthy, NC

The intent of the school health program is to coordinate necessary health related services and provide health counseling to assist students in making the most of their educational opportunities through program needs assessment, planning, development, and evaluation.

The primary purpose of Healthy Independent School District's school health program is the optimal maintenance, promotion, protection, and improvement of student, staff and community health. The school health program personnel work collaboratively with students, parents, educators, staff members and other community resources to help the student develop competence to confidently cope with the complexities of life. The program is designed to assure a safe, healthy environment that is conducive to learning and to provide professional care for those who become ill or injured while at school.

The school health program is no substitute for the health care that parents should provide for children. Rather than relieving parents' responsibilities, this program is established to encourage individuals to use the services of private health care providers (physician, dentist, eye care professional) and/or community health agencies.
III. Goals

The goals for a school health program should correspond to the educational goals of the school district. Goal formation follows the establishment of a health program’s philosophy and purpose. A program’s goals should state achievable expectations derived from problems that have solutions. Goals are statements of what a program is designed to do, and they guide the development of district health policies.

Steps in Goal Development

1. Assess needs.
2. List goals in order of priority.
3. Evaluate effectiveness of goal achievement.
4. Re-assess needs and revise or form new goals, if needed.
Coordinated School Health Program Model

(Sample Goals)

I. Coordinated School Health Program Model

The coordinated school health program model shall incorporate the following eight components within a single framework:

1. A school environment that is safe; that is physically, socially, and psychologically healthful; and that promotes health-enhancing behaviors;

2. A sequential health education curriculum taught daily in every grade, pre-kindergarten through twelfth, that is designed to motivate and help students maintain and improve their health, prevent disease, and avoid health-related risk behaviors and that is taught by well-prepared and well-supported teachers;

3. A sequential physical education curriculum taught daily in every grade, pre-kindergarten through twelfth, that involves moderate to vigorous physical activity; that teaches knowledge, motor skills, and positive attitudes; that promotes activities and sports that all students enjoy and can pursue throughout their lives; that is taught by well-prepared and well-supported staff, and that is coordinated with the comprehensive school health education curriculum.

4. A nutrition services program that includes a food service program that employs well-prepared staff who efficiently serve appealing choices of nutritious foods; a sequential program of nutrition instruction that is integrated within the comprehensive school health education curriculum and coordinated with the food service program; and a school environment that encourages students to make healthy food choices.

5. A school health services program that is designed to ensure access or referral to primary health care services; foster appropriate use of health care services; prevent and control communicable disease and other health problems; provide emergency care for illness or injury; and is provided by well-qualified and well-supported health professionals.

6. A counseling, psychological, and social services program that is designed to ensure access or referral to assessments, interventions, and other services for students’ mental, emotional, and social health and whose services are provided by well-qualified...
and well-supported professionals.

7. Integrated **family and community involvement activities** that are designed to engage families as active participants in their children's education; that support the ability of families to support children's school achievement; and that encourage collaboration with community resources and services to respond more effectively to the health-related needs of students; and

8. A **staff health promotion program** that provides opportunities for school staff to improve their health status through activities such as health assessments, health education, and health-related fitness activities.

II. **Physical Activity**

Every student in each grade, pre-kindergarten through twelfth grade, shall participate in daily physical education for the entire school year, including students with disabling conditions and those in alternative education programs.

1. Students in the elementary grades shall participate in physical education for at least 150 minutes during each school week; and
2. Students in middle schools and high schools shall participate for at least 225 minutes per week.

III. **School Health Advisory Council**

A school health advisory council shall be established that is composed of diverse members of the school community representing the eight components of the coordinated school health program, plus members of the community, family members, and students as appropriate.

1. The council shall meet regularly to assess the progress of all aspects of the school health program; and assist district/school leaders with general oversight, planning, evaluation, and periodic revisions of all aspects of the school health program; and
2. The scope of duties, reporting procedures and means of coordination for this council and for all other advisory councils and planning committees, shall be established in writing.

1-800-220-5183 or www.nasbe.org
IV. Policies and Procedures

A policy is a broad statement of an intended course of action. Policies instruct on the WHAT and WHY of work. They reflect the values of a community and are the rules of an agency. Procedures, on the other hand, are a series of steps that instruct on the HOW of doing the work of an agency.

The school health program policies should reflect a corollary adjunct to school district policy. Professional organizations in the community particularly interested in health promotion, such as nursing, medicine, mental health, public health, dentistry or optometry, may be of assistance in the development of policies.

School health services should be considered an essential part of the educational program of school children in North Carolina. These services should be provided to all children in accordance with standards established by the Department of Health and Human Services, the Public Schools of North Carolina, the nursing profession, and applicable federal and state laws. Local programs should address the functions outlined below through policies and procedures.

1. Identification of Students With Acute or Chronic Health Care Needs or Conditions

Policies and procedures should be in place to help identify students with special health care needs. The School nurse is responsible for assessing the student and determining the level of health services needed. A policy and procedures should be written in accordance with state and federal laws. (See Section B Chapter 4)

Additionally, a process for the annual identification of students with chronic illness, special health care procedures, life-threatening medical conditions and/or disabilities is needed. (See Student Health History Form, Section D, Chapter 3.) This process and the follow-up procedures should be written and followed by all school personnel. Information regarding a student’s health conditions is confidential and should be shared only with school staff who have “a legitimate need to know”. Sharing information outside the school system requires parent permission. Ongoing review of frequent health room visits is likely to detect problems needing intervention. Also, the following students need to be identified:

- children with frequent, repeated, short periods of absence or those with longer periods of not attending school;
- students with low achievement; and
2. **Provision of Emergency Care**

Well-organized plans of action should be written for the management of emergencies, including bioterrorism. The preparation would include fire, tornado, hurricane and intruder drills. Likewise, written guidelines should be in place for handling individual emergencies. Emergency medical service (EMS or 911) telephone numbers should be known by building personnel and posted in conspicuous places. Schools should have readily available emergency information, provided by a parent/guardian, on each student. It is highly desirable that two to three individuals (first responders), in addition to health professionals in each school building, be trained in first aid, cardiopulmonary resuscitation and AED use. (American Red Cross or American Heart Association Training) Poison control center information should also be included in written guidelines. (Resource: “Emergency Guidelines for Schools” NC Office of Emergency Medical Services for Children, 2009)

3. **Reporting Student Injuries**

Injuries are common occurrences in the school-age population. The school has responsibility for the safety and well-being of students during the bus ride to and from school, during the hours of school attendance, while on school property, or during school-sponsored activities. Local school district policies should address:

- measures necessary to prevent injury occurrences, including playground and sports safety;
- action to be taken if a serious injury or other emergency occurs, including parent notification;
- facilities and supplies to accommodate the special needs of injured students; and,
- documentation and reporting of injuries.

4. **Medication Administration**

Each school district shall adopt a policy and develop procedures concerning the administration of medication to students at school. (See Section E for recommendations and Appendix II for North Carolina law.) School employees shall have immunity from civil liability from damages or injuries resulting from the
administration of medication to a student if (1) the school district has received authorization from a health care provider and (2) a written request to administer the medication from the parent. The medication must be supplied in the original container, properly labeled. This should include the student’s name and dosage directions. Nothing herein should be construed to grant immunity from civil liability for injuries resulting from gross negligence. (For example, legal liability may be incurred if a school employee gave one child’s medication to another child.)

Training for medication administration by school personnel should be conducted annually by the school nurse or other qualified health personnel. Records of medication administered should be kept, including the time and name of the person administering the medication. Responsibilities of parents and schools should be clearly defined in written procedures and a policy should be adopted by the local district school board.

5. Health Screenings, Referral and Follow-Up

The intent of screening programs is not to diagnose, but to separate students with no apparent problem in the areas being screened from those who need further evaluation to determine if treatment is necessary. Screening programs in the schools should target conditions that may obstruct or interfere with learning and use the data to remediate the problems or defects that are identified. They should also educate students, parents, and school staff about the areas being screened. For screening programs to be effective, referral and follow-up components must be included. The most common conditions that may impact learning are vision and hearing.

6. Prevention and Control of Communicable Diseases/ Infection Control

To reduce the risk of spreading communicable diseases in the school setting, there must be guidelines for teachers and staff as well as students. The school nurse should make sure that policies exist for the following:

- Immunization requirement compliance and the protection of students who are not immune due to religious and/or medical exemptions
- Reporting and isolation of students who pose a serious communicable disease threat to others at school
- Staff members who perform invasive health care procedures
- OSHA Blood-borne pathogens/disease prevention
- Use of the health room and prevention of cross-contamination.
7. **Reporting Child Abuse / Neglect**

Any person having cause to believe that a child’s physical or mental health or welfare has been or may be adversely affected by abuse or neglect shall report the situation in accordance with North Carolina General Statutes. An individual reporting in good faith has protection from legal liability. Failure to report is punishable by fine and/or imprisonment. (See Appendix II)

8. **Transportation during illness/injury (non-school bus)**

Although medical emergencies requiring transport to a hospital and/or other health center rarely happen, the potential does exist. The school is responsible for assuring safe transport. Schools are discouraged from using school staff vehicles or personal cars to transport children home, to emergency settings, or to health providers. In developing the Transportation Policy, each local school district education agency should address:

- clearly identified situations that require transportation arrangements, i.e., extreme emergencies for immediate transportation to hospital/health care provider;
- utilization of staff in transporting students in non-emergency situations; and
- liability/insurance issues.

9. **Maintenance of School Health Records**

Records in school health programs serve three primary purposes: administrative, medical and educational.

Administrative health records show which children have received mandated immunizations, screening and examinations. Injury reports are also considered administrative records.

Medical health records form the data base for health care of individual children when the school assumes responsibility for health supervision of students. Clinical records include both positive and negative findings and individual health treatment plans.

Educational health records indicate health-based recommendations for special health care management of students while they are in the school.

The access to storage, retention and confidentiality of student health records should be a part of every school district’s written policies and procedures and be in compliance with FERPA and HIPAA.
10. **Do Not Resuscitate (DNR) Response**

Do Not Resuscitate is a directive for specifying that CPR not be used in the event of cardiac or respiratory arrest. DNR orders are used when death is inevitable...the defining issue is that the child will ultimately suffer more harm than good if resuscitated. Parent request that schools honor DNR orders for their children appear to be increasing. Whether to accept or deny a request for DNR in the schools is up to local policy. Convene a multidisciplinary task force to determine school policy so the widen range of viewpoints and experience can be examined. Closely review state statutes on the subject to determine how the state relates to and interprets constitutional rights and protection. Also review:

- Emergency Medical Services (EMS) regulations governing DNR orders
- The school’s obligation in loco parentis
- The school’s responsibility/authority to honor DNR orders
- Logistical operations of the EMS system
- Proximity of EMS to the schools
- The perceived mission and responsibilities of the schools
- Normal health care responsibilities assumed by the schools
- The availability and qualifications of nursing and other school health personnel. ¹

11. **Diabetes Training – general and intensive**

Each school district shall implement guidelines established by the State Board of Education regarding care of students with diabetes (see Appendix II) and assure that each school building follows the guidelines. All school employees (system-wide) must have annual **generalized** diabetes training. In each school building in which one or more students with diabetes are enrolled, at least two staff members must have a more **intensive** training on insulin administration, diabetes emergency procedures, and identifying and treating symptoms of hyperglycemia and hypoglycemia in order to appropriately support and assist students with diabetes.

Each LEA must provide to the State Board of Education a yearly report of these trainings.

V. Planning, Implementing and Evaluating the School Health Program

A school district’s procedures for the school health program should include implementation and evaluation. Planning should be directed toward both short and long-term goals. Each person concerned with the school health program should have knowledge of its overall goal and the function of specific personnel. It is helpful for a district to write goals in clear, concise, measurable statements. These statements can then be extended into specific action plans in a procedure manual.

A systematic, ongoing approach for evaluation of the school health program includes procedures for collecting, analyzing and interpreting data. Nursing services involve activities that not only help the child deal with problems but also prevent and reduce their occurrence. Interventions should be goal oriented and based on the specific needs of the child. The interventions should be evaluated based on their impact on the child.

A monthly summation report on health services activities may be helpful in gathering data. Revisions or re-evaluation of goals and procedures of the school health program may be based on interpretation of data findings.
VI. School Health Advisory Council

Purpose

The School Health Advisory Council should have one purpose: to help build and improve a strong district-wide health program. Designed to provide close liaison between the school and members of local, private and public health agencies, the Council should:

1. Provide school administrators with current information on health procedures and equipment.
2. Provide professional advice in designing and presenting effective instruction to students.
3. Promote a strong program of school/community relations in the health field.

Organization of Council

A well-designed plan is essential for developing a productive Advisory Council. This plan should include a well-defined purpose for the group. Once the purpose has been defined, the steps outlined below should be taken.

1. Draft a complete proposal, including the Council’s purpose, suggested membership, long-range goals and short-term objectives, meeting schedule, and organization.
2. Present this proposal to the district superintendent.
3. Work cooperatively with the school district administration in drafting and implementing necessary changes in the plan.
4. Assist the superintendent in presenting the proposal to the local board of education.
5. Implement the plan under the direction of the superintendent or the superintendent’s representative.
Membership

A well-planned and effective Advisory Council should broaden the perspective of the school district staff. For this reason, prospective members should be selected both for their knowledge of the health field and broad viewpoint concerning the needs of the public schools and the community.

Professional members of the Council should be drawn from the nursing, medical, dental and medical technology fields. Mental health, public health and social services representation should also be included. Additional viewpoints would be contributed by interested parents and members of other community groups. However, care should be taken to keep the Council small enough to be workable and effective.

Operational Practices

The effectiveness of any advisory council will depend on its sense of purpose, its own elected leadership, and the guidance it receives from the district. While operational practices will vary in detail with individual advisory councils, the elements described below are common to most groups.

a. A clear definition of purpose should be prepared and presented both orally and in writing by the district representative assigned to work with the School Health Advisory Council.
b. An outline of the district’s plans for health services and related activities should be presented by the superintendent or a top-level representative.
c. Specific tasks or objectives related to these plans should be presented to the Council, along with a suggested time line or schedule.
d. A program of work, including responsibilities of members, should be planned and implemented under the leadership of the Council’s elected chairperson.
e. Reports of progress based on Council recommendations should be presented by the district liaison staff member on a regular basis. If any recommendation is not implemented, the Council should also be told the reasons and be given suggestions for possible new directions.
Strong leadership is essential for any council or group of individuals to function as a unit. For this reason, the original membership roster must include individuals with both professional knowledge and the ability to work effectively as group leaders. Each School Health Advisory Council should include:

1. Elected officers, usually including chairperson, vice chairperson, and secretary.
2. Stated terms of service for members.
3. Procedure for establishing subcommittees.
4. Provisions for compiling minutes and setting schedules.
5. Procedure for replacing members.

Reference:


For additional information regarding School Health Advisory Councils, consult the N. C. Healthy Schools Website: www.NCHealthySchools.org for the N.C. State Board of Education’s “Healthy Active Children” Policy (01/09/2003 - Amended 04/07/2005).

See Appendix II for reference to N.C. State Board of Education policy on School Health Advisory Councils.
School Health Advisory Council Statement of Purpose

Sample

HEALTHY INDEPENDENT SCHOOL DISTRICT
Healthy, NC

School Health Program
Advisory Council Statement of Purpose (Charter)

The Board of Education of Healthy Independent School District authorizes the establishment of the Healthy Independent School District School Health Advisory Council on this ___ day of _____, 20____. The function of the Healthy Independent School District School Health Advisory Council is to provide advice and counsel to the administrative staff and school board. The Council is not given authority for policy decisions and is expected to operate within the guidelines set forth.

The purpose of the School Health Advisory Council is to contribute to the development and implementation of a coordinated school health program in the Healthy Independent School District. These contributions may be provided by activities such as but not limited to:

- Assessing, documenting and recommending specific health instruction, and health service needs;
- Providing input on staffing patterns, equipment, and facilities that is both current and relevant to students’ needs, and
- Promoting community public relations.

_________________________________ Board Chairperson

_________________________________ Superintendent
School Health Services

School health services must be comprehensive in design to meet the educational objectives and health needs of students. The purpose of the program is to focus on the needs of children and youth, and on the mutual goal of a healthy child who is prepared to maximize his/her opportunity to learn and grow in preparation for a healthy and productive life. Health is the key to the basics of education and should be part of the continuum of school services available to every student.

The health services portion of the school health program utilizes personnel from nursing, medical, dental, other professional disciplines, and ancillary health paraprofessionals. School health services are primarily the responsibility of the school nurse, working with others in the school community and as a liaison to establish and nurture networks and linkages with both the private and public health and social systems of the community at large. School health programs are most productive when collaborative efforts are preventive in their focus and epidemiological in their approach.

The health problems of school children today include not only problems related to disabilities, disease and injury, but also those related to behavioral and emotional factors and developmental delays. The range of services needed extends beyond the simple identification and control of contagious disease. School nurses today have responsibility for disease prevention and health protection as well as for initiating activities that promote positive health behaviors relevant to the child’s developmental stage, educational level and ability to accept and assume self care and self control. These services are most aptly understood when considered in the primary, secondary and tertiary framework used to describe preventive health care.

Primary Prevention

Includes all activities related to health promotion and specific protection from known threats to health to keep students from becoming diseased or injured. Frequently involves a variety of disciplines.
Examples:
- Assure immunization compliance
- Provide dental sealants
- Counsel students, families and school personnel on risks to health
- Monitor the school environment to identify and eliminate specific health hazards
- Coordinate health promotion activities with other partners to raise awareness and encourage healthy lifestyles
Secondary Prevention

Refers to early detection and intervention of disease or disability to reduce/minimize the negative consequences

Examples:

- Provide physical appraisals, including health history and developmental assessment, at school entry and at appropriate intervals during the course of a child's development
- Conduct screening programs for detection of problems that may interfere with learning, such as vision or hearing deficits
- Provide crisis intervention, assessment, and care management for students with physical, emotional or social problems.

Tertiary Prevention

Includes services intended to prevent additional disability and to maximize the use of remaining capabilities. Many children requiring this level of intervention have complex health problems requiring professional nursing management.

Examples:

- Assist students with health deficits by developing individual health plans which include follow-up activities to ensure treatment
- Implement or adapt screening and assessment procedures to accommodate the special needs of students
- Participate in multi-disciplinary placement conferences for children with health-related problems to provide input from the medical and nursing perspective
- Administer medication and/or treatments as needed to sustain school attendance and participation
- Instruct teachers and non-professional staff in needed special procedures and services
- Provide in-school case management activities to improve attendance and functioning of children with health deficits
An essential part of providing quality health services is having a properly designed and equipped health office area. The design of the space should be one with the goal of a safe, welcoming environment that efficiently meets health needs in the school setting. Whether planning a new school with a health office suite or remodeling an old space, the school nurse could be a great asset in the planning process.

The size, layout, furnishings and equipment of a school health office should be adequate to meet the health needs of the students and staff, and the mission of the school health program. Regardless of school size, the health office space should include several areas in order to address health care needs such as: a waiting and triage area, an area to provide health assessments and first aid, a private conference area, an isolation area, a rest area and a bathroom that meets ADA requirements.

Placement of the school health office should be based on optimal use. Location is important: have it located near the administrative offices and other student support services (social work, counseling, psychological) as well as convenient to students and families. Locating it near high traffic or high noise areas such as a playground, cafeteria, gymnasium, band room or noisy machinery should be avoided. The atmosphere of the health office ought to be one that is calming and soothing.

Besides being a serene place, the health area must be one in which students, family and staff can be ensured privacy and confidentiality. It should also easily accommodate a wheelchair and be quickly accessible to community emergency personnel and the use of a stretcher. Cleanliness and infection control are also to be considered. The walls, floors, counter tops and other surfaces should be made of material easily cleaned and sanitized. For both privacy and infection control purposes, the health office area should be used only for that purpose. It should not become an extension of the staff lounge, staff bathroom, or eating area. Nor, should it become a storage area for school supplies, other than health room supplies.

In addition to meeting the health needs of the students, the space should provide adequate work space for the school nurse serving the school. Suitable work space should also be provided for school employees or other health professionals who provide health care treatments, administer medications or provide first aid for students. A phone, computer, and lockable filing cabinet are basic necessities. The school nurse should be responsible for coordinating and directing health services provided by school employees or other ancillary health service team members.
Health Office Facilities

The size and layout of a school health office should be based on the number and age of students, prevalent health needs of the students, and the mission of the school health program.

Acknowledging that, some generalizations may be made about the square footage of the space:

- An elementary school serving 300-600 students should be 500-750 square feet
- A middle or high school serving 300-600 students should be 600 to 800 square feet.

All school health offices should include:

- A writing surface with a nearby telephone outlet and computer line.
- A private conference space where health counseling can be provided for an individual in a confidential manner
- A secured area with locked storage for medication, health supplies and equipment
- A secured, locked storage area for students’ health records (easily accessible, yet secure)
- An area for maintaining professional reference books and manuals, as well as health education materials for the students and families

A configuration that allows for specific separate areas for providing health care is important:

- A bathroom meeting ADA requirements with a grab bar next to toilet, a sink (with hot and cold water), and good ventilation, plus a changing table for facilitating special needs
- Area for assessments/treatments, first aid and medication administration
- Area for screenings such as vision and hearing
- Area for short rest periods when necessary (one cot for every 300 students)
- Area for isolation when a communicable disease/illness is suspected
- Area for triage and waiting (to be seen or to go home after being seen)
In addition, all school health facilities should have:

- The area designated for only health-related services (no staff food preparation/washing dishes/etc.)
- The area accessible for disabled students and for emergency transport
- At least one electrical outlet every six feet, with surge protection distributed throughout health office and bathroom area
- A sink outside the bathroom in the assessment and treatment area for hand washing
- All sinks equipped with liquid soap, and paper towel dispenser
- Lockable wall and base cabinets for storage of medications, supplies and equipment
- Easily cleanable counter tops, floors, and walls (to facilitate disinfection of soiled areas)
- A refrigerator of adequate size for storing medications and snacks for special-needs students
- Access to ice maker
- Adequate ventilation to support infection control
- A window to the cot and waiting area to provide visibility (with blinds/one-way glass for privacy)
Health Office Basic Supplies and Equipment

Desk Equipment/Supplies

- Networked, up-to-date computer and printer and with privacy features to ensure confidentiality of information
- Desk with lockable drawers and adequate work area and surface for telephone and computer
- General desk necessities (stapler, pens, paper, desk supplies, access to photocopier, etc.)
- Lockable file cabinets for storage of student records, informational and instructional materials
- Professional reference materials for school nurse or other health care workers:
- **Plus**, local health care policy and procedure manual and local health record forms

Health-Related equipment  (Keep a schedule to replace batteries, calibrate equipment, etc.)

- Physical assessment and screening tools (BP cuffs, stethoscope, penlight, otoscope, vision screening equipment, thermometers, etc.)
- Wall-mounted liquid soap dispensers adjacent to all sinks
- Wall-mounted paper towel dispensers adjacent to all sinks
- Pedal-controlled, covered waste receptacle with disposable liners
- First aid station with washable counter tops and adequate storage space
- Folding screens or draperies to provide privacy in separate student care areas
- Washable surfaces or disposable sheeting to allow for disinfecting between students
- Disposable blankets, pillows with disposable covers
- Gooseneck and/or magnifying floor lamp
- Wall-mounted height measuring device
- Balanced scale
- Portable stretcher
- Wheelchair
- Clock with second hand
- Sharps container for disposal of hazardous medical waste
- Eye wash station
Health Supplies

It is important to keep an ongoing supply list/inventory. This helps with tracking what is actually used and ordering new supplies. It is also very helpful to new staff members. Supply needs differ with each school but some of the basics include:

- Bandages/bandaids/dressings of various sizes and some that are non-latex
- CPR mask - one-way
- Cold packs - small and large
- Diabetic supplies
- Elastic wrap 2, 3, and 4 inches
- Emesis basin
- Eye charts
- Eye pads
- Eyewash solution
- First aid kit
- Fingernail clipper
- Gauze/sponges of various sizes and both sterile and non-sterile
- Gloves – non-latex small, medium and large
- Medication/pill envelopes (for field trips)
- Measuring device for liquid medications
- Peak flow meter with disposable mouth pieces
- Penlight/flashlight
- Plastic bags - sealable large and small
- Safety pins – small, medium and large
- Sanitary pads individually wrapped
- Scissors
- Sharps containers – small and large
- Slings
- Soap
- Splints – finger and board
- Tape ½, 1, and 2 inch
- Tissues
- Tongue blades
- Tweezers
Classroom First Aid Kit

At the beginning of the school year, each teacher should be given a re-sealable plastic bag or box containing soap, adhesive bandages, paper towels (if necessary), and instructions for the student on how to manage their own cuts and scratches. Instructions (written or verbal) given to teachers should include information that is consistent with the school’s OSHA Infection Control policies concerning provision of first aid to students. At the end of the school year, the teachers should return all unused supplies.

Supplies

- Liquid soap and/or bacteriocidal wipes
- Adhesive bandages such as Band-Aids
- Non-latex gloves
- Waterless hand cleaner

Purpose: For Classroom Care of Small Cuts and Scratches:

A. Prevents loss of pupil time from class.
B. Provides first-aid supplies for playground or field trips.
C. Teaches pupils how to care for minor injuries.

Directions:

1. Child should be taught to care for injury by washing cut or scrape with soap and water thoroughly for 2 minutes. Wipes can be used when running water is not available, but children should be encouraged to wash area as soon as possible.

2. Teacher or aide should inspect the area.

3. Adhesive bandages should be applied as needed.

4. Teacher should wash hands with soap and water or use waterless hand cleaner before and after if she/he assists with care.

5. Teacher should wear gloves when assisting in the care of the child.
References:


Guidelines for Developing and Implementing a School Health Program Plan

As a means for developing a coordinated health services plan, a contract or memo of agreement should be drawn up between the local health department and the school system. This contract should define the specific roles and responsibilities of each agency in providing health services to school children. This includes addressing mandated as well as “best practice” activities.

Mandated activities are:
- Kindergarten health assessments
- Communicable disease control, including immunizations
- Child abuse and neglect reporting
- Selected health screenings in the Exceptional Children’s program
- Special health care services
- Services under Section 504
- Infection control for invasive procedures and OSHA
- Compliance with CLIA regulations for waived procedures
- Care of Students with Diabetes at School
- Healthy Active Children (GCS-S-000) requirements for School Health Advisory Councils and Physical Activity
- Prohibiting the use of tobacco products in public school buildings

Other components that should be described in the plan are:
- Program goals and objectives
- Roles and responsibilities of each agency
- Process for developing/maintaining Local Education Agency approved policies and procedures
  - Medication administration
  - Prevention/control of communicable disease
  - Reporting student injuries
  - Maintenance of school health records
  - Provision of emergency care
  - Special health care services
  - Transportation during illness/injury (non-school bus)
  - Health screenings, referral and follow-up
  - Identification of students with acute or chronic health care needs / conditions
  - DNR response
Provision for annual revision of agreement

The Memorandum of Agreement should be reviewed and/or revised annually by representatives of both agencies, including at least one school nurse, for the purpose of assessing needs, evaluating current activities, or establishing new services.
Local Health Department/Local Education Agency Memorandum of Agreement (MOA) Guidelines

The North Carolina Department of Public Instruction and the North Carolina Department of Health and Human Services/Division of Public Health share a commitment to provide school aged children and youth a free, appropriate, public education in the least restrictive environment in an atmosphere that promotes good mental and physical health.

The importance of school health has never been higher. Increasingly, communities are recognizing the role that good health plays in the academic success of students. Local health departments and local school systems are the primary agencies entrusted with the health and education of our children and youth, and it is imperative that they work together.

In light of this, a Memorandum of Agreement (MOA) between each local health department and each local school system is an important part of the requirements of the Child Health Agreement Addenda for all local health departments. The purpose of this MOA is to clarify the roles and responsibilities of each agency and to promote a dialogue regarding school health between agencies.

The MOA should focus on joint activities of the two agencies and include items tailored to the individual community’s needs. (See following Guidelines) A well-designed MOA can help communities establish priorities and avoid confusion during situations such as communicable disease outbreaks and emergencies. By making joint decisions in advance about the role of school health staff in these potential situations, the loss of time can be avoided when time becomes critical.

The MOA must be updated annually, and a copy sent to the office of the State School Nurse Consultant, by September 1 of each year.

If you have questions regarding your Memorandum of Agreement, please contact your Regional School Nurse Consultant.
Guidelines for LHD/LEA Memorandum of Agreement

According to the N.C. Division of Public Health Child Health Agreement Addenda, the local health department will maintain a written agreement with the local school district(s) within its service area. A written agreement is required even if agency activities are limited to communicable disease control or environmental health activities.

The agreement must reflect joint planning and include each of the following four areas. Items under the headings are examples of activities that may be included in the agreement. It should be individually tailored for the parties involved.

I. SCHOOL HEALTH PROGRAM GOALS AND OBJECTIVES
(These should be developed individually in collaboration with representatives from both the local health department and the local education agency.)

II. ROLES/RESPONSIBILITIES FOR EACH AGENCY
Administration, supervision, joint program planning and evaluation
• School Health Advisory Council participation
• Participation in Child Family Support Team trainings and activities, if applicable
• If the school nurses are hired by the health department or other agency include:
  o Hiring, termination, and supervision of school health personnel
  o Maintenance, storage, destruction, and archiving of Health Records (FERPA, 1974; NC DCR, 1999)
  o Provision of supplies and facilities for school health program personnel
  o Professional development of school health program personnel
  o Quality assurance policies and procedures
  o Data collection policies and procedures

Communicable disease control and prevention activities
• Immunization compliance (GS 130A-155)
• Immunization events
• Responsibilities during communicable disease outbreaks
• Infection control activities
North Carolina School Health Program Manual

Section C

Coordinated School Health Program

Chapter 5

Developing, Implementing, Evaluating a School Health Program

Health Education

- Classroom instruction (if LHD shares an adjunctive role)
- Staff training on emergency procedures and medications (if nurses are hired by LHD or other agency)
- Wellness activities

Safe environment

- Provision of safe environment in school setting
- Medical and dental emergencies
- If nurses are hired by LHD:
  - Management of acute health care problems
  - Staff training in CPR and first aid

Identification and monitoring of children with health care needs that may interfere with learning

- Kindergarten health assessment review (GS 130A-440)
- Participation in early intervention activities
- If nurses are hired by the LHD:
  - Compliance with SBE (State Board of Education) Policy GCS-G-006-.0402 on Special Health Care Services
  - Health assessments
  - School nurse participation on student services teams
  - Services under Section 504 of Americans with Disabilities Act (ADA)
  - Medication administration oversight and training
  - CLIA (Clinical Laboratory Improvement Amendment) regulations for waived procedures
  - Compliance with GS 115C-307: Invasive procedure delegation, oversight, and training
  - Development and implementation of emergency plans and individual healthcare plans
  - Case management
  - Procedures for following GS 115c-47: Diabetes Care for Students in Schools

Environmental health

- “Tobacco Free Schools” policy
- Cafeteria, water and sanitation inspections
Access to healthcare

- Screening programs designed to identify and reduce or eliminate barriers to learning
- Referrals, follow up and securing care
- Assistance in finding medical homes

Emergency/disaster preparedness

- Areas of responsibility and oversight
- Liability issues
- Emergency training for school health personnel
- Periodic assessment and evaluation of emergency plans

School Based/Linked Health Centers

If applicable, list roles and responsibilities of school health personnel

HD personnel (school nurses or others) working in the schools are responsible for abiding by board of education approved policies and related procedures

Suggested school health policies and procedures:

- Medication administration
- Prevention/control of communicable disease
- Injury reporting
- Maintenance of school health records
- Provision of emergency care
- Health problem identification
- Special healthcare services
- Transportation of students in medical emergencies (non-school bus)
- Health screenings, referral and follow-up activities
- Case management activities
- DNR Response

III. PROVISION FOR ANNUAL REVISION OF AGREEMENT

The Memorandum of Agreement should be reviewed and/or revised annually by representatives of both agencies, including at least one school nurse. A copy should be sent to the State School Nurse Consultant no later than September 1 each year. If there are no changes, a signature page signed and dated by representatives of both agencies is sufficient.
References:
Family Education Rights and Privacy Act, 1974
NC Dept. of Cultural Resources, Division of Archives and History, Feb. 1999, Health Records Retention and Disposition Schedule
Occupational Safety and Health Act, US Dept. of Labor, Standard 29, CFR
State School Nurse and Child Health Consultants
Regional School Nurse and Child Health Consultants
Contract for School Nursing Services by the local Health Department

For Public Health Nursing Services to the school children of
_________________________County, ___________________ School District
agrees to reimburse________________County Health Department $_________.

THE UNDERSIGNED AGREE TO THE FOLLOWING CONDITIONS:

1. The term of this agreement shall be from (dates) ____________ .

2. This agreement may be canceled and terminated by either party hereto, but the
   party desiring to terminate or cancel must give written notice of its intention
   thirty (30) days prior to the end date of this agreement.

3. The amount of nursing service to the school children of _____ County shall be
   no less than _________________ for the duration of the agreement.

4. The Public Health Nursing Supervisor from the________ County Health
   Department shall have the authority for nursing administration, supervision, and
   periodic evaluation of the quality and quantity of nursing service. The types of
   services in the schools, and of routine and special reports to be submitted, will be
   determined by joint conferences of the School District Superintendent (or his
   designee), the Nursing Supervisor, and the Public Health Nurses.

5. Prior to the employment of a school nurse, applications for employment must be
   submitted to the Public Health Nursing Section of the __________County
   Health Department for review and approval, based on recommended Personnel
   Standards. The School Superintendent (or his designee) also will have equal input
   in the review and approval process.

6. Reimbursement will be made (frequency) ______ based on a sum equal to
   _______ of the agreed amount. Monies will be used for salary payments,
   mileage, and such nursing supplies and equipment as appropriate. Nursing
   personnel in _______ County will be employed and paid for (including travel
   and office expenses) by the_____________________County Health Department.

________________________________________________________________________
(School District Superintendent)                          (Local Health Department Director)
Date:     ____________________________
Evaluation of a School Health Program

Evaluation of school health services is a continuous process and necessary if the needs of students, school personnel, and the community are to be met. Evaluation is, or should be, a learning process. An evaluation is a set of systematic procedures to appraise a program and/or provide information about the program’s goals, activities, outcomes and cost in order to make program improvements. The evaluation requires asking many related questions and a careful analyzing of the relevance of the information received. One of the greatest fears of evaluation is that one must have specialized knowledge or complicated tools with which to conduct an evaluation. Many tools have now been developed to assist in evaluation of school health services. Use of these tools can reduce the perceived challenges.

The main purposes of evaluation are to: (1) assess the effectiveness of a program in achieving its objectives; (2) identify strengths and weaknesses of a program; and (3) monitor standards of practice, a quality assurance process. For example, medications may be safely given and documented, but effectiveness in achieving their overall purpose for the student’s improved health or performance must be determined. Likewise, when conducting a screening program, resolution of problems found, including presence or absence of adequate resources for treatment, must be evaluated. The evaluation results will assist school health administrators in focusing on current needs, including implication for their cost-benefit, in each phase of the school health program. Evaluation will assist with decisions to modify or discontinue those practices shown to have no effect on the health status of students.

A program must be evaluated for both its present and future worth. Any program revolving around school children is undergoing constant change. More and more, school programs are being required to produce evidence of their effectiveness and efficiency by documenting program achievements. The best type of evaluation committee is one involving both school and community members who are interested in school health services.

Some of the benefits to be gained from evaluating the school health services are:

1. Demonstrating the contribution nursing service offers to educational programs for students;
2. Stimulating professional interest and desire to improve the program;
3. Comparing the existing program to recommended standards, programs, and practices;
4. Improving procedures and practices for detecting possible defects and for making referrals which should result in improved health of the children;
5. Identifying community needs for resources for school-age children
6. Involving more community members in the school program and improving the lines of communication between the school and the community, and,
7. Sharing the results of the evaluation with involved school personnel and community groups, such as the School Health Advisory Council, and parents so there can be a joint effort to improve the school health services program.
Essential Steps in Evaluation Process

There are some essential steps in the evaluation process. The process is the same whether one is evaluating an individual procedure in the school health service program or evaluating the total program. The seven essential steps include:

1. Identify values.
2. Identify standards and criteria.
3. Obtain data.
4. Make interpretations.
5. Identify alternate courses of action.
6. Choose action and take it.
7. Evaluate results.

Source: The source of the symbolic graphic of the essential steps in the evaluation process is unknown; it has been part of the School Health Program Manual since 2005.
Identify Values. Identify the values of the school personnel, the community members, the health professionals, the students and their parents around school health services. What are the social values, school philosophy and goals, professional values, scientific knowledge, and established theories? What are the values of the school nurse(s)? What are the values of the School Health Program Advisory Committee?

Identify Standards and Criteria. What type of school health services are mandated by state law and/or federal law? What does the Nursing Practice Act mandate? What do the Pharmacy Act and the Medical Practice Act regulate in the school setting? What are the school district’s policies and procedures for school health? What do the Standards of School Nursing Practice developed by the American Nurses’ Association and the National Association of School Nurses recommend? What other standards and criteria can be identified that will impact upon the school health program?

Obtain Data. What data is available in the district about school health services? This might include an annual school nurse screening data report, monthly school nurse activity reports, statistical information from the Public Schools of North Carolina, immunization summary reports, and daily health room reports. What other data need to be obtained to provide essential information?

An assessment tool can be used to obtain additional information. Either use an established assessment tool or develop one for the school district. There are many assessment forms printed to use in evaluating school health services. An Evaluation Guide for School Nursing Practice was designed to be used in conjunction with the Standards of School Nursing Practice. This guide is printed to help evaluate school nursing practice by self or peer review. Both documents were developed by representatives from five different nursing organizations that have an interest in school health, and school nurses are strongly encouraged to use them.

Make Interpretations. Based on the findings and measurements of values, standards, criteria and data, make interpretations to identify the strengths and weaknesses of the school health services program. Set priorities for correcting the weaknesses. DO NOT make too many changes at one time.

Identify Alternative Courses of Action. Identify the different possibilities for making a change by reviewing alternative solutions and change strategies. The place to begin change is at those points in the system where some stress and strain exist. Remember that when a change is made in a system, it will cause other changes to occur. In deciding on a course of action, look at the intended as well as unintended impacts on the total system.
Choose Action and Take It. For an effective planned change, involve other members of the school system and community “experts” as needed in diagnosing the need for change and in deciding the action to be taken to bring about the change. Present the facts to them in a clear and concise manner. In deciding the plan of action, take into consideration the factors listed below which influence adoption of change.

1. **Relative Advantage** – Is it to the advantage of the students and school to make the change?

2. **Compatibility** – Is it agreeable to those people in the school and community who will be affected?

3. **Complexity** – Keep the change as simple as possible. If it is too complex, break it down into steps.

4. **Test Sites** – Can test sites or pilot projects be established?

5. **Observability** – Can the outcome be observed? Does it make a difference?

After taking these factors into consideration, choose a plan of action and take it.

Evaluate Results. After a designated time period, review the results of the change and determine how successful (or unsuccessful) it was. If necessary, make modifications so the change will be more acceptable. When a change has been successful, keep going. Look at the list of priorities for correcting weaknesses in the school health services program and select the next item to address.

In summary, evaluation is an ongoing process. There is always room for improvement. There are changes in laws, rules and regulations, improvements in standards of practice, and changes in the school nurse’s own areas of special interest. All of these have an impact upon school health services and meeting the needs of the students.

Resources:
N.C. Program Assessment Tool, Section E
N.C. End of Year Report - Annual Report of School Health Services in North Carolina Public Schools, Section E Chapter 7
School Health Education

Health education instruction is required by North Carolina law G.S. 115C-81(e1) and by the State Board of Education to be part of the instructional program, of every school, grades kindergarten through high school. Even if it were not formally required, health education would still be an essential part of any coordinated school health program.

The primary reasons for schools to deliver health instruction are that healthy students: 1) generally are better learners than unhealthy ones; 2) are likely to stay in school longer; 3) have better attendance records, and 4) tend to be more alert, productive, and therefore academically successful. These benefits apply to post-school life as well.

In recent years, ample evidence has accumulated demonstrating that health education instruction, when delivered according to best practices such as those outlined in the 2007 National Health Education Standards does, in fact, reduce risk taking behaviors and develop health literacy when it is carried out according to certain principles. A “successful” (i.e., capable of changing health-related behaviors) school health education program is built on the following principles:

- Focuses on health-related behavioral outcomes;
- Addresses individual values and norms that support health promoting and health enhancing behaviors;
- Addresses the various peer and social influences that impact responsible health promoting decision making;
- Includes instruction and assessment on the essential health skills applied to real world scenarios;
- Takes a comprehensive sequential approach to all health topic areas;
- Actively engages students in student-centered instructional and assessment activities;
- Correlates behavioral health priorities to the appropriate cognitive levels;
- Provides opportunities to reinforce essential health skills and health behaviors;
- Incorporates culturally inclusive instructional strategies;
- Has continuity in its scope and sequence within and across the grade levels;
• Has adequate instructional time at each grade level;

• Is taught by well-informed, well-trained teachers grounded in school health education pedagogy;

• Provides opportunities to extend instruction beyond the classroom by connecting to school/community policies, parents/guardians, health services, community services/programs, and student services, and

• Is reinforced across the curricula at every grade level and by school professionals who model key health concepts.

In addition to a planned course of instruction, health education concepts and skills become contextually meaningful when applied to all aspects of a coordinated school health program. For example, educating students on why non-violent behavior at school is the expected standard is strengthened when connected to existing school policies that have no tolerance for violence. Moreover, health education instruction on the concepts, skills, and applications of how to respond non-violently are reinforced when parent engagement activities, community and school services, and programs like Positive Behavior Support are linked to student-centered instructional activities.

A similar example can be made with nutrition and lifetime fitness education delivered in a health education classroom. When extension activities that support the key nutrition and lifetime fitness health concepts and essential health skills are taught, assessed, and linked to nutrition services, physical education, school environment polices or staff wellness, students have opportunities to become participants in their own learning as well as within their own school community.

All clinical school services, such as school nursing and school counseling/psychological services, should be viewed as partners in the school health education instructional program. As many personal health issues come to the forefront as a result of direct health education instruction, it is imperative that clinical support services are prepared to provide support to students and their families. Moreover, clinical support services are a resource to reinforce instruction as well as provide opportunities for students to become more engaged in their own school community. All school professionals, especially clinical health services professionals, not only serve as a resource but also can model responsible health promoting behaviors as the desired outcome.

The school health advisory council, composed of representatives of the community (including the health professions), can serve all the components of the coordinated school health program, especially the school health education instruction component. The
benefits of comprehensive sequential health education instruction and assessment may not be clearly understood by all community members. An effective school health advisory council can support school Board members and school personnel in educating community members and parents about the characteristics and benefits of an effective school health education instructional program.

Health education instructional programs are also well served by the presence of a central office school health education coordinator/administrator. A health education coordinator, in the person of a professional school health educator, does the following:

- Establishes and coordinates a K – HS school health education professional learning community made of elementary, middle, and high school health education teachers,
- Connects teachers to research-based instructional resources and practices, professional development opportunities, and opportunities to regularly examine the courses of study at each grade level,
- Advocates for and serves as a resource of comprehensive sequential school health education instruction and assessment at every school in every grade level
- Links teachers to professional development designed for the specific needs of K – HS health education teachers some of whom may not have current professional preparation in health teaching;
- Helps to coordinate school and community health education efforts;
- Promotes the continuity and sequence of the health education curriculum through the grade levels and for special populations of students;
- Assures that the content of the health education curriculum corresponds to the health needs of local students;
- Coordinates the health education component with the other aspects of the coordinated school health program; and
- Evaluates the impact of the program.

Resource:
Johanna Chase, MA CHES
Health Education Consultant
NC Dept. of Public Instruction, Raleigh NC 27699-6349
919-807-3857 ph  jchase@dpi.state.nc.us
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School Counseling Services
School Health Counseling

Counseling and Psychological Services is one of the eight components of the coordinated school health program model. The CDC defines this component as: “Services provided to improve students’ mental, emotional, and social health.” It further states: “Professionals such as certified school counselors, psychologists, and social workers provide these services….These services include individual and group assessments, interventions, and referrals.”  

The services may be provided as a scheduled planned event for a specific topic (e.g., violence and bullying prevention to a classroom, support for students who are experiencing family stress), or as a result of a referral for an individual request, either self-referral by the student, or on behalf of a student by a teacher, principal or other staff member, or by the student’s parent.

Together with other members of the student support services staff, school nurses can participate in school-based mental health services and collaborate with counselors, social workers and psychologists in serving students and families. The National Association of School Nurses (NASN) holds the position that the school nurse plays a supporting role in this component “by collaborating with counseling staff to identify student psychosocial problems and provide input and intervention.” 2 Within a collaborative environment, “[e]ach discipline brings its own unique knowledge base, skills and strengths, and it is crucial for each to understand the role and capabilities of the others.” 3

In nursing, counseling is often labeled “health counseling.” Health counseling can be defined as “any assistance to an individual seeking to solve any health problem” 4 or to a group of individuals. The North Carolina Board of Nursing recognizes counseling as a component of nursing practice for the Registered Nurse, consistent with G.S. 90-171.20(7)g. “Teaching and counseling include, but are not limited to: (a) assessing the client’s needs, abilities and knowledge level; (b) adapting teaching content and methods to the identified needs, abilities of the client(s) and knowledge level; (c) evaluating effectiveness of teaching and counseling; and (d) making referrals to appropriate resources.” (N.C. Administrative Code, Title 21, Chapter 36.0224(RN)

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Health counseling is a very important component of the nursing process, as part of both the assessment phase and in the list of possible interventions. While nurses in acute practice settings may have limited time in which to provide health counseling, school nurses are in a unique position to provide long-term health counseling and problem solving. School nurses, when providing health counseling, should utilize the best practice recommendations of mental health professionals while providing this service. In order to maximize a school nurse’s delivery of health counseling, a nurse should learn and actively practice the skills and strategies that are needed. For the less experienced school nurse or the school nurse who wants to learn more, there are many courses available.

Basic principles of school nurse health counseling

1. Establish effective working relationships by using good communication and interpersonal skills.
   - Practice active listening.
   - Allow the student or staff member to express their feelings and concerns without interruption.
   - Do not be judgmental or insert opinion while the student, parent or staff member is describing his or her feelings.
   - Correct errors in fact regarding health information, such as immunization side effects, after the person has had time to explain his or her thoughts and feelings. Try to find the source of the mis-information in a non-judgmental manner.

2. Consider the person’s cultural background or ethnicity as a source of differences from the way you might approach a health problem.

3. Assess the point in the “stages of change” at which the student or adult finds him or herself: precontemplation, contemplation, preparation, action, and maintenance. Different health counseling interventions may be more successful if applied at the appropriate stage.

4. Practice motivational interviewing, an evidence-based counseling approach that has been shown effective in helping people enact behavioral change. It has been shown effective in enacting behavioral changes that are among the most difficult to make: altering substance abuse, HIV risk reduction, diet and exercise, and health safety practices.  

5. Assess the person’s level of trust in you or in health care personnel in general. What is the person’s attitude about the other health care personnel, if any, who have already offered health counseling?

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6. Evaluate the person’s strengths and weaknesses; for example, is there good family support to assist in solving the health problem? Is access to affordable health care available?

7. When providing any health counseling, assure that the interventions you are offering are sound, based on best practice guidelines and scientifically-based health interventions.

8. Involve the student in assuming responsibility for his or her own behavior choices while providing options that reinforce appropriate health habits.

9. Timing anticipated health counseling to upcoming events can utilize the “teachable moment” and provide the nurse an opportunity to motivate students to react positively to the anticipated change when they are personally involved in the event or situation and presumably their interest is high.

10. Document your findings and the results of your health counseling. Whenever possible, link the health counseling to a positive educational outcome, such as missed less time away from class, teacher reported increased attentiveness, etc.

**Suggested Health Counseling Activities**

Provide planned and scheduled health counseling for anticipated events, such as entering puberty, or specific health promotion and prevention practices, such as immunizations, healthy snack foods, and personal hygiene.

Make appointments for individual health counseling of students facing unexpected events, such as an initial diagnosis of diabetes, or exacerbation of asthma. Prepare yourself by learning what instructions and prescriptions have been recommended by the student’s health care provider, and reinforce those instructions by repetition and support.

If a student is not adhering to a prescribed medical or nursing regimen, look for the causes by asking open-ended questions. If the diagnosis is misunderstood, provide an interpretation of the students’ health-related data. If the regimen is understood but not being practiced, helping the student verbalize his or her thoughts may lead the student to explore his or her own decision-making skills.

Incorporate health counseling informally, during the course of assessing a student for any health problem. This activity presents opportunity to promote health and encourage wellness; to identify health habits that place the student at risk and offer suggestions for change; and to advise students when medical care is necessary. Well-timed health counseling can prevent further deterioration of a health problem and improve health status.
Many health problems encompass both physical and emotional aspects. In those cases, consider co-counseling the student with a school social worker or counselor. Referrals to a social worker or counselor may need parental permission; follow school policy and protocol.

In consultation with the social worker, psychologist or counselor, make available information on other health and social services that the student or family may need and are beyond the scope of the school (hospital emergency room, public health department, local or state Division of Social Services, civic service clubs, mental health resources, community substance abuse programs, and voluntary agencies, such as immigrant support groups).
Promoting a Safe and Healthy School Environment

Environmental health services are provided jointly to schools by local health departments, the Division of Public Health and the Department of Environment and Natural Resources (DENR). The environmental health program objectives for schools are to assure that morbidity and mortality due to environmental health hazards associated with several program components are minimized as directed by specific General Statutes. The lead agencies for environmental health programs are the Division of Public Health and the Division of Environmental Health in DENR, in cooperation with local health departments.

Current environmental health programs include school sanitation and food service facility inspection, water quality monitoring, vector control activities, and hazardous waste management. Under school sanitation inspections, the following items are considered:

- Water supply
- Drinking water facilities
- Liquid waste disposal
- Toilet rooms
- Hand washing facilities
- Floors, walls, and ceiling
- Storage areas, furnace room
- Lighting
- Indoor air quality and ambient (outdoor) air quality
- Solid waste disposal
- Gymnasium
- Premises and surroundings

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1 This chapter reviewed and revised by David Lipton, Industrial Hygiene Consultant, Occupational and Environmental Epidemiology Branch
(919) 707-5961

2 Rules for Sanitation of Public, Private and Religious Schools are in Title 15A Subchapter 18A of the North Carolina Administrative Code (T15A.18A .2401 - .2417)
School food service operations are inspected routinely by environmental health specialists. This includes examining the facilities for producing, processing, transporting, storing, and serving foods, and post-serving cleanup and disposal activities. Food must be from an approved source, in its original container, and properly labeled. Food is required to be protected from contamination at all times and to meet temperature requirements during storage, preparation, display, service, and transportation. An adequate and potable water supply, proper waste disposal facilities, and properly designed and constructed equipment in a suitable structure are among the essential facilities required. Unless it is operated properly, even the best equipment will not guarantee the production of safe food. Most of the reported food-borne disease outbreaks can be traced to improper handling of foods, particularly improper maintenance of temperature, either during preparation, processing, storing or serving. Proper facilities and proper operation, therefore, are essential to providing safe foods at school.

Keeping Lunches Brought from Home Safe
Another way to prevent foodborne illness in school is to make sure lunches brought from home are stored properly once the student arrives at school. It is best if the lunch is packed in an insulated lunch box with a freezer gel pack. If there is a refrigerator at school available for the children’s use, have them put any lunches not in insulated lunch boxes in the refrigerator. If not, make sure lunches are kept out of direct sunlight and away from radiators, baseboards and other heat sources found in the classroom.

Schools may contact their local health department or state school nutrition services programs for “fact sheets” that can be sent home to parents to advise them on proper packing of school lunches.

Water for most schools is provided by either a community public water supply such as a city or county or a well located on the school grounds. The Public Water Supply Section, in the Division of Environmental Health, enforces requirements related to water safety. Representatives of the Public Water Supply Section and the local health departments are available to provide technical assistance as needed. Plans and specifications for water systems to serve schools must be approved by the Public Water Supply Section prior to construction.

Solid waste is also an area in which environmental health services are provided. Solid and hazardous waste specialists and local environmental health specialists monitor and advise schools. Additional technical assistance on proper storage and schedules for removal of routine solid waste is provided by solid and hazardous waste specialists.
Vector control activities, primarily advice about abatement and prevention of arthropod (mosquitoes, ticks, fleas, lice, mites) and rodent infestations, and information about pets in the classroom, are provided by local health departments and the Public Health Pest Management Section in the Division of Environmental Health. The presence of vermin at a school facility usually signals the need for immediate control steps and the need for better interior and premises sanitation practices.

Other areas of the environment of which the State Division of Public Health and local health departments may not be the lead agency for are as follows:

Noise: Day and night, at home, at work, and at play, noise can produce serious physical and psychological stress. The Environmental Protection Agency writes that 20 million or more Americans are exposed daily to noise that is permanently damaging to their hearing. No one is immune to this stress. Except for the serious problem of hearing loss, there is no human illness known to be directly caused by noise. Throughout dozens of studies, noise has been clearly identified as an important cause of physical and psychological stress, and stress has been directly linked with many of our most common health problems. Thus, noise can be associated with many of those disabilities and diseases, which include heart disease, high blood pressure, headaches, fatigue, and irritability.

Air Quality: Schools should be located in areas that are relatively free of outdoor air pollution. Several sources are available for health authorities to obtain information about which industries and facilities may pollute the air in their communities. Local Emergency Planning Committees (LEPC), usually coordinated by County Emergency Management Agencies, collect data and maintain records about accidental release of certain chemicals and assure that industry immediately notifies appropriate federal, state and local agencies when releases occur. Businesses that store, use or manufacture one of approximately 360 chemicals that EPA considers extremely hazardous, must report to the LEPC the amount, general location and hazards caused by that chemical's use or storage. Annually, industry must submit to the State Emergency Response Commission (SERC) and to EPA, a Toxic Release Inventory which reports on the amounts of toxic chemicals they routinely emit into the air, water or ship off-site for treatment or disposal.

Industries that release certain hazardous air pollutants (HAPS) or toxic air pollutants (TAPS) must obtain permits from the North Carolina Division of Air Quality under North Carolina Rules and the Clean Air Act. Health authorities can use these programs to obtain information and data about emission inventories and permitted industries in their communities.

The North Carolina Air Awareness Program is a public outreach and education program of the North Carolina Division of Air Quality DENR. The goal of the program is to
reduce air pollution though voluntary actions by individuals and organizations. Between April 1 and November 1 each year, daily air quality forecasts for ozone and fine particulates are published for major metropolitan areas of the state. Children tend to be more sensitive to ozone and fine particle air pollution because they breathe at a higher respiratory rate, their lungs are still developing, and are likely to be active outdoors. Children also have a higher rate of asthma. The air quality forecast is color coded for easy reference into five categories: Green (good), Yellow (moderate) Orange (unhealthy for sensitive individuals) Red (unhealthy) and Purple (very unhealthy). When the air quality index is code orange or greater, either the amount of ozone or fine particulate in the air exceeds the Environmental Protection Agency National Ambient Air Quality Standards and active children and adults, and people with respiratory disease, such as asthma, should limit prolonged outdoor exertion. Air Quality Forecasts are available at www.ncair.org/airaware/forecast/.

Most people are aware that outdoor air pollution can damage their health but many do not know that indoor air pollution can also have significant health effects. Environmental Protection Agency (EPA) studies of human exposure of air pollutants indicate that indoor levels of pollutants may be 2-5 times, and occasionally more than 100 times, higher than outdoor levels. These levels of indoor air pollutants may be of particular concern because most people spend about 90 percent of their time indoors. A definition of good indoor air quality management includes addressing the control of airborne pollutants such as mold, dust, chemicals, gases and pests. Introduction and distribution of adequate outdoor air and maintenance of acceptable temperature and relative humidity also contribute to healthy and productive indoor environments.

Four basic factors determine the quality of air in a school:
- sources of air
- heating ventilation air conditioning (HVAC) systems
- driving forces
- building occupants

Sources of indoor air contaminants can originate from within the building or can be drawn in from outdoors. Controlling sources of pollutants is an important method to enhance air quality. HVAC systems control temperature and humidity, distribute adequate amounts of outdoor air to meet dilution ventilation needs of school occupants and isolate/remove odors and air pollutants through pressure control, filtration and exhaust ventilation. Driving forces are airflow patterns resulting from mechanical ventilation, natural effects, and occupants. Air pressure differences created by these forces move air pollutants around the building. Occupants include students and staff who may be sources of pollutants such as water vapor, bio-effluents, and infectious agents.
Occupants may be exposed to readily identifiable air pollutants such as carbon monoxide from malfunctioning combustion appliances, mercury spills, and irritating chemicals used for cleaning or emitted from building materials and contents. Identifying and mitigating these agents that may cause building related illnesses should be a top priority. Building-related illnesses usually affect several people with similar clinical symptoms. Objective abnormalities can be found on clinical or laboratory evaluation, and one or more identifiable sources or agents known to cause infectious, immunologic, or allergic diseases can be determined.

People often report effects from poor indoor air quality that are non-specific symptoms such as headache, fatigue, shortness of breath, sinus congestion, coughing and sneezing, eye nose and throat irritation, dizziness and nausea. These types of symptoms may or may not be related to poor air quality. Other environmental stressors such as poor lighting, noise, vibration, overcrowding, poor ergonomics, and psychosocial stressors can produce similar symptoms but require different solutions. These building related symptoms are a challenge because a relatively few people are affected with different symptoms, clinical or laboratory tests are inconclusive and no causative agent can be found.

Because of varying sensitivity and susceptibility among people, some people may react to indoor air pollutants while others display no ill effects. People’s reactions to indoor air pollutants may also differ. Nevertheless, certain groups of people such as people with allergies, asthma or chemical sensitivity, people with respiratory disease or people with suppressed or impaired immune systems are more susceptible to the effects of indoor air pollutants.

Failure to respond promptly and effectively to indoor air quality concerns in schools can increase the potential for long-term and short-term health problems for students and staff, affect student attendance and comfort, reduce teacher and staff performance because of sickness or absenteeism, accelerate deterioration and reduce efficiency of the school physical plant and equipment, increase the potential that schools may be closed and/or temporarily relocated, strain relations between school administrators, staff and parents, create negative publicity and create potential liability.

Industrial hygienists in the Occupational and Environmental Epidemiology Section of the Division of Public Health provide information about indoor air quality and can conduct investigations in schools. Check the following website for additional information: http://www.epi.state.nc.us/epi/air.html

Via school maintenance directors, the Plant Operation Section in the School Support Division of the Department of Public Instruction is another resource for managing healthy indoor school environments.
Occupational Safety and Health: Each school system is required to provide its employees with a safe and healthful working environment according to the Occupational Safety and Health Act of 1978. The Occupational and Environmental Epidemiology Branch is able to assist a school system in evaluating and recommending controls for any situation or condition which poses a safety and/or health hazard to employees. Areas of concern may be (1) inadequate ventilation in laboratories, maintenance shops and garages which can result in over-exposure to varied solvents and acids, asbestos, wood dust and welding fumes; (2) exposure to noise, heat, radiation, too little light and vibration; (3) prevention of bloodborne pathogen exposure. The Occupational and Environmental Epidemiology Branch provides technical assistance upon request.

The North Carolina Department of Labor, Occupational Safety and Health Division, Bureau of Consultative Services is another resource to help schools meet safety and health regulations and develop effective safety and health management programs. Free full-service on-site safety and health surveys, or surveys tailored to specific needs are available. Confidential reports and recommendations are provided. The reports and recommendations are not shared with other Bureaus in the Department of Labor. The Consultative Services Bureau can be contacted at 919-807-2899.

Management of Small Volumes of Toxic or Hazardous Substances: A major safety and health hazard may exist in several schools due to improper management storage and disposal of small volumes of toxic or hazardous substances. The Division of Environmental Health works with school systems to develop acceptable plans for explosive or reactive materials (e.g., picric acid, or other peroxides), toxic metal salts and toxic organic solutions.
School Children’s Health Act of 2006

In 2006 the North Carolina General Assembly ratified the School Children’s Health Act of 2006, Session Law 2006-143, requiring schools to protect children from certain toxic exposures at school, including:

- copper chromated arsenic from treated wood in playgrounds
- exposure to diesel emissions from school buses
- mold prevention and mitigation
- pesticides
- elemental mercury

General Statute 115-C was amended with four new subdivisions which require use of integrated pest management (addressing pesticide use in schools); removal of arsenic treated wood on playgrounds and soils; removal of bulk and chemical mercury; and reducing students’ exposure to diesel exhaust emissions.

For details of General Statute 115-C and the four new subdivisions which address these toxic exposures, see Appendix II.

Other items for schools to consider

Asbestos Hazard Management

The Asbestos Hazard Emergency Response Act requires schools to designate a person responsible for managing asbestos containing materials in schools. Each school is required to maintain a readily available manual that describes the locations of asbestos materials in the school and the measures used to prevent asbestos fibers from becoming airborne.

Reducing Lead Paint Hazards

In 2010 new rules will require that workers who perform any renovation, repair and painting projects that disturb lead-based paint are required to be certified and follow specific work practices to prevent lead contamination in any child occupied building (children less than 6 years old) built before 1978.

Polychlorinated Biphenyls (PCB)’s in Caulk

Between 1950 and 1978, caulk containing potentially harmful PCBs (polychlorinated biphenyls) was used in many buildings, including schools. Although PCBs were banned in the United States in 1978, contaminated caulk still exists in older establishments that
have not had the caulk replaced. EPA and the State of New York have guidance documents for assessment and remediation of PCB containing caulks.

Green Cleaning
Schools are heavily used buildings that need effective cleaning to minimize health and safety hazards and provide an optimal situation for learning. “Green cleaning” or cleaning for health is intended to meet three goals; effective removal of soils, contaminants and bio-films, minimizing use/exposure to toxic agents in cleaning chemicals, and minimizing environmental impact of cleaning activities. Cleaning and custodial practices and schools need assessment and ongoing evaluation in areas such as:

- the degree of cleanliness required for specific locations and settings;
- the use of potentially hazardous chemicals;
- use of barriers such as entrance mats;
- use of equipment such as vacuums, burnishers, and microfiber mops that trap and extract soils from the environment, and
- development of partnerships between administrators, custodial staff, teachers and students.

Hand washing, hand sanitation, infection control
Schools often implement programs and practices that enhance student personal hygiene and sanitation as well as prevent spread of infectious diseases including bacteria and viruses, such as influenza, the common cold, norovirus, and Hepatitis A.

Hand washing, hand sanitation and infection control at schools can be supported and enhanced by:

- Providing instructional materials for use in the classroom and restrooms, which reinforce proper hand washing;
- Assisting principals in instructing teachers on proper hand washing procedures;
- Assisting the classroom teachers in instructing students on proper hand washing procedures;
- Communicating with principals, food service managers, and teachers any concerns related to increases in visits to the nurses’ office, which may be the result of improper hand washing or a food-borne illness outbreak;
- Developing guidelines for selection and use of hand cleaners, hand soaps and hand sanitizers.
- Developing guidelines and recommendations and providing information and education for enhanced cleaning and disinfection of school contents during disease outbreaks such as the novel H1N1 influenza, Norovirus, MRSA and other infectious diseases. These guidelines should reflect available evidence about the disease and its transmission route. Other considerations may include the added benefit/effectiveness
of enhanced disinfection practices, added costs for enhanced disinfection, risks associated with antimicrobial disinfecting agents, and types of surfaces, materials, and contents where enhanced cleaning, disinfection would provide the most benefit in reducing the spread of diseases.
School Nutrition Services

An integral part of every school student’s day is lunch, and commonly, breakfast is included in the school food options. Federal child nutrition programs provide funds for school districts to offer meals and snacks for eligible children while they are in school, before and after school, and during the summer. Eligibility is determined based on a student’s household income. Local school food managers make decisions about which specific foods to serve and how these foods are prepared. However, dietary guidelines must be met. Access to a nutritious and affordable meal during the school day is essential in order for students to gain full benefit from the education provided. Often, the school nurse is the one who facilitates this access for students with allergies, diabetes and other special health care needs.

The Centers for Disease Control lists nutrition services as one of the eight components of a Coordinated School Health Program model. “School nutrition programs reflect the U.S. Dietary Guidelines for Americans and other criteria to achieve nutrition integrity. The school nutrition services offer students a learning laboratory for classroom nutrition and health education, and serve as a resource for linkages with nutrition-related community services.”¹ The National Association of School Nurses views the role of the school nurse in school nutrition services as: “…providing education about nutritious foods, monitoring menus and food preparation, and encouraging the inclusion of healthy foods on menus, in vending machines, and for classroom snacks.”² In addition, the school nurse facilitates accommodations for the dietary needs of students with special health care needs.

Federal regulations require that substitutions must be made to the reimbursable meal for students who are unable to eat school meals because of their disabilities, when that need is certified by a physician. The physician statement must identify the student’s disability and why the disability restricts the student’s diet, the major life activity affected by the disability, the food(s) to be omitted from the diet, and the food or choice of foods to be substituted. School nurses provide essential coordination and referrals for students with special health care needs, and may have a role in the Individual Education Plan (IEP) for children with special dietary needs such as tube feedings. As members of the multidisciplinary teams serving students with 504 accommodation plans and IEPs, school nurses work with parents to obtain the physician statement when food adaptations are needed. North Carolina Department of Public Instruction Child Nutrition Services, provides a form, Medical Statement for Students with Special Nutritional Needs for

² National Association of School Nurses, Issue Brief, School Nurse Role in Education: School Meal Programs, November 2003
School Meals (See Appendix III) on which a physician would prescribe the nutritional needs for a student’s school meals, if needing modification. Among the conditions that may require special diets are: high blood pressure, dyslipidemia, diabetes, autism, muscular dystrophy, PKU, food allergies, cerebral palsy, Down syndrome, obesity, celiac disease, epilepsy, cystic fibrosis and spina bifida. Food allergy or intolerance does not automatically qualify as a disability; therefore, school food services may, but are not required to, make food substitutions for allergies. Allergies resulting in severe anaphylactic reaction meet the definition of disability and in those cases, food substitutions must be made, upon physical statement. Common food allergies are to peanuts and other nuts; seafood, including shell fish; milk, particularly cow’s milk; eggs; soy; and wheat, oats, barley and rye.

In the case of students needing assistive technology in order to obtain nutrition, school nurses work to obtain the physician orders, and in many cases, train school staff to provide the feedings through alternative routes. The school nurse troubleshoots issues related to tracheostomies, ventilators and feeding tubes. In complex cases, the student may need the assistance of one-to-one nursing care or one-to-one care of a staff member who serves as unlicensed assistive personnel (UAP).

School nurses may also play a role in providing services such as monitoring height and weight and BMI for students who are experiencing eating disorders: underweight, and overweight or obese.

Other school personnel with whom the school nurse collaborates in order for a student to obtain appropriate nutrition include speech-language pathologist; occupational therapist; school food services director; school cafeteria staff; teachers and teaching assistants and registered dietitian.

For assistance in assuring a student’s nutritional needs during the school day, North Carolina School Meals Initiative (SMI) consultants are available for consultation. (See Appendix I for a map of North Carolina Department of Public Instruction SMI and Child Nutrition consultants.)
Standards of Professional School Nursing Practice

School nursing has had standards of practice since 1983, when a nationwide task force of nursing leaders produced the first set of standards to help improve the quality of care provided to students. Standards of practice represent agreed-upon levels of quality in practice and reflect the values and priorities of the profession. In 1998, new national standards of practice for school nursing, based upon the format and language of the American Nurses Association (ANA) Standards of Clinical Nursing Practice, were developed. ANA’s 2005 publication of the “Scope and Standards of School Nursing Practice,” ¹ can be used to help school nursing personnel articulate a practice role and develop tools for evaluation of practice. These standards are written within a framework of the nursing process and include data collection, nursing diagnosis, planning, intervention and evaluation.

The following is a brief statement of these practice standards as set forth by the National Association of School Nurses.

The School Nurse:

- collects comprehensive student data pertinent to the client’s health or the situation;
- analyzes the assessment data to determine the diagnosis or issues;
- identifies expected outcomes for a plan individualized to the client or the situation;
- develops a plan that prescribes strategies and alternatives to attain expected outcomes;
- implements the identified plan, and
- evaluates progress towards achievement of outcomes.

The following is a brief statement of the standards of professional performance.

The School Nurse:

- systematically enhances the quality and effectiveness of school nursing practice;
- attains knowledge and competency that reflects current school nursing practice;
- evaluates one’s own nursing practice in relation to professional standards and guidelines, relevant statutes, rules, and regulations;
- interacts with, and contributes to the professional development of, peers and school personnel as colleagues;
- collaborates with the client, the family, school staff, and others in the conduct of school nursing practice;
- integrates ethical provisions in all areas of practice;
- integrates research findings into practice;
- considers factors related to safety, effectiveness, cost and impact on practice in the planning and delivery of school nursing services;
- provides leadership in the professional practice setting and the profession, and
- manages school health services.

Recommended Maximum Ratios of School Nurses to Students

1 nurse to 750 students: regular education student population
1 nurse to 250 students: student population with children with special health care needs
1 nurse to 125 students: severely and/or multi-handicapped student population

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2 American Nurses Association (2005), National Association of School Nurses (2010), the American School Health Association (1998), American Academy of Pediatrics (2009), Healthy People 2010 (CDC)
North Carolina Standards for School Health Programs

On July 18, 2004 the General Assembly of North Carolina ratified House Bill 1414, which provided funds for school nurses (HB 1414, section 10.33). As a result, the School Nurse Funding Initiative (SNFI) had its beginning. The purpose of the initiative is to improve the school nurse to students ratio in the school district in order to have a positive impact on improving children’s health and their readiness to learn. Implementation of the initiative identified six health services areas that are the focus of activities for SNFI nurses. As the number of “initiative nurses” has increased in North Carolina, those six health service areas have become the basic standard of service expectation for North Carolina school health programs. The six health service areas are:

1) preventing and responding to communicable disease outbreaks;

2) developing and implementing plans for emergency medical assistance for students and staff;

3) supervising specialized clinical services and associated health teaching for students with chronic conditions, other special health needs and/or developmental disabilities;

4) managing medication administration, including administering, delegating when appropriate, and providing associated health teaching;

5) providing or arranging for routine health assessments, such as vision, hearing or dental screening and follow up of referrals to determine if care has been secured, and

6) assuring that mandated health related activities are completed, e.g., Kindergarten Health Assessments, OSHA requirements, etc.
Roles and Responsibilities of the Nurse in the School Health Program

In 1999, the National Association of School Nurses defined school nursing as:

A specialized practice of professional nursing that advances the well-being, academic success, and life-long achievement of students. To that end, school nurses facilitate positive student responses to normal development; promote health and safety; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self management, self advocacy, and learning.

In 2002, the National Association of School Nurses further defined the practice of professional school nursing in an issue brief describing seven roles of the school nurse. ¹

1. The school nurse provides direct health care to students and staff.
2. The school nurse provides leadership for the provision of health services.
3. The school nurse provides screening and referral for health conditions.
4. The school nurse promotes a healthy school environment.
5. The school nurse promotes health.
6. The school nurse serves in a leadership role for health policies and programs.
7. The school nurse serves as a liaison between school personnel, family, community and health care providers.

Each school nurse must complete a needs assessment of the school (student, staff and community population) in order to set priorities among those seven described roles. The activities of each school nurse are dependent on the acuity level of the students’ health care needs; the available resources; and the number of schools and/or students in his or her caseload.

The following chart is designed to assist a school nurse in establishing priorities. ²

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¹ National Association of School Nurses. 2004. Issue Brief: Role of the School Nurse. NASN, Silver Spring, MD

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### Setting School Nurse Priorities

<table>
<thead>
<tr>
<th>(#1) Highest Priority and Life Threatening</th>
<th>(#2) High Priority and Not Life Threatening</th>
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<tbody>
<tr>
<td>1. ABC Emergencies</td>
<td>1. MD orders</td>
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<td>2. Identification of students with life</td>
<td>2. IHP/EAP development for non-life</td>
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<td>threatening chronic conditions</td>
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<td>3. EAPs for life threatening issues</td>
<td>3. Staff training for same</td>
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<td>4. MD orders for life threatening issues</td>
<td>4. Medication training</td>
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<td>5. Staff training for life threatening</td>
<td>5. Communicable Disease control for</td>
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<td>issues</td>
<td>seasonal and outbreaks</td>
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<td>6. Suicide Assessment</td>
<td>6. Nursing assessment of students referred</td>
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<td>7. Orientation of brand new staff</td>
<td>for issues, not acute care (outcome of</td>
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<td>assessment determines priority of</td>
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<th>(#3) Lower Priority and Not Life Threatening</th>
<th>(#4) Time permitting, when higher priorities</th>
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<tr>
<td>1. Delegation supervision</td>
<td>1. Kindergarten orientation for parents</td>
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<td>2. Review, revision, development of policy</td>
<td>2. Daily, routine acute care of students</td>
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<td>4. Follow-up for screenings – secured care</td>
<td>phone duty, hall duty, proctoring for</td>
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<td>5. Regular faculty/principal meetings</td>
<td>EOGs</td>
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<td>7. General staff training – immunization,</td>
<td>5. Classroom health instruction as adjunct</td>
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<td>CPR, OSHA, diabetes, lice, etc</td>
<td>to teacher</td>
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<td>8. Reports</td>
<td>6. Performing routine mass screenings</td>
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<td>9. Self Inservice</td>
<td>7. Lice response</td>
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<td>10. IEP, 504, SAT meetings</td>
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<td>11. Staff assessment for self referred issues</td>
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<td>12. F/U Immunizations/Immun Review</td>
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<td>14. General record maintenance</td>
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<td>15. General call response (parent, agencies,</td>
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<td>etc)</td>
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<td>16. Developing student resources –</td>
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<td>(knowledge of resources in the</td>
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<td>community/staying abreast of changes)</td>
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<td>17. Understanding the school system</td>
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- The level of services provided by the school nurse is dependent on the number of schools and/or the acuity level of the students. A nurse serving one school with a population at or below the recommended level of 750 regular education students may be able to address the activities in all four squares. Regardless of ratio, each school nurse must prioritize. The order of the priorities is established by (in order) the threat to life, the requirements of the law, the practice standards that exist and school based policy and procedure.

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Adapted from *Four Square Organizer – D. F. Pooley*; and *The 7 Habits of Highly Effective People, S. Covey*
Competencies in School Nursing Practice

The components of nursing practice in North Carolina are defined and regulated by the North Carolina Board of Nursing as documented in 21NCAC 36.0224, Components of Nursing Practice for the Registered Nurse. Consistent with those regulations, a competency tool based on the School Nursing Standards of Practice (ANA & NASN, 2005), developed by the Connecticut State Department of Education, is applicable to North Carolina school nursing practice and is described in this chapter.

There are 16 standards outlined in the School Nursing Standards of Practice. Each section in this tool represents a separate standard. The tool is designed to assess where each nurse is for that particular standard at that point in time. While each standard complements the others, the competency tool is designed to look at each standard independently. The performance evaluation tool is designed to provide an overall picture of an individual school nurse’s achievement in meeting all of the school nursing standards of practice.

The tool is presented in a checklist format in order for the school nurse/school nurse supervisor to identify the skills and knowledge that the school nurse applies in his/her daily practice. As you read each standard, the columns build from left to right, from novice to expert. In other words, to be considered proficient, the school nurse would have successfully accomplished all the competencies identified under the emergent and competent level as well as the competencies delineated for proficient. Each standard should be considered separately; therefore, a school nurse may find that he/she is at the expert level for assessment but only at the emergent level for research.

In order to fully utilize these competencies to guide individual school nurse practice, it is essential that some overarching principles are in place at the district level. These include an introduction to district policies and procedures, familiarity with the data system within the district for data collection and nursing documentation, knowing how and when to access the nursing supervisor, and having access to available resources both inside and outside the school district.

This competency tool is intended to be used as:
- an orientation plan for new nurses;
- an evaluation tool by a nursing supervisor;
- a self evaluation tool by the school nurse;
- a program planning tool, and
- a goal setting tool for school nurses.

Each school nurse should review the entire tool at http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/Nursing_Competencies.pdf
Supervision and Evaluation of School Nurses

Nursing is viewed as an independent practice profession in North Carolina. As such, the North Carolina Board of Nursing states “RN practice encompasses the full scope of nursing and includes caring for all clients in all settings. The RN scope of practice in all steps of the nursing process is independent and comprehensive. RN practice does not require assignment or supervision by a higher level health care provider.”

In the school setting the registered nurse is often organizationally placed under an administrative supervisor, such as the Director of Student Services. This relationship allows supervision of employee-related position requirements, but does not include nursing practice-related position requirements. As stated by the National Association of School Nurses, “A distinction needs to be made between supervision in the context of employee performance and employment law and supervision in the context of nursing practice and nursing law.” Employee related item examples include compliance with district policies and procedures, use of leave time, punctuality, etc. All staff benefit from regular evaluation to foster employee and professional growth. To this end, sample evaluation forms for use by an administrative supervisor, or principal, are included in this manual.

School nurses also benefit from opportunities for professional development provided by practice review and evaluation. Those nurses with a registered nurse as a supervisor can be practice evaluated by that individual. School nurses without a registered nurse supervisor who work with a peer group of registered nurses can still obtain a practice review and evaluation through completion of a peer review. This would be consistent with the Board of Nursing requirement that supervision and evaluation of a registered nurse’s practice may only be completed by another registered nurse.

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2 North Carolina Board of Nursing, RN Scope of Practice – Clarification, Position Statement for RN Practice, January 2010.
3 National Association of School Nurses, Position Statement, School Nurse Supervision/Evaluation, June 2008
School Nurse Association of North Carolina School Nurse Evaluation Tool

The Professional Practice & Standards Committee of the School Nurse Association of North Carolina developed and adopted a suggested tool for nurse evaluation on September 11, 2008. A copy of the tool is available in Appendix I. As with the job description, the evaluation tool must be individualized to fit the needs of the system and the individual nurse. Job descriptions will vary based on the number of schools and complexity of student needs as well as other criteria individual to each system.

The purpose of the evaluation process is to ensure accountability, high quality services, and professional growth. The evaluation process includes data obtained from multiple sources including: observations, interviews, document analysis and personal and professional goals. Performance standards are based on the school nurse’s job description, N.C. Nurse Practice Act, and best practice as defined in Scope and Standards of School Nursing Practice.

The nurses’ performance aligns with the school/district/state priorities. School nurses are responsible for planning, implementing, coordinating, monitoring outcomes and evaluating school health services that:

- maximize the quantity of in-class time by reducing the incidence of health-related absenteeism;
- eliminate or minimize health problems which impair learning and future academic/social success;
- promote the highest degree of independent functioning possible, and
- promote student, staff and community awareness of and participation in healthy behaviors.

The school nurse supervisor completes an annual review. It is recommended that interim evaluations be completed during the first year of employment. More frequent reviews may be indicated if performance needs improvement.
Functional Health Pattern Assessment:
School-age Child and Adolescent

Professional organizations, such as the National Association of School Nurses (NASN), encourage the use of standardized, or common, nursing language in planning, documenting and communicating nursing care of clients. NASN has produced a position statement on standardized nursing language, which is included in Appendix I of this manual. The recommended standard for nursing language is found in the taxonomies of the North American Nursing Diagnosis Association (NANDA), the Nursing Intervention Classification system (NIC) and the Nursing Outcome Classification system (NOC). These taxonomies are evaluated and updated every four years.

Although nurses may use any systematic method of client assessment, these taxonomies are based on the use of a Functional Health Pattern assessment as described by Marjory Gordon, nursing theorist. Functional Health Patterns create a framework for the organization of similar system related client data that assists the nurse in identifying functional strengths and needs of the child and family. The following is a brief overview of Functional Health Pattern Assessment, from Gordon, Marjory (2006) *Manual of Nursing Diagnosis*, Jones & Bartlett Publishers. A companion reference by Carpenito-Moyet, *Handbook of Nursing Diagnosis*, 2007, 12th ed., is useful for relating a nursing diagnosis to a functional health pattern. The reference is updated every four years.

I. HEALTH PERCEPTION-HEALTH MANAGEMENT PATTERN:
Describes the perceived pattern of health and well-being including preventive health practices

*Subjective data*
General health of family and student (may want to use family tree)
Significant perinatal and past history including accidents, serious illnesses and hospitalizations
Current health concerns; treatments, etc.
Health care providers: physicians, dentists, others; dates of last visit(s)
Allergies
Medications
Immunization status
School absences
What does she/he do to stay well?
How easy is it for student to follow health advice?
Objective data
Describe general appearance

II. NUTRITION-METABOLIC PATTERN:
Describes the pattern of fluid and food consumption relative to metabolic needs

Subjective data
Type of diet, vitamins, other supplements
Weight loss or gain, growth pattern
Appetite, special diet, eating ability, feeding tubes
Skin problems, lesions, scars, hair, dental problems, healing capacity

Objective data
Height, weight (actual values and BMI)
24-hour recall and analysis
Skin and hair color and condition, hydration, teeth, mucous membrane

III. ELIMINATION PATTERN:
Describes the pattern of excretory function

Subjective data
History of elimination dysfunction, use of enemas and/or laxatives, colostomy, diarrhea, constipation
Body cavity drainage, current toilet and urinary patterns
History of nausea or vomiting

Objective data
Lab screening, catheterization procedure, observation and assessment results

IV. ACTIVITY-EXERCISE PATTERN:
Describes the patterns of activity, exercise, leisure and recreation; activities of daily living, home and school maintenance, neuromuscular and/or cardiovascular-pulmonary function.

Subjective data
Current mobility, activity, exercise pattern, play, etc.

Objective data
Vital signs (TPR and BP)
Range of motion, gait, posture
Respiratory pattern: depth/rhythm
Lung sounds
Heart sounds
Pulses

V. SLEEP-REST PATTERN:
Describes sleep and nap pattern including quality and quantity, energy level.

Subjective data
Sleep pattern: estimated hours, generally rested, restlessness, nightmare, nocturia, enuresis, naps

Objective data
Appearance, energy level

VI. COGNITIVE-PERCEPTUAL PATTERN:
Describes sensory, perceptual and cognitive functions including vision, hearing, taste, touch and smell. Includes compensation or prosthesis used for disturbances as well as activities such as language, memory, and decision-making.

Subjective data
Reported vision deficit
History of ear infections, use of hearing aid, speech pattern, therapy, ability to tell needs
Learning style and changes, school performance
Pain or discomfort (chronic or temporary), severity, management

Objective data
Vision: most recent vision exam; near or far acuity, muscle balance, stereopsis and color perception
PERRLA, Red reflex
Hearing screen
Developmental assessment (attach DDST or other age-appropriate test results or drawings)
JOMAC, Glasgow, or similar neurological assessment tool
Neurological assessment

VII. SELF-PERCEPTION/SELF-CONCEPT PATTERN:
Describes self-concept including perceptions of attitude, abilities, body image, identity, sense of worth and emotional pattern.

Subjective data
How describes self, feels good about self (most, some, all) of the time?
How feels about body, changes, abilities?
Feelings (often, seldom, never) of anger, fear, anxiety, depression, loneliness, etc. What helps these feelings?
How much sense of control over life, health, moods?
Friends, liked by others?

**Objective data**
Drawings, projective techniques, doll play, interactions with peers and adults
Eye contact, openness of communication

**VIII. ROLE-RELATIONSHIP PATTERN:**
Describes roles and relationships, responsibilities, and satisfaction with those

**Subjective data**
Household structure, relationships within family and extended family; family interactions, roles, responsibilities; satisfaction with home/work/school
How family deals with illness, chronic disease, limitations
Major stressors: maturational and situational
Discipline and behavior management
Parent-child interaction (give examples)

**Objective data**
Observation of interactions with family, peers, adults, and care providers
Social interaction, aggressive or withdrawn

**IX. SEXUALITY-REPRODUCTIVE PATTERN:**
Describes satisfaction or dissatisfaction with sexuality and issues related to the reproductive system in an age appropriate manner

**Subjective data**
Gender identity: feeling of maleness and femaleness; identification with adults and peers of same or opposite sex
Reproductive history, secondary sex characteristics, menses
Questions about sexuality, family response, and interactions
Sexual activity, contraception, and safe sex awareness and practices
Effects of chronic or acute illness on current and future sexuality
Objective data
Age and situation appropriate

X. COPING/STRESS-TOLERANCE PATTERN:
Describes general coping and effectiveness, modes of handling stress, and support systems

Subjective data
Recent changes or crises in family or health status
Stress producers
Level of stress tolerance
Family tense or relaxed
Use of medicines, drugs or alcohol to reduce tension by child/family
How are individual and family problems handled, how successful?

Objective data
Observations, results of coping and stress scales and inventories

XI. VALUE-BELIEF PATTERN:
Describes values, goals, or beliefs (including spiritual) that guide choices and decisions.
Identifies perceived conflicts in values and expectations which are health-related.

Subjective data
Plans for future, including short and long-term goals
Perceived impact of illness on goals
Family rules, norms, expectations, culture variables
Moral development; importance of religion, values, spirituality

Objective data
Observation of actions and environment for congruence between stated and the practice of values/beliefs
Child Health Appraisal: School Nurse Worksheet

Name ______________________  Age _____  DOB _____  Grade _____  Teacher ______________________________
Parent/Step/Guardian(s) ___________________________ _________  Phone ________________________________
Address ___________________________________________ ___________________________________________
Known medical diagnosis ____________________________ Physician _________________________________

ASSESSMENT

Health Perception/Health Management Pattern

Family History (attach Genogram and identify family/unit/significant health concerns)

Male
Female
Deceased
Separated
Divorced

Past History Allergies:

Illnesses/Accidents/Hospitalizations ________________________________
Immunization Status ____________________________________________

Current Health Status

Exceptional Children program or 504 identification _______ Yes ______ No ________ Pending
Special school modifications _______________________________________
Medication: taken at home _________________________________________
Medications administered during school hours _______________________
Treatments administered at home ________________ during school hours _____________________
## Nutrition-Metabolic Pattern

### Subjective:
- Appetite and thirst
- Diet (attach 24 hr recall)
- Last dental visit ______
- Dentist ___________

### Objective:
- **Anthropometrics**
  - HT ______
  - W ______
  - BMI ______ Results ______ %
- Assessment of Skin
- Hair and scalp
- Mouth
- Teeth

## Elimination Pattern

**bladder/bowel**

### Subjective:
- Infections (past/present)
- Surgery
- Enuresis ______
- Encopresis ______
- Assistive devices for bowel/bladder

### Objective:
- (as appropriate)

## Activity-Exercise Pattern

### Subjective:
- Past/Family History
- Trauma
- Joint/bone pain/swelling
- Assistive devices:

### Objective:
- **ADLs**
  - 1= independent
  - 2= some assistance
  - 3= dependant
  - 4= equipment
- Feeding ______
- Spoon ______
- Knife & fork ______
- Use toilet ______
- Wash hands ______
- Brush teeth ______
- Bathe ______
- Dress ______
- Tie laces ______
- Button ______
- Unbutton ______
- Other (gait/feet/spine/ROM)

## Respiration-Circulation Pattern

### Subjective:
- Past History
- Heart
- Vascular
- Respiratory
- Asthma
- Frequent infections
- Other:

### Objective:
- **Vital Signs**
  - T____
  - P____
  - R____
  - BP_____/
  - Hct____
  - Hgb____
- Tb Test______
- Results_____
- Other: (auscultation of heart/lungs)

## Sleep-Rest Pattern

### Subjective:
- Usual bed time ______
- Usual waking time ______
- Routines ______
- Nightmares ______

### Objective:
- **Facilities:**
### Cognitive-Perceptual Pattern

**Subjective:**
- Eyes:
- Ears:
  - Infections
- Nose:
- Neurologic
  - Trauma
- H/A

**Objective:**
- Vision:
  - Correction: Y N
  - Muscle Balance: ___pass ___fail ___NA
  - Binocularity: ___pass ___fail ___NA
  - Color Vision: ___pass ___fail ___NA
  - Stereopsis: ___pass ___fail ___NA

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**Otoscopic Inspection of ear:**

**School Performance:**

**Neurodevelopmental (attach instruments)**

**Laterality:** ___self ___examiner

**Eye** L R **Ear** L R **Hand** L R **Motor persistence**

**Role-Relationship Pattern**

**Subjective:** Child/family/peers/teacher

**Objective:** Observation:
- Class/playground/lunchroom/bus/home

**Coping-Stress-Tolerance Pattern**

**Subjective:** Stressors/examples
## Sexuality-Reproductive Pattern

**Subjective:**
- Relationships with peers
- Siblings
- Family
- Endocrine conditions
- Puberty

**Objective:**
- Observation as appropriate
- SMR / Tanner staging 1 2 3 4 5

## Value-Belief Pattern

**Subjective:**
- Cultural Variations
- Religious practices
- Dietary Restrictions

**Objective:**

## Home Visit: (or parent interview)

**Subjective Data:**
- Home Description

**Objective Data:**
- Size, type, rooms, facilities, utilities
- Condition of facilities

### Members living in home
- Routine in home
- Community Resources

### Assessment Summary:
- Client is a _____ yr. Attends___________ School in _____ Grade with ____________ as teacher.
- Lives with:
- Home is:
- Strengths of child/family:
- Concerns/Needs of child/family:
Nursing Diagnoses:
(for nursing diagnoses grouped under Functional Health Patterns see Carpenito-Moyet, L.J. HANDBOOK OF NURSING DIAGNOSIS (2007), 12th ED.PHILADELPHIA: J.B. LIPPINCOTT)

Case Management Plans:
IEP: _____yes _____no _____ needed
504: _____yes _____no _____ needed
IHP: _____yes _____no _____ needed
EAP: _____yes _____no _____ needed
Medication Forms: _____yes _____no _____ needed
Treatment Forms: _____yes _____no _____ needed
Referrals: __________________________________________________________
Section D
School Nursing Practice
Chapter 3
Health Assessment

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Nursing Care Plans:

Plan of Care

Individualized Health Care Plan (IHP)

Students with chronic health problems may or may not be eligible for special education services, depending on local school district, state or national program criteria. If a special education student also has related health care needs, or if a health impairment was a qualifying disability, then special education goals and objectives related to this condition should be included as a part of the individualized education program (IEP). In North Carolina, public school systems may be able to recover some expenses of medically-ordered nursing care for public school students who have specialized health needs and also qualify for an IEP. N.C. Division of Medical Assistance requires a Plan of Care (POC) as part of the documentation for those billable services. The IHP may be substituted for a POC if applicable. (See Appendix III for N.C. Division of Medical Assistance Plan of Care form.) Policies on this issue may differ according to school system. Regardless of eligibility it is a good practice to develop an individualized health care plan (IHP) to direct the health care provided by school staff. The IHP is a specially adapted care plan for use in the school setting. It provides a format for summarizing key information, synthesizing a problem statement based on a nursing diagnosis, and formulating goals and a plan for action. It enhances communication among health providers, school staff, administrators, health aides, and family. It also helps in directing comprehensive and high quality health care.

The first step in developing an IHP is to determine the impact of the health problem(s) on the student and his/her peer relationships through a nursing assessment and development of a nursing care plan. A nursing care plan follows the nursing process as mandated by the North Carolina Board of Nursing and directs the nurse in the overall nursing care for a student. A nursing care plan may be a detailed, formal document that is regularly evaluated and updated when the student receiving care requires on-going intervention by the nurse or has a complex set of problems. For example, most case-managed students will have a formal nursing care plan. Students with various chronic conditions such as asthma, diabetes and seizure disorders may benefit from a nursing care plan. Often a student may have a less involved health care need that requires little regular assistance from the nurse, or ongoing evaluation and amendment of nursing care. The nurse will follow the nursing process in making this determination, but may not need to develop a formal, written nursing care plan. This is often the case in crisis or episodic care.
An IHP is developed for any student whose health problem could be a deterrent to learning and who could benefit from special interventions from the school nurse and from the teacher or other school personnel. An IHP is a component of a nursing care plan that is written in terms that are understandable to school personnel and non-nursing care givers. It represents the portion of the nursing care in which the school staff is involved in monitoring or provision.

Components and Definitions of the Nursing Care Plan and IHP

The format is similar to the individualized education plan. An IHP is not mandated by federal law or regulations and should not be confused with the IEP. The components are:

- Nursing diagnosis (nursing care plan)
- Student Problems (IHP)
- Goal(s)
- Desired outcomes(s)
- Intervention strategies
- Evaluation

In 1985 the North Carolina General Assembly passed a law requiring school districts to utilize registered nurses for care planning. GS 115C-12(9)c: GS 115C-81: GS 115C-307(c) states:

Each LEA shall make available a registered nurse for assessment care planning, and on-going evaluation of students with special health care service needs in the school setting. Special health care services include procedures that are invasive, carry reasonable risk of harm if not performed correctly, may not have a predictable outcome, or may require additional action based on results of testing or monitoring…… (See Appendix II)

Nursing Diagnosis: According to the North American Nursing Diagnosis Association (NANDA), a nursing diagnosis is a clinical judgment about the response(s) of an individual, family, or community to actual or potential health problems or life processes. The nursing diagnosis provides the basis for the selection of intervention strategies to achieve desired outcomes for which the nurse is accountable. The language of nursing diagnoses is unfamiliar to school staff and non-nursing personnel. As a result, in an IHP the nursing diagnosis may be restated as a student problem in lay terminology. The professional nurse should have a working understanding of the process and components of writing a nursing diagnosis. References are provided at the end of this sub-section to assist in the development of nursing diagnoses.
Student Problem: This is the statement of the nursing diagnosis on an IHP in “lay” terminology for the school staff.

Nursing Diagnosis and Student Problem Priority: The focus of school nursing practice is the development of the student’s capacity to learn and to grow. As a result priorities should be established in the following order:

1. Safety of the student in the school setting
2. Effect on the student’s basic health needs in the school setting
3. Management capabilities of student/family/school
4. Conditions that interfere with learning
5. Other issues that can enhance student’s lifestyle

School nurses have found that Maslow’s Hierarchy of Needs is a helpful framework for setting priorities. Student need, time limitations, and student capability may limit the nursing diagnoses or student problems that can be addressed in a certain time frame or year. The school nurse has the opportunity to develop long-term relationships with the student and family. These may extend over several years or the school career of the student. Nursing diagnoses may extend and develop over the same period.

Goal: The goal or goals define what the future or resolution will be for the student. Goals are broad or global. Plans can be written to show both short-and long-term goals.

Desired Outcome: Desired outcomes are measurable behaviors that indicate problem resolution or progress toward the goal or valued health state. These are written before nursing interventions and after nursing diagnosis selection. The projected outcome can be written by converting the nursing diagnosis into the desired health state.

Example: Nursing diagnosis - Impaired Skin Integrity
A desired outcome would be that redness, pain or swelling will be reduced, and changes will be promptly reported to the appropriate person.

The school nurse is encouraged to use standardized nursing language in the identification of outcomes. The Nursing Outcomes Classification (NOC) system standardizes the vocabulary available to evaluate the effectiveness of care by outcome measurement.

Intervention Strategies: These are actions taken to help the student move from the present state to the state of projected outcome and thus to accomplish the goal. Strategies would include choices, capabilities, and resources of student, family and community, plus the research, findings and creativity of the school nurse. Also included might be:
1. Screening and referral
2. Treatment(s) and medications(s)
3. Health maintenance
4. Education
   a. Counseling
   b. Behavior management program
   c. Alterations in environment
   d. Referral to other services

The school nurse is encouraged to use standardized nursing language in the identification of intervention strategies. The Nursing Interventions Classification (NIC) system can assist the nurse in planning the activities that will best facilitate attainment of positive student outcomes.

**Evaluation:** Evaluation is a systematic review of the progress with the plan and revision as needed. This includes who, what, when, where, how much, etc. J. Denehy, in “Using Nursing Languages in School Nursing Practice,” (2004), states that: “In the school setting, school nurses have access to students over long periods of time, making revision more likely as student problems emerge and are resolved. Therefore, they have a greater opportunity to evaluate the effectiveness of interventions they have implemented and test the accuracy of their nursing diagnoses over time.”

References to assist in development of nursing diagnoses:


How to Develop a Nursing Care Plan and Individualized Healthcare Plan

Nurses who provide ongoing care and/or manage the healthcare for students are directed by their nursing assessment and subsequent development of the nursing care plan. This is a required North Carolina Board of Nursing practice component and the recognized standard in professional nursing. School personnel often also must provide healthcare activities and are not expected to utilize a nursing care plan. An individualized healthcare plan (IHP) or emergency action plan (EAP) is developed and provided to school staff for these activities. An IHP or EAP is a “subset” of the care planned in the nursing care plan. It is the portion that is only applicable for the “lay” school staff to perform. It is written in language that staff can understand and does not incorporate any judgment or health care decision making on the part of the staff. The Nursing Care Plan for nurses who are providing ongoing care, or case management activities for students, also includes activities that are not a part of an IHP or EAP.

According to School Nursing: Scope and Standards of Practice, to complete the IHP process, the school nurse develops the plan collaboratively with the student, parents, health care providers, school community and others as appropriate and individualizes the plan specific to the student’s needs to provide for continuity of care (NASN & ANA, 2005). The registered professional school nurse manages the activity of the plan.

The North American Nursing Diagnosis Association (NANDA) list of approved nursing diagnoses has been grouped by functional health patterns (Gordon) by L. J. Carpenito-Moyet in the Handbook of Nursing Diagnosis and is used for the instructions that follow.

Process:

1. Using a Gordon’s functional health pattern assessment tool (see Section D, Chapter 3), or the assessment tool utilized by your system, gather subjective/objective data related to this student. A parent conference on-site or by phone will be required in most cases, whether the student is a child or adolescent.

2. Make a copy of a blank nursing care plan with sections for each step. (Section D, Chapter 4)

3. Using a list of nursing diagnoses by functional health patterns (Section D, Chapter 3), select nursing diagnosis(es) pertinent to this student based on your assessment, citing related or risk factors as evidenced by defining characteristics.

4. Write a goal(s) and desired outcome(s) for each nursing diagnosis.
5. Write your intervention strategies for each nursing diagnosis.

6. If a procedure and/or treatment will be delegated/assigned, identify who will be doing the procedure, if known. A separate attachment to the IHP will be a copy of the individual procedure used, a daily work/time sheet, and training/supervision requirements and dates.

7. Highlight the appropriate nursing diagnoses, goals and interventions to be completed this year.

8. Evaluate progress of plan regularly and document. Revise the plan as needed.

9. Date and sign (full name and discipline) the nursing care plan. It may be necessary for potential reimbursement (e.g. Medicaid) billing purposes to state the amount of time needed to perform the oversight and evaluation of the plan.

10. Decide which portions of the nursing care plan will be the regular responsibility of other school personnel. Assure that all requirements of the North Carolina Board of Nursing regarding the delegation process are followed (Section D, Chapter 7).

11. Make a copy of a blank generic IHP or EAP form (Section D, Chapter 4).

12. Complete the identifying information on the form.

13. Transfer to the form the information from each nursing diagnosis that is applicable to the care provided by school staff. Avoid the use of nursing or medical terminology that might not be understood by “lay” professionals.


15. Current IHPs and EAPs may be kept in the student’s cumulative folder for access, per local policy. However, each person responsible for the student should receive an individual copy. In addition, the original should be retained in the student’s Individual Health Record. Plans from previous years can be archived or destroyed based on local policy. The only plan in the student’s cumulative folder should be the current year’s plan. IHPs and EAPs should be handled and protected in a manner that maintains student confidentiality.
Verbs for Use in Developing Student Goals and Objectives

**Student Goal:** The following verbs are broad indicators of student performance.

- explore
- increase
- decrease
- obtain
- maintain
- develop
- accept
- improve
- cope
- plan
- express
- experience
- resume
- share
- eliminate
- reduce
- regain
- restore
- attain
- prevent
- establish
- idealize
- replace
- display

**Student Outcomes and Objectives:** The following measurable verbs reflect student actions that are seen or heard.

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<td>deep breathe</td>
<td>irrigate</td>
<td>listen</td>
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<tr>
<td>drink</td>
<td>suction</td>
<td>refer</td>
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</table>
**Non-Specific Verbs to Avoid:** avoid using these verbs when developing goals, outcomes and objectives in health care plans.

<table>
<thead>
<tr>
<th>encourage</th>
<th>let</th>
<th>have</th>
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Individual Health Care Plan Form  *(sample)*

Name ____________________________ School __________________

School Year ___________________ Grade/Teacher ____________________________

Description of health problem:

Symptoms:

**Student Specifics:**

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<tr>
<th>Problem</th>
<th>Intervention</th>
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I have read and agree to the contents of this plan. Please notify necessary school staff with this form.

Parent Signature ____________________________ Date __________

School Nurse ____________________________ Phone __________

For internal use: Staff who were notified and have a copy of this plan, which is kept confidential from those who do not have a specific need to know.

Name: ________________ Date: ________________ Name: ________________ Date: ________________

Name: ________________ Date: ________________ Name: ________________ Date: ________________

Name: ________________ Date: ________________ Name: ________________ Date: ________________
Health Care Plan

Latex Allergy

(name)

Name _________________________________________ School ___________________

School Year ____________________ Grade/Teacher ____________________________

Description: Allergy to latex is a potentially life-threatening condition which is increasing in incidence throughout the world. The term *latex* is used here to describe products made from natural rubber latex, not synthetic (e.g., latex paint). The extensive use of latex in everyday items and health care (such as gloves) has greatly increased the exposure rate of the average person.

Symptoms: Symptoms may range from a rash when the person touches a product containing latex to breathing difficulties, hives, wheezing, swelling of the face and neck, tingling of the lips, etc. when the allergic person breathes in airborne latex particles. The allergy worsens with repeated exposures.

Student Specifics: The above named student currently responds with large blisters on the exposed skin, especially the palms. These break easily and become painful. Staff should always be observant for more serious progression of symptoms with each exposure.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Intervention</th>
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</thead>
</table>
| Blistering of skin with exposure to latex. | 1. Note student specific symptoms above.  
2. Avoid contact with objects containing latex. (See attached list).  
3. If exposure suspected, immediately have student wash affected body part thoroughly and rinse well.  
4. Loosely cover any blisters that form and protect them from breaking.  
5. Notify parents of exposure.  
6. Use vinyl gloves in first aid.  
7. If a severe reaction develops call 911 and transport to nearest hospital. |
I have read and agree to the contents of this plan. Please notify necessary school staff with this form.

Parent Signature __________________________ Date ________________

School Nurse __________________________ Phone ____________

For internal use: Staff who were notified and have a copy of this plan, which is kept confidential from those who do not have a specific need to know.

Name: Mrs. Brown, 504 Coordinator  Date: 12-14-09
Name: Mrs. Smith, homeroom teacher  Date: 12-14-09
Name: Mrs. Johnson, school secretary / First Responder  Date: 12-14-09
# Sample Nursing Care Plan Form

**IEP:** Yes [ ] No [ ]  
**Date Initiated:**

<table>
<thead>
<tr>
<th>Name: ____________________________</th>
<th>DOB: ______</th>
<th>Sex: M [ ] F [ ]</th>
<th>Relevant Diagnosis: ____________________________</th>
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</thead>
<tbody>
<tr>
<td>Health Care Provider: ______________</td>
<td>Allergies: ____________________________</td>
<td>Medical History: ____________________________</td>
<td></td>
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<td>Medical History: ____________________________</td>
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<th>Diet: ____________________________</th>
<th>Mobility: ____________________________</th>
<th>Equipment: ____________________________</th>
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<tr>
<th>Print Name: ____________________________</th>
<th>Signature: ____________________________</th>
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<tbody>
<tr>
<td>School Nurse</td>
<td>School Nurse</td>
</tr>
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</table>

**Principal Contacts:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Nursing Diagnoses</th>
<th>Goals</th>
<th>Desired Outcomes</th>
<th>Intervention Strategies</th>
<th>Evaluation</th>
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# Nursing Care Plan

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<th>Date</th>
<th>Nursing Diagnoses</th>
<th>Goals</th>
<th>Desired Outcomes</th>
<th>Intervention Strategies</th>
<th>Evaluation</th>
</tr>
</thead>
</table>

N.C. School Health Program Manual – *January 2010*
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Nursing Documentation: Health Records and Health Forms

Rationale for Nursing Documentation:
- Professional Responsibility
- Accountability
- Legal Protection
- Quality Assurance
- Communication with Other Health Professionals

The North Carolina Nursing Practice Act requires the recording and reporting of the nursing assessment, plan for care, care given and client’s response to that care. The National Standards of School Nursing Practice require adherence to the nursing process and systematic and continuous documentation of care. Such documentation includes: subjective data, objective data, nursing diagnosis based on the above data, a management plan and ongoing reassessment and revision of the plan as needed. Professional standards of documentation and correction of records should always be used. In addition, the Standards require a data management system to facilitate the planning, implementing and evaluating of the school health program, and to monitor the health of the school population.

Federal legislation and nursing licensure mandate confidentiality in all record-keeping. The school nurse must maintain appropriate records in order to provide health care support in school while protecting the student and family from the release of personal medical information.

In the school setting, there are two main types of health records: the Student’s Permanent Health Record (NC form PPS-2P), and an individual health record, where most nursing documentation will go. In addition, various health-related forms exist. The storage and management of all health records and forms should be addressed in the LEA procedures.

Documentation in Student’s Permanent Health Record

The NC Student’s Permanent Health Record (Guidelines available in the School Health Program Manual Appendix III - PPS-2P) is stored within the cumulative education record. It holds health related information that will further a student’s academic achievement and/or maintain a safe and orderly teaching environment and some mandated health information.

It also contains: student’s health status, immunization information, emergency health information, notations that an EAP or IHP exists, and screening results and follow up disposition. School staff with a legitimate educational interest may access this record. It follows the cumulative folder within the system and upon student transfer to another system.
Documentation in the Individual Student Health / Nursing Record

The **Individual Health/Nursing Record** is an individually retrievable record generated by the school nurse or other health care providers. It should be established for documentation of health room visits, detailed health issues and health issues not pivotal to educational achievement. It is stored separately from the cumulative educational record. School nurses are the interpreters of the health record. Information is shared with others within the school setting when necessary for the student, but access to all of the student’s individual health/nursing records should remain restricted to school health professionals (School nurses or school nurse substitute/ school nurse clinical supervisor/ medical advisor). Health records must be confidential, secure, protected from unauthorized access and protected from data loss. Restricting access enhances both confidentiality and security. The record should be securely stored (electronically or in a locked file cabinet) and accessible to the school nurse in the building where the student is enrolled.

**Medical Records** obtained by parent consent from outside providers may be stored in the **Individual Health/Nursing Record**. If the records are deemed to be important and need to be maintained by the school, they become part of the education record and are governed by FERPA. This type of information should be stored in the student’s individual health record.

**Medical information** that is typically protected under the NC Minor’s Consent law (such as information about treatment for HIV/AIDS, STDs, Family Planning, drug or alcohol abuse, mental health issues) should be carefully evaluated before being incorporated into the individual health record at school. If this type of information is needed for educational planning, health management during school hours, or for the student’s safety, then it is important to maintain at school and should go in the individual health record. If not needed for these purposes, it is not necessary to retain such information in the school records. Once incorporated into the health record, it too is governed by FERPA and is no longer protected from parental review under the NC minor’s consent law.

There are **additional health forms** used for many purposes such as: medication authorization and administration forms, injury report forms, IHPs and EAPs, health care procedure documentation, emergency information cards, and immunization records. Where to store and maintain health forms should be addressed in the LEA procedures.

**Data collection** is another type of health information generated by schools. It is used for reports to supervisors/others. This tool should be non-student specific, with no personally identifiable information and does not need to be stored in a student’s record.
Health Room Visit Documentation

Do not use logs. Use of a daily log that lists the name of the student along with his/her “chief complaint” is not recommended because it compromises confidentiality and is not an individual retrievable record. The school nurse may wish to develop a system that does not contain personally identifiable information to supply statistics for monthly/yearly activity reports.

The National Association of School Nurses, Inc. recommends the use of a personal card file system (each student with a separate card) or a notebook with a separate section per student or a computer record system. These would provide a place to record nursing process, document sensitive health issues, and record episodic health room visits. Nursing records should be kept in a secured cabinet with access only to nursing staff.

When school personnel request pertinent medical/hospital records, only a summary is needed and should be so stated on the release of information permission form. Schools should supply additional confidential protection for such records.

The school nurse must be informed of and comply with local school system policy on access to and confidentiality of records.

General Principles of Documentation

1. Sign every entry. If using initials, the nurse’s full signature (first initial, last name and discipline) must appear on one side of the page.

2. Be legible, factual, concise, and complete.

3. Be aware of the risks of using abbreviations. Use an LEA or LHD or hospital approved list of medical abbreviations, or a published manual of medical abbreviations. Do not use abbreviations that may be common only to one person. Do not use abbreviations that may be confused with other similar abbreviations. (See Appendix I for “Do Not Use” list offered by the Joint Commission.)

4. Document promptly and in ink.

5. Note date and time of care on all documentation.

6. Use authorized abbreviations.
7. Correctly identify late entries.

8. Correct inaccuracies by crossing through the error with a single line, writing “Mistaken Entry” above error, and initial correction. Do not erase or alter previous written notes. If using an electronic record, assure that the software contains overwrite protection that includes not only who changed the record and when, but also what words or numbers were changed. The previous, erroneous entry into the electronic record should be as readable as the paper record would be.

9. Document exact quotes, non-adherence to medications or treatments, and missed procedures.
Confidentiality of Health Information in Schools

The National Association of School Nurses (NASN) and the National Association of State School Nurse Consultants affirm that student health information, written, oral, and electronic, is confidential. The information should only be shared with those individuals who could enhance the educational process of the student by understanding an underlying health problem. Issues related to protecting health records are presented in the NASN Issue Brief: Privacy Standards for Student Health Records (2004).

Traditionally, most school children have been healthy and have needed school health services primarily for basic screening procedures or communicable disease control. In addition to this focus on physical health, the health of school children now addresses psychosocial concerns such as behavioral disturbances, child abuse, stress, and substance abuse. Similarly, passage of PL 94-142 and PL 99-457 has meant that children with complex medical problems who formerly were served in acute care institutions are now being educated in classrooms across the nation. In order to provide for the safety and well-being of these students during the school day, an understanding of existing health problems needs to be communicated to appropriate personnel.

It is essential to treat all information confidentially. There may be a need to know of an existing health condition in order to modify an education plan to meet health and safety needs of a student. In accordance with law, local policies and professional standards, the registered school nurse has the specialized skill, judgment and knowledge to determine which health information is educationally relevant and which school personnel would need the information. Sharing of confidential information for any other purpose would be inappropriate and unethical. Breach of confidentiality could result in financial or civil liability and/or professional discipline.

School Boards governing public, private and charter educational facilities should adopt policies and procedures that govern the manner in which confidential student health information will be protected. The Second National Task Force on Confidential Student Health Information provides the following guidelines for these policies:

Standard 1: Transparency
School districts make publicly available on an annual basis clear explanations of their policies, procedures, and practices regarding the collection, use, storage, release, and destruction of personally identifiable student health information.

Standard 2: Consent
School district officials obtain valid informed consent from parents, eligible students, or qualified minor students for collecting, using, and disclosing student health information.
within the school district and from and to health care providers and other agencies outside the school district, except when the law permits disclosure without consent.

Standard 3: Collection Limitation
School districts limit the collection of student health information to the minimum required for current needs or reasonable projected future needs, and these needs are made explicit at the time consent is obtained.

Standard 4: Access
Parents, eligible students, and qualified minor students are allowed access to student health information in their child’s (or their own) education records.

Standard 5: Use Limitation
School districts limit the sharing and use of student health information to those legitimate educational purposes for which the information was obtained and to those purposes made explicit when consent was given.

Standard 6: Quality
School officials seek to ensure that health information in educational records is accurate, complete, and up-to-date.

Standard 7: Security
Districts protect student health information in education records from unauthorized access by using reasonable security measures appropriate to the sensitivity of the record.

Standard 8: Accountability
All members of the school community, including volunteers, consultants, and business associates, are accountable for adhering to strict standards for protecting student health information during its collection, use, transfer, storage, and destruction.

Additional references:

American School Health Association: Protecting and Disclosing Student Health Information (2005); NASSNC Position Statement of Confidentiality, 2010 (see Appendix I).
Managing school health records is a challenging responsibility of school nurses. These responsibilities, which should be shared with school district administrators, should include policies and procedures for documentation that include the generation and maintenance, protection through secured storage and access, disclosure and destruction of students’ school health records. School systems generally have a record policy and procedures. School nurses should ensure that the policy and procedures address health records, whether integrated or added as an additional “health records” section.

FERPA (Family Educational Rights and Privacy Act) allows for health information to be shared with other individuals within a school system who have been determined to have a legitimate educational purpose. In other words, sharing is allowed when the information will benefit the student academically, when it is needed for the individual to carry out his/her duty related to that student, or when necessary for the health/safety of the student. This type of disclosure does not require parental consent. FERPA permits school districts to define who in their district has a legitimate educational interest in accessing and disclosing various types of student records. (See Appendix II, FERPA, for additional information.)

Any individually identifiable student health information contained in an “education record” as defined by FERPA, is subject to FERPA’s privacy protections. An education record is any form of information directly related to a student that is collected, maintained or used by the school. Records generated by the school nurse are considered education records, whether the school nurse is employed by the school system or by another agency providing school health services by contract. Such records are covered by FERPA.

FERPA allows for the transfer of educational records without parental consent to another school where the student seeks to enroll. (It does not require the transfer of all records. Often, a summary is sufficient.) Procedures for the transfer of student health records should address each type of health record maintained.

All school districts receiving federal funds must follow FERPA’s provisions governing the disclosure of records, and prevent unauthorized disclosure. HIPAA imposes no additional privacy requirements concerning educational records, and has a broad exemption for education records.
Keeping the preceding recommendations in mind, the following points should be included in the Record Procedures.

**Health Record Procedures**

**Generation and Maintenance**

- Distinguish health records from other types of school records.

- Inform students and families how their health information is handled. (Clearly state in the student handbook/other parent information sources.)

- Develop two types of health records and clarify what will go in each record.
  - Student’s Permanent Health Record
  - Individual Health/Nursing Record

- State how/where the records will be stored.
  - The Student’s Permanent Health Record within the cumulative education record

- Individual Health/Nursing Record is kept separately from the cumulative record secured or locked in a file cabinet accessible to the school nurse in the building where the student is enrolled.

- Computerized health records should be maintained with overwrite protection, multi-user passwords, multi-level access, and automatic back up (work with the IT - information technology – specialists).

**Secured Storage and Access**

- Provide staff training annually and as needed, on the legal and ethical principles of confidentiality and school district policy and procedures regarding the privacy and confidentially of student health information.

- Define by title, persons that have access to each type of student health information.
  - Student’s Permanent Health Record - all professionals providing services to the student
  - Individual health/nursing record - limit access to health care professionals as defined in the introduction (This includes third party medical records from outside sources and sensitive health information.)
Releasing / Disclosing Student Health Information

Internally: Within the school system

- Direct access to the Individual Health/Nursing Record is limited to school health professionals, as defined in the introduction.

- As the primary health care provider, the school nurse may determine on a case by case basis, how much and when school staff would have access to the individual health information. Limit to details necessary to benefit the student.

- Health information that may impact the child’s academic achievement must be shared with school staff that work directly with the student and who have a legitimate need to know the information.

- Clearly define how and implement measures to ensure school health records (both the Student Permanent Health Record and the Individual Health/Nursing Record) progress to other buildings/individual schools within the district.

- Avoid circulating lists/making logs with multiple student names or diagnosis as this violates privacy laws and FERPA regulations.

Externally: Transferring to another school system

- Outline how both types of health records will be transferred to another school system.

- The Student’s Permanent Health Record (PPS-2P and its content) is usually part of the cumulative educational record and may be forwarded with the standard educational records.

- The Individual Health/Nursing Record (separate health record) may be sent to another system without consent, but it is best to provide a summary of the information that is relevant to academic success/health or safety needs of the student. It may be sent by certified mail in a sealed envelope and labeled “Confidential- for School Nurse”. (This provides acknowledgment of receipt and ensures it goes to another nurse.) The school system usually retains the original record.

- Medical records obtained from an outside provider through a “release of information” process may be forwarded to another school system if important to the academic success of the student or to meeting the health/safety needs of the student. It is recommended
that such records be stored in the individual health/nursing record and follow the same procedures listed above.

- If there are other types of health records maintained for students, those should be addressed in the procedures.

(Note) School Based or Linked Health Centers are separate from the school system, operated by independent agencies. As far as FERPA regulations go, they are considered “outside agencies”, and consent is required to disclose records to such centers. The centers are regulated by the rules of HIPAA.

Externally: Releasing/Receiving health information outside school systems

The school system is responsible for protecting personally identifiable student health information, and may not release it beyond a student’s school system without written parental consent (or student’s consent if 18 or emancipated) except as described above in transfer to a student’s new school system. FERPA’s definition of disclosure includes release, transfer, or communication by any means including oral, written or electronic.

- Require written parental consent before releasing Individual Health/Nursing Records or the Student’s Permanent Health Record outside a school system.

- The consent to disclose should include: the name of the agency releasing the information; the identification of the person or agency to whom the disclosure will be made; the name of the student; the specific information and how much is to be disclosed; the purpose for the disclosure; a statement that consent may be revoked (until acted upon); the date or condition when the consent expires; signature of the parent (and sometimes the student); the date the consent is signed; a statement that the signer has a right to a copy of the release.

- If there are other types of health records maintained for students, those should be addressed in the procedures.

- Establish an interagency agreement, including confidentiality issues, with other agencies providing services to students. (These agency employees working in the school are still bound by FERPA)

- If transmitting by fax use a cover page addressing the fax to a specific individual and labeling it confidential. Call ahead to ensure the recipient is present.
It is best to avoid using emails to transfer health information. If used, take measures to maintain confidentiality such as encryption (a method that may be provided by your IT – information technology – specialists).

There are some allowable exceptions to obtaining parent (or student) consent prior to releasing information outside the school system:

- Reporting suspected child abuse/neglect as required by state law
- If there is reason to believe that the student may be dangerous to him/her self or to others, which may be shared per school guidelines
- Reporting communicable diseases per state law
- Releasing to law enforcement agencies/juvenile courts as required by state law
- Complying with subpoenas and court orders (the system must make a reasonable effort to notify the parent of receipt of the subpoena)
- State and federal officials responsible for supervising and auditing school funds
- Contractors providing education or support services for a student (contractors are bound by FERPA)
- During health and safety emergencies information may released to appropriate parties providing emergency care.

Externally: Receiving health information from outside sources

The US Department of Education has ruled that medical records sent to schools are subject to FERPA regulations and treated as other “education records”.

- To obtain information from an outside source, the school district should send an individual cover letter explaining why specific information is needed along with a signed parent consent form. (The consent form should contain the same elements listed under releasing health information.)

- Only appropriate school health professionals should receive confidential health information, even if requested for educational planning purposes.

- Unrequested health information should be returned to the sender or shredded.
Archiving and Destruction

Follow the guidelines found in *Health Records Retention and Disposition Schedule* issued by N.C. Department of Cultural Resources, Division of Historical Resources.

The N.C. Department of Public Instruction Records Retention and Disposition Schedule can be found at: [http://www.records.ncdcr.gov/default.htm](http://www.records.ncdcr.gov/default.htm). This is the main page for the government records. Once at this website, navigate to “community and municipal records” then “records retention and disposition link” and then “local education agencies.”

At this website: [http://www.records.ncdcr.gov/local/default.htm](http://www.records.ncdcr.gov/local/default.htm) you will find the listings of all the records schedules published by the N.C. Division of Historical Resources. In the link to Local Education Agencies, the schedule for school student health records begins on page 39.

Resources:

*Guidelines for Protecting Confidential Student Health Information*, National Taskforce on Confidential Student Health Information, American School Health Association, ISBN # 0-917160-00-2


*National School Board Association Draft* - June 2004
Position Statement on the Storage of Student/Employee Health Information

We have learned that many of you have questions and concerns about the proper maintenance of and access to sensitive health information regarding students and employees. This memorandum is intended as guidance to assist you with these issues. Please feel free to share this information with appropriate staff, such as principals and school nurses.

Students

The Family Educational Rights and Privacy Act (the “Buckley Amendment”) governs the collection, maintenance, and dissemination of student education records. The Act does not address whether all student information should be maintained in a single file or whether it can be maintained in separate files depending upon the nature of the contents. We believe that it is proper to maintain separate files for sensitive health information – items such as health care plans, treatment protocols, and medical authorizations. We recommend that you apply some safeguards for student health information.

For example, student health information should be kept in a safe, locked record storage that is separate from the student’s other school records. The principal may share student health information with persons who have (i) direct guidance, teaching, or supervisory responsibility for the student, and (ii) a specific need to know in order to protect the safety of the student or others. Access to sensitive health information should be limited to persons who meet those two criteria. The information should be available to these persons on a daily basis in the event that the need to access it should arise.

We recommend that you follow these procedures while the student remains enrolled in your school system. Once the student departs from the school, it is appropriate to merge this information with any copy of the cumulative record that you keep for records maintenance purposes. If the student transfers to another school system, best practice is to forward the original student records to the new system and retain a copy if your policy is to keep information on students who transfer.

Employees

Although employee personnel files are confidential pursuant to G.S. § 115C-319, the following two sections make certain exceptions. G.S. § 115C-320 allow the public to obtain limited information about any employee and G.S. § 115C-321 permits access to confidential information to four categories of person. Because of the potential for the inadvertent release of confidential, sensitive health information from an employee’s file, we believe that it is also proper to house this information separate from the regular personnel file.

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1 Undated Position Statement during administration of N.C. Superintendent of Public Instruction Michael E. Ward, 1996 to 2004
Delegation of School Health Services to Unlicensed Assistive Personnel

Definitions

The North Carolina Board of Nursing (NCBON) defines and regulates the process of delegation in this state. A 2007 NCBON Position Statement defines delegation as "the transfer to a competent individual the authority to perform a selected activity in a selected situation. The delegator retains accountability for the delegation.” The critical underlying concept is that when the Registered Nurse (RN) determines that someone who is not licensed to practice nursing can safely provide a selected nursing activity or task for an individual student, and delegates that activity to the individual, the RN remains responsible and accountable for the care provided.

The Position Statement further defines Unlicensed Assistive Personnel (UAP) as “any unlicensed personnel, regardless of title, who may participate in student care activities through the delegation process.” Supervision is “the provision of guidance or direction by a licensed nurse to unlicensed assistive personnel (UAP). Supervision is that component of assignment and/or delegation by which the licensed nurse maintains accountability for the nursing care given by personnel to whom the care has been assigned and/or delegated.”

Rationale

Across the nation students with special health care needs are attending school and placing demands on school districts. Local school boards must provide sufficient staff and resources to ensure a level of school health services previously not required. Related factors include:

1) Changes in the health care system resulting in the medical treatment of children, even those with complex medical problems, in outpatient community settings rather than inpatient, acute care settings;

2) Advances in medical technology resulting in far greater mobility of those who are technology dependent, allowing them to live at home and attend school;

3) Federal mandates ensuring students with health-related disabilities access to appropriate educational programs and related services in the least restrictive environment; and
4) Parents’ expectations regarding their children's rights to care in school.

These trends raise issues regarding educational placement and maintenance of student health and student safety, as well as school and professional accountability. In making decisions about the educational placement of students with health care needs and the provision of nursing services, the primary concern must be the health and safety of the student. A secondary concern is the liability of all involved parties (e.g., the school board, school administrators, school staff and the school RN). School administrators are legally responsible for the safety of all students, including the provision of required health services by qualified staff. Using non-qualified staff risks harm to students. In addition, non-licensed school staff are liable for their actions if they practice nursing or medicine without a license.
Nurses' Responsibility for Quality Care

By professional and legal mandate, school RNs are ultimately responsible to the student for the quality of nursing care rendered. The RN can be personally and professionally liable for errors in nursing judgment. If the RN's actions violate the requirements of the nursing practice act, the state board of nursing can take disciplinary action against the RN, including revocation of his/her license to practice nursing. Actions related to the delegation process account for three of the 23 defined reasons for disciplinary action established by the N.C. Board of Nursing.

While school district administrators have certain responsibilities regarding the educational placement of students, they cannot legally be responsible for deciding the level of care required by an individual student with special health care needs. The RN, based on the state's nursing practice act and related state rules and regulations, determines whether care should be provided by a licensed nurse or delegated to trained and supervised unlicensed assistive personnel.

The registered professional school nurse is responsible for determining whether delegation of nursing care is appropriate in each individual situation even if a physician or other health professional states or "orders" that such care should be provided by a UAP, unless a physician or other professional takes full responsibility for the training and supervision of the UAP. Furthermore, it must be both legally and professionally appropriate for that professional to engage in delegating the specific health care activity to unlicensed individuals.

While parents sometimes believe that they should determine the level of care required for their child, it is critical for parents to distinguish between themselves as care takers at home and employed school personnel as care providers at school. Among other variables, the school setting is an environment entirely different from the home: school personnel have different responsibilities in their positions and different obligations under the law, school personnel change, and the parent does not have the authority in the school to make administrative decisions or to supervise school staff. In addition, while nursing practice acts make exceptions for parents or family members who provide nursing care to a family member in their homes, this exception to the licensure provisions does not empower families to extend that right to other individuals in other settings. It is essential that the family, school RN, school team and health care providers work in collaboration to plan and provide the student with high-quality care in an environment that is not only least restrictive, but also safe for all students and staff.
Questions about Delegating Care

There are two critical questions involved in delegating and supervising a nursing care activity:

1. *Is the activity a nursing task under the state's definition of nursing?*

   Nursing activities are defined by state statute and interpreted by the state board of nursing. A state's attorney general's opinion, court decision or other mandate may modify the state's definition of nursing or interpretation of its scope or practice. Based on these definitions and interpretations, the nurse decides whether or not the activity or procedure is one that can only be performed by a registered nurse.

2. *Can the activity be performed by unlicensed assistive personnel under the supervision of a registered nurse?*

   The delegation of nursing activities to UAPs may be appropriate if:
   
   . it is not otherwise prohibited by state statute or regulations, legal interpretations, or agency policies;
   . the activity does not require the exercising of nursing judgment; and
   . it is delegated and supervised by a registered nurse.

Determinations Required in Each Case

The delegating and supervising registered nurse makes the following determinations, on a case-by-case basis, for each student with health care needs and each required nursing care activity:

1) The RN validates the necessary physician orders (including emergency orders), parent/guardian authorization, and any other legal documentation necessary for implementing the nursing care.

2) The RN conducts an initial nursing assessment.

3) Consistent with the state's nursing practice act and the RN's assessment of the student, the RN determines what level of care is required: registered professional nursing, licensed practical or vocational nursing, other professional services, or care by unlicensed assistive personnel (UAP).
4) Consistent with the state board of nursing regulations, the RN determines the amount of training required for the UAP. If the individual to whom the nurse will delegate care has not completed standardized training, the RN must ensure that the UAP obtains such training in addition to receiving the child-specific training.

5) Prior to delegation, the nurse evaluates the competence of the individual to perform the task safely.

6) The RN provides a written care plan to be followed by the unlicensed staff member.

7) The RN indicates, within the written care plan, when RN notification, reassessment and intervention are warranted, due to change in the student's condition, the performance of the procedure or other circumstance.

8) The RN determines the amount and type of RN supervision necessary.

9) The RN determines the frequency and type of student health reassessment necessary for ongoing safety and efficacy.

10) The RN trains the UAP to document the delegated care according to the standards and requirements of the state's board of nursing and agency procedures.

11) The RN documents activities appropriate to each of the nursing actions listed above.

If the School Nurse Determines that Care Cannot be Safely Provided in School

After consultation with the family, student's physicians, other health care providers, other members of the school team, and appropriate consultants, the RN may determine that the level of care required by the student cannot be safely provided under current circumstances in the school. In that event, the school nurse should refer the student back to the initial assessment team and assist the team in reassessing the student's total needs and exploring alternative options for a safe and appropriate program. If such a program is not designed and the student continues in an unsafe situation, the RN should:

1. Write a memorandum to his/her immediate supervisor explaining the situation in detail, including:
   a. Recommendations for safe provisions of care in the school; or,
   b. The reason the care or procedure should not be performed in school and a rationale to support this.
2. Maintain a copy of the memo.
3. Forward a copy of the memo to the following, as indicated: the state board of nursing, the district superintendent, the state school nurse consultant, and the Exceptional Children's Division, Public Schools of North Carolina.
4. If the district allows the student to attend school despite the RN's notification that the situation is unsafe, the school RN should regularly notify his/her supervisor, and others as appropriate, that the unsafe situation continues to exist until the issue is resolved.

Reference:

North Carolina Board of Nursing. (2007). Position Statement for RN and LPN Practice, Delegation: Assignment and Delegation of Nursing Activities by the RN and LPN.
The Five Rights of Delegation

All decisions related to delegation of nursing activities must be based upon the fundamental principle of public protection. Licensed nurses have ultimate accountability for the management and provision of nursing care, including all delegation decisions. However, seldom is a single nurse accountable for all aspects of the delegation decision-making process, its implementation, supervision, and evaluation. The Five Rights of Delegation, identified in Joint Statement on Delegation American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN), 2006, can be used as a mental checklist to assist nurses from multiple roles to clarify the critical elements of the decision-making process. Nursing service administrators (all levels of executive/management nurses) and staff nurses each have accountability in assuring that the delegation process is implemented safely and effectively to produce positive health outcomes.

Nursing service administrators and staff nurses must work together collaboratively and cooperatively to protect the public and maintain the integrity of the nursing care delivery system. The following principles delineate accountability for nurses at all levels.

Right Task

<table>
<thead>
<tr>
<th>Nursing Service Administrator (NSA)</th>
<th>Staff Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Appropriate activities for consideration in delegation decisions are identified in UAP job descriptions/role delineation.</td>
<td>• Appropriate delegation activities are identified for specific client(s).</td>
</tr>
<tr>
<td>• Organizational policies, procedures and standards describe expectations of and limits to activities</td>
<td>• Appropriate activities are identified for specific UAP.</td>
</tr>
</tbody>
</table>

Generally, appropriate activities for consideration in delegation decision-making including those:

1. which frequently reoccur in the daily care of a client or group of clients;
2. which do not require the UAP to exercise nursing judgment;
3. which do not require complex and/or multi-dimensional application of the nursing process;
4. for which the results are predictable and the potential risk is minimal; and
5. which utilize a standard and unchanging procedure.

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1 Joint Statement on Delegation American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN), 2006
Right Circumstances

<table>
<thead>
<tr>
<th>Nursing Service Administrator (NSA)</th>
<th>Staff Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assess the health status of the client community, analyze the data and identify collective nursing care needs, priorities and necessary resources.</td>
<td>• Assess health status of individual client(s), analyze the data and identify client specific goals and nursing care needs.</td>
</tr>
<tr>
<td>• Provide appropriate staffing and skill mix, identify clear lines of authority and reporting, and provide sufficient equipment and supplies to meet the collective nursing care needs.</td>
<td>• Match the complexity of the activity with the UAP competency and with the level of supervision available.</td>
</tr>
<tr>
<td>• Provide appropriate preparation in management techniques to deliver and delegate care.</td>
<td>• Provide for appropriate monitoring and guiding for the combination of client, activity and personnel.</td>
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</tbody>
</table>

Right Person

<table>
<thead>
<tr>
<th>Nursing Service Administrator (NSA)</th>
<th>Staff Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Establish organizational standards consistent with applicable law and rules which identify educational training requirements and competency measurements of nurses and UAP.</td>
<td>• Instruct and/or assess, verify and identify the UAP’s competency on an individual and client specific basis.</td>
</tr>
<tr>
<td>• Incorporate competence standards into institutional policies; assess nurse and UAP performance; perform evaluations based upon standards; and take steps to remedy failure to meet standards, including reporting nurses who fail to meet standards to board of nursing.</td>
<td>• Implement own professional development activities based on assessed needs; assess UAP performance; perform evaluations of UAP based upon standards; and take steps to remedy failure to meet standards/</td>
</tr>
</tbody>
</table>
Right Direction/Communication

<table>
<thead>
<tr>
<th>Nursing Service Administrator (NSA)</th>
<th>Staff Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Communicate acceptable activities, UAP competencies and qualifications, and the supervision plan through a description of a nursing service delivery model, standards of care, role descriptions and policies/procedures.</td>
<td>• Communicate delegation decision on a client specific and UAP-specific basis. The detail and method (oral and/or written) vary with the specific circumstances.</td>
</tr>
<tr>
<td>• Situation specific communication includes:</td>
<td></td>
</tr>
<tr>
<td>☐ Specific data to be collected and method and timelines for reporting</td>
<td></td>
</tr>
<tr>
<td>☐ Specific activities to be performed and any client specific instruction and limitation, and</td>
<td></td>
</tr>
<tr>
<td>☐ the expected results or potential complications and timelines for communicating such information.</td>
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</table>

Right Supervision/Evaluation

Supervision may be provided by the delegating licensed nurse or by other licensed nurses designated by nursing service administrators or the delegating nurse. The supervising nurse must know the expected method of supervision (direct or indirect), the competencies and qualifications of UAP, the nature of the activities which have been delegated, and the stability/predictability of client condition.

<table>
<thead>
<tr>
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<th>Staff Nurse</th>
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<tbody>
<tr>
<td>• Assure adequate human resources, including sufficient time, to provide for sufficient supervision to assure that nursing care is adequate and meets the needs of the client.</td>
<td>• Supervise performance of specific nursing activities or assign supervision to other licensed nurses.</td>
</tr>
<tr>
<td>• Identify the licensed nurses responsible to provide supervision by position, title, role delineation</td>
<td>• Provide directions and clear expectations of how the activity is to be performed:</td>
</tr>
<tr>
<td></td>
<td>☐ monitor performance</td>
</tr>
<tr>
<td></td>
<td>☐ obtain and provide feedback,</td>
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<td></td>
<td>☐ intervene if necessary, and</td>
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<td></td>
<td>☐ ensure proper documentation.</td>
</tr>
<tr>
<td>• Evaluate outcomes of client community and use information to develop quality assurance and to contribute to risk management plans.</td>
<td>• Evaluate the entire delegation process:</td>
</tr>
<tr>
<td></td>
<td>☐ evaluate the client, and</td>
</tr>
<tr>
<td></td>
<td>☐ evaluate the performance of the activity.</td>
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</table>
Delegation Decision Making Tree

The North Carolina Board of Nursing Decision Tree for Delegation to UAP is a tool developed to assist nurses in making delegation decisions. Licensed nurses have ultimate accountability for the management and provision of nursing care, including all delegation decisions.

To use the Delegation Decision Making Tree on the next page, start with a specific client, care-giver and nursing activity. Beginning at the top of the tree, ask each question as presented in the box. If you answer “no” to the question, follow the instructions listed to the right of the box and arrow. If you answer “yes”, proceed to the next box. If you answer “yes” to all questions, the task is one that can be delegated. If you answer “no” to any question, the task can not be delegated.

The grid can be used:
• for nurses making delegation decisions;
• for staff education regarding delegation;
• for orientation of new staff, both nurses and UAPs;
• for nursing education programs providing basic managerial skills for students;
• for nursing continuing education;
• for supervising nurses responding to questions about delegation (may consider including this tool as part of a delegation information packet);
• for orientation of new school board members and school attorneys;
• for workshops and presentations regarding delegation issues, or
• for evaluation of complaints involving delegation concerns.

The North Carolina Board of Nursing website provides regularly updated resources for nurses regarding many topics, including delegation. The reader is referred to that site at www.ncbon.com. In addition to copies of nursing law and rules, relevant resources available include:

• Decision Tree for Delegation to UAP
• Delegation and Assignment of Nursing Activities
• Delegation of Immunization Administration to UAP
• Delegation: Non-Nursing
DECISION TREE FOR DELEGATION TO UAP

Is the task within the scope of practice for a licensed nurse?  
No  
Cannot delegate to UAP  
Yes  
RN assessment of client’s nursing care needs complete?  
No  
RN to complete assessment, then proceed with consideration of delegation  
Yes  
Is the RN/LPN competent to make delegation decisions?  
No  
Do not delegate  
Yes  
is accountable for the decision to delegate, to implement the steps of the delegation process, and to assure that the delegated task is appropriate.  
Is the task consistent with the rules for delegation to UAP?  Must meet all the following criteria:  
No  
Do not delegate  
Yes  
Frequently recurs in the daily care of a client or group of clients  
Is performed according to an established sequence of steps  
Involves little to no modification from one client care situation to another  
May be performed with a predictable outcome  
Does not inherently involve ongoing assessment, interpretation, or decision making which cannot be logically separated from the procedure(s) itself; and  
Does not endanger the client’s life or well being.  
Is the UAP properly trained and validated as competent by the RN to accept the delegation?  
No  
Provide didactic education and validation of competency. Then proceed with consideration of delegation.  
Yes  
Are there agency policies and procedures in place for this task?  
No  
Do not proceed until policies/procedures are developed.  
Yes  
Is appropriate supervision available?  
No  
Do not delegate.  
Yes  
Proceed with delegation.  
The UAP is responsible for accepting the delegation, seeking clarification of and affirming expectations, performing the task correctly and timely communicating results to the nurse.  
Only the implementation of a task/activity may be delegated. Assessment, planning evaluation and nursing judgment cannot be delegated.
Definitions

Assignment – Designation of nursing activities to be performed by an individual consistent with his/her licensed scope of practice.

Accountability -- Being responsible for actions or inactions of self or others in delegation.

Authority -- The source of the power to act.

Delegation -- Transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for the delegation.

Five Rights of Delegation -- Made up of the Right Task, Right Circumstances, Right Person, Right Direction/Communication, and Right Supervision / Evaluation. The Five Rights can be used as a mental checklist to remember the essential elements of delegation.

Licensed Nurse Competence -- The application of knowledge and the interpersonal decision-making and psychomotor skills expected for the practice role, in the context of public health, safety and welfare.

Nursing Assessment – The establishment of a database through the gathering of objective and subjective information relative to a client, confirmation of the data, and communication of the information.

Nursing Judgment -- The process by which nurses come to understand the problems, issues or concerns of clients, to attend to salient information and to respond to client problems in concerned and involved ways. Includes both conscious decision-making and intuitive response. (Based on Benner’s definition of clinical judgment in Expertise in Nursing Practice: Caring, Clinical Judgment and Ethics)

Supervision – The provision of guidance or direction, evaluation and follow-up by the Registered Nurse for accomplishment of a nursing task delegated to Licensed Practical Nurse and unlicensed assistive personnel.

Unlicensed Assistive Personnel (UAP) -- Any unlicensed health care providers, regardless of title, to whom nursing tasks are delegated.

Unlicensed Person Competence -- The ability to use effective communication; to collect basic objective and subjective data; to perform selected non-complex nursing activities
safely, accurately and according to standard procedures; and to seek guidance and direction when appropriate.

**Regulatory Perspective: A Framework for Managerial Policies**

NC Board of Nursing has the legal responsibility to regulate nursing and provide guidance regarding delegation. Registered Nurses (RNs) may assign certain nursing tasks to Licensed Practical Nurses (LPNs) and delegate to unlicensed assistive personnel (UAP). LPNs may also assign certain tasks within their scope of practice to other LPNs and delegate to unlicensed assistive personnel providing there is **continuous availability of the RN**. The licensed nurse has a responsibility to assure that the task is performed in accord with established standards of practice, policies and procedures. The nurse who delegates retains accountability for the task delegated.

The regulatory system serves as a framework for managerial policies related to the employment and utilization of licensed nurses and unlicensed assistive personnel. The Registered Nurse who assesses the patient’s needs and plans nursing care should determine the tasks to be delegated and is accountable for that delegation. It is inappropriate for employers or others to require nurses to delegate when, in the nurse’s professional judgment, delegation is unsafe and not in the patient’s best interest. In those instances, the nurse should act as the patient’s advocate and take appropriate action to ensure provision of safe nursing care.

**Acceptable Use of the Authority to Delegate**

The delegating nurse is responsible for an individualized assessment of the patient and situational circumstances, and for ascertaining the competence of the delegatee before delegating any task. The practice-pervasive functions of assessment, evaluation and nursing judgment must not be delegated. Supervision, monitoring, evaluation and follow-up by the nurse are crucial components of delegation. The delegatee is accountable for accepting the delegation and for his/her own actions in carrying out the task.

The decision to delegate should be consistent with the nursing process (appropriate assessment, planning, implementation and evaluation). This necessarily precludes a list of nursing tasks that can be routinely and uniformly delegated for all patients in all situations. Rather, the nursing process and decision to delegate must be based on careful analysis of the patient’s needs and circumstances. Also critical to delegation decisions are the qualifications of the proposed delegatee, the nature of the nurse’s **delegation authority as set forth in the Nursing Practice Act**, and the nurse’s personal competence in the area of nursing relevant to the task to be delegated.
Delegation Decision Making Process

In delegating, the nurse must ensure appropriate assessment, planning, implementation and evaluation. The delegation decision-making process, which is continuous, is described by the following model:

I. Delegation criteria
   A. Nursing Practice Act
      1. Permits delegation
      2. Authorizes task(s) to be delegated or authorizes the nurse to decide delegation
   B. Delegator qualifications
      1. Within scope of authority to delegate
      2. Appropriate education, skills and experience
      3. Documented/demonstrated evidence of current competency in the delegation process
   C. Delegatee qualifications
      1. Appropriate education, training, skills and experience
      2. Documented/demonstrated evidence of current competency

Provided that this foundation is in place, the licensed nurse may enter the continuous process of delegation decision-making.

II. Assess the situation
    A. Identify the needs of the patient, consulting the plan of care
    B. Consider the circumstances/setting
    C. Assure the availability of adequate resources, including supervision

If patient needs, circumstances, and available resources (including supervisor and delegatee) indicate patient safety will be maintained with delegated care, proceed to III.

III. Plan for the specific task(s) to be delegated
    A. Specify the nature of each task and the knowledge and skills required to perform it
    B. Require documentation or demonstration of current competence by the delegatee for each task
    C. Determine the implication for the patient, other patients and significant others

If the nature of the task, competence of the delegatee, and patient implications indicate patient safety will be maintained with delegated care, proceed to IV.
North Carolina School Health Program Manual

Section D  Chapter 6
School Nursing Practice  Delegation

IV. Assure appropriate accountability
   A. As delegator, accept accountability for performance of the task(s)
   B. Verify that delegatee accepts the delegation and the accountability for carrying out the task correctly

If delegator and delegatee accept the accountability for their respective roles in the delegated patient care, proceed to V.

V. Supervise performance of the task
   A. Provide directions and clear expectations of how the task(s) is to be performed
   B. Monitor performance of the task(s) to assure compliance to established standards of practice, policies and procedures.
   C. Intervene if necessary
   D. Ensure appropriate documentation of the task(s)

VI. Evaluate the entire delegation process
   A. Evaluate the patient
   B. Evaluate the performance of the task(s)
   C. Obtain and provide feedback

VII. Reassess and adjust the overall plan of care as needed

The Five Rights of Delegation provide an additional resource to facilitate decisions about delegation.

Conclusion

The guidelines presented in this paper provide a decision-making process that facilitates the provision of quality care by appropriate persons in all health care settings. The North Carolina Board of Nursing believes that this paper will assist all health care providers and health care facilities in discharging their shared responsibility to provide optimum health care and to provide the public with safe nursing care.
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Initiating Activities for the New School Nurse

"How to Begin"

How does a new school nurse get started where there is no nurse supervisor or local plan for orientation?

1. Establish who is your supervisor. Is there an identified Lead Nurse or another experienced nurse employed by the system? Ask the supervisor, Lead Nurse, and/or experienced nurse for the school’s expectations of the school nurse and how do they see the role of the school nurse?

2. Is there a job description? Is it realistic? Does it reflect what you should be doing and/or what you do? (Refer to sample job description approved by School Nurse Association of N.C., found in Appendix I or at www.snanc.org.)

3. What health policies and procedures exist? Read them.

4. Where is the nurse based (e.g. central office, one of the schools)? For which schools are you responsible? Are there health rooms/supplies/equipment in each school? Where is the school nurse mailbox? (If there isn't one, arrange to have one in each school).

5. Meet the principals and office staff. Establish how health issues are dealt with in each school, especially re:
   - immunizations
   - kindergarten health assessments
   - emergencies
   - first aid; who are first responders?
   - infection control/OSHA
   - medication administration
   - diabetes care training

6. Locate the health records. Check on what type of health information is available, who maintains health records and how current is the information. Determine how confidentiality is maintained. Who has access to the records?

7. Is a comprehensive data base of students with chronic health problems available? How up to date is it? Compile or update a data base as needed to be used only by the nurse. If there is not a system to identify students with chronic illnesses, life-threatening medical conditions, and/or disabilities, develop one. (See Section E Chapter 4)

8. Obtain information needed to plan a schedule, taking into consideration the number of
schools, number and type of students, number of grades in each school, and days for multi-disciplinary staffing meetings. Make out a tentative school nurse schedule.

9. Determine from the principal when faculty meetings are scheduled and ask to be on the agenda. At the meeting introduce yourself, describe your role, and discuss how students are referred to the nurse. Distribute a copy of your schedule, reminding staff that changes occur when unexpected needs develop at one of your schools.

10. Meet with the coordinator of the exceptional children's program and determine how you will collaborate. What other support personnel are there (e.g., social workers, counselors)?

11. If time allows, get acquainted with the cafeteria manager and workers, the bus drivers' supervisor, and the school custodian. Observe to see what health problems or health hazards are present and how assistance in solving these problems may be rendered.

12. Become acquainted with community contacts such as the Health Department (review the MOA), Mental Health, and Social Services. What community service clubs are available, such as Lion's Club, Kiwanis, and women's organizations? Where are students sent for emergency care? How active is the School Health Advisory Council and what is your role with them?

13. Attend OSHA training. Who is in charge of the OSHA program? Who is in charge of Infection Control?

14. Become acquainted with the type of statistical data to be collected on the school nurse's activities for accountability of the school health program and contribution to the N.C. Annual School Health Services Report (N.C. Division of Public Health).

After becoming familiar with this necessary background information, the nurse should plan a tentative schedule of programs, including previously determined goals and objectives. (The school nurse is referred to “Setting School Nurse Priorities” in Section D, Chapter 2.) The new school nurse should continue the programs in operation according to accepted policies and procedures until desirable changes can be made. If needed written policies or procedures are missing, identify those of top priority and begin to work with administrators to develop appropriate ones.
Suggested School Health Policies (See Section C Chapter 2)

- Diabetes training – general/intensive
- Health screenings, referral and follow-up
- Identification of students with acute or chronic health needs/conditions
- Maintenance of school health records
- Medication administration
- Prevention and control of communicable disease – Infection control (including OSHA, immunizations)
- Provision of emergency care
- Reporting child abuse / neglect (mandated)
- Reporting student injuries
- Response to DNR (Do Not Resuscitate) directives
- Transportation during student illness / injury (non-school bus)
Communicable diseases are the leading cause of childhood morbidity and school absences. Students and staff with communicable diseases that can be transmitted directly or indirectly from one individual to another require special consideration in the school setting. Local school district policies should address:

- The preventive measures necessary to protect the health of all students and staff.
- The procedures for the immediate care of students or staff that develop a potentially communicable illness.
- The special needs of children with chronic infectious illnesses which are determined to be non-contagious under normal conditions.

Rationale

- The spread of infectious disease can be prevented or deterred if students and staff adhere to basic principles of good personal hygiene, cleanliness, and recommended use of any necessary personal protective measures.

- Transmission of infectious disease is controlled by routinely using standard procedures and techniques to maintain environmental cleanliness and personal protection.

- Schools are legally authorized to prohibit the attendance of teachers or pupils if necessary to prevent the spread of contagious diseases, as directed by local public health officials within General Statutes and under the direction of the state Department of Health and Human Services (DHHS), Division of Public Health. DHHS holds responsibility for initiating preventive measures to suppress or prevent the spread of disease and for implementing regulations relating to isolation, quarantine, and other control measures to protect the public.

- Case management activities include timely identification and referral of students and staff with communicable disease. Appropriate follow-up to ensure treatment and prompt return to class or work will inhibit the spread of contagious illness in school and minimize excessive absence.

1 The information provided in this chapter is to be used as a reference and is not intended to be the single source of information on specific diseases. Readers should refer to their state and local public health department for the most current information. Data on the websites listed in this document are updated frequently, and sources, particularly specific links to web pages, may no longer be available at the time the reader is searching this document. Refer to the “home page” of websites for the most current information.
Federal and state courts have held that children with chronic infectious diseases are entitled to a free appropriate public education in the least restrictive environment.

Persons with suppressed immune systems run a higher-than-normal risk of severe complications from common communicable illness.

Parents, students, and teachers should understand their responsibilities in communicable disease control. Measures to effectively control communicable disease are:

- Immunizations.
- Environmental sanitation.
- Voluntary isolation of persons with a communicable disease until no longer contagious. In rare cases, the state may quarantine a person with a contagious disease.
- Prophylaxis and treatment.

Communicable disease control is vested by law in public health officials. The North Carolina Division of Public Health, Epidemiology Section, recommends the following references as a guide to administrators and/or teachers and nurses for interpretation of regulations as they concern school policies:


The nurse providing health services to the school should coordinate the school health service program. He/she has the professional expertise to provide information to school personnel, students, and parents to foster understanding and compliance with communicable disease control requirements and practices.
Recommendations

- The basic principles of good hygiene and personal cleanliness should be incorporated into the health curriculum.

- School nurses should supplement the curriculum with classroom health materials, individual counseling, and/or home visits as appropriate and necessary.

- Personal and environmental cleanliness are promoted and practiced using standard procedures and techniques to prevent transmission of infectious disease. (See “Guidelines for Handling Body Fluids” in this chapter.)

- Students and staff are instructed regarding cleanliness and hygiene measures including proper hand washing techniques. They are provided equipment and facilities to accommodate such endeavors.

- Students with signs and symptoms of communicable diseases may be isolated for the period of communicability and return to class in accordance with recommendations of the personal physician, DHHS Regulations for Control of Communicable Disease, and local school district policy. Health authorities including the students’ health care provider, public health specialists, and school nurse should provide input into the decision on whether and for how long to recommend a child be absent from school for health reasons.

- The school nurse may provide or arrange in-service education for teachers and school staff regarding the signs and symptoms of common communicable illness, mode of transmission, and period of communicability. Information should include local school district policies governing recommendations for temporary isolation and readmission to class, and a mechanism for health service referrals.

- Local school district policies should be developed in accordance with the "Recommendations Concerning School Attendance of Children with AIDS and HIV Infection" in this chapter.

- The school nurse should serve as the in-school case coordinator for the student who has a chronic infectious disease. He/she is responsible for monitoring and assessing students with infectious diseases and maintaining liaisons with the student’s home, community health agencies, and personal physician.
• The parents or health care provider of a student with a suppressed immune system may want to remove the student from school for his or her own health protection during an outbreak of contagious disease among classmates. The decision to remove the student is made by the student's physician and parent in consultation with the school nurse.

• According to G.S. 130A, Article a, Part 2 and 15A NCAC 19A.0406, physicians, local health departments and the N.C. Division of Public Health shall, upon request and without consent, release immunization information to schools (K-12), licensed registered child care facilities, Head Start, colleges and universities, HMOs and other state and local health departments outside of North Carolina.
Students are excluded from school in cases of certain reportable communicable diseases. While the list of diseases reportable to the state Division of Public Health is lengthy, the number of such diseases common to the school age child, is not. When a student is suspected of having one of those reportable communicable diseases, it is the responsibility of the parent to take the child to the local health department or primary health care provider for verification and treatment before that student can return to school. For reportable conditions, school staff should follow the school policies and procedures for timely communication with local health departments about reportable conditions. Students should be temporarily excluded from school if presenting symptoms of those diseases. In each case, readmission to school should also take into account whether the child is able to participate in school. In some cases, a student with a disabling disease, who is no longer contagious but may need ongoing care, may be eligible for additional services under Section 504 of the Rehabilitation Act. (See Section B for further information on that federal law.)

The school will maintain a list of students who have not been vaccinated for religious or medical reasons or who have illnesses that cause immunosuppression, so that appropriate action can be taken to protect these individuals when serious communicable disease outbreaks do occur.

The following is a list of some of the more common childhood reportable communicable diseases and the state recommendations for exclusion and treatment:

**Measles (Rubeola/Rubella):** Student is excluded until 4 days after the beginning of the rash.

**Pertussis:** Student should be separated from the general population if paroxysmal coughing is noted. Please notify the local health department in order to have an investigation started and to identify the close contacts who will need to be treated. Students can usually return to school after 5 days of appropriate antibiotic treatment but ideally the decision should be made in consultation with the child’s primary health care provider and/or the local health department.

**Mumps:** Students should be separated once large swelling of the head and neck glands appear and for 5 days after swelling is noted, since the virus is active in saliva from 7 days before to 9 days after swelling of glands.
Hepatitis A: Most infections are contagious the two weeks before the onset of symptoms (jaundice). The risk for transmission continues for at least a week after the onset of jaundice.

Tuberculosis: Individuals with infection, but without active disease, are not contagious. Adolescents and adults who have active TB may spread the bacteria by coughing and contaminating the environment.

Salmonella: Generally spread by contaminated food, this illness is responsible for severe diarrhea, making it difficult to maintain good sanitation.

References:

North Carolina Department of Health and Human Services, Division of Public Health, Epidemiology Section.


Prevention and Control of Non-Reportable Communicable Diseases

(sample policy)

The school administration makes every effort to reduce the prevalence of disease-causing germs through assuring cleanliness of the environment, emphasizing frequent hand-washing of students and staff, and following proper decontamination procedures of items used in mealtime and other activities. Despite those actions, the school age child is often the source of, and conduit for, communicable diseases, ranging from the “common cold” to ringworm, among many. The majority of such diseases are not among the diseases for which the state Division of Public Health, following guidelines issued by the Centers for Disease Control and Prevention, has issued mandatory isolation rules. For those diseases not among those for which isolation is mandated, the decision on whether a child with a mild illness should stay home rests with the parent, in consultation with their health care provider. The school nurse can be a resource for that information, but the child’s physician is the best source of medical advice for your child. In many cases, the child with a mild illness is able to attend school and participate in all activities. In some cases, the child should remain out of school until the symptoms improve and the child is able to benefit from all school activities.

In some cases, a student with a disease that has become chronic and personally disabling, may need modifications at school and may be eligible for services under Section 504 of the Rehabilitation Act. (See Section B for further information on that federal law.)

The following are some common diseases for which school staff provides these recommendations:

Conjunctivitis (Pink Eye): There are a number of causes of red or “pink” eye. A child who is exhibiting such symptoms for more than a day should be evaluated by a physician. Many physicians are following new guidelines from the American Academy of Pediatrics and do not automatically prescribe antibiotics for conjunctivitis. A child with conjunctivitis does not need to be isolated from other students, and treatment is not required in order for that student to return to school. However, the student’s parents may decide to keep the student home if the child meets other criteria such as fever or other behaviors changes.

Diarrhea: Diarrhea is not a disease but a symptom of a disease or condition. A student with frequent loose stools, especially if the child is unable to control those bowel movements, should be evaluated by a physician as the condition may lead to dehydration.
Impetigo: Child is considered contagious until the skin sores are treated with antibiotics for at least 24 hours or the crusting lesions are no longer present. The affected area should be washed, the sores covered, and if the child is at school when the lesions are discovered, should be taken out of direct contact with other children for the rest of the day. The student should remain out of direct contact with other children if he or she has more than three to four sores or until seen by a physician for evaluation and treatment, as recommended by the physician. Typically, the student returns to school when topical, oral or other systemic antibiotics are started if the sores can be covered and kept dry.

MRSA: MRSA, or methicillin-resistant staphylococcus aureus, can be cultured from open and draining wounds. Having or harboring MRSA bacteria (carrier) is not a reason for exclusion from school. No effective and long-lasting way to eradicate MRSA infection has been found when someone in the family is colonized with MRSA.

Pediculosis: A common condition (not a disease) that is often seen in and spread by school aged children is pediculosis (head lice). See additional information later in Section E regarding suggestions for prevention and control of pediculosis.

Scabies: Student is usually isolated from direct contact with other students until one or more treatments with prescription medication. A treatment is usually completed overnight.

Streptococcal Pharyngitis (strep throat) and Scarlet Fever: Many sore throats are caused by mild viruses or allergies. Any student with a sore throat and fever for more than 24 hours should be seen by a physician to rule out these potentially serious sources of “sore throat.” If a physician diagnoses either strep throat or scarlet fever, typically, the student remains home until 24 hours after treatment has been started and any fevers have abated.

Varicella (Chicken pox): Student is usually isolated from contact with other students until all blisters have dried or crusted.

References:
“Epidemiology and Prevention of Vaccine-Preventable Diseases,” Centers for Disease Control and Prevention, 11th Edition Revised May 2009
N.C. DHHS, http://www.epi.state.nc.us/epi/index.html, topics A-Z (found at links on home page)
U.S. DHHS, Centers for Disease Control and Prevention, http://www.cdc.gov/, A-Z Health Topics (found across the top of the home page of the CDC website).
Immunization Requirements for North Carolina School Attendance

Every child in North Carolina, whether in school or not in school, must, by state law, be immunized against these vaccine-preventable diseases at appropriate ages:

- Diphtheria
- Tetanus
- Pertussis (whooping cough)
- Poliomyelitis
- Mumps
- Rubella (German measles)
- Measles (red measles)
- Haemophilus influenzae type b (Hib)
- Hepatitis B
- Varicella (Chicken pox)

As conditions change and new vaccines emerge, states, including North Carolina, find it necessary to update or change their school entry requirements. Centers for Disease Prevention and Control (CDC) Advisory Committee on Immunization Practices (ACIP) makes regular recommendations for vaccinations. Visit the website: [www.cdc.gov/niip/acip](http://www.cdc.gov/niip/acip) for periodic updates. General Statutes direct North Carolina-specific minimum entry requirements. For specific immunization requirements, refer to the following website: [http://www.immunizenc.org](http://www.immunizenc.org)

The state law requiring immunizations (General Statute [G.S] 130A-152) applies whether or not the child is in school. In addition, no student may attend any grade (Pre-K-12) without presenting a certificate of immunization. If a certificate is not presented on the student's first day of attendance, notice, preferably in writing, must be given to the parent/guardian. The parent has 30 calendar days from the student's first day of attendance to show proof of the required immunizations.

By the end of this 30-day period, the student must show proof of completed immunizations. If the required immunizations have not been completed, regardless of whether or not a student has an appointment, the student must be excluded from school. If the required immunizations have not been completed due to the necessary interval between doses, the student may attend school if the student is in the process of completion of vaccinations. The health care provider administering the immunizations to the student must verify in writing that the student is “in process” of obtaining the required vaccinations. This verification should include the date of the last vaccine given and the date of the next scheduled vaccine. Upon termination of the 30 calendar days or the extended period, the principal shall not
permit the student to attend school unless he/she is immunized. Refer to www.immunizenc.org for the most current information on vaccination schedules.

Religious or medical exemptions from this law require that a statement be on file at school in the student's cumulative record. The medical exemption must be written by a medical doctor licensed to practice in North Carolina and shall state the basis of the exemption, the specific vaccine or vaccines the individual should not receive and the length of time the exemption will apply for the individual. The medical exemption must be written on the form approved by the state Division of Public Health. For the specific form on which a medical exemption must be filed, go to www.immunizenc.org.

With regard to religious exemptions, if the bona fide religious beliefs of the parent, guardian or person in loco parentis of a child, or an adult student, are contrary to the immunization requirements, the child/student shall be exempt from the requirements upon submission of a written statement of the religious beliefs and opposition to the immunization requirements. Local district policy may require that this statement of religious beliefs contrary to immunizations be filed with the school annually.

The school shall maintain on file a copy of the certificate of immunization. Within 60 calendar days after commencement of a new school year, the school shall file a kindergarten and sixth grade immunization summary report with the Division of Public Health.
Most frequently asked questions and answers:

What North Carolina statute requires immunization?

G.S. 130A-152 requires immunizations for every child present in this state. The parent, guardian, or person in loco parentis is responsible for ensuring that children receive the required immunizations.

What is the parent/guardian’s responsibility when a child is presented for attendance at school?

Parents must present a Certificate of Immunization on the first day of attendance to the school principal for each child attending school—public, including charter schools; private; or religious. All children entering kindergarten in public schools are also required to present the completed Kindergarten Health Assessment Report on or before the first day of attendance, as required by G.S. 130A-440.

What is the school’s responsibility when a child is presented for admittance without a certificate of immunization?

1. The student may attend school for 30 days without proof.

2. The school must notify the parent(s), guardian or person in loco parentis in writing that:
   a. The student is not in compliance with state requirements on immunizations required for school attendance
   b. The student will be excluded from school due to non-compliance with immunization law.

3. If the certificate of immunization is not presented on or before the 30th day, the student must be excluded from attendance until proof of immunization, or medical exemption, or religious exemption statements are provided.
What does the law allow when a student needs more than 30 calendar days to receive required immunizations?

To support time needed beyond the 30-calendar-day period, the parent(s), guardian or person in loco parentis must provide a physician's, physician extenders or health department's written statement indicating the date when immunizations will be administered. (This is sometimes referred to as "in process.") Upon the due date of the next immunization, the proof of immunization must be presented, or the child must be suspended until proof of immunization is presented to the principal.

Is a transfer student considered “in process” while waiting for records from another state?

Transfer students may not exceed 30 calendar days from the first day of attendance. The parent(s), guardian or person in loco parentis should be informed on the first day of attendance that they must submit an immunization record within 30 calendar days.

What is the school’s responsibility if evidence of adequate immunization has not been presented within 30 calendar days?

Upon termination of the 30-calendar-day period, the principal shall not permit any child to attend school unless he/she provides a Certificate of Immunization as required by law.

Who may issue the Certificate of Immunization and what must it contain?

A physician, health clinic or local health department administering required vaccines must give a Certificate of Immunization to the person who presented the child for immunization. The certificate or record shall include:

a. name, sex and date of birth of the student;
b. name and address of the parent or guardian;
c. number of vaccine doses given;
d. date vaccine doses were given (month/day/year); and
e. signature of physician, physician extenders or health department stamp.
Are there any exemptions to the required immunizations?

Yes, there are two:

(1) Medical Exemption - An exemption is permitted for medical reasons when an immunization is or may be harmful to a student for a specific reason. Valid medical exemptions shall be written and signed by a physician licensed to practice medicine in North Carolina and must indicate:

1. basis of the exemption;
2. specific vaccine(s) the child should not receive; and
3. the length of time the exemption will apply for the child.

The medical exemption must correspond to those medical contraindications specified in the North Carolina Immunization Rules [15A NCAC 19A.0404], or an exception to the Rules must be approved by the State Health Director. All written statements must be maintained in the student’s permanent record.

(2) Religious Exemption - Parent(s), guardian or person in loco parentis of a child or an adult student who claims a bona fide religious objection to immunization requirements must place a signed statement on file in the student's permanent record. An objection based upon a “scientific” belief (“a foreign substance or chemical may be harmful”) or non-religious personal belief or philosophy (“clean living, fresh air, pure water”) is not acceptable.

The written statement must be maintained in the student's record containing at a minimum:

1. Student’s name;
2. Parent(s), guardian or person in loco parentis statement detailing the bona fide, religious objection; and
3. Parent(s), guardian or person in loco parentis signature and date signed.

What record must be kept on file at school?

The school is required to maintain immunization records which contain information required for a Certificate of Immunization (as stated above) for all children attending the school. The certificate from NCIR (North Carolina Immunization Record) satisfies the requirements for a Certificate of Immunization. The immunization record from NC WISE or other school data report is not sufficient to serve as the Certificate of Immunization.
Each student with an exemption from immunizations must also have that record in his or her school health records.

A record of the students who are not protected against vaccine-preventable diseases must be kept in the school to refer to in the event of an outbreak of a vaccine-preventable disease.

A child has had either measles, rubella, varicella or mumps disease, is vaccination required?

**Measles:** A person who has been diagnosed prior to January 1, 1994 by a physician as having measles shall not be required to receive measles vaccine. Lacking such proof, vaccination is required. An individual who has a documented laboratory result of a protective antibody titer against measles is not required to receive the vaccine.

**Rubella:** A physician's diagnosis is NOT acceptable. The person must be immunized or have documented laboratory results of a protective antibody titer against rubella.

**Mumps:** A physician's diagnosis is NOT acceptable. The person must be immunized or have documented laboratory results of a protective antibody titer against mumps.

**Varicella:** Proof of varicella must be made by a physician, or antibody titer. **Parent report is not sufficient.**

What is required when a child’s immunization record is lost and cannot be located?

When a record of immunization cannot be provided, the law requires that the student be re-vaccinated on an age-appropriate, accelerated schedule to the minimum required by law.

When a student transfers, may a school refuse to send a student’s immunization record to another school?

No, G.S.130A-155 requires North Carolina schools, upon request, to send a copy of the child's immunization record at no charge to the student's new school. The former school cannot refuse to forward a child's immunization record because of unpaid fees, e.g., school books, overdue or lost library books.
Can a healthcare provider administer vaccines before the minimum age requirements?

A healthcare provider shall administer immunizations in accordance with the law. However, if the healthcare provider administers vaccine up to and including the 4\textsuperscript{th} day prior to the minimum age requirements for immunization, the individual dose shall not be required to be repeated.

What is the requirement for DPT/DTaP boosters?

A 4\textsuperscript{th} dose (booster) dose is required on or after the 4\textsuperscript{th} birthday. A booster dose of Tdap is required for those entering 6\textsuperscript{th} grade on or after August 1, 2008 if 5 years or more since the last dose of tetanus/diphtheria toxoid.

Is parental consent required to obtain an immunization record?

Health care providers shall release an immunization record to the school upon request without parental consent in order to meet the requirements for school attendance.

Can the school release an immunization record to others without parental consent?

Currently, under FERPA, the school may not release an immunization record to another agency or person, except to another school, without authorized parental consent.
Guidelines for Prevention and Control of Pediculosis

Few conditions cause so much concern and anxiety in schools and homes as head lice infestations. Following decades of advice that forced students to spend many days at home removing lice and nits, recent research documented that such practices did little to reduce the incidence of head lice. Based on that research, a number of national school health organizations have reviewed their former advice and issued new guidelines. What follows are guidelines that reflect the latest research and recommendations from the American Academy of Pediatrics and the National Association of School Nurses.


History

A prehistoric survivor, head lice (pediculosis capitis) are small parasitic insects that live on the scalp and neck hairs of their human hosts. They have had no basic changes in their morphology during the last 2,000 years (Pe’er & BenEzra, 1998). While much despised, lice are not known to be vectors for illnesses. Complications of infestations are rare and involve secondary bacterial skin infection. Pruritis (itching) is the most common symptom (Vessey, 2000).

Description of issue

Families and school staff expend innumerable hours and resources attempting to eradicate lice infestations, expending equal efforts on parasites and their nits. Reliable data describing the usual incidence of infestation in the general public, in the average school community, and during particular seasons of the year is lacking. Williams and colleagues (2001) report an estimated 6 to 12 million infestations annually.

Annually, millions of dollars are spent on pediculicides, lice combs, physician visits, and parental time away from work. Reports of drug resistance for the treatment of an infestation are increasing. In an effort to find an easy, effective, and safe treatment, a variety of alternative therapies (e.g., oil-based and grease-based products, animal shampoos, and insecticides) have been tried. These alternative treatments may have some merit. However, there is little scientific evidence regarding their effectiveness, and all have a cost (Vessey, 2000).

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2 National Association of School Nurses, Position Statement, July 2004
Anxiety on the communicable level of head lice often occurs in communities hit by the disease. Embarrassment and social stigma frequently accompany identification of infestation. Schools may be blamed as the source of contraction for students. Historically, in an effort to decrease head lice infestations, many U.S. schools adopted "no nit" policies. Subsequently, schools report extended student absences related to chronic infestation in certain students. Study of attendance records found 12 to 24 million school days were lost annually in the U.S. due to exclusion of students for nits (Price, Burkhart, Burkhart, Burkhart, & Islam, 1999). Exclusion from school for any reason has been correlated with truancy (Scott, Gilmer, Johannessen, 2004), as well as with poor academic performance.

Presence of nits does not indicate active infestation and no evidence is found that presence of nits correlates with any disease process (Scott, Gilmer, Johannessen, 2004). Other studies show that lice are not highly transferable in the school setting (Hootman, 2002) and no outbreaks of lice resulted when allowing children with nits to remain in class (Scott, Gilner, & Johannessen, 2004).

**Rationale**

The school nurse is the most knowledgeable professional in the school community and so ideally suited to provide education and anticipatory guidance to the school community regarding "best practices" of pediculosis management. The school nurse’s goals are to contain infestation, provide appropriate health information for treatment and prevention, prevent overexposure to potentially hazardous chemicals, and minimize school absence.

There is no scientific consensus on the best way to control head lice infestation in school children. No pediculicide is 100% ovicidal, and resistance has been reported with lindane, pyrethrins, and permethrin (Frankowski & Weiner, 2002). Head lice screening programs have not had a significant effect on the incidence of head lice in the school setting over time and have not proven to be cost effective (American Academy of Pediatrics, 2003).

**Conclusion**

It is the position of the National Association of School Nurses that the management of pediculosis should not disrupt the education process. Children found with live head lice should be referred to parents for treatment. Data does not support school exclusion for nits. Because no disease process is associated with head lice, schools are not advised to exclude students when nits remain after appropriate lice treatment, although further monitoring for signs of re-infestation is appropriate. [bolded in original NASN position statement.] The school nurse, as student advocate and nursing
expert, should be included in school district-community planning, implementation, and evaluation of vector control programs for the school setting. The school nurse retains an important role in educating all constituencies about pediculosis and dispelling myths and stigmas regarding lice infestation.

References/Resources:


North Carolina Recommendations Regarding Pediculosis Humanus Capitus

Lice are parasites of the human host dependent on frequent meals of human blood and are not known to transmit disease. Pediculosis control programs should include education, screening of others who have been in close contact and treatment, if desired. These national organizations, National Association of School Nurses, American Academy of Pediatrics and American School Health Association, recommend that students should not be excluded and no-nit policies are not recommended.

Rationale

- Widespread outbreaks of head lice among school students are rare.
- Dissemination of accurate information is of primary importance in both prevention and control. Desensitizing school faculty, students and parents in the community will help them deal rationally with this nuisance.
- Identification of active cases and assurances that intervention and treatment have been completed can effectively limit the spread of head lice.
- Treatment with a pediculicide, follow-up activities, plus environmental treatment of the home may be necessary.
- Because reports of head lice are common topics of rumor in schools, every parent should be informed of school policy and every student with head lice should be treated according to policy, with attention to privacy and confidentiality.

Recommendations

- School nurses play an important role in educating the school community regarding head lice. Teachers and other classroom staff should receive instruction in the epidemiology of head lice, and what lice are and what they are not. They should know the signs and symptoms of head lice and initiate referral to a school nurse.
- The child with head lice should go home at the end of the school day with written recommendations for treatment procedures and return to school the next day. Follow-up by the school nurse or designee may be conducted the next school day, according to district policy.
- Re-checking the scalp of a child treated for pediculosis can help assure that no re-infestation occurs.
- Removal of nits (lice ova) as a requirement for return to school is neither necessary nor recommended.
- Treatment directions should be carefully followed. The child should be re-treated in accordance with the instructions on the pediculicide product.
According to the American Academy of Pediatrics, none of the remedies using common household products (e.g., salad oils, mayonnaise, petroleum jelly) or chemicals intended for other purposes have been shown to be effective against head lice. Some such remedies that have been tried, such as kerosene, are very dangerous.

Mass screening for head lice has not been found to be effective in lice control measures.

**Head Lice (P. Humanus Capitus)**

**A. Characteristics**

- Occur in all socioeconomic levels regardless of age, sex or standards of personal hygiene.
- Are dependent on human blood for nourishment and can live off host for approximately 48 hours.
- Do not jump, hop, or fly.
- Do not transmit communicable diseases.
- Are spread by direct and indirect contact.
- Occurrence rates do not significantly differ between long and short hair.
- Occurrence rate is highest in elementary school children and special education classes.
- Uncommon in African American children.

**B. Description**

- Head lice are two to four mm. in length, wingless, gray-brown, hairy, flat, six-legged insects that are difficult to see because of their size and coloring.
- Eggs are laid by the adult female louse at a rate of eight to 10 per day. They hatch in seven to 10 days from a nit (egg casing) which appears as a clear, graying white ellipsoid, firmly attached to the hair shaft at the junction of the scalp. Hatched or empty nits can be distinguished by their milky color and missing top. Empty nits are also seen on the hair shaft that has grown away from the scalp junction.

**C. Symptoms**

- Itching of the scalp, especially back of neck and behind ears, is caused by bite and blood sucking activity of the lice.
- Excoriations, rash and enlarged cervical lymph notes may be noted as a result of scratching to relieve itching, with possible secondary bacterial infections.
D. **Mode of Transmission**

- Direct contact (i.e., head-to-head with infested person)
- Indirect contact (e.g., using infested combs and brushes; wearing infested clothing, especially hats, scarves, and coats; lying on infested carpets, beds, or upholstered furniture)

E. **Inspection of a student suspected to have head lice**

- Mass screenings are not an effective means of controlling the spread of head lice.
- Check individual children observed scratching their heads. Directly inspect the hair and scalp to detect the presence of crawling lice or nits. Observe for movement on or near the scalp, especially at the nape of the neck and behind the ears.
- Examine the hair carefully for the presence of nits. The presence of only nits is suspicious for but does not confirm the presence of head lice. It does not indicate that treatment should be initiated, unless other signs are present. However, as many nits as possible should be removed, for aesthetic reasons and to minimize confusion about reinfestation of children who have been treated successfully.
- The presence of live lice indicates an active infestation that requires treatment. When an individual case is found, inspect that student's closest associates (e.g., best friends, playmates, classmates, siblings, transportation (bus or car) contacts).

F. **Management of the individual case of head lice**

- When an active head lice infestation is detected, the child’s parent or guardian should be notified of the presence of lice. If the parent or guardian can come to the school at the end of the day, it is an opportunity to demonstrate identification techniques to parents to use with other family members, as well as to confirm presence of active infestation. Treatment options can be discussed. If a parent is unable to come to school, the child with head lice should go home at the end of the school day with written recommendations for treatment procedures. The parent may then consult a physician or treat with an over-the-counter product. Until the end of the school day, the child with head lice should avoid any activity that involves head-to-head contact with other children, nor should the child share any headgear.
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G. **Recommended Treatment**

- Use either an over-the-counter pediculicide or consult with a pharmacist or health care provider for a recommendation on which product to use. Follow package directions very carefully. If the product used provides instructions to repeat treatment, follow instructions exactly as written. Re-treatment, with some products, is necessary to kill the newly hatched nymphs (young lice). Since this second treatment occurs before nymphs can reach the reproductive stage, the infestation should then terminate.

- Alert all household contacts and treat any infested family members at the same time as the infested individual.

- Disinfect personal articles by washing in hot water for 20 minutes and drying on a hot setting; or by professionally dry cleaning, or by sealing in air-tight plastic bags for at least two days. Articles that can not be laundered or dry-cleaned may be sealed in air-tight plastic bags for at least two days if there is concern about lice having crawled from an infested child onto those articles. Combs and brushes can be soaked in a disinfectant solution or one of the pediculicide products, or heated in a pan of boiling water for five to 10 minutes.

- Vacuum carpeting and upholstered furniture, especially where children may sit or lie to play or watch TV. The use of insecticide sprays or fumigants is not necessary or recommended and can pose a health hazard to young children or pets.

- Repeat pediculicide application in seven to 10 days following the initial treatment to kill the newly hatched nymphs. Since this second treatment occurs before nymphs can reach sexual maturity, the infestation should terminate.

H. **Return to School**

The student does not need to miss any school hours. Absences related to treatment for head lice should not be marked as “excused.” A parent may wish to return with the child to school for re-examination of the scalp by a trained school staff member. Trained school personnel should screen the student for evidence of effectiveness of treatment. If no lice are found, the student may resume usual school activities. If live lice remain present, and treatment was given according to package instructions, the parent/guardian should consult a health care provider for additional options. Nit removal can decrease diagnostic confusion but is not necessary and “no-nit” policies are unjust and should be discontinued.
Upon parental request, the student may be checked again in 7 to 10 days to assure that no newly-hatched lice are present.

Be aware that itching results from an allergic reaction to the saliva of the lice, and itching may persist for weeks after the infestation has resolved.

References:

American Academy of Pediatrics. Volume 126, Number 2, August 2010
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Managing HIV Infection and AIDS in School

Acquired Immune Deficiency Syndrome (AIDS) was first recognized in 1981. HIV, the causative agent, was identified in 1984. This virus is transmitted through direct exposure to blood and blood products, sexually, and perinatally by infected mothers to their infants at or prior to birth and/or through breast feeding. This virus is not transmitted by casual contact, a fact attested to by the absence of cases in household contacts of AIDS patients who were neither sexual partners nor needle sharers. HIV infection is more difficult to acquire than hepatitis B, which is transmitted in the same manner.

As noted above, children may acquire HIV infection perinatally from infected mothers or through transfusion of contaminated blood or blood products. While some of these children may be too ill to attend school, many others will be well enough to do so.

1. Most children with AIDS or HIV infection represent no threat for HIV transmission in the classroom and should be provided an education in the usual manner.

2. Screening for HIV antibodies is inappropriate as a condition for school attendance.

3. Children with HIV infection who have behavioral abnormalities (e.g., aggressive and/or destructive behaviors, biting others), or who have open oozing wounds or sores which cannot be adequately covered, may pose a risk for HIV transmission to others. If the attending physician of a child infected with HIV believes that the child may pose a risk of transmission in the classroom, the physician shall notify the local health director as required by 15A NCAC 19A .0201(3) (See Appendix II). The local health director and the school superintendent or private school director shall then act in accordance with public health regulations to determine whether the child can safely attend school, and if necessary, define an appropriate alternative educational setting.

4. Confidentiality must be protected and strictly enforced by the school system for all children known to have HIV infection.

5. School officials should notify parents of children known to have AIDS or HIV infection when illnesses that may represent a threat to immune-suppressed children are occurring in the school. These include chickenpox, measles, whooping cough, meningitis, and influenza.
6. Guidelines for cleaning up blood or body fluid spills should be followed at all times. See “Universal Precautions: Guidelines for Handling Body Fluids,” elsewhere in Section E. These provisions will prevent infection with HIV, hepatitis C, herpes virus, and other infectious agents.

7. School personnel should receive training in how HIV/AIDS and other blood-borne infectious diseases are acquired, how transmission can be prevented, and how to handle body fluids in schools.

8. North Carolina law requires that public schools educate students about AIDS and how they can protect themselves from acquiring HIV infection (G.S. 115c-81 (el.)
Recommendations Concerning School Attendance of Students with HIV Infection and AIDS

The following public health recommendations address the school attendance of children with AIDS or with HIV infection which causes AIDS. These recommendations follow guidelines developed by the United States Public Health Service.

1. Risk of transmission of HIV infection is virtually non-existent in the normal unrestricted school setting, since the primary pathways of HIV infection do not exist in school activities. For this reason, children with AIDS or HIV infection should be allowed to attend school and after-school day care without restriction, except when medical or behavioral impairments exist which are severe enough to be a hazard to the infected child or to his/her classmates.

2. Infected children who may be neurologically impaired, lack control of body functions, bite, or have uncoverable oozing lesions should be educated in restricted settings until their medical or behavioral problems improve. Educational settings should minimize exposure of other children to blood or body fluids. This should be carried out in accordance with administrative code NC 15A NCAC 19A.0202(3).

3. The decision to modify the educational setting for any particular child because of medical or behavioral reasons should be made jointly by the child’s physician, public health personnel, the child’s parent or guardian, and appropriate personnel associated with the particular school. Decisions should be made on a case-by-case basis after weighing risks and benefits to the infected child as well as to others in the school or day care setting.

4. Teachers or other employees, including food handlers, who may have AIDS or HIV infection should be under no work restrictions. They present no appreciable infectious risk to school children or other employees under normal school work conditions.

5. Persons providing care and education for children with AIDS or HIV infection should respect each child’s right to privacy, including maintaining confidentiality. The extent of personnel who are aware of the child’s condition is governed by parents, and that number should be kept to a minimum (NC 130A-143).
Universal Precautions:
Guidelines for Handling Body Fluids

(Note: Guidelines included here apply to all body fluids regardless of the student or staff member’s health condition. All body fluids except sweat may contain potentially infectious disease and should be handled following the principle of “standard” or “universal” precautions.)

Many schools already have procedures for handling spills of body fluids (vomitus, feces, urine, blood). Since body fluids may contain a variety of germs (bacteria and viruses), it is important for all school personnel to know how to clean them up properly to prevent the spread of infection to students, school personnel, and to themselves.

While body fluids often contain various germs, it is unusual for illnesses to be spread in this manner when ordinary hygiene practices are observed. In order to cause disease, germs must find their way to the part of the body they infect through a specific route (e.g., the mouth, nose or break in the skin). They must also enter in sufficient numbers to cause infection. Most body fluids contain too few germs to cause infection unless they are placed directly into the blood stream or people fail to wash their hands after contamination and then place their hands or other contaminated objects into their mouths. Though this is unlikely to occur, it is important for all blood and body fluid spills to be regarded as potentially infectious since many germs may be carried in the body without symptoms (e.g., those causing hepatitis A and B, HIV infection, and Salmonella). Therefore, these guidelines should be followed in all cases, regardless of whether the source is known or appears to be infected. By following a few simple steps, clean-up can be an effective and safe procedure.

1. Disposable gloves should be worn when cleaning up blood, feces, vomitus, and urine. This is to be done in addition to, not as a substitute for, hand washing. Using non-latex gloves decreases the possibility of becoming latex-sensitive and protects those who are.

2. Hands should be washed thoroughly as soon as it is practical following exposure to body fluids such as blood, vomitus, feces, urine, saliva, nasal or other respiratory secretions. Proper hand washing require the use of soap and vigorous washing under a stream of running water for at least 10 seconds.
3. Wiping of body fluids is an essential step and may be done with paper towels. Drying or sanitary absorbing agents may be used with large volumes of body fluids (e.g. vomitus). These products are not, however, disinfectants. All disposable clean-up materials should be placed in a sealed plastic bag for discarding. Non-disposable items such as dust pans and brooms should be cleaned with one of the disinfectants listed below.

4. Clothing or throw rugs contaminated with body fluids should be laundered.

Many germs may be carried by individuals who have no symptoms of illness. These individuals may be at various stages of infection: incubating disease, mildly infected without symptoms, or chronic carriers of certain infectious agents including the AIDS and hepatitis viruses. Because simple precautions are not always carried out, transmission of communicable diseases is more likely to occur from contact with infected body fluids of unrecognized carriers than from contact with fluids from recognized individuals.

For specific guidance on strategies for clinical management of infectious agents within the school community go to www.cdc.gov or http://www.epi.state.nc.us. For key prevention steps to prevent the spread of MRSA see the charts at the CDC website.
Note:

In prior editions of the North Carolina School Health Program Manual, Chapter 1 concluded with a chart, “Control of Communicable Diseases in Schools.” Because research continues to provide school health professionals with new information on specific diseases, the reader is advised to find the information for a specific communicable disease at either the North Carolina Public Health website (www.ncpublichealth.com) or the website of the U.S. Centers for Disease Control and Prevention (www.cdc.gov).
Section E  Chapter 1
School Health Services  Precautions for Handling Body Fluids

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Guidelines for Medication Administration

The needs of children who require medication during school hours to maintain and support their continued presence in school should be met in a safe and prudent manner. Local school district policies should address administration of both prescription and non-prescription medications and protocols for administering emergency medication. It is the responsibility of the school staff to ensure that medications are administered according to state laws, local written policies and procedures, and professional standards.

Rationale

- Implementation of the IDEA (Individuals with Disabilities in Education Act) and amendments since enactment, most recently in 2009, has led to an increased number of children whose health problems require medication to be given while at school.

- Students with chronic illness, such as asthma, may be dependent on routine medications which enable them to participate more fully in all aspects of school activities and to minimize their absences.

- Students may require the administration of controlled substances during the school day in order to maximize their classroom performance.

- Some students with infections and communicable diseases are able to resume school attendance based on continuation of their medication regimen.

Recommendations

- All medications administered by school personnel during school hours must be prescribed by a licensed health care provider. (General Statutes of North Carolina – Chapter 115C-307).

- All medications administered at school must have a written request/permission signed by the parent or legal guardian. (G.S. Ch. 115 - 307)

- General Statute 115C-375.2 permits students with asthma and/or at risk for anaphylactic allergic reaction, to possess and self-administer medication on school property under certain parameters.

- All medications should be administered according to the six “rights” of medication administration.
Preparation of School Personnel to Administer Medications

Written local policies and procedures should be in place and reviewed periodically to keep current. A variety of personnel are capable of assisting students with their medicines. These include teachers, school counselors, administrators, teacher assistants, school secretaries and paraprofessionals. A program of careful instruction, with ongoing technical assistance and supervision from the school nurse, is essential.

School personnel should be knowledgeable of state laws, local policies and guidelines, and record keeping. They need up-to-date information on storage and handling of medications, the common routes of medication administration, and the six “rights” for safety while giving medicines. On-going communication with parents/guardians is also an essential part of safe medication administration.

Written Policies and Procedures Should Address:

- Training and supervision of school employees;
- Written authorizations from physicians and parents;
- Safe storage and handling of medication;
- Record keeping and reporting of administration errors;
- Safe disposal of unused/discontinued medications;
- Confidentiality;
- Student self-medication (limited to those listed in General Statutes of N.C.);
- Safety methods in assisting students with their medications;
- Field trips, and
- Medication access during school evacuation.

Prevention and Management of Errors Made When Giving Medications at School

School policies and procedures should outline what action to take if mistakes or errors happen when giving medications. It is recommended that any error be documented and reported (see further in this Section E for Medication Administration Incident Report Form).

Examples of errors include:

- missing a student dose of medication
- giving the medicine to the wrong child
- giving the wrong medicine or the wrong dose
- giving the medicine at the wrong time
- giving the medicine by the wrong route
Honesty and prompt reporting is always in the best interest of the student and the employee who made the error.

To avoid making errors, follow the six “rights” listed below when giving medicine:

- **Right Child** – Some schools attach a photo of the child to their record. Always double-check by asking the student his/her name.
- **Right Medication** – Always compare the label on the bottle with the medical information sheet that is signed by the health care provider.
- **Right Dosage** – Always double-check the dosage on the pharmacy label with the dosage on the provider authorization form.
- **Right Time** – Check the medication log for the time it is to be given. Up to 20 minutes before or after the prescribed time is acceptable.
- **Right Route** – Check the medication log and pharmacy label to be sure it is to be given by mouth, or to be dropped in the eye or ear, for example. Double- and triple-check if any uncertainty is present.
- **Write** – Immediately document in writing that medication has been given.

Selected References for Medication Administration at School:

2. A module on medication administration, with links to video segments, is available at www.cmpnc.org (current as of 2010-2011 school year).
4. Other medication references, such as Physician’s Desk Reference or Nurse’s Drug Handbook. Check for latest publication date.
The Responsibility of the Parent or Legal Guardian

1. Limit the medications that must be given during the school day to only those necessary in order to maintain the child at school.

2. Come to school and administer medications to the child as prescribed OR provide a written request for school personnel to administer the medication.

3. Completion of an authorization form, written by a health care provider licensed to prescribe medications, which includes the following:

   - Name of child.
   - Name of medication
   - Date it was prescribed
   - Dosage
   - How the medicine is to be given at school
   - When the medicine is to be given at school
   - Special instructions about the child receiving the medication or about the medicine itself
   - Until what date the medicine is to be given at school
   - Possible side effects of the medication
   - Possible adverse reactions to the medicine
   - Name of the health care provider and how to locate or communicate with him or her if necessary.

4. 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.

Over-the-counter medications administered at school must be provided in their original packaging labeled with the student name.

4. Provide the school with new, labeled containers when dosage or medication changes are prescribed.

5. Retrieve all unused medications from school when medications are discontinued, and/or at end of school year (according to local written policy).
6. Sign a request/permission form (a sample of “Request for medications to be given during school hours” form is in this section). Return completed form to school. A separate parent request/permission form must be completed for each medication given at school.

7. Maintain communication with the school staff regarding any changes in the medical treatment and child’s needs at school.

8. Do not give the medication to the child to be transported. In the event that transmittal of the medication to the school presents an undue hardship for the parent or guardian, arrangements may be made to secure the medication in several ways, dependent on local school policy.

   Example: • The bus driver can be authorized to transport the medication.
   • Another designated school personnel can arrange for its pickup.

   If school or local health department personnel are involved in transporting medications, written agreements with the parent or guardian should specify that these personnel are acting as agents of the school and of the specific child. The amount of medication provided for transport should be noted and then verified when the medication is logged in at the school.

**The Responsibility of the Local School Administration**

1. Develop a written policy and procedures for medication administration that is to be implemented in all schools within the system. (It is recommended that the policy and procedures be jointly developed by a committee of physicians, nurses, parents, school staff and others who have a need to support and implement these procedures at school.)

2. Provide proper storage space in each school to ensure that medications are secure, yet readily accessible to staff and students involved. Some medications cannot be locked, such as those that students need to carry with them at all times (e.g., asthma inhalers or epinephrine auto injectors). Security for these medications must be planned on an individual basis. Confidentiality and privacy must be maintained regardless of the health condition.

3. Provide refrigerated storage for medications as needed. These medications are to be kept separate from food. Assure that temperature ranges are appropriate for the medications, as directed on label.
4. Designate one or more persons in every school with responsibility for the security and administration of the medications. A back-up person will be needed when the designated person is absent.

5. Maintain records of all medications administered by school personnel. All written parent and doctor authorizations and medication logs and records should be retained on file at school for as long as the child is enrolled in the school system and until the student reaches age 29 (or longer, if litigation is in process). (See Appendix II Item # 23-f, for full details.) Sample medication log form is included in Section E).

6. Provide parent communication and instruction regarding school policy on medication administration. Parent handbooks, websites and newsletters are good vehicles for this as well as individual letters and forms as needed. A sample form letter to parents is included in this Section E.

7. Develop a procedure for disposition of medications not retrieved by parents after a medication has been discontinued, the student has transferred, or the school year has concluded. (Follow recommendations of the U.S. FDA, available at www.usfda.org).

Recommendations on Role of the School Nurse in Medication Administration

In most school districts, the school nurse serves more than one school. It is unrealistic and in most cases impossible for the RN to administer all medications to students. Therefore, the school nurse must delegate and train non-licensed staff (teachers, assistants, secretaries, and others) to administer medications, following N.C. Board of Nursing regulations and guidelines.

The decision on who administers medications in the school should be a decision reached by the school nurse, taking into account the needs of students, the nurse to student ratio, and other information on which the RN bases the decision. In cases of routine medications, student should obtain medications from a consistent source, not someone who is available on a limited basis. Following this recommendation reduces the potential for error.

The school nurse also:

1. Serves on school system committee for the development and annual evaluation of written school policy and procedures for medication administration.
2. Coordinates, monitors and audits the administration of medication in each school according to adopted policy.

3. Reviews the documentation of medication in the school. Periodically audit the completed forms and procedures for quality, accuracy, safety, and compliance with written guidelines. Recommend changes to principals and school staff.

4. Serves as consultant to principals, school staff, parents, and students regarding medications. The registered nurse is often, in the school setting, the single source of medically-accurate information regarding pharmaceuticals. The N.C. Board of Nursing has issued guidelines regarding the Registered Nurse making recommendations about the use of over-the-counter pharmaceutical products and non-prescriptive devices. Each RN who makes such recommendations is accountable for the decision and must monitor the outcomes of his or her recommendations. The ability to monitor is not available to most school nurses who are not in boarding or residential schools.

5. Serves as the “gate keeper” for medications of students within the school. Any new medication (not given before in the school) should be reviewed by the RN for appropriate usage, dose, route of administration and side effects that may be expected. In addition, the first dose of a medication the student has never before taken should not be given at school. Any RN may refuse to delegate or may postpone administration of any medication based on his or her nursing judgment.

6. Serves as liaison with parents, physicians and the appropriate individuals regarding status and effectiveness of student’s medication treatment plan.

7. Provides training for school staff who are assigned the responsibility for administering and safely securing medications at school.

8. Assures access to emergency medication for all students and assistance for students needing help.

9. Makes available to staff a current copy of a medication reference book such as Physician’s Desk Reference (PDR) or Drug Facts and Comparison, for use as a standard resource in reviewing medications.
Special Circumstances Regarding Medications When Building Must Be Evacuated

Schools may experience the need to evacuate for a variety of reasons such as a local disaster or bomb threat. Medications related to conditions such as diabetes, asthma and life-threatening allergies, among others, must be available to students at all times. As a result, the school emergency response plan should address medication access for these and other possible situations, such as lock down.

In case of building evacuation, emergency medications should be removed from the building by the school’s designated daily medication provider. If policy allows individual classroom teachers to store emergency medication in their classroom then they should remove those medications from the building on vacating. Evacuation drills should include the removal of emergency medications for practice and in case needed during the drill.

School medication providers may be assigned a known location during a school evacuation that would allow staff and students to access a student’s emergency medication. It is the responsibility of the medication provider to assure that the student has access to his/her emergency medication, if needed.

Emergency medication should be kept confidential and in safe storage while out of the building. This may be facilitated by the use of a portable, lockable storage container that is readily available. Each medication given during such emergencies should be documented in accordance with policy. If the medication log is not available during evacuation, document the administration of medication in a temporary manner that can be retained and then add that document to the medication administration log upon return to the building.
Self-Medication Procedures

There are a limited number of health conditions which may require the student to carry medication at all times. These include asthma (inhalers), diabetes (insulin or source of glucose), and severe anaphylactic allergies (emergency epinephrine). In addition to ready access to medication, an objective of a student’s medical program is often self-responsibility for medication. Parents should be informed that students who self-carry are independent in the management of their medication with no oversight from school staff.

When medications such as asthma inhalers, diabetes medications and emergency medications must be self-administrated, an appropriate individualized health care plan will be completed by the parent and school nurse. An authorization form will be completed by the physician and signed by the parent. Students will be assessed for their knowledge and competence in self-administering the medications and will agree to keep their medicine secure from other students.

When children who are subject to health hazards such as severe allergies attend school, it is the parent’s or guardian’s responsibility to assure that the school administration is aware of the situation and prepared to implement emergency measures. The plan developed between the student’s parent or guardian, personal physician or health care source, and the school, for responding to such an emergency shall include:

- administering medication to reduce the impact of an allergic reaction until the student can be transported to the emergency room and/or
- instituting other first aid measures as directed.

Each student’s specific needs and procedures should be included in an individualized written emergency plan developed for the student, and approved by the parent or guardian and physician. The after care of the student is determined by the attending physician who sees the student either in the office or in the emergency room. The parent or guardian has responsibility for assuring that an emergency care plan is developed for the child, and that written permission is given by them to institute emergency measures.

Students may self-medicate as their plan requires if the following criteria are met.

A written request shall be required annually from:

1) A licensed health care provider, to include:
a. Verification of the student’s diagnosis that permits self-carry and self-administration of medication;
b. Verification that the medication has been prescribed for use during the school day, school activities and/or in transit;
c. A written statement that the student understands, has been instructed in self-administration of the medication and has demonstrated the skill level necessary to use the medication and any device necessary to administer the medication;
d. A written treatment plan and written emergency protocol formulated by the health care practitioner who prescribed the medicine.

Also included in the documentation:
- Student’s name and birth date
- Name of medication
- Dosage at school
- Relationship to meals if applicable
- When medication should be given
- How often medication should be given
- Expected side effects
- Reason(s) that the medication should be withheld
- Date medication should be stopped
- Health care provider signature, telephone number and date

2) Written authorization from the student’s parent or guardian for the student to possess and self-administer medication, and authorize school personnel to allow the student to carry the medication. Include parent/guardian signature; telephone number and date. (May use Medication Authorization Form included in this Section E). The parent must provide to the school back-up medication that will be kept in a location in school to which a student has immediate access.

The request is reviewed by the school nurse, who provides the student with health counseling to include:

1. Review of health condition, medications, triggers, precautions.
2. Assessment of student’s knowledge and developmental ability to be independent with medication.
3. Role play of procedure to be used when necessary and how to obtain help when needed.
4. Review of school medication policy/procedures, disciplinary actions for sharing medication or failure to safeguard it.
5. Assure the student understands and signs a self-medication agreement. (See Sample Student Agreement in this Section E)
6. Instruct the student’s teacher(s), as appropriate, on the student’s condition and authorization to self-carry and self-administer. This instruction may include cautions on usage and dosage of the medication.
Student Agreement for Self-Carried Medication  
(Sample)

Student: ___________________________________________ Grade: _________
School: ________________________________________________

Parent: __________________________ Telephone Number/s: ________________
Health Care Provider: ___________________ Telephone 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 Authorization Form. Student’s name must appear on the medications and devices.

**RESPONSIBILITIES**

I plan to 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 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, and

I will not allow any other person to use my medication or equipment.

Student’s 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.

Comments: ________________________________________________

School Nurse Signature: ____________________________ Date: ______________

Principal Signature: ____________________________ Date: ______________
(This section intentionally left blank.)
Recommendations on Medication Administration Policy

Chapter 115C-307 of the General Statutes of North Carolina enables public school employees, when given the authority by the Board of Education or its designee, to administer medication prescribed by a health care provider upon written request of the parents. As a result, a medication administration policy has been jointly developed by a committee comprised of physicians, nurses, legal experts, a pharmacist consultant and school personnel to address the needs of school employees and students. Review of the medication administration policy and procedures should occur annually.

Medications administered during school hours by school personnel should be kept to a minimum. The student in need of medication to sustain his or her attendance in school may have a chronic health problem, special health care need, or have an unusual health problem where emergency measures are indicated. Every effort should be made for medications to be given at home before or after school hours. If the dosage schedule requires school-time administration, it is the parent’s or guardian’s responsibility to make arrangements with the school administration for medication to be given during school hours. Pursuant to state law, school employees may administer medication prescribed by a doctor upon written request of the parents. (G.S. 115C – 307, -375.1, & - 375.2)

Procedures are written to describe how the policy is implemented. Medication administration procedures should include all steps of implementing the policy including written authorization forms and all other forms used to document inventory, incidents, and administration of medications, training and supervision of designated staff to administer medications and safe storage. For complete guidance see Section E Chapter 3.
Letter to Parent Regarding Administration of Medication in School

(Sample)

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 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. Students must demonstrate the necessary knowledge and developmental maturity to safely assume responsibility for self-carry medications.

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 the school nurse at the following number: __________.

Thank you for your cooperation,

School Nurse ____________________ Principal ______________________________
Request for Medication Administration in School
(Sample Form)

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: ____________________
To be given from: (date)_________________ to/through: ________________________
Significant Information (include side effects, toxic reactions, reactions if omitted, etc.)

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________________________
      Telephone________________________
   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.
   [Asthma/allergic reaction □MDI (*Metered Dose inhaler) □MDI with spacer *
    □Epinephrine □diabetes – insulin □ diabetes – glucose ]
   *Parent/guardian must provide an extra inhaler/epinephrine injector/source of glucose 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 The student also must have a self-medication agreement on file.

Date________________  Physician’s Signature__________________________________

(Over)
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).

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
Principal’s Signature

Reviewed by _______________________________                  Date
School Nurse’s Signature
Administration of Medication at School, on Field Trips & at School-Sanctioned Activities
(Sample Policy)

Chapter 115C-307 of the General Statutes of North Carolina enables public school employees, when given the authority by the Board of Education or its designee, to administer medication prescribed by a health care provider upon written request of the parents. As a result, a medication administration policy has been jointly developed by a committee comprised of physicians, nurses, legal experts, a pharmacist consultant and school personnel to address the needs of school employees and students.

Medication Administration Policy

Medications administered during school hours by school personnel should be kept to a minimum. The student in need of medication to sustain his attendance in school may have a chronic health problem, special health care need, or have an unusual health problem where emergency measures are indicated. The policy is intended for this type of child.

1. Acutely ill children may need medications for short periods of time to enable them to remain in school. Medications can be given at home before or after school hours. If this is not possible, it is the parent’s or guardian’s responsibility to make arrangements with the school administration for medication to be given during school hours.

2. When medications such as asthma inhalers, diabetes medications and emergency medications must be self-administered, an individualized plan and authorization to self-administer form must be on file. Students will be assessed by the school nurse for their knowledge and competence in self-administering the medications and will agree to keep their medicine secure from other students.

3. When children who are subject to unusual health hazards, such as allergy to bee stings, attend school, it is the parent’s or guardian’s responsibility to assure that the school administration is aware of the situation and prepared to implement emergency measures. The plan developed between the student’s parent or guardian, personal physician or health care source, and the school, for responding to such an emergency shall include, at minimum:
   • instructions for administering medication to slow allergic reactions until the student can be transported to the emergency room and/or
   • instructions for instituting first aid measures.

This information is also included in the student’s Emergency Action Plan, part of overall health planning developed for the student and approved by the parent or guardian and physician. The parent or guardian has responsibility for assuring that an emergency care plan is developed for the child, and that written permission is given by them to institute emergency measures.
Field Trip Medication Administration to Students
A Sample Protocol for School Employees

Introduction:

When a medication authorization exists for any student during school hours, it is the responsibility of the school staff to ensure that medications are given to students as ordered while at school. This includes any off-campus school activity such as field trips. Guidance from the North Carolina Board of Pharmacy suggests instructing parents to request a second pharmacy labeled child resistant prescription vial for each medication. The Board of Pharmacy recommends that only school nurses “repackage a day’s” worth of medication for a field trip. In addition, the North Carolina Board of Nursing in its 2007 revised position statement, “Assisting Clients with Self-Administration of Medication”, states “the unlicensed assistant may not perform pre-filling and labeling of medication holders”.

Prior to the Field Trip:
1. One adult (plus one or two back-ups if needed) will assume the duty as the “medication and first aid provider” for the field trip.
2. The “med/first aid provider” for the field trip will cross check the student field trip roster with the school’s routine daily medication staff member.
3. Identify any students who may need routine daily medication during the field trip as well as any student needing ready access to emergency “prn” medications.
4. As students are identified, the school nurse will prepare the student’s daily dose for the field trip. If the nurse is not available to re-package medications for a daily dose, then the entire properly labeled medication container must be taken by the school staff member/“med/first aid provider,” for this event.
5. **School Nurse preparation of medication for field trip for each individual student:**
   Remove the number of doses needed for the field trip from the original pharmacy-labeled bottle and place in an individual dose packet (example: a small plastic zip-lock bag). Label each dose packet with the student’s name, name of medication, time to receive the medication, and any instructions, such as to be taken with plenty of water or taken with food or taken on an empty stomach.

   Obtain a list of the students who will be on the field trip and name of adult who will be giving the medications for that date and for the particular field trip.

   Provide these medications doses, any emergency medications, and any special directions for the field trip “med/first aid provider.”
Provide a one-page instruction list stating who to call at school if questions arise, the six safety rights about giving medications, and general “do’s and don’ts”.

Make copies of any emergency information sheet or Emergency Action Plan for the field trip “med/first aid provider.” You may also consider making copies of each student’s medication authorization form for the field trip “med/first aid provider.”

6. The field trip “med/first aid provider” consults the school nurse for assistance if specific skills or training are needed by the field trip staff prior to the day of the field trip. This is to assure that staff are prepared for students who may need an emergency medication or who are at known risk for certain health emergencies. Also consult parents, when needed, to assure that all field trip staff are adequately prepared to care for any student with special needs on the field trip.

7. The “med/first aid provider” identifies who to call and how to reach them (such as the school nurse) if telephone consultation may be needed while on the field trip.

On the day of the field trip:

1. The field trip “med/first aid provider” will pick up all student medications, any emergency medications, copies of medication authorizations and emergency action plans and the first aid supply box at school from the school’s designated daily medication staff member.

2. All medications and forms will be kept secure from possible theft or loss. Medications may be kept by the “med/first aid provider” in a locked box, or by wearing a back pack or fanny pack to ensure that medications and information sheets are never left unattended or out of sight at any time.

3. The field trip “med/first aid provider” will assure that each student receives his or her doses at the correct time and by the correct route according to the school medication authorization form. (check this form prior to giving any dose to prevent risk of error).

4. The field trip “med/first aid provider” will note any errors or incidences about the medications if not given or if given incorrectly for any reason.

5. The field trip “med/first aid provider” will keep all student-labeled empty packets, all unused emergency medications, and all student information sheets to return to school after the field trip is over.

Upon returning to school after the field trip:

1. The field trip “med/first aid provider” will return all student-labeled empty packets, any medications not taken, all emergency medications, all student information forms, and all unused first aid supplies to the school’s daily medication staff member.
2. The field trip “med/first aid provider” will record all doses given on each student’s medication log sheet witnessed by the school’s daily medication staff member.

3. The field trip “med/first aid provider” will give written error or incidence reports that may have occurred on the field trip to the school’s daily medication staff member.

   ** All medication errors or incidences will be reported to the school nurse or school administrator for follow-up or prompt parent notification if needed.

4. The daily medication staff member will check the field trip list (created in step #4 prior to the field trip) to assure that all student medication logs are documented for the field trip day and that all emergency medications and single doses are accounted for.

5. The daily medication staff member will consult with the school nurse to discuss events or questions about any field trip incidents as needed.
**Medication Administration Incident Report**  
*(Sample Form)*

Today’s Date____________________

Name of School_____________________________________________________

Name of Student___________________________________ Birthdate: ________________

Date and time of incident__________________________ _______________________________

Name of person administering medication__________________________

Name of medication and dosage prescribed: ___________________________

Describe incident and circumstances: __________________________________________

___________________________________________________ ___________________________

Describe action taken: _______________________________________________________

___________________________________________________ ___________________________

Persons notified of incident:

Supervisor_____________________________________________________

Principal ________________________________________ ________________________

Parent ___________________________________________ _______________________

Physician (if applicable)______________________________________________

Other (including school nurse) ____________________________________________

Signature (person completing incident report) ____________________________

Follow-up information if applicable:______________________________________
**MEDICATION INVENTORY LOG**

<table>
<thead>
<tr>
<th>Date</th>
<th>Student’s Name</th>
<th>Medication/Dose</th>
<th>Amount Received</th>
<th>Received by (signature)</th>
<th>Received from (signature)</th>
<th>Disposed and/or returned to parent</th>
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1 This inventory log may be used as a temporary record before transferring the information to the student’s individual medication record.
The following medication logs are recommended for use with N.C. Division of Medical Assistance (Medicaid) billing procedures. The forms are also available on the N.C. DMA website.

If using these logs for purposes other than Medicaid billing, the ICP codes may not be needed.
Nursing Services Documentation of Medication

[*May be used for Medicaid School-Based Services Documentation – (*) do not need completion unless billing Medicaid]

Note: A separate sheet is required for each medication to be administered or procedure performed.

Student Name: Medicaid requires the student’s legal name to be on all service documentation.

Date of Birth: Enter the student’s date of birth. This is helpful in identification of the student and for Medicaid billing.

District/School: Enter the school that student will be attending during the year. If student transfers, enter the name of the new school.

Medicaid requires documentation of the place where the service was rendered. If provided any place other than the school listed, make a comment on side 2 of the form and state where it occurred. (home, field trip, etc.)

*ICD-9 Code and Medicaid #: Medicaid requires an ICD-9 diagnosis code for billing to support the medical need for the nursing service. The number is essential for billing accuracy.

Medication name: Medicaid requires that documentation include a description of the service to be provided and at what frequency.

MD/ NP/ PA: Enter the student’s physician or other health care provider prescribing the service. Order must be attached and written on or before first date of medication given.

Date and Time of Service: Medicaid requires that service documentation include the date and time the service is provided.

RN Review/date: The RN transcribing the order signs here and includes the date of the order review.

Initials: The individual administering the mediation must initial each time it is done to indicate that the service was provided.

SIDE TWO OR PAGE TWO

[For Medicaid billing: At a minimum, weekly documentation of the student’s response to medication is required by the RN.]

Student’s reaction to medication: Complete NARRATIVE NOTES & REVIEW OF RESPONSE TO MEDICATION (at least weekly for Medicaid billing). The RN completes with input from other caregiver, UAP, if appropriate. After administering the medication, evaluate the student’s response. If the student misses or refuses the dose, has an adverse reaction, or other untoward response, document as event occurs.

Signature/Credentials: The individual performing the service must sign the form and provide appropriate title or credentials the first time the service is rendered. Sign each time an entry is made on the Narrative Notes page.

Codes: The appropriate code must be entered in the day’s box when the service is not performed or the medication not administered. The same code may be used in the reaction box. When indicated, or if (C) is entered, add an explanation on the continuation page, side 2.
# MEDICATION ADMINISTRATION FLOW SHEET (January – June)

[Form may be used for Medicaid School-Based Services Documentation – (*) does not need completion unless billing Medicaid]

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<th>Name of LEA:</th>
<th>School:</th>
<th>Grade:</th>
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<td>Student name:</td>
<td>Date of Birth:</td>
<td>*Medicaid #:</td>
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<td>Name of Medication:</td>
<td>Date Begun:</td>
<td>Dose of medication (in mg):</td>
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Initials Full Name & Title Signature Date

INSTRUCTION/CODES

X = Weekend / Non-Scheduled School Day  A = Absent  D/C = Discontinued
D = Early Dismissal (left school before scheduled time)  N = No Medications/supplies available for procedure – Parent Notified (document on reverse side)
O = Medication/procedure Omitted (document reason on reverse side)  R = No Show/Student Refusal (document on reverse side)

(Keep current form with Medication Administration Authorization. File in student’s folder when complete.)
### Medication Administration Flow Sheet (July – December)

[Form may be used for Medicaid School-Based Services Documentation – (*) does not need completion unless billing Medicaid]

<table>
<thead>
<tr>
<th>Name of LEA:</th>
<th>School:</th>
<th>Grade:</th>
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<tbody>
<tr>
<td>Student name:</td>
<td>Date of Birth:</td>
<td>*Medicaid #:</td>
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<tr>
<td>Name of Medication:</td>
<td>Date Begun:</td>
<td>Dose of medication (in mg):</td>
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RN Review (Signature, Credentials, Title): | Date: |

| Month | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|-------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| July  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Aug.  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Sept. |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | X |
| Oct.  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Nov.  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | X |
| Dec.  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

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O = Medication/procedure Omitted (document reason on reverse side)  
R = No Show/Student Refusal (document on reverse side)

(Keep current form with Medication Administration Authorization. File in student’s folder when complete.)
### NARRATIVE NOTES & REVIEW OF RESPONSE TO MEDICATION (Side 2 of Flow Sheet)

(For Medicaid billing, TO BE COMPLETED AT LEAST WEEKLY BY THE RN, with UAP IF APPROPRIATE)

<table>
<thead>
<tr>
<th>STUDENT NAME: ___________________________</th>
<th>Date of Birth ___________________________</th>
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<tbody>
<tr>
<td>Date: ___________________________</td>
<td>Time: ___________________________</td>
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**STUDENT NAME:**

**Date of Birth:**

**Date:**

**Time:**

**Comments:** (response to med., side effects, reason for omission, etc.)

**RN Signature:**

---

**Documentation INSTRUCTIONS:**
- One form is needed for each different medication.
- Give medication within 30 minutes of time scheduled.
- Initial immediately in the box to indicate medication was given & time given.
- **Use pen for documentation, no markers or pencils.**
- Do not alter with “white out” or erasures. If you make an unintentional entry, mark through it with a single line & initial, date. Explain on Side 2.
- If student does not take medication, use appropriate code and explain on notes page.
- Sign your full name once, on the front, the first time administered or performed.
- Sign your full name once, on the back, each first time you add comments on the narrative notes page.

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**GENERAL INSTRUCTIONS FOR ADMINISTERING MEDICATIONS:**
- Wash hands before assisting students.
- Review the 6 R’s to insure safety each time: *right student, right medication, right dose, right time, right route, Write-document*
- **Keep medications secured at all times.**
- Make two documented contacts with the parent/guardian to pick up expired or discontinued medications before disposing. Document disposal and have a witness.
- Once poured, do not leave medication unattended.
- Immediately report errors to parent, physician and RN. Complete Incident Report.
- Do not repeat medication if a student spits it out unless you are sure he did not retain any. Notify RN for further instructions.
- Do not repeat medication if student vomits. Notify parent.
Guidelines for Managing Medical Emergencies

Injuries and illness are common occurrences in the school-age population. Although medical emergencies rarely occur in schools, the potential does exist. The school has responsibility for the safety and well-being of students during the hours of school attendance, while on school property, or during school-sponsored activities. Therefore, local school district policies should address:

- Measures necessary to prevent injury occurrence;
- Action to be taken if a serious injury or other emergency occurs; and,
- Facilities and supplies to accommodate the special needs of ill or injured students.

Rationale

- Between 10 and 20 percent of childhood injuries occur in school or in route to and from school.\(^1\)

- Injuries account for a significant portion of health problems cared for by school health personnel.

- School injuries account for approximately a quarter of missed days of school.

- Mandated school attendance convenes large numbers of active children, which increases the likelihood that injuries will occur.

- Environmental hazards frequently cause unintentional school injuries.

- Students with chronic health problems or handicapping conditions often are at greater risk for injury or illness. Medical emergencies and/or acute episodes occur with greater frequency among them.

- Timely and appropriate administration of first aid can be life saving or can minimize disability in the event of a medical emergency.

- Injuries should be carefully documented to preclude misinformation related to events which might later involve school liability.

\(^1\)“Healthy Youth: Injury and Violence”, Centers for Disease Control and Prevention, 10/15/2007
Recommendations

- School safety, injury prevention, and first aid should be incorporated into the health curriculum and emphasized via health promotion activities.

- The school nurse should be part of a school-based team that periodically monitors the school environment for safety hazards and audits injury reports to identify high occurrence areas. Areas identified as high-risk should be assessed for hazards and a report submitted to the principal for corrective action.

- The school nurse should supplement the curriculum with classroom health resources and individual counseling as necessary, based on information derived from environmental monitoring and/or review of injury reports.

- Each school should have adequate health service facilities, supplies, and trained personnel to handle injuries and/or sudden illness.

- Emergency flip charts should be posted in convenient areas as a readily-accessible reference for school personnel and health room volunteers.

- The Emergency Guidelines for Schools, 2009 Edition, a publication of the N.C. DHHS, Office of Emergency Medical Services for Children program, should be available at each school main office and can be loaded onto teacher computers for easy reference.

- An emergency information card for each student should be maintained in the health room or office and available for staff members’ use. (See sample form in this section.)

- All school personnel, including school bus drivers and cafeteria workers, should be able to give immediate and temporary first aid care for acute illness or injury.

- The teacher or other staff member responsible for the student at the time an injury occurs should complete appropriate reports according to school policy. (See sample form later in this chapter.)
A copy of the injury report should be filed with the student’s health record and a copy given to the principal.

All incidents involving a head injury should be carefully documented. A parent/guardian of a student sustaining a head injury should be notified immediately. Head injury symptoms may not manifest themselves until later. Parents must be made aware of later evolving signs and symptoms.

Ingestion of poisonous substances should be managed in accordance with recommendations of the N.C. Poison Control Center.

All animal bites should be reported to the proper authorities after emergency care has been given.

Parents should be notified in the following situations:

- Temperature of 100 degrees or more
- Severe abdominal pain
- Nausea, vomiting and diarrhea, if persistent
- Injury where there is swelling, severe pain, or a question of sprain or broken bone
- Injury where there is significant bleeding or if bleeding does not stop in a short period of time.
- Chipped or avulsed tooth
- Eye injury
- Rash accompanied with fever
- Dog or other animal bite
- Burns
- Head injury
- Poisoning
- Any problem about which there is concern.
Planning for Health Emergencies

Individual health plans for chronically ill children should address potential emergency situations based on each student’s health condition.

Written protocols with precise instructions signed by the attending physician must be on record if a student or staff member has a health condition which requires special treatment in certain defined emergency circumstances.

Local school district policies for managing school emergencies should be reviewed by a physician-consultant, such as private physician, health department medical director, or physician member of the School Health Advisory Council.
Preparing Schools to Cope with Disasters

Historically, schools have been viewed as locations for shelters and as resources for mass transport when a disaster occurs in a community. To assure an appropriate response to a range of possible situations that could overwhelm basic school/community emergency responses, school administrators and staff should be prepared for a range of possible scenarios. Schools should plan for these scenarios not in isolation but in collaboration with the local health department, county or regional disaster preparedness team, hospitals, police and sheriff departments, fire and rescue agencies, and social service agencies. By developing a comprehensive school disaster preparedness response plan, staff, students and the community are positioned to implement a plan based on knowledge of personnel and material resources available at the school. The plan should be based on fundamental steps that could apply to a range of situations. For more information on those steps and the specific resources that may be available, visit the state website for public health preparedness: [http://www.epi.state.nc.us/epi/phpr/](http://www.epi.state.nc.us/epi/phpr/)

If clearly defined, a disaster preparedness response plan can work to ensure the safety of students and staff. The school nurse has a unique set of skills that should be utilized by the school administrator to assure that major health concerns are addressed. The school has a responsibility to plan a response that offers the greatest measure of protection possible. All phases of the disaster response should be addressed, including:

- Mitigation
- Planning
- Response
- Recovery

Once the written draft of the plan has been developed, training and drills should be utilized to assure dissemination. Drills offer the opportunity to use the plan, identify critical gaps and revise specific areas prior to an actual disaster.

The following steps can guide the development of a school site or school system disaster plan:

- Identify school staff and community participants involved in the development of the disaster plan.
• Review the phases of disaster preparation through the use of documents such as "Disaster Preparedness Guidelines for School Nurses," by J. Doyle and E. Loyacono, NASN, 2007
• Use the sample school plan and a staff skills survey to complete a basic plan for each school site and to determine the best utilization of staff.

Consider:
✓ Communication systems—will they work under most/all situations? Will they work with other community systems? What is the back-up system?
✓ Are key positions staffed three-deep in case staff are injured or absent?
✓ Does the plan address all buildings on campus, how rescue vehicles will be staged, and how parents will reunite with their children?
✓ Is there a designated command center and officer?
✓ Where are the student and staff evacuation sites?

The planning committee should discuss these and other issues. The plan and skills survey are a starting point. Contact your county emergency manager to develop a strategy for approaching this challenging and multi-faceted issue.
Emergency Care for Injury and Sudden Illness

*(Sample Policy)*

Parent(s)/guardian(s) of every student will be required to provide the following emergency information:

- Parents'/guardians’ location and phone number during the school day;
- The name, address and phone number of the student’s physician;
- Name and phone number of a relative or neighbor who may be contacted in an emergency, and
- Information concerning a student’s particular physical disability or medical condition.

This information will be required annually and will be kept on file in an accessible location.

In the event of serious injury or illness to a student, the parent(s) will be notified as to whether to pick up the child at school or meet the child at the hospital. If the parent(s) cannot be reached, the student will be transported to the hospital emergency room and the physician identified on the emergency information card will be notified. Efforts to notify the parent(s) will continue until they are completed.

Principals will inform the superintendent immediately of any serious injuries suffered by students or teachers while under the jurisdiction of the school. A report of such injury will be filed in the offices of both the principal and the superintendent. Forms for reporting injuries are available from the office of the superintendent. For all injuries serious enough to require medical attention or requiring the student to be taken home, or in all cases that the staff member in charge deems desirable, reports will be made and filed as stated above.

No ill or injured student will be taken home or sent home unless a parent, or someone designated by the parent(s), is at home to accept the responsibility for the student.

Parents who object to the procedures contained in this policy are responsible for submitting to the principal a written emergency plan for his/her approval.
Student Emergency Card
(Sample Form)

Date____________________________

Name of Student ________________________________________________
(Last)                    (First)                             (Middle)

Address____________________________________________ _____________________

School ____________________________________________ _____________________

Home Phone_____________________Grade___________Birth Date_______________

Teacher/Homeroom________________________________________________________
Bus #_____________________

Where can parents be reached if not at home:________________________________________

Mother’s Name__________________________________Phone_____________________

Father’s Name ___________________________________Phone:_____________________

List two neighbors or relatives who can assume temporary care of your child if you can
not be reached.

1. Name_______________________________Phone______________________________

   Address____________________________ Phone______________________________

2. Name______________________________Phone______________________________

   Address____________________________ Phone______________________________

In case of a medical emergency, call 911 or take other appropriate action.

_________________________                       ________________
Parent/Guardian’s Signature                             Date
Student Emergency Card (on back or second page)

Hospital Preference

Serious Health Condition

List any medications taken daily or medications needed in a medical emergency

IMPORTANT MEDICAL CONDITIONS

_____ Allergies (list)
_____ Asthma
_____ Diabetes
_____ Seizures
_____ Sickle Cell Disease
_____ Vision problems
_____ Hearing problems
_____ Heart problems
_____ Bleeding disorders
_____ Orthopedic problems
_____ Other
Guidelines for Management of Common Student Health Problems

This information presented in this section can assist school nurses and other school personnel in recognizing and handling some of the common problems that are seen in the health room. Some of the recommended procedures may need to be reviewed and approved by the local school district consulting physician.²

In obtaining the history of an illness, it is important that each caregiver have the following information: (1) how long since the student was entirely well, (2) symptoms of this condition, (3) habits found with this condition, (4) exposures, and (5) treatment.

It is important to know when the student last was well to ascertain whether the present illness is a slow, chronic process or a sudden, acute episode. Some students and/or parents can tell this progression in an orderly, detailed way; others need some guidance and prodding. The nurse should ask about the student’s condition three days ago, two days ago, yesterday and today. The nurse may have to ask whether certain conditions, such as coughing, diarrhea, constipation, vomiting, earache, stomachache, and pain, are present and which symptom(s) is (are) bothering the student or parent the most.

Determine the student’s general habits since the condition has appeared (e.g., appetite, elimination, sleeping, level of activity). The student who is eating as usual, having no bowel problems, sleeping through the night, and playing or going to school as usual is probably not as ill as the one who is not eating, having diarrhea, waking at night with a cough, and/or refusing to go to school.

Exposure to disease can be another important factor. The nurse should ask whether the student has recently been exposed to anyone with a bacterial or viral infection. Ask if anyone in the immediate family, close friends, or neighbors are ill, and, if so, how are they ill. Determine if these members are having the same symptoms or the same progression of illness, and what has been the outcome.

² Local school district consulting physician may be a private physician, Health Department Medical Director, or member of the School Health Advisory Council.
Find out what kind of treatment the student has received so far, including what the parent has been doing for the condition. Ask if the student has been seen by another nurse or doctor. Determine if the student has been taking any medication and if it seemed to work. Include questions about home remedies or non-traditional treatment.
Teacher Observation and Referral

Teaching is most effective when the teacher has a basic understanding of the student being taught. Inherent in this basic understanding is knowledge of the student’s health status. Learning is hampered when a student is in pain, ill, tense, anxious, frustrated, or depressed. There is a proportional relationship between the student’s achievement and his or her physical, social and emotional well-being. Daily contact with students in many activities and in varied situations affords the teacher an opportunity to observe signs and symptoms indicative of deviations which otherwise might be missed.

Attaining and maintaining a high level of physical, mental, social, and emotional well-being enables the student to work at his or her maximum capacity in the classroom and to become a healthy, happy and productive adult. In North Carolina, the teacher has long been recognized as a key person in the appraisal of the student’s level of well being. The teacher is with the student long enough to detect signs or symptoms of illness, injury, or other deviations from normal behavior which might need some type of health intervention. The teacher who sees the student daily and knows how he or she looks and acts when well readily recognizes when he or she is not well.

Classroom observation is an important activity for teachers. They should look for major deviations from normal behavior. In order to do this, teachers must have an understanding of what is normal and healthy for each individual student as well as for the age group they serve.

The teacher is often the first person the student turns to when he or she has a problem or does not feel well. The intent of the following “Guide for Teacher’s Referral to Nurse” is to assist in detecting conditions which may need additional assessment and follow-up. Depending upon school policy and the availability of other resources, teachers may also be involved in mass screening of students for problems related to vision, hearing, dental health and Body Mass Index (BMI).
Section E                          Chapter 3  
School Health Services           Health Problems  
---------------------------------  - Guidelines for teacher referral

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Guide for Teacher’s Referral to School Nurse

The following conditions should be referred to the school nurse:

**EYES:**

a. Sties or crusted eye lids  
b. Inflamed eye lids  
c. Crossed eyes  
d. Repeated headaches  
e. Squinting, frowning, or scowling  
f. Protruding eyes  
g. Watery eyes  
h. Rubbing of eyes  
i. Twitching of the lids  
j. Excessive blinking  
k. Holding head to one side  
l. Complaints of blurry vision

**SKIN AND SCALP:**

a. Unusual pallor of face  
b. Eruptions or rashes  
c. Habitual scratching of scalp or skin  
d. Nits on the hair  
e. State of uncleanness  
f. Excessive redness of face

**GROWTH:**

a. Failure to gain regularly over 6-month period  
b. Unexplained loss in weight  
c. Unexplained rapid gain in weight

**GENERAL APPEARANCE AND CONDITION:**

a. Underweight - very thin  
b. Overweight - very obese  
c. Does not appear well  
d. Tires easily  
e. Chronic fatigue  
f. Nausea or vomiting  
g. Faintness or dizziness  
h. Chronic menstrual discomfort

**BEHAVIOR:**

a. Over studious, docile, withdrawing  
b. Bullying, over-aggressiveness  
c. Unhappy and depressed  
d. Overexcitable, uncontrollable emotions  
e. Stuttering or other forms of speech difficulty  
f. Poor accomplishment in comparison with ability  
g. Lying (imaginative or defensive)  
h. Lack of appreciation of property rights  
i. Abnormal sexual behavior  
j. Antagonistic, negative, quarrelsome  
k. Excessive use of toilet  
l. Enuresis (accidental wetting)
North Carolina School Health Program Manual

Section E
School Health Services

Chapter 3
Health Problems
- Guidelines for teacher referral

EARS:

a. Discharge from ears
b. Earache
c. Failure to hear questions
d. Picking at the ears
e. Turning head to hear
f. Talking in a monotone
g. Inattention
h. Anxious expression
i. Excessive noisiness of child
j. Ringing in ears
k. Dizziness

TEETH AND MOUTH:

a. State of uncleanliness
b. Gross caries
c. Irregular teeth
d. Stained teeth
e. Gum boils
f. Offensive breath
g. Mouth habits such as thumb sucking
h. Complaints of toothache
i. Swollen jaw

POSTURE & MUSCULATURE:

a. Uneven alignment of spine/hips
b. Peculiarity of gait
c. Uneven alignment of spine
d. Muscular development
e. Coordination
f. Muscle Tone

HEART:

a. Excessive breathlessness
b. Easily tires
c. Bluish lips or fingernails
d. Excessive pallor

NOSE AND THROAT:

a. Persistent mouth breathing
b. Frequent sore throats
c. Recurrent colds
d. Chronic nasal discharge
e. Frequent nose bleeding
f. Nasal speech
g. Frequent tonsillitis
h. Chronic coughing

GLANDS:

a. Enlarged glands at side of neck
b. Enlarged thyroid
ANY CHRONIC ILLNESS:
(known or suspected diagnosis)

- Diabetes
- Seizure disorder
- Rheumatic fever
- Cystic fibrosis
- Orthopedic condition
- Severe hearing loss
- Uncorrected visual loss or handicap
- Other special conditions
- Sickle cell anemia

OTHER:

- Students who lack medical care due to financial situation or religious views.
- Known or suspected social, family, financial situations affecting the health of the student
- Prolonged absenteeism
- Homebound students
- Suspected or known pregnancies
- Signs of physical abuse
- Children receiving medications for prolonged time and/or for chronic conditions.
- Students new to school district if health problems are noted on the transfer record
Referral To School Nurse  
(Sample Form)

Please complete form and provide to nurse or school office. Thank you!

Person Making Referral ________________________________________________________________

Student Being Referred ________________________________________________________________  Grade ______

Date _______________ Homeroom Teacher __________________________________________________

Student’s Schedule:  1st ______________  2nd ___________  3rd ______________

4th _______________  5th _____________________  6th _________________________

Reason Student is Being Referred
___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Nurse’s Findings/Recommendations _______________________________________________________
___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Nurse’s Signature _______________________________ Date ___________________________
Student Health History
(Sample Form)

School __________________________
Teacher/Grade _____________________
Date ______________________________

Dear Parents/Guardian:

The following is a brief health history form. Please complete it and return to your child’s teacher or the school nurse as soon as possible. This information is essential for providing adequate treatment in case of illness or injury and in meeting your child’s health needs at school. If your child needs medication at school, a medication authorization form must be completed and returned to the office. The form can be obtained at school. Contact the school secretary if you need to talk with the school nurse.

Name of Student ________________________ Birthdate ____________________________

Homeroom ________________________________

Father

name ____________________________ daytime phone numbers ___________________ place of employment ______________________

Mother______________________________

name ____________________________ daytime phone numbers ___________________ place of employment ______________________

Alternate person to contact for health information

name ____________________________ daytime phone numbers ___________________

relationship to child __________________

Where does your child receive health care?

Name of doctor or clinic ______________________ Phone number ______________________

Date of last physical exam ________________________________

Name of dentist ______________________ Phone number ______________________

Date of last dental exam ________________________________
Please circle “yes” or “no,” or answer the question as appropriate.

**DOES YOUR CHILD HAVE......**

**Allergies**

- Yes
- No

If yes, what is your child allergic to? _____________________________________________________________

Is medication needed at school? _________________________________________________________________

**Asthma**

- Yes
- No

If yes, when was the last episode? _______________________________________________________________

Is medication needed at school? _________________________________________________________________

**Diabetes**

- Yes
- No

Does your child use insulin? ________________________________________________________________

**Seizures**

- Yes
- No

If yes, when was the last seizure? _______________________________________________________________

Is your child on medication for seizures? __________________________________________________________

Is medication needed at school? _________________________________________________________________

**Vision Problems**

- Yes
- No

Does your child wear glasses or contacts? _________________________________________________________

Has your child ever failed a vision screening?     Yes     No

**Hearing Problems**

- Yes
- No

Does your child have a known hearing loss? _______________________________________________________

Does your child wear a hearing aid? _______________________________________________________________

**Heart Problems**

- Yes
- No

If yes, name of problem _________________________________________________________________

Is exercise limited?     Yes     No

Is child on medication for this problem?     Yes     No
Orthopedic Problems

If yes, name of problem _____________________________

Other health problems

If yes, please describe _________________________________

Was your child hospitalized or did your child have major changes in health within the past year?

Yes  No
First Aid

One of the objectives of the school health program is the appropriate management of emergencies and life-threatening medical situations in the school setting. Policies for first aid management should be reviewed and training of appropriate school staff should occur each year, as early into the school year as possible.

All students known to have potentially life-threatening conditions must have an Emergency Action Plan (EAP) written and reviewed with all relevant staff as soon as possible. Children & Youth Branch of the Division of Public Health recommends that the school nurse write those EAPs by the 10th day of the condition being made known to him or her.

All staff should be able to access, through in-class phones or emergency alert methods, the 911 emergency response system. All staff should know or have posted for ready access, the phone number of the local poison control center. The nurse should follow the school's policy for notification of administrative staff when an emergency occurs. As a rule, the principal is always made aware when 911 has been called.

A nurse is not always available at the time of the emergency. Even if a full time nurse is in the building, teachers and other staff must also know how to respond appropriately. Each school should have a printed or electronic copy of “Emergency Guidelines for Schools” readily available for easy reference. Schools should also have policies or plans in place to meet the emotional needs of students during crisis.

All injuries occurring at school should be documented on an injury/incident form and filed in the student’s permanent record or stored as the school system’s policy states. The school nurse should receive a copy of all injury reports.

All school staff should follow these points when responding to a student emergency:

- Never leave an injured or seriously ill child unattended.
- Parents must be notified immediately. If the staff member can not do so without leaving the child, then delegate that duty to another person. The principal must also be notified.

As soon as feasible during the emergency, contact the school nurse or teacher to ask if there is a written emergency plan for this student.

Recognize your limits: physical, scope of training, scope of licensure, and job description.
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Injury Report
(Sample Form)

The N.C. Department of Health and Human Services (DHHS) provides the following Student Injury Report Form and guidelines as a sample for districts to use in tracking the occurrence of school-related injuries. NC DHHS suggests completing the form when an injury leads to any of the following:

1. The student misses ½ day or more of school.

2. The student seeks medical attention (health care provider office, urgent care center, emergency department).

3. EMS 9-1-1 is called.

Schools are encouraged to review and use the information collected on the injury report form to influence local policies and procedures as needed to remedy hazards.

Instructions

- Student, parent and school information: self-explanatory.
- Check the box to indicate the location and time the incident occurred.
- Check the box to indicate if equipment was involved; describe involved equipment. Indicate what type of surface was present where the injury occurred.
- Using the grid, check the body area(s) where the student was injured and indicate what type of injury occurred. Include all body areas and injuries that apply.
- Check the appropriate box(es) for factors that may have contributed to the student’s injury.
- Provide a detailed description of the incident. Indicate any witnesses to the event and any staff members who were present. Attach another sheet if more room is needed.
- Incident response: include all areas that apply.
- Provide any further comments about this incident, including any suggestions for what might prevent this type of incident in the future.
- Sign the completed form.
Route the form to the school nurse and the principal for review/signature.
Original form and copies should be filed according to district policy.
North Carolina Department of Health and Human Services

STUDENT INJURY REPORT FORM

Student Information
Name_________________________________________ Date of Incident_____________________
Date of Birth__________________________________ Time of Incident_____________________
Grade_______________________________________

Parent/Guardian Information
Name(s)_______________________________________ __________________________________
Address_______________________________________ __________________________________
Phone # Work_________________________________
                                            Home________________________________

School Information
School________________________________________ Phone #_______________________________
Principal_______________________________________

Location of Incident (check appropriate box):
- Athletic Field
- Cafeteria
- Classroom
- Gymnasium
- Hallway
- Bus
- Stairway
- Restroom
- Other (explain):_________________________________________ ____________

When Did the Incident Occur (check appropriate box):
- Recess
- Athletic Practice/Session
- Field Trip
- Lunch
- Athletic Team Competition
- Unknown
- P.E. Class
- Intramural Competition
- Other__________
- In Class (not P.E.)
- Before School
- Class Change
- After School

Surface (check all that apply):
- Asphalt
- Dirt
- Lawn/Grass
- Wood Chips/Mulch
- Gymnasium Floor
- Carpet
- Gravel
- Mat(s)
- Tile
- Other (specify)________
- Concrete
- Ice/Snow
- Synthetic Surface

Contributing Factors (check all that apply):
- Animal Bite
- Overextension/Twisted
- Contact with Hot or Toxic Substance
- Collision with Object
- Foreign Body/Object
- Drug, Alcohol or Other Substance Involved
- Compression/Pinch
- Hit with Thrown Object
- Weapon
- Fall
- Struck by Object (bat, swing, etc.)
- Unknown
- Fighting
- Struck by Auto, Bike, etc.
- Other_________________________________________
### Type of Injury (check all that apply):

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<th>Eye</th>
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<th>Nose</th>
<th>Mouth/Lips</th>
<th>Nose/Throat</th>
<th>Chin</th>
<th>Collarbone</th>
<th>Shoulder</th>
<th>Upper Arm</th>
<th>Wrist</th>
<th>Hand</th>
<th>Finger</th>
<th>Fingernail</th>
<th>Chest/Ribs</th>
<th>Back</th>
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### Description of the Incident:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

### Witnesses to the Incident:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

### Staff Involved:

- [ ] Teacher
- [ ] Nurse
- [ ] Principal
- [ ] Assistant Staff
- [ ] Custodian
- [ ] Bus Driver
- [ ] Secretary
- [ ] Cafeteria
- [ ] Other

(specify)

### Incident Response (check all that apply):

- [ ] First Aid
  - Time __________________ By Whom ________________________________
- [ ] Parent/Guardian Notified
  - Time __________________ By Whom ________________________________
- [ ] Unable to Contact Parent/Guardian
  - Time __________________ By Whom ________________________________
- [ ] Parents Deemed No Medical Action Necessary
- [ ] Returned to Class
- [ ] Sent/Taken Home
  - Days of School Missed ________________________________
Assessment/Follow-up by School Nurse
Action Taken

Called 9-1-1

Taken to Health Care Provider/Clinic/Hospital/Urgent Care
Diagnosis
Days of School Missed

Hospitalized
Diagnosis
Days of School Missed

Restricted School Activity
Explain
Length of Time Restricted
Days of School Missed

Other

Describe care provided to the student:

Additional Comments:

Signature of Staff Member Completing Form Date/time
Nurse's Signature Date/time
Principal's Signature Date/time
First Aid for Common Health Problems

The following pages, found also in the DHHS Emergency Guidelines for Schools, provide basic first aid information for many of the common medical emergencies that occur in the school setting. The information on these pages, as well as the EGS manual, can be used by the school nurse to train staff. They also can be used as a reference following the training.

Although the first aid measures are written in terms of student injury or illness (e.g., notify parent, etc.), the first aid measures may also apply to illness of or injury to faculty, staff or visitor. An adult, however, may refuse first aid or a call to 911. If the adult is determined to be conscious and aware of what is occurring, the desire to refuse treatment should be respected.

Additional Resources:


"Disaster Preparedness Guidelines for School Nurses,” by J. Doyle and E. Loyacono, NASN, 2007


Students with life-threatening allergies should be known to appropriate school staff. An emergency care plan should be developed. Staff in a position to administer approved medications should receive instruction.

Children may experience a delayed allergic reaction up to **2 hours** following food ingestion, bee sting, etc.

Does the student have any symptoms of a severe allergic reaction which may include:
- Flushed face?
- Dizziness?
- Seizures?
- Confusion?
- Weakness?
- Paleness?
- Hives all over body?
- Blueness around mouth, eyes?
- Difficulty breathing?
- Drooling or difficulty swallowing?
- Loss of consciousness?

Symptoms of a mild allergic reaction include:
- Red, watery eyes.
- Itchy, sneezing, runny nose.
- Hives or rash on one area.

Adult(s) supervising student during normal activities should be aware of the student’s exposure and should watch for any delayed symptoms of a severe allergic reaction (see above) for up to 2 hours.

If student is so uncomfortable that he/she is unable to participate in school activities, contact responsible school authority & parent or legal guardian.

CALL EMS 9-1-1. Contact responsible school authority & parent or legal guardian.
A student with asthma/wheezing may have breathing difficulties which may include:
- Uncontrollable coughing.
- Wheezing – a high-pitched sound during breathing out.
- Rapid breathing.
- Flaring (widening) of nostrils.
- Feeling of tightness in the chest.
- Not able to speak in full sentences.
- Increased use of stomach and chest muscles during breathing.

- Did breathing difficulty develop rapidly?
- Are the lips, tongue or nail beds turning blue?

Refer to student’s emergency care plan.

CALL EMS 9-1-1

Does the student have doctor – and parent/guardian – approved medication?

Has an inhaler already been used? If yes, when and how often?

Remain calm. Encourage the student to sit quietly, breathe slowly and deeply in through the nose and out through the mouth.

Administer medication as directed.

Are symptoms not improving or getting worse?

CALL EMS 9-1-1

Contact responsible school authority & parent/legal guardian.

Students with a history of breathing difficulties including asthma/wheezing should be known to appropriate school staff. A care plan which includes an emergency action plan should be developed. N.C. law allows students to possess and use an asthma inhaler in the school. Staff must try to remain calm despite the student's anxiety. Staff in a position to administer approved medications should receive instruction.
BEHAVIORAL EMERGENCIES

Behavioral or psychological emergencies may take many forms (e.g., depression, anxiety/panic, phobias, destructive or assaultive behavior, talk of suicide, etc.). Intervene only if the situation is safe for you.

Refer to your school’s policy for addressing behavioral emergencies.

Does student have visible injuries?

YES

See appropriate guideline to provide first aid. CALL EMS 9-1-1 if any injuries require immediate care.

NO

CALL THE POLICE.

YES

• Does student’s behavior present an immediate risk of physical harm to persons or property?
• Is student armed with a weapon?

NO

The cause of unusual behavior may be psychological, emotional or physical (e.g., fever, diabetic emergency, poisoning/overdose, alcohol/drug abuse, head injury, etc.). The student should be seen by a health care provider to determine the cause.

Suicidal and violent behavior should be taken seriously. If the student has threatened to harm him/herself or others, contact the responsible school authority immediately.

Contact responsible school authority & parent/legal guardian.
Bites (Human & Animal)

1. Wear disposable gloves when exposed to blood.
2. Wash the bite area with soap and water.
3. Press firmly with a clean dressing. See "Bleeding".
4. Is student bleeding? YES → Hold under running water for 2-3 minutes. NO → Check student’s immunization record for tetanus. See "Tetanus Immunization".
5. Is bite from an animal or human? HUMAN → Is bite large or gaping? YES → Contact responsible school authority & parent/legal guardian. NO → Is bleeding uncontrollable? YES → Call Poison Control 1-800-222-1222. Follow their directions. NO → Contact responsible school authority & parent/legal guardian.
6. ANIMAL → If skin is broken, contact responsible school authority & parent/legal guardian. URGE IMMEDIATE MEDICAL CARE.
7. Bites from the following animals can carry rabies and may need medical attention:
   - Dog
   - Opossum
   - Raccoon
   - Coyote
   - Bat
   - Skunk
   - Fox
   - Cat
8. If bite is from a snake, hold the bitten area still and below the level of the heart. CALL POISON CONTROL 1-800-222-1222. Follow their directions.
9. Parents/legal guardians of the student who was bitten and the student who was biting should be notified that their student may have been exposed to blood from another student. Individual confidentiality must be maintained when sharing information.
10. Report bite to proper authorities, usually the local health department, so the animal can be caught and watched for rabies.
Wear disposable gloves when exposed to blood or other body fluids.

Is injured part amputated (severed)?

**NO**

• Press firmly with a clean bandage to stop bleeding.
• Elevate bleeding body part gently. If fracture is suspected, gently support part and elevate.
• Bandage wound firmly without interfering with circulation to the body part.
• **Do NOT** use a tourniquet.

**YES**

CALL EMS 9-1-1.

• Place detached part in a plastic bag.
• Tie bag.
• Put bag in a container of ice water.
• **Do NOT** put amputated part directly on ice.
• Send bag to the hospital with student.

Is there continued uncontrollable bleeding?

**YES**

CALL EMS 9-1-1.

• Have student lie down.
• Elevate student’s feet 8-10 inches unless this causes the student pain or discomfort or a neck/back injury is suspected.
• Keep student’s body temperature normal.
• Cover student with a blanket or sheet.

If wound is gaping, student may need stitches. Contact responsible school authority & parent or legal guardian.

**URGE MEDICAL CARE.**

Contact responsible school authority & parent or legal guardian.
Wear disposable gloves when exposed to blood and other body fluids.

Wash the area gently with water. Use soap if necessary to remove dirt.

Is blister broken?

- **YES**
  - Apply clean dressing and bandage to prevent further rubbing.

- **NO**
  - **Do NOT break blister.**
    - Blisters heal best when kept clean and dry.

If infection is suspected, contact responsible school authority & parent or legal guardian.
If student comes to school with unexplained unusual or frequent bruising, consider the possibility of child abuse.

- Is bruise deep in the muscle?
- Is there rapid swelling?
- Is student in great pain?

If yes, contact responsible school authority & parent or legal guardian.

If no, rest injured part.

Apply cold compress or ice bag covered with a cloth or paper towel for 20 minutes.

If skin is broken, treat as a cut. See "Cuts, Scratches & Scrapes"
If student comes to school with pattern burns (e.g., iron or cigarette shape) or glove-like burns, consider the possibility of child abuse.

Always make sure the situation is safe for you before helping the student.

What type of burn is it?

**ELECTRICAL**

Is student unconscious or unresponsive?

**NO**

See “Electric Shock”

**YES**

CALL POISON CONTROL 1-800-222-1222 while flushing burn and follow instructions.

**CHEMICAL**

What type of burn is it?

**HEAT**

Flush the burn with large amounts of cool running water or cover it with a clean, cool, wet cloth. **Do NOT use ice.**

• Is burn large or deep?
• Is burn on face or eye?
• Is student having difficulty breathing?
• Is student unconscious?
• Are there other injuries?

**NO**

Cover/wrap burned part loosely with a clean dressing.

**YES**

Check student’s immunization record for tetanus. See “Tetanus Immunization”

Call EMS 9-1-1

Contact responsible school authority & parent or legal guardian.
NOTES ON PERFORMING CPR

The American Heart Association (AHA) issued new CPR guidelines for laypersons in 2005.* A new compression-to-ventilation ratio of 30:2 is one of several key changes in these guidelines. Other organizations such as the American Red Cross also offer CPR training classes. If the guidance in this book differs from the instructions you were taught, follow the methods you learned in your training class. In order to perform CPR safely and effectively, skills should be practiced in the presence of a trained instructor. It is a recommendation of these guidelines that anyone in a position to care for students should be properly trained in CPR. The State of North Carolina supports school personnel to become trained in CPR and use of AEDs by authorizing community colleges to waive tuition and registration fees to elementary and secondary school employees enrolled in courses in first aid or CPR. G.S. 115D-5.b

Current first aid, choking and CPR manuals, and wall chart(s) should also be available. The American Academy of Pediatrics offers many visual aids for school personnel and can be purchased at http://www.aap.org.

CHEST COMPRESSIONS

The AHA is placing more emphasis on the use of effective chest compressions in CPR. CPR chest compressions produce blood flow from the heart to the vital organs. To give effective compressions, rescuers should:

- Follow revised guidelines for hand use and placement based on age.
- Use a compression to breathing ratio of 30 compressions to 2 breaths.
- “Push hard and push fast.” Compress chest at a rate of about 100 compressions per minute for all victims.
- Compress about 1/3 to 1/2 the depth of the chest for infants and children, and 1½ to 2 inches for adults.
- Allow the chest to return to its normal position between each compression.
- Use approximately equal compression and relaxation times.
- Try to limit interruptions in chest compressions.

BARRIER DEVICES

Barrier devices, to prevent the spread of infections from one person to another, can be used when performing rescue breathing. Several different types (e.g., face shields, pocket masks) exist. It is important to learn and practice using these devices in the presence of a trained CPR instructor before attempting to use them in an emergency situation. Rescue breathing technique may be affected by these devices.

CHOKING RESCUE

It is recommended that schools that offer food service have at least one employee who has received instruction in methods to intervene and assist someone who is choking to be present in the lunch room at all times.

*Currents in Emergency Cardiovascular Care, American Heart Association, Winter 2005-2006.
CARDIOPULMONARY RESUSCITATION (CPR)
FOR INFANTS UNDER 1 YEAR

CPR is to be used when an infant is unresponsive or when breathing or heart beat stops.

1. Gently shake infant. If no response, shout for help and send someone to call EMS.
2. Turn the infant onto his/her back as a unit by supporting the head and neck.
3. Lift chin up and out with one hand while pushing down on the forehead with the other to open the AIRWAY.
4. Check for BREATHING. With your ear close to infant’s mouth, LOOK at the chest for movement, LISTEN for sounds of breathing and FEEL for breath on your cheek.
5. If infant is not breathing, take a normal breath. Seal your lips tightly around his/her mouth and nose. While keeping the airway open, give 1 normal breath over 1 second and watch for chest to rise.

IF CHEST RISES WITH RESCUE BREATH (AIR GOES IN):

6. Find finger position near center of breastbone just below the nipple line. (Make sure fingers are NOT over the very bottom of the breastbone.)
7. Compress chest hard and fast at rate of 30 compressions in about 20 seconds with 2 or 3 fingers about 1/3 to 1/2 the depth of the infant's chest.

   Use equal compression and relaxation times. Limit interruptions in chest compressions.
8. Give 2 normal breaths, each lasting 1 second. Each breath should make chest rise.
9. REPEAT CYCLES OF 30 COMPRESSIONS TO 2 BREATHS AT A RATE OF 100 COMPRESSIONS PER MINUTE UNTIL INFANT STARTS BREATHING EFFECTIVELY ON OWN OR HELP ARRIVES.
10. Call EMS after 2 minutes (5 cycles of 30 compressions to 2 rescue breaths) if not already called.

IF CHEST DOES NOT RISE WITH RESCUE BREATH (AIR DOES NOT GO IN):

6. Re-tilt had back. Try to give 2 breaths again.

IF CHEST RISES WITH RESCUE BREATH, FOLLOW LEFT COLUMN.

IF CHEST STILL DOES NOT RISE:

7. Find finger position near center of breastbone just below the nipple line. (Make sure fingers are NOT over the very bottom of the breastbone.)
8. Using 2 or 3 fingers, give up to 5 chest thrusts near center of breastbone. (Make sure fingers are NOT over the very bottom of the breastbone.)
9. Look in mouth. If foreign object is seen, remove it. Do not perform a blind finger sweep of lift the jaw or tongue.
10. REPEAT STEPS 6-9 UNTIL BREATHS GO IN, INFANT STARTS TO BREATHE ON OWN OR HELP ARRIVES.
CPR is to be used when a student is unresponsive or when breathing or heart beat stops.

1. Tap or gently shake the shoulder. Shout, “Are you OK?” If child is unresponsive, shout for help and send someone to call EMS and get your school’s AED if available.
2. Turn the child onto his/her back as a unit by supporting the head and neck. If head or neck injury is suspected, DO NOT BEND OR TURN NECK.
3. Lift chin up and out with one hand while pushing down on the forehead with the other to open the AIRWAY.
4. Check for normal BREATHING. With your ear close to child’s mouth, take 5-10 seconds to LOOK at the chest for movement, LISTEN for sounds of breathing and FEEL for breath on your cheek.
5. If you witnessed the child’s collapse, first set up the AED and connect the pads according to the manufacturer’s instructions. Incorporate use into CPR cycles according to instructions and training method. For an unwitnessed collapse, perform CPR for 2 minutes and then use AED.
6. If child in not breathing, take a normal breath. Seal your lips tightly around his/her mouth; pinch nose shut. While keeping airway open, give 1 breath over 1 second and watch for chest to rise.

**IF CHEST RISES WITH RESCUE BREATH (AIR GOES IN):**

7. Find hand position near center of breastbone at the nipple line. (Do NOT place your hand over the very bottom of the breastbone.)
8. Compress chest hard and fast 30 times in 20 seconds with the heel of 1 or 2 hands.* Compress about 1/3 to 1/2 depth of child’s chest. Allow the chest to return to normal position between each compression.

*Hand positions for child CPR:
- **1 hand:** Use heel of 1 hand only.
- **2 hands:** Use heel of 1 hand with second on top of first.

**IF CHEST DOES NOT RISE WITH RESCUE BREATH (AIR DOES NOT GO IN):**

7. Re-tilt head back. Try to give 2 breaths again.

**IF CHEST RISES WITH RESCUE BREATH, FOLLOW LEFT COLUMN.**

**IF CHEST STILL DOES NOT RISE:**

8. Find hand position near center of breastbone at the nipple line. (Do NOT place your hand over the very bottom of the breastbone.)
9. Compress chest fast and hard 5 times with the heel of 1 or 2 hands.* Compress about 1/3 to 1/2 depth of child’s chest to avoid pressure on ribs.
10. Look in mouth. If foreign object is seen, remove it. Do NOT perform a blind finger sweep or lift the jaw or tongue.
11. REPEAT STEPS 6-9 UNTIL BREATHS GO IN, CHILD STARTS TO BREATHE EFFECTIVELY ON OWN OR HELP ARRIVES.

*Hand positions for child CPR:
- **1 hand:** Use heel of 1 hand only.
- **2 hands:** Use heel of 1 hand with second on top of first.

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Copyright American Heart Association.
CPR is to be used when a person is unresponsive or when breathing or heart beat stops.

1. Tap or gently shake the shoulder. Shout, “Are you OK?” If person is unresponsive, shout for help and send someone to call EMS AND get your school’s AED if available.
2. Turn the person onto his/her back as a unit by supporting head and neck. If head or neck injury is suspected, DO NOT BEND OR TURN NECK.
3. Lift chin up and out with one hand while pushing down on the forehead with the other to open the AIRWAY.
4. Check for normal BREATHING. With your ear close to person’s mouth, LOOK at the check for movement, LISTEN for sounds of breathing and FEEL for breath on your cheek. Gasping in adults should be treated as no breathing.
5. If you witnessed the collapse, first set up the AED and connect the pads according to the manufacturer’s instructions. Incorporate use into CPR cycles according to instructions and training method. For an unwitnessed collapse, perform CPR for 2 minutes and then use AED.
6. If victim is not breathing, take a normal breath, seal your lips tightly around his/her mouth; pinch nose shut. While keeping airway open, give 1 breath over 1 second and watch for chest to rise.

**IF CHEST RISES WITH RESCUE BREATH (AIR GOES IN):**

7. Give a second rescue breath lasting until chest rises.
8. Place heel of one hand on top of the center of breastbone. Place heel of other hand on top of the first. Interlock fingers. (Do NOT place your hands over the very bottom of the breastbone.)
9. Position self vertically above victim’s chest and with straight arms, **compress chest hard and fast about 1½ to 2 inches at a rate of 30 compressions in about 20 seconds with both hands.** Allow the chest to return to normal position between each compression. **Lift fingers when compressing to avoid pressure on ribs.** Limit interruptions in chest compressions.
10. Give 2 normal breaths, each lasting 1 second. Each breath should make the chest rise.
11. **REPEAT CYCLES OF 30 COMPRESSIONS TO 2 BREATHS AT A RATE OF 100 COMPRESSIONS PER MINUTE UNTIL VICTIM RESPONDS OR HELP ARRIVES.**
12. Call EMS after 2 minutes (5 cycles of 30 compressions to 2 rescue breaths) if not already called.

**IF CHEST STILL DOES NOT RISE:**

8. Place heel of one hand on top of the center of breastbone. Place heel of other hand on top of the first. Interlock fingers. (Do NOT place your hands over the very bottom of the breastbone.)
9. Position self vertically above person’s chest and with straight arms, compress chest at a rate of 30 compressions in about 20 seconds with both hands about 1½ to 2 inches. Lift fingers to avoid pressure on ribs.
10. Look into the mouth. If foreign object is seen, remove it. Do not perform a blind finger sweep or lift the jaw or tongue.
11. **REPEAT STEPS 6-9 UNTIL BREATHS GO IN, PERSON STARTS TO BREATHE EFFECTIVELY ON OWN OR HELP ARRIVES.**
CHOKING (Conscious Victims)

Call EMS 9-1-1 after starting rescue efforts.

INFANTS UNDER 1 YEAR

Begin the following if the infant is choking and is unable to breathe. However, if the infant is coughing or crying, do NOT do any of the following, but call EMS, try to calm the child and watch for worsening of symptoms. If cough becomes ineffective (loss of sound), begin step 1 below.

1. Position the infant, with head slightly lower than chest, face down on your arm and support the head (support jaw; do NOT compress throat).
2. Give up to 5 back slaps with the heel of hand between infant’s shoulder blades.
3. If object is not coughed up, position infant face up on your forearm with head slightly lower then rest of body.
4. With 2 or 3 fingers, give up to 5 chest thrusts near center of breastbone, just below the nipple line.
5. Open mouth and look. If foreign object is seen, sweep it out with the finger.
6. Tilt head back and lift chin up and out to open the airway. Try to give 2 breaths.
7. REPEAT STEPS 1-6 UNTIL OBJECT IS COUGHED UP OR INFANT STARTS TO BREATHE OR BECOMES UNCONSCIOUS.
8. Call EMS after 2 minutes (5 cycles of 30 compressions to 2 rescue breaths) if not already called.

IF INFANT BECOMES UNCONSCIOUS, GO TO STEP 6 OF INFANT CPR

CHILDREN OVER 1 YEAR OF AGE & ADULTS

Begin the following if the victim is choking and unable to breathe. Ask the victim: “Are you choking?” If the victim nods yes or can’t respond, help is needed. However, if the victim is coughing, crying or speaking, do NOT do any of the following, but call EMS, try to calm him/her and watch for worsening of symptoms. If cough becomes ineffective (loss of sound) and victim cannot speak, begin step 1 below.

1. Stand or kneel behind child with arms encircling child.
2. Place thumbside of fist against middle of abdomen just above the navel. (Do NOT place your hand over the very bottom of the breastbone. Grasp fist with other hand).
3. Give up to 5 quick inward and upward abdominal thrusts.
4. REPEAT STEPS 1-2 UNTIL OBJECT IS COUGHED UP, CHILD STARTS TO BREATHE OR CHILD BECOMES UNCONSCIOUS.

IF CHILD BECOMES UNCONSCIOUS, PLACE ON BACK AND GO TO STEP 7 OF CHILD OR ADULT CPR (p. 37 or 38).

FOR OBESE OR PREGNANT PERSONS:

Stand behind person and place your arms under the armpits to encircle the chest. Press with quick backward thrusts.

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Wear disposable gloves when exposed to blood or other body fluids.

Is the wound:
- Large?
- Deep?
- Bleeding freely?

NO

- Wash the wound gently with water. Use soap if necessary to remove dirt.
- Pat dry with clean gauze or paper towel.
- Apply clean gauze dressing (non-adhering or non-sticking type for scrapes) and bandage.

Check student’s immunization record for tetanus. See “Tetanus Immunization”

Contact responsible school authority & parent/legal guardian.

YES

See “Bleeding”
DIABETES

A student with diabetes may have the following symptoms:
- Irritability and feeling upset.
- Change in personality.
- Sweating and feeling "shaky.
- Loss of consciousness.
- Confusion or strange behavior.
- Rapid, deep breathing.

A student with diabetes should be known to appropriate school staff. An emergency care plan must be developed. Staff in a position to administer any approved medications must receive training.

Refer to student’s emergency care plan.

Is the student:
- Unconscious or losing consciousness?
- Having a seizure?
- Unable to speak?
- Having rapid, deep breathing?

Give the student “sugar” such as:
- Fruit juice or soda pop (not diet) 6-8 ounces.
- Hard candy (6-7 lifesavers) or ½ candy bar.
- Sugar (2 packets or 2 teaspoons).
- Cake decorating gel (½ tube) or icing.
- Instant glucose.

- Continue to watch the student in a quiet place. The student should begin to improve within 10 minutes.
- Allow student to re-check blood sugar.

Is blood sugar less than 60 or “LOW” according to emergency care plan?
- YES
  - Continue to watch the student. Is student improving?
- NO
  - Is blood sugar “HIGH” according to emergency care plan?
  - YES
    - CALL EMS 9-1-1.
    - If the student is unconscious, see “Unconsciousness”.
  - NO
    - Contact responsible school authority & parent/legal guardian.
DIARRHEA

Wear disposable gloves when exposed to blood or other body fluids.

A student may come to the office because of repeated diarrhea or after an “accident” in the bathroom.

Does student have any of the following signs of probable illness:
- More than 2 loose stools a day?
- Oral temperature over 100.0 F? See “Fever”
- Blood present in the stool?
- Severe stomach pain?
- Student is dizzy and pale?

YES

NO

- Allow the student to rest if experiencing any stomach pain.
- Give the student water to drink.

If the student’s clothing is soiled, wear disposable gloves and double-bag the clothing to be sent home. Wash hands thoroughly.

Contact responsible school authority & parent/legal guardian.

URGE MEDICAL CARE.
**EAR PROBLEMS**

**DRAINAGE FROM EAR**

Do NOT try to clean out ear.

Contact responsible school authority & parent or legal guardian.

URGE MEDICAL CARE.

**EARACHE**

Contact responsible school authority & parent/legal guardian.

URGE MEDICAL CARE.

**OBJECT IN EAR CANAL**

Ask student if he/she knows what is in the ear.

Do you suspect a live insect is in the ear?

- NO
  - Gently tilt head toward the affected side.
  - Did the object come out on its own?
    - YES
      - If there is no pain, the student may return to class. Notify the parent or legal guardian.
    - NO
      - Do NOT attempt to remove.

- YES OR NOT SURE
  - Do NOT attempt to remove.

Contact responsible school authority & parent or legal guardian.

URGE MEDICAL CARE.
**ELECTRIC SHOCK**

- TURN OFF POWER SOURCE, IF POSSIBLE. DO NOT TOUCH STUDENT UNTIL POWER SOURCE IS SHUT OFF.
- Once power is off and situation is safe, approach the student and ask, “Are you OK?”

If no one else is available to call EMS, perform CPR first for 2 minutes and then call EMS yourself.

If student unconscious or unresponsive?

- CALL EMS 9-1-1.
- Keep airway clear.
- Look, listen and feel for breath.
- If student is not breathing, start CPR. See “CPR”

Treat any burns. See “Burns”

Contact responsible school authority & parent or legal guardian. URGE MEDICAL CARE.

Contact responsible school authority & parent/legal guardian.
**EYE PROBLEMS**

**EYE INJURY:**

With any eye problem, ask the student if he/she wears contact lenses. Have student remove contacts before giving any first aid to eye.

Keep student lying flat and quiet.

- Is injury severe?
- Is there a change in vision?
- Has object penetrated eye?

If an object has penetrated the eye, do **NOT** remove object.

Cover eye with a paper cup or similar object to keep student from rubbing, but do **NOT** touch eye or put any pressure on eye.

**CALL EMS 9-1-1.** Contact responsible school authority & parent or legal guardian.

Contact responsible school authority & parent or legal guardian. **URGE IMMEDIATE MEDICAL CARE.**
EYE PROBLEMS

PARTICLE IN EYE

Keep student from rubbing eye.

- If necessary, lay student down and tip head toward affected side.
- Gently pour tap water over the open eye to flush out the particle.

If particle does not flush out of eye or if eye pain continues, contact responsible school authority & parent/legal guardian.

URGE MEDICAL CARE.

CHEMICALS IN EYE

- Wear gloves and if possible, goggles.
- Immediately rinse the eye with large amounts of clean water for 20 to 30 minutes. Use an eyewash if available.
- Tip the head so the affected eye is below the unaffected eye and water washes eye from nose out to side of the face.

CALL POISON CONTROL.

1-800-222-1222
Follow their directions.

Contact responsible school authority & parent/legal guardian.

If eye has been burned by chemical, CALL EMS 9-1-1.
Fainting may have many causes including:
- Injuries.
- Illness.
- Blood loss/shock.
- Heat exhaustion.
- Diabetic reaction.
- Severe allergic reaction.
- Standing still for too long.

If you know the cause of the fainting, see the appropriate guideline.

If you observe any of the following signs of fainting, have the student lie down to prevent injury from falling:
- Extreme weakness or fatigue.
- Dizziness or light-headedness.
- Extreme sleepiness.
- Pale, sweaty skin.
- Nausea.

Most students who faint will recover quickly when lying down. If student does not regain consciousness immediately, see “Unconsciousness”

- Is fainting due to injury?
- Was student injured when he/she fainted?

NO

- Keep student in flat position.
- Elevate feet.
- Loosen clothing around neck and waist.

YES

- Keep airway clear and monitor breathing.
- Keep student warm, but not hot.
- Control bleeding if needed (wear disposable gloves).
- Give nothing by mouth.

Are symptoms (dizziness, light-headedness, weakness, fatigue, etc.) still present?

NO

If student feels better, and there is no danger of neck injury, he/she may be moved to a quiet, private area.

YES OR NOT SURE

Treat as possible neck injury. See “Neck & Back Pain”

Do NOT move student.

Keep student lying down. Contact responsible school authority & parent or legal guardian. URGE MEDICAL CARE.

Contact responsible school authority & parent/legal guardian.

N.C. DHHS, 2009/2010
Take student’s temperature. Note oral temperature over 100.0°F as fever.

Have the student lie down in a room that affords privacy.

Give no medication, unless previously authorized.

Contact responsible school authority and parent or legal guardian.
FRACTURES, DISLOCATIONS, SPRAINS OR STRAINS

Treat all injured parts as if they could be fractured.

Symptoms may include:
- Pain in one area.
- Swelling.
- Feeling “heat” in injured area.
- Discoloration.
- Limited movement.
- Bent or deformed bone.
- Numbness or loss of sensation.

- Is bone deformed or bent in an unusual way?
- Is skin broken over possible fracture?
- Is bone sticking through skin?

CALL EMS 9-1-1.

- Rest injured part by not allowing student to put weight on it or use it.
- Gently support and elevate injured part if possible.
- Apply ice, covered with a cloth or paper towel, to minimize swelling.

After period of rest, re-check the injury.
- Is pain gone?
- Can student move or put weight on injured part without discomfort?
- Is numbness/tingling gone?
- Has sensation returned to injured area?

Contact responsible school authority & parent/legal guardian.

If discomfort is gone after period of rest, allow student to return to class.

URGE MEDICAL CARE.
FROSTBITE

Frostbite can result in the same type of tissue damage as a burn. It is a serious condition and requires medical attention.

Exposure to cold even for short periods of time may cause “HYPOTHERMIA” in children (see “Hypothermia”). The nose, ears, chin, cheeks, fingers and toes are the parts most often affected by frostbite.

Frostbitten skin may:
- Look discolored (flushed, grayish-yellow, pale).
- Feel cold to the touch.
- Feel numb to the student.

Deeply frostbitten skin may:
- Look white or waxy.
- Feel firm or hard (frozen).

• Take the student to a warm place.
• Remove cold or wet clothing and give student warm, dry clothes.
• Protect cold part from further injury.
• Do NOT rub or massage the cold part or apply heat such as a water bottle or hot running water.
• Cover part loosely with nonstick, sterile dressings or dry blanket.

Does extremity/part:
- Look discolored – grayish, white or waxy?
- Feel firm/hard (frozen)?
- Have a loss of sensation?

CALL EMS 9-1-1.
Keep student warm and part covered.

Contact responsible authority & parent or legal guardian.
Encourage medical care.

Keep student and part warm.

Contact responsible authority & parent or legal guardian.
Give no medication unless previously authorized.

Has a head injury occurred?

- Is headache severe?
- Are other symptoms present such as:
  - Vomiting?
  - Oral temperature over 100.0 F (see “Fever”, p.61)?
  - Blurred vision?
  - Dizziness?

If headache persists, contact parent/legal guardian.

Have student lie down for a short time in a room that affords privacy.

Apply a cold cloth or compress to the student’s head.

See “Head Injuries”

Contact parent/legal guardian.

URGE MEDICAL CARE.
Many head injuries that happen at school are minor. Head wounds may bleed easily and form large bumps. Bumps to the head may not be serious. Head injuries from falls, sports and violence may be serious. If head is bleeding, see “Bleeding”

If student only bumped head and does not have any other complaints or symptoms, see “Bruises”

- With a head injury (other than head bump), always suspect neck injury as well.
- Do NOT move or twist the back or neck.
- See “Neck & Back Pain” for more information.

Have student rest, lying flat.
Keep student quiet and warm.

Turn the head and body together to the side, keeping the head and neck in a straight line with the trunk.

Watch student closely. Do NOT leave student alone.

- Unconsciousness?
- Seizure?
- Neck pain?
- Student is unable to respond to simple commands?
- Blood or watery fluid in the ears?
- Student is unable to move or feel arms or legs?
- Blood is flowing freely from the head?
- Student is sleepy or confused?

Check student’s airway.
Look, listen and feel for breathing.
If student stops breathing, start CPR. See “CPR”

Give nothing by mouth. Contact responsible school authority & parent or legal guardian.

Even if student was only briefly confused and seems fully recovered, contact responsible school authority & parent or legal guardian. URGE MEDICAL CARE. Watch for delayed symptoms.

CALL EMS 9-1-1.
Heat emergencies are caused by spending too much time in the heat. Heat emergencies can be life-threatening situations.

Heat Stroke – Heat Exhaustion

Strenuous activity in the heat may cause heat-related illness. Symptoms may include:
- Red, hot, dry skin.
- Weakness and fatigue.
- Cool, clammy hands.
- Vomiting.
- Loss of consciousness.

Remove student from the heat to a cooler place.
Have student lie down.

Is student unconscious or losing consciousness?

Quickly remove student from heat to a cooler place.
Put student on his/her side to protect the airway.
Look, listen and feel for breath.
If student stops breathing, start CPR. See “CPR”.

Does student have hot, dry, red skin?
Is student vomiting?
Is student confused?

Give clear fluids such as water, 7Up or Gatorade frequently in small amounts if student is fully awake and alert.

Contact responsible authority & parent/legal guardian.

Cool rapidly by completely wetting clothing with room temperature water.
Do NOT use ice water.

CALL EMS 9-1-1.
Contact responsible authority & parent or legal guardian.
HYPOTHERMIA
(EXPOSURE TO COLD)

Hypothermia happens after exposure to cold when the body is no longer capable of warming itself. Young children are particularly susceptible to hypothermia. It can be a life-threatening condition if left untreated for too long.

Symptoms may include:
- Confusion
- Weakness
- Blurry vision
- Slurred speech
- Shivering
- Sleepiness
- White or grayish skin color
- Impaired judgment

**Hypothermia can occur after a student has been outside in the cold or in cold water.**

- Take the student to a warm place.
- Remove cold or wet clothing and wrap student in a warm, dry blanket.

Continue to warm student with blankets. If student is fully awake and alert, offer warm (NOT HOT) fluids, but no food.

Does the student have:
- Loss of consciousness?
- Slowed breathing?
- Confused or slurred speech?
- White, grayish or blue skin?

**CALL EMS 9-1-1.**
- Give nothing by mouth.
- Continue to warm student with blankets.
- If student is asleep or losing consciousness, place student on his/her side to protect airway.
- Look, listen and feel for breathing.
- **If student stops breathing, start CPR.**
  See “CPR”

Contact responsible authority & parent or legal guardian.
Encourage medical care.
MENSTRUAL DIFFICULTIES

Is it possible that student is pregnant?

YES OR NOT SURE

See "Pregnancy"

Are cramps mild or severe?

MILD

For mild cramps, recommend regular activities.

SEVERE

A short period of quiet rest may provide relief.

Give no medications unless previously authorized by parent/legal guardian.

Urge medical care if disabling cramps or heavy bleeding occurs.

Contact responsible school authority & parent/legal guardian.
Check student’s immunization record for tetanus. See “Tetanus Immunization”.

Wear disposable gloves when exposed to blood or other body fluids.

Do you suspect a head injury other than mouth or jaw?

See “Head Injuries”

Have teeth been injured?

See “Teeth”.

Has jaw been injured?

Do NOT try to move jaw.
• Gently support jaw with hand.

If tongue, lips or cheeks are bleeding, apply direct pressure with sterile gauze or clean cloth.

Is cut large or deep?
• Is there bleeding that cannot be stopped?

Contact responsible school authority & parent/legal guardian.
URGE IMMEDIATE MEDICAL CARE.

Place a cold compress over the area to minimize swelling.
Suspect a neck/back injury if pain results from:
- Falls over 10 feet or falling on head.
- Being thrown from a moving object.
- Sports.
- Violence.
- Being struck by a car or fast moving object.

Has an injury occurred?  

YES

Did student walk in or was student found lying down?  

WALK IN

LYING DOWN

- Do NOT move student unless there is immediate danger of further physical harm.
- If student must be moved, support head and neck and move student in the direction of the head without bending the spine forward.
- Do NOT drag the student sideways.

- Keep student quiet and warm.
- Hold the head still by gently placing one of your hands on each side of the head.

A stiff or sore neck from sleeping in a “funny” position is different than neck pain from a sudden injury. A non-injured stiff neck with neurological symptoms or fever could be an emergency.

If student is so uncomfortable that he or she is unable to participate in normal activities, contact responsible school authority & parent/legal guardian.

Have student lie down on his/her back. Support head by holding it in a face up position.

Try NOT to move neck or head.

CALL EMS 9-1-1. Contact responsible school authority & parent or legal guardian.
NOSEBLEED

Wear disposable gloves when exposed to blood or other body fluids.

Place student sitting comfortably with head slightly forward or lying on side with head raised on pillow.

Encourage mouth breathing and discourage nose blowing, repeated wiping or rubbing.

If blood is flowing freely from the nose, provide constant uninterrupted pressure by pressing the nostrils firmly together for about 15 minutes. Apply ice to nose.

If blood is still flowing freely after applying pressure and ice, contact responsible school authority & parent/legal guardian.

• Care for nose as in “Nosebleed” above.
• Contact responsible school authority & parent/legal guardian.
• URGE MEDICAL CARE.

BROKEN NOSE

See “Head Injuries” if you suspect a head injury other than a nosebleed or broken nose.
NOSE PROBLEMS

OBJECT IN NOSE

Is object:
- Large?
- Puncturing nose?
- Deeply imbedded?

Yes or Not Sure

No

Have student hold the clear nostril closed while gently blowing nose.

Do NOT attempt to remove. See “Puncture Wounds” if object has punctured nose.

Contact responsible school authority & parent or legal guardian.

URGE MEDICAL CARE.

Did object come out on own?

Yes

If there is no pain, student may return to class. Notify parent or legal guardian.

No

If object cannot be removed easily, do NOT attempt to remove.
Poisoning & Overdose

Poisons can be swallowed, inhaled, absorbed through the skin or eyes, or injected. Call Poison Control when you suspect poisoning from:
- Medicines.
- Insect bites and stings.
- Snake bites.
- Plants.
- Chemicals/cleaners.
- Drugs/alcohol.
- Food poisoning.
- Inhalants.

Or if you are not sure.

Possible warning signs of poisoning include:
- Pills, berries or unknown substances in student’s mouth.
- Burns around mouth or on skin.
- Strange odor on breath.
- Sweating.
- Upset stomach or vomiting.
- Dizziness or fainting.
- Seizures or convulsions.

- Wear disposable gloves.
- Check student’s mouth.
- Remove any remaining substance(s) from mouth.

If possible, find out:
- Age and weight of student.
- What the student swallowed.
- What type of “poison” it was.
- How much and when it was taken.

CALL POISON CONTROL
1-800-222-1222
Follow their directions.

Send sample of the vomited material and ingested material with its container (if available) to the hospital with the student.

CALL EMS 9-1-1.
Contact responsible school authority & parent or legal guardian.

Do NOT induce vomiting or give anything UNLESS instructed to by Poison Control. With some poisons, vomiting can cause greater damage.
Do NOT follow the antidote label on the container; it may be incorrect.

If student becomes unconscious, place on his/her side. Check airway.
Look, listen and feel for breathing.
If student stops breathing, start CPR. See “CPR”
Pregnant students should be known to appropriate school staff. Any student who is old enough to be pregnant, might be pregnant.

Pregnancy may be complicated by any of the following:

- **SEVERE STOMACH PAIN**
  - CALL EMS 9-1-1. Contact responsible school authority & parent or legal guardian.

- **SEIZURE**
  - This may be a serious complication of pregnancy.

- **VAGINAL BLEEDING**
  - Contact responsible school authority & parent or legal guardian. URGE IMMEDIATE MEDICAL CARE.

- **AMNIOTIC FLUID LEAKAGE**
  - This is NOT normal and may indicate the beginning of labor.
  - Contact responsible school authority & parent/legal guardian.

- **MORNING SICKNESS**
  - Treat as vomiting. See “Vomiting”
Wear disposable gloves when exposed to blood or other body fluids.

Has eye been wounded?

- See “Eyes – Eye Injury”
- Do NOT touch eye.

Is object still stuck in wound?

- Do NOT try to probe or squeeze.

- Wash the wound gently with soap and water.
- Check to make sure the object left nothing in the wound (e.g., pencil lead).
- Cover with a clean bandage.

- See “Bleeding” if wound is deep or bleeding freely.

Check student’s immunization record for tetanus. See “Tetanus Immunization”

Is object large?

- Is wound deep?
- Is wound bleeding freely or squirting blood?

- See “Bleeding” if wound is deep or bleeding freely.

- Contact responsible school authority & parent or legal guardian.

- CALL EMS 9-1-1.
Rashes may have many causes including heat, infection, illness, reaction to medications, allergic reactions, insect bites, dry skin or skin irritations.

Some rashes may be contagious. Wear disposable gloves to protect self when in contact with any rash.

Rashes include such things as:
- Hives.
- Red spots (large or small, flat or raised).
- Purple spots.
- Small blisters.

Other symptoms may indicate whether the student needs medical care. Does student have:
- Loss of consciousness?
- Difficulty breathing or swallowing?
- Purple spots?

CALL EMS 9-1-1. Contact responsible school authority & parent/legal guardian.

If any of the following symptoms are present, contact responsible school authority & parent or legal guardian and URGE MEDICAL CARE:
- Oral temperature over 100.0 F (See “Fever”)
- Headache.
- Diarrhea.
- Sore throat.
- Vomiting.
- Rash is bright red and sore to the touch.
- Rash (hives) all over body.
- Student is so uncomfortable (e.g., itchy, sore, feels ill) that he/she is not able to participate in school activities.

See “Allergic Reaction” and “Communicable Disease” for more information.
Seizures may be any of the following:
- Episodes of staring with loss of eye contact.
- Staring involving twitching of the arm and leg muscles.
- Generalized jerking movements of the arms and legs.
- Unusual behavior for that person (e.g., running, belligerence, making strange sounds, etc.).

A student with a history of seizures should be known to appropriate school staff. An emergency care plan should be developed, containing a description of the onset, type, duration and after effects of the seizures.

Refer to student’s emergency care plan.

- If student seems off balance, place him/her on the floor (on a mat) for observation and safety.
- **Do NOT** restrain movements.
- Move surrounding objects to avoid injury.
- **Do NOT** place anything in between the teeth or give anything by mouth.
- Keep airway clear by placing student on his/her side. A pillow should **NOT** be used.

Observe details of the seizure for parent/legal guardian, emergency personnel or physician. Note:
- Duration.
- Kind of movement or behavior.
- Body parts involved.
- Loss of consciousness, etc.

- Is student having a seizure lasting longer than **5 minutes**?
- Is student having seizures following one another at short intervals?
- Is student **without a known history** of seizures having a seizure?
- Is student having any breathing difficulties after the seizure?

Seizures are often followed by sleep. The student may also be confused. This may last from 15 minutes to an hour or more. After the sleeping period, the student should be encouraged to participate in all normal class activities.

Contact responsible school authority & parent or legal guardian.

CALL EMS 9-1-1.
If injury is suspected, see “Neck & Back Pain” and treat as a possible neck injury.

Do NOT move student unless he/she is endangered.

Any serious injury or illness may lead to shock, which is a lack of blood and oxygen getting to the body tissues.  
- Shock is a life-threatening condition.  
- Stay calm and get immediate assistance.  
- Check for medical bracelet or student’s emergency care plan if available.

See the appropriate guideline to treat the most severe (life or limb threatening) symptoms first.  
Is student:  
- Not breathing? See “CPR” and/or “Choking”  
- Unconscious? See “Unconsciousness”  
- Bleeding profusely? See “Bleeding”

- Keep student in flat position of comfort.  
- Elevate feet 8-10 inches, unless this causes pain or a neck/back or hip injury is suspected.  
- Loosen clothing around neck and waist.  
- Keep body normal temperature. Cover student with a blanket or sheet.  
- Give nothing to eat or drink.  
- If student vomits, roll onto left side keeping back and neck in straight alignment if injury is suspected.

CALL EMS 9-1-1.

- Contact responsible school authority & parent or legal guardian.  
- URGE MEDICAL CARE if EMS not called.

Signs of Shock:
- Pale, cool, moist skin.  
- Mottled, ashen, blue skin.  
- Altered consciousness or confused.  
- Nausea, dizziness or thirst.  
- Severe coughing, high pitched whistling sound.  
- Blueing in the face.  
- Fever greater than 100.0 F in combination with lethargy, loss of consciousness, extreme sleepiness, abnormal activity.  
- Unresponsive.  
- Difficulty breathing or swallowing.  
- Rapid breathing.  
- Rapid, weak pulse.  
- Restlessness/irritability.
Wear disposable gloves when exposed to blood or other body fluids.

Check student’s immunization record for tetanus. See “Tetanus Immunization”

Gently wash area with clean water and soap.

Is splinter or pencil tip:
- Protruding above the surface of the skin?
- Small?
- Shallow?

• Leave in place.
• Do NOT probe under skin.

Contact responsible school authority & parent or legal guardian.
Encourage medical care.

• Remove with tweezers unless this causes student pain.
• Do NOT probe under skin.

Were you successful in removing the entire splinter/pencil tip?

Wash again. Apply clean dressing.
STABBING & GUNSHOT INJURIES

- CALL EMS 9-1-1 for injured student.
- Call the police.
- Intervene only if the situation is safe for you to approach.

Refer to your school’s policy for addressing violent incidents.

Wear disposable gloves when exposed to blood or other body fluids.

Is the student:
- Losing consciousness?
- Having difficulty breathing?
- Bleeding uncontrollably?

YES

Check student’s airway.
Look, listen and feel for breathing.
If student stops breathing start CPR. See “CPR”

NO

Lay student down in a position of comfort if he/she is not already doing so.
Elevate feet 8-10 inches, unless this causes pain or a neck/back injury is suspected.
Press injured area firmly with a clean bandage to stop bleeding.
Elevate injured part gently, if possible.
Keep body temperature normal. Cover student with a blanket or sheet.

Check student’s immunization record for tetanus.
See “Tetanus Immunization”

Contact responsible school authority & parent or legal guardian.
Students with a history of allergy to stings should be known to all school staff. An emergency care plan should be developed.

Does student have:
- Difficulty breathing?
- A rapidly expanding area of swelling, especially of the lips, mouth or tongue?
- A history of allergy to stings?

**STINGS**

A student may have a delayed allergic reaction up to 2 hours after the sting. Adult(s) supervising student during normal activities should be aware of the sting and should watch for any delayed reaction.

- Remove stinger if present.
- Wash area with soap and water.
- Apply cold compress.

Contact responsible school authority & parent or legal guardian.

If available, administer approved medications.

CALL EMS 9-1-1.

- Check student’s airway.
- Look, listen and feel for breathing.
- **If student stops breathing, start CPR.** See “CPR”.

See “Allergic Reaction”
STOMACHACHES/PAIN

Stomachaches/pain may have many causes including:

- Illness.
- Hunger.
- Overeating.
- Diarrhea.
- Food poisoning.
- Injury.
- Menstrual difficulties.
- Psychological issues.
- Stress.
- Constipation.
- Gas pain.
- Pregnancy.

Suspect neck injury. See “Neck and Back Pain”

Contact responsible school authority & parent/legal guardian.

URGE PROMPT MEDICAL CARE.

Has a serious injury occurred resulting from:

- Sports?
- Violence?
- Being struck by a fast moving object?
- Falling from a height?
- Being thrown from a moving object?

Take the student’s temperature. Note temperature over 100.0 F as fever. See “Fever”

Does student have:

- Fever?
- Severe stomach pains?
- Vomiting?

Allow student to rest 20-30 minutes in a room that affords privacy.

Does student feel better?

If stomachache persists or becomes worse, contact responsible school authority & parent or legal guardian.

Allow student to return to class.
TEETH PROBLEMS

BLEEDING GUMS

Bleeding gums:
• Are generally related to chronic infection.
• Present some threat to student’s general health.

No first aid measure in the school will be of any significant value.

Contact responsible school authority & parent/legal guardian.
URGE DENTAL CARE.

TOOTHACHE OR GUM INFECTION

See “Mouth & Jaw” for tongue, cheek, lip, jaw or other mouth injury not involving the teeth.

These conditions can be direct threats to student’s general health, not just local tooth problems.

No first aid measure in the school will be of any significant value.

Relief of pain in the school often postpones dental care. Do NOT place pain relievers (e.g., aspirin, Tylenol) on the gum tissue of the aching tooth. They can burn tissue.

Contact responsible school authority & parent/legal guardian.
URGE DENTAL CARE.
TEETH PROBLEMS

DISPLACED TOOTH

Do NOT try to move tooth into correct position.

CONTACT RESPONSIBLE SCHOOL AUTHORITY & PARENT/Legal GUARDIAN.

OBTAIN EMERGENCY DENTAL CARE.

KNOCKED-OUT OR BROKEN PERMANENT TOOTH

- Find tooth.
- Do NOT handle tooth by the root.

If tooth is dirty, clean gently by rinsing with water.

Do NOT scrub the knocked-out tooth.

The following steps are listed in order of preference.

Within 15-20 minutes:
1. Place gently back in socket and have student hold in place with tissue or gauze, or
2. Place in HBSS (Save-A-Tooth Kit) if available or
3. Place in glass of milk, or
4. Place in normal saline, or
5. Have student spit in cup and place tooth in it, or
6. Place in a glass of water.

TOOTH MUST NOT DRY OUT.

Contact responsible school authority & parent or legal guardian.

OBTAIN EMERGENCY DENTAL CARE. THE STUDENT SHOULD BE SEEN BY A DENTIST AS SOON AS POSSIBLE.

Apply a cold compress to face to minimize swelling.
Protection against tetanus should be considered with any wound, even a minor one. After any wound, check the student’s immunization record for tetanus and notify parent or legal guardian.

A minor wound would need a tetanus booster only if it has been at least 10 years since the last tetanus shot or if the student is 5 years old or younger.

Other wounds such as those contaminated by dirt, feces and saliva (or other body fluids); puncture wounds; amputations; and wounds resulting from crushing, burns, and frostbite need a tetanus booster if it has been more than 5 years since last tetanus shot.
Students should be inspected for ticks after time in woods or brush. Ticks may carry serious infections and must be completely removed. **Do NOT handle ticks with bare hands.**

**Refer to your school’s policy regarding the removal of ticks.**

Wear disposable gloves when exposed to blood and other body fluids.

Wash the tick area gently with soap and water before attempting removal.

- Using tweezers, grasp the tick as close to the skin surface as possible and pull upward with steady, even pressure.
- **Do NOT twist or jerk the tick as the mouth parts may break off.** It is important to remove the **ENTIRE** tick.
- Take care not to squeeze, crush or puncture the body of the tick as its fluids may carry infection.

- After removal, wash the tick area thoroughly with soap and water.
- Wash your hands.
- Apply a bandage.

Ticks can be safely thrown away by placing them in container of alcohol or flushing them down the toilet.

Contact school authority & parent/legal guardian. Urge parents to mark their calendars and watch, for 30 days, for any signs of illness. If present, report tick bite to their physician.
If student stops breathing, and no one else is available to call EMS, administer CPR for 2 minutes and then call EMS yourself.

Unconsciousness may have many causes including:
- Injuries.
- Blood loss/shock.
- Poisoning.
- Severe allergic reaction.
- Diabetic reaction.
- Heat exhaustion.
- Illness.
- Fatigue.
- Stress.
- Not eating.

If you know the cause of the unconsciousness, see the appropriate guideline.

Did student regain consciousness immediately?

NO

Is unconsciousness due to injury?

YES

- See “Neck & Back Pain” and treat as a possible neck injury.
- Do NOT move student.

NO

- Open airway with head tilt/chin lift.
- Look, listen and feel for breathing.

CALL EMS 9-1-1.

Did student breathing?

YES

Begin CPR. See “CPR”

NO

CALL EMS 9-1-1.

Contact responsible school authority & parent/legal guardian.

- Keep student in flat position of comfort.
- Elevate feet 8-10 inches unless this causes pain or a neck/back or hip injury is suspected.
- Loosen clothing around neck and waist.
- Keep body normal temperature. Cover student with a blanket or sheet.
- Give nothing to eat or drink.
- If student vomits, roll onto left side keeping back and neck in straight alignment if injury is suspected.
- Examine student from head-to-toe and give first aid for conditions as needed.
If a number of students or staff become ill with the same symptoms, suspect food poisoning.

CALL POISON CONTROL 1-800-222-1222. and ask for instructions. See “Poisoning” and notify local health department.

Vomiting may have many causes including:
- Illness.
- Bulimia.
- Anxiety.
- Pregnancy.
- Injury/head injury.
- Heat exhaustion.
- Overexertion.
- Food Poisoning

Wear disposable gloves when exposed to blood and other body fluids.

Take student’s temperature. Note oral temperature over 100.0 F as fever. See “Fever”.

- Have student lie down on his/her side in a room that affords privacy and allow him/her to rest.
- Apply a cool, damp cloth to student’s face or forehead.
- Have a bucket available.
- Give no food or medications, although you may offer student ice chips or small sips of clear fluids containing sugar (such as 7Up or Gatorade), if the student is thirsty.

Does the student have:
- Repeated vomiting?
- Fever?
- Severe stomach pains?
- Is the student dizzy and pale?

Contact responsible school authority & parent/legal guardian.

URGE MEDICAL CARE.

Contact responsible school authority & parent/legal guardian.

YES

NO
Introduction to Health Screening Programs

Screening for health problems in children and youth should be carried out using a “systems of care” approach that utilizes the skills and resources of a variety of health care providers, including primary care providers, local health departments, hospitals, community health centers, and school staff. The Children & Youth Branch of the N.C. Division of Public Health promotes the goal that “all children will be screened early and continuously for special health care needs.” The health problems for which screening methods are available are many and include asthma, dental caries, overweight/underweight, hearing deficits, vision deficits, blood pressure, social-emotional concerns, and others.

In the school setting, the health screening program is primarily coordinated by the school nurse. Supplemental help for diagnosis and treatment is the function and responsibility of the physician or dentist. A successful school screening program utilizes the school health professional, the medical and dental professional and unlicensed assistive personnel such as volunteers and classroom assistants. Volunteers and other non-medical assistants help carry out the screening program under the management of the school nurse.

This chapter on screening procedures and recommendations provides the information in an easy-to-use format, suitable for the health professional and the lay person alike. Step-by-step directions for each screening procedure are included in addition to other pertinent information, which will be useful to the school nurse. Incorporated into each segment of the screening section is information as to:

1) who is to be screened and at what intervals;
2) special alerts;
3) the conditions and equipment needed;
4) "cook book" directions on how to do each procedure;
5) how each procedure is scored and recorded;
6) when the student should be referred for diagnosis or further evaluation;
7) the resources available for diagnosis and treatment;
8) incidence; and
9) some thoughts on the significance of preventive care with the particular problem for which screening is being done. Each screening procedure is described in this same order.

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What is screening and why should it be done? Screening is an intervention to discover a health problem early. If a potentially handicapping condition can be identified before it becomes symptomatic, then diagnosis and treatment can be undertaken at the optimum time, and sometimes at less cost. Screening is an easy, relatively inexpensive way to sort out from a large number of apparently well children and youth, those who may be at risk of a health problem. Screening is a cost-efficient expenditure of scarce resources, because elaborate and costly assessment and diagnostic procedures are reserved for those persons most likely to have a health problem or potentially handicapping condition. Additionally, people at low risk are spared the trouble and expense of undergoing those more involved procedures.

Before a school health professional should embark on a screening program, decisions need to be made. The decisions are related to determining what diseases or conditions will be identified and what screening procedures should be used to identify such conditions. Criteria for selecting diseases and health programs for which to screen include:

1. Condition is treatable or controllable.
2. Early treatment improves academic outcome.
3. Screening and follow up time is adequate.
4. Firm diagnosis is possible.
5. Condition is relatively prevalent.
6. Condition is serious.
7. Condition is one which may interfere with learning.

Criteria for selecting which screening procedures are to be used include:

1. Acceptability to both professionals and to the public.
2. Simplicity, requiring no complicated or hard-to-move equipment.
3. Reliability (repeatability of results).
4. Validity (frequency with which the screening test result is confirmed by the diagnosis).
5. Appropriateness for the population being screened.
In addition to deciding what condition and which procedures to use, the school nurse must consider the implications of such programs for those being screened. In a school screening program, the nurse is well-served to keep in mind that, in most cases, the nurse, or school administration, is taking the initiative, not the student. In other words, the nurse assumes responsibility for seeking out potential problems in asymptomatic persons. One must weigh the discomfort, inconvenience, and anxiety caused by the screening process against the benefits of knowing that a problem condition exists. In the school setting, it is also important to focus on screening for conditions that may impair or interfere with learning.

The nurse's decisions about these concerns may rest upon the following considerations:

1. The condition may be a barrier to learning.
2. Medical knowledge should be adequate to deal effectively with a problem which may be identified.
3. Health care providers should be available to deal with any problems discovered and other facilities such as laboratories, hospitals, etc. should be accessible.
4. Time and knowledge should be available to assist the family in finding and using available resources, if necessary. This follow-up component may take more time than the screening.

Since the success of any screening program ultimately depends upon securing the cooperation of the student, the family, the family physician, and other health professionals, it is essential to design a program which addresses everyone's concerns and needs. Arrangements which cause problems (e.g., delays, inconvenience, what may appear to be unnecessary red tape) may lessen willingness to participate and thereby limit the effectiveness of the program. Careful planning can reduce such problems. The following steps should be considered:

1. Use simple administrative procedures. Complicated ones may discourage students. Time-consuming ones may not be practical in the school setting.
2. Avoid unnecessary delays. Long time lapses between the screening and the referral for evaluation/treatment make the student and parent think the problem is not very important.
3. Eliminate unnecessary referrals. For example: All failed vision screenings done by volunteers should be rescreened by the school nurse before a referral is made.
4. Communicate fully with student, parents, and physician.

5. Provide both a setting and staff that promote the comfort and self-esteem of the student.

6. Avoid duplication of services.

7. Provide supportive services when possible, (e.g., translators, transportation).

8. Protect confidentiality.

9. Know what resources are available in your community.

10. Work with the community to help develop new resources.

There is a distinction between screening and a screening program. Screening is a means of acquiring significant data about a population. A screening program uses the data to remediate the problems or defects that are identified. The distinguishing characteristic between the two terms is intervention, which is an essential component of a screening program. Intervention in the school setting might mean adapting the school program to meet the student's needs if a problem cannot be or has not been corrected.

If appropriate referral activities and follow-up measures are determined to be unavailable for a particular non-mandated screening, a program should not be initiated. School children need screening programs, not just screenings. The successful outcome of the N.C. Division of Public Health, Children & Youth Branch, goal, that “all children will be screened early and continuously for special health care needs,” is that those children identified for a need, have their needs met.
Conducting Student Health Fairs

Student health fairs present an excellent opportunity to promote health awareness and invite personal commitment to health. The target audience participates in various health screening tests, observes demonstrations of safety procedures, and has access to current health information via learning centers and/or special exhibits. This special event can encourage positive health behaviors by increasing knowledge about healthy alternatives and encouraging decision making and self-responsibility. The target population may include students, school staff, parents and/or members of the community. A student health fair may be effectively planned with and conducted by students as a school activity or as a collaborative community outreach activity with multiple agency involvement.

Rationale

- Students are provided opportunities to learn important elements of selected health status indicators which become personalized through active participation.
- Participants can acquire health information for discussion and review in a non-threatening environment.
- The health curriculum is enhanced and supplemented by stimulating student interest in healthy lifestyles.
- Students involved in planning and conducting the fair gain experience in decision making and delegating tasks while providing a needed service.
- Collaborative interagency efforts effectively maximize community resources.

Recommendations

Planning should be initiated two to three months prior to the planned event and should include the following:

1. Obtain authorization from school administrators to hold fair.
2. Decide location and date.
3. Identify personnel and target audience.
4. Explore community agency interest and commitment for personnel and/or exhibits.
5. Identify types of screenings to be offered and equipment needed.
6. Establish training schedule.
(This page intentionally left blank.)
Parent Advisory Referral Letter  
(Sample Form)

Date of Referral ___________________

Name of Student ___________________________________ Date of Birth _________

Homeroom _________________________________________ Grade ___________________

School ____________________________________________ 

Dear Parent:

Your child has been referred to the School Health Nurse for the following health problem(s):

Findings:__________________________________________ ____________________________________

Based on these findings, it appears that your child should have a more thorough examination by:

☐ Physician        ☐ Dentist        ☐ Other

Please return this form to me at your child’s school after the examination. Please call if you have any questions about this referral.

_________________________________________________  _______________
School Nurse        Phone

*NOTE: Parent/guardian is responsible for all costs associated with examination and correction of the condition, if necessary.

Report of Examination

Diagnosis or explanation:

___________________________________________________ __________________________________

Plan of treatment:

___________________________________________________ __________________________________

Recommended actions for school to take (modifications, etc.):

___________________________________________________ __________________________________

___________________________________________________ __________________________________

Signature of Examiner        Phone

School Health Program Manual – January 2010
N.C. Division of Public Health – Children & Youth Branch – School Health Unit
Anthropometric Measurements

Height and weight measurements of school children should be part of the total physical assessment completed on any child at regular intervals as recommended by the health care provider.

Increasingly, mass screenings for height/weight and BMI (Body Mass Index) are being conducted at school in order to:

1. Collect data as part of a school-wide needs assessment to establish objectives and priorities.
2. Establish a school-wide baseline of BMI prior to implementing a nutrition or physical activity program designed to lower overall BMI of the student population;
3. Collect data to measure outcomes of students who participated in a school-wide program to reduce overall BMI.

If not measured for the above benefit of a school population, then elective screenings at school should be limited to sub-populations of students such as those with chronic illnesses that may affect normal growth patterns or those suspected of having eating disorders or weight management issues. Measurements of height and weight also may be used as a hands-on-activity for teachers or nurses as part of a health lesson.

Rationale

- Stature and weight measurements are valuable pieces of information for the total assessment of children. Their value lies in their being used to identify children who may be at risk for overweight, underweight, or delayed growth. This can be accomplished only when measurements are plotted on age and gender-specific CDC growth grids for comparison with other children in the United States and tracked over time to evaluate a child’s individual growth pattern.
- Height and weight measurements must be obtained correctly following a standard procedure and must be recorded accurately on the student’s record.
- Height and weight measurements obtained as part of a health lesson activity should not be documented on the health record unless standard procedures have been followed and monitored for quality assurance.
- Teacher referrals can assist the nurse in identifying children with apparent deviations from normal growth patterns for their age group, as well as those who exhibit a
sudden change in their growth pattern and children with any known disease condition that has nutritional implications (e.g., diabetes, renal problems, PKU and other metabolic conditions, and gastrointestinal disorders, HIV/AIDS or severe feeding problems).

Recommendations

▪ Height and weight measurements should be obtained on all children as part of their school entry physical appraisal by the provider. (Kindergarten Health Assessment [KHA], Pre-K health appraisals).
▪ The decision on whether to embark on school-wide screening for deviations from normal for height and weight should be carefully made based on measurable objectives for either the student population or individual students.
▪ Children should be weighed in light clothing and without shoes.
▪ All height and weight measurements are to be plotted on a growth chart (included in this manual) and maintained with the student’s individual health record.
▪ Scales should be tested at least annually to assure accuracy. Testing for accuracy can be accomplished by requesting services in writing at the following address:

North Carolina Department of Agriculture
Standards Division, Measurement Section
1050 Mail Service Center
Raleigh, NC 27699-1050
(919) 733-3313

This written request should include the name and phone number of a contact person at the school, a time frame for when the service is needed and the site/location of the scale to be tested.
▪ School nurses should complete a nutrition and physical activity screening on all teacher referrals for height and weight measurement, and provide basic health counseling as necessary and appropriate. (See this Section for a sample form.)
▪ Students with newly-identified or untreated nutritional deficits should be referred to their physician or other local community resource.

Equipment

▪ Quality beam balance or electronic scales that weigh in 0.1 kg (100 gm) or ¼ lb increments and with a stable weighing platform. Scales should be calibrated at least twice annually to assure accuracy.
▪ A vertical measurement board or metallic measuring tape attached to a flat wall with
Procedures

The following sections provide step-by-step instructions for taking accurate measurements, and may be used as a quality assurance check list.

1. Obtain accurate weight and stature measure. (Repeat measures should agree with 0.1 kg or ¼ lb and 0.1 cm or 1/8 in.)
2. Select the appropriate growth chart for age and gender.
3. Record the correct measurements on the growth chart.
4. Determine the age of the student to the nearest ¼-year.
5. Calculate and record Body Mass Index (BMI)
   a. BMI = Weight (lb)/Height (in.)² X 703
   b. OR
   c. BMI = Weight (kg)/Height (cm.)² X 10,000
   d. (Note: BMI tables may be downloaded from the CDC website (see “resources”) and may be used in place of calculations to determine BMI)
6. Plot measurements by finding the child’s age on the horizontal axis and the appropriate measure (weight, stature or BMI) on the vertical axis. Use a straight-edge or right-angle ruler to mark the precise intersection for the student’s age and weight/stature/BMI.
7. Interpret the plotted measurements based on the percentile ranking and the percentile cutoff corresponding to the nutrition indicator.

Recording and Plotting Measurement on Growth Charts

- Growth charts show how a student’s height, weight and BMI compare with those of other children in the United States. They are tools that help the school nurse separate students who are growing typically for age and sex from those who may be at risk for overweight, underweight, or delayed growth.

- Separate CDC-authorized charts are used for boys and girls 2 to 18 years of age and may be duplicated for inclusion with the school health record.

- The date on which the measurements are taken, the student’s age to the nearest ¼ year, the height, weight and BMI all can be recorded in the data entry table on the chart.
The growth charts should be a permanent part of a student’s health record. Measurements should be recorded on the chart each time they are taken to document the student’s growth pattern over time. When students transfer, their chart should be included as part of their school health record.

Criteria for Referral

- Check for errors in measurement and/or recording if the current measurements vary by as much as two percentile curves from established growth pattern.
- Parent’s height should be considered before referring a student who is unusually short or tall.
- The table on the next page can be used to develop nursing care plans.
### Screening and Follow-up

<table>
<thead>
<tr>
<th>Screening Method</th>
<th>Obese Body Mass Index for age</th>
<th>Overweight Body Mass Index for age</th>
<th>Underweight Body Mass Index for age</th>
<th>Delayed Growth Stature for Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria to flag a potential problem</td>
<td>Above 95&lt;sup&gt;th&lt;/sup&gt; percentile</td>
<td>84&lt;sup&gt;th&lt;/sup&gt; to 95&lt;sup&gt;th&lt;/sup&gt; percentile</td>
<td>5&lt;sup&gt;th&lt;/sup&gt; percentile or below</td>
<td>5&lt;sup&gt;th&lt;/sup&gt; percentile or below</td>
</tr>
<tr>
<td>Action to take</td>
<td>Higher percentile than earlier measurements Assessment and counseling or referral</td>
<td>Higher percentile than earlier measurements Assessment and counseling or referral</td>
<td>Lower percentile than earlier measurements Assessment and counseling or referral</td>
<td>Lower percentile than earlier measurements Referral for further assessment and counseling Measure stature for age every three months</td>
</tr>
<tr>
<td>Follow-up needed</td>
<td>Determine BMI at least annually</td>
<td>Determine BMI monthly</td>
<td>Determine BMI monthly</td>
<td></td>
</tr>
<tr>
<td>Monitoring required</td>
<td>At least annually</td>
<td>Monthly until weight gain is stable</td>
<td>Monthly until weight has gained sufficiently</td>
<td>Every three months until problem resolved</td>
</tr>
</tbody>
</table>

- The Individualized Health Plan (IHP), Individualized Education Plan (IEP), or 504 Accommodation Plan for a student with chronic illness or disability should address any special nutritional needs. For students requiring diet modifications, a “Diet Modification Order” form available at [www.ncpublicschools.org/childnutrition](http://www.ncpublicschools.org/childnutrition) should be completed.

- Special support groups should be initiated as a school activity where incidence and interest warrants.

- Local public health and/or school district nutritionists are a valuable resource for the school nurse needing assistance in the management of students with nutritional needs.
Guidelines for Teacher Referral to School Nurse

Further investigation and evaluation is indicated for a student with:

- Weight above the 95th or below the 5th percentile.
- Sudden weight loss or rapid weight gain.
- Any known disease conditions with nutritional implications (e.g., diabetes, renal problems, PKU and other metabolic conditions, gastrointestinal disorders, cystic fibrosis, HIV/AIDS, severe feeding problem).

Resources


Growth charts for boys and girls, ages 2 to 20: [http://www.cdc.gov/growthcharts](http://www.cdc.gov/growthcharts)
Medical Statement for Students with Special Nutritional Needs for School Meals

The N.C. Department of Public Instruction, Child Nutrition Division, provides a USDA-approved form on which the needs of a student for modification of school meals must be documented in order for the school meals to be reimbursable. The form includes all the requirements of the U.S. Department of Agriculture School Meals Program. Although a school district may modify the form for their own needs, all the components on the DPI Child Nutrition form must be included.

The form is available at: http://www.ncpublicschools.org/docs/childnutrition/publications/special-diet/medical-statement.doc

For assistance with the special nutritional needs of students contact the N.C Department of Public Instruction School Meals Initiative Consultants. A map of their region and contact information can be found at: http://www.ncpublicschools.org/childnutrition/directory/
### 24-Hour Diet Recall

Name of Student ____________________________ Date of Interview ________________

Grade _____ Age (yrs) _____

<table>
<thead>
<tr>
<th>Time</th>
<th>Food and Amount Eaten</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Food Groups</th>
<th>Servings</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bread, Cereal, Rice and Pasta Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vegetable Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fruit Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milk, Yogurt and Cheese Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meat, Poultry, Fish, Dry Beans, Eggs, Nuts Group</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name and Title of Person Completing Assessment ________________________________

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**North Carolina School Health Program Manual**

Section E                                Chapter 4
School Health Services                   Special Nutritional Needs

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**School Health Program Manual – January 2010**
N.C. Division of Public Health – Children & Youth Branch – School Health Unit
## DAILY SERVING SIZES FOR CHILDREN AND ADOLESCENTS

<table>
<thead>
<tr>
<th>Food Group</th>
<th>Number of Servings Per Day</th>
<th>1-3 Years</th>
<th>4-5 Years</th>
<th>6-12 Years</th>
<th>12 Years and Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breads, Cereals, Pasta &amp; Grains</td>
<td>5 or less</td>
<td>1/2 slice or 1/4 cup</td>
<td>1/2 slice or 1/3 cup</td>
<td>1 slice or 1/2 cup</td>
<td>1 slice or 1/2 cup</td>
</tr>
<tr>
<td>Vegetables</td>
<td>3-5</td>
<td>1/4 cup</td>
<td>1/3 cup</td>
<td>1/2 cup</td>
<td>1/2 cup</td>
</tr>
<tr>
<td>Fruits</td>
<td>2-4</td>
<td>1/4 cup</td>
<td>1/3 cup</td>
<td>1/2 cup</td>
<td>1/2/cup</td>
</tr>
<tr>
<td>Milk &amp; Milk Products / Calcium *</td>
<td>2-3</td>
<td>1/2 cup</td>
<td>3/4 cup</td>
<td>1 cup</td>
<td>1 cup</td>
</tr>
<tr>
<td>Meat &amp; Meat Alternatives</td>
<td>2-3</td>
<td>1 oz or 1/4 cup</td>
<td>1 1/2 oz. or 1/3 cup</td>
<td>2 oz or 1/2 cup</td>
<td>2-3 oz or 1/2 cup</td>
</tr>
</tbody>
</table>

* Fat Free or 1% milk, yogurt, low sugar calcium fortified juices

**What is a serving?** A serving is the amount of food typically eaten. Serving sizes change based on a child's age. Offering children too many servings or servings that are too large for them can lead to overeating. Try eating the suggested number of servings in the amount or size recommended on most days.

**Understanding Serving Sizes**
- Healthy eating with healthy serving sizes requires meal planning.
- Measure food with a measuring cup or kitchen scale to get an idea of how much to eat.
- If a serving is larger, it might equal two servings of that food group. (1 cup of fruit is 2 servings for a 6 year old.)
- If a serving is smaller, it might equal one-half serving. 1/2 slice of bread is 1/2 serving for a 10 year old.

Audiometric Hearing Screening

Regulations

The N.C. Department of Public Instruction (DPI) guidelines propose hearing screening as one of the recommended procedures used to identify children with handicapping conditions in need of special education and/or related services, as required by federal law and state policy.

North Carolina General Statute 90-294 (6) stipulates that all personnel conducting audiometric screening must be under the supervision of a physician or an audiologist. Persons who are neither audiologists nor physicians must be under the supervision of an audiologist or physician.

All screenings should be presented at a fixed intensity level when conducted by speech-language pathologists or by school nurses under the supervision of an audiologist or physician. Only licensed or DPI-certified audiologists are permitted to conduct threshold tests.

Who Is To Be Screened?

Mass hearing screening may be conducted for select grades based on availability of resources to conduct the screenings and to provide follow up with referrals. Additional screening should be completed on all students:

1) in special education programs, at the time of initial or re-evaluation;
2) who failed a screening during the previous year and the referral was not resolved;
3) who failed academically the previous year and are referred for eligibility determination;
4) referred by their parent or teacher for hearing concerns.

The number of children screened should take into consideration the extent of personnel available and should be conducted under supervision as defined in General Statutes (see further in this section.)

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This section reviewed and revised by N.C. Division of Public Health Audiologists.
Student Preparation

Prepare students for the screening activity through a classroom instructional unit. The classroom instruction should include education about the effects of noise exposure on hearing. Students should be told that they are going to have their hearing screened and that they will hear different sounds through the earphones that sound like a beep or the chirping of a bird. Where possible, an audiometer should be taken to the classroom and the sounds should be demonstrated by setting the intensity level to 100 dB and the frequency to 2000 or even 4000 Hz. The earphones should not be placed on a student but instead, should be held facing the class. The tone should then be directed toward the class from the earphone. Students should be instructed to raise a hand each time the sound is heard and hold the hand in the air as long as the sound is heard. (Any consistent response the student can give is acceptable.)

Screening Environment

A quiet room, as free as possible from conversational voices, distractions, machine noises, building sounds such as humming lights, fans, etc., should be used for the audiometric screening. The room should be large enough for six to eight students at one time, to save time. Additionally, as each student is screened, the others are allowed to observe, which will prepare them for their screening. After the student has been screened, he/she should be allowed to leave the room.

Equipment

A Pure Tone Audiometer, which is calibrated annually, must be used for audiometric screening. A table with two chairs will be needed, one for the student and one for the person conducting the screening. If desired, additional chairs may be provided for students waiting to be screened.

Procedure

Prior to starting the screening each day and repeated throughout the screening day, if noise levels appear to change, the person conducting the screening should conduct a listening check with the audiometer to determine if noise in the room interferes with the screening intensity level. To determine if the environment is quiet enough to perform valid audiometric screening, the person conducting the listening check (assuming that person has normal hearing) should listen to the audiometer under earphones at 1000, 2000, and 4000 Hz at a level of 20 dB. If environmental noise is too high for adequate screening of students at any of the frequencies above, another site or time should be selected.
Pure Tone Air Conduction Screening (for children 4 years to 21 years)

1. Seat the student facing away from you (where he or she can not see you operate the audiometer).

2. Give simple but complete instructions, such as, "I want you to listen very carefully. You will hear some very soft beeps, one at a time. When you hear the beep, raise your hand. Leave your hand up as long as you can hear the beep; when the beep goes off, put the hand back down."

3. Place the earphones on the student's head (red on the right ear, blue on the left). Be sure each earphone is centered over the opening of the ear canal. Be careful that you don’t fold the ear, underneath the earphone. Hair must be out of the way. If a child wears glasses or large earrings, have them remove them.

4. Test the right ear first as a matter of standard procedure unless you know that the student has an existing loss in one ear, in which case, test the best ear first.

5. After the right or better ear is screened, switch the earphone control on the audiometer and test the other ear.

6. Set the tone switch in the "normal-off" position so that the tone will sound only when the interrupter switch is pressed down.

7. Do not present the tone in a rhythmic pattern. Both the length of the tone and the interval between tones must be varied continually. The student must indicate when he/she begins to be aware of the tone as well as the time when he/she can no longer hear it.

8. Begin offering the sound at 35 decibels at 1000 Hz to acquaint the student with the tone for which he/she will be listening. Then move to the 20 dB intensity level for screening.

9. Screen the first ear starting with 1000 Hz, followed by 2000 Hz, and then 4000 Hz. Repeat 1000 Hz. Switch to the other ear and start with 1000 Hz. Then proceed to 2000 Hz, and 4000 Hz.

10. Work quickly; offer praise. This helps the student "stay with you" as you test.
11. Failure to respond appropriately at a single frequency in either ear constitutes a failure. Immediately re-screen the student if he/she has failed the test. Remove the earphones and repeat the instructions. Then repeat steps 8 & 9.

12. If the student still fails audiometric screening after he/she has been re-screened, he/she should be brought back in two to three weeks for re-testing prior to referral to an audiologist or physician.

**Tympanometry (optional)**

Tympanometry is a test which screens the function of the middle ear. This should only be conducted by the audiologist and it should never replace pure tone hearing screening since it does not test hearing acuity. However, it can identify middle ear problems before they become severe enough to cause a hearing loss. Failing the tympanometric screening, but passing the pure tone screening, indicates a possible mild middle ear problem. The child should be re-screened with the tympanometer two weeks after the initial screening. If the child fails the second tympanometric screening, he/she should be referred for medical evaluation.
Screening the Young/Hard-to Test Child

Screening a young or hard-to-test child requires a different approach from that used with older ones. It is necessary to condition this child to respond appropriately to the tone. The following is suggested procedure:

1. Seat the child so that he/she can see your face but not see the buttons on the audiometer.

2. Tell the child to listen for a “birdie” or a “beep.”

3. With the earphones off the child's head (lay the earphones on the table, facing the child) and separated from its headband, turn the audiometer up to 100 dB at 2000 Hz and present the tone.

4. Tell the child to respond (find something fun for the child such as “giving you a high five” or dropping blocks in a bucket, throwing paper wads into a trash can, etc.) when they hear the “birdie” or beep.

5. Practice with the child to be sure they understand how to respond. You should get at least three reliable practice responses. Reward the child verbally when the correct response is made. You may need to hold the child’s hand for a couple of practice attempts and guide the response.

6. Take your hand away, and have the child respond by him or herself. If the child seems unsure, then repeat step 5. If the child responds correctly, proceed to the next step.

7. Turn the audiometer down to 60 dB.

8. Tell the child you want them to wear the earphones (or you may tell them that you want them to listen to the phone) and listen for the “little birdies” or very soft “beep.”

9. Place the earphones on the child; red on the right and blue on the left.

10. Make sure the audiometer has been turned down to 60 dB set for 1000 Hz and ask the child if she or he is ready.

11. Seat the child so that he/she cannot see you or your manipulation of the audiometer.

12. Present the tone at 60 dB.

13. Present the tone at 40 dB.

14. Present the tone at 20 dB.
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School Health Services       Audiometric Hearing Screening

15. You are ready to start the actual screening procedure.

16. Screen at 20 dB at 1000, 2000, and 4000 Hz in each ear. Failure is considered one miss in either ear. Children failing the screening should be re-screened immediately and if still failing, re-screened in two weeks. If the child continues to fail, he/she should be referred to an audiologist or physician.

Additional Suggestions for Screening the Hard-to Test Child

✓ It is always helpful to allow the child to watch other children or his/her teacher being tested before he/she is tested.

✓ Always make it a fun game. Maintain a kind and patient demeanor.

✓ Praise the child promptly for correct responses.

✓ Try to do the test as quickly and as crisply as possible. Young children tire and bore easily.

✓ Always repeat the conditioning procedure any time the child seems unsure of the way to do it or is unresponsive.

Do not ask the child if he/she hears the sound. He/she must give independent, un-coached responses for the test to be accurate.

Some suggestions for other response activities:

- “Give me five.”
- Dropping blocks into a container.
- Pushing a toy car or truck to you.
- Put the child’s hand flat on the table, and ask the child to raise a finger when they hear a sound.
- Throw wadded paper into a trash can, or “play basketball” with the wads of paper.
- Hold child’s hand above the table. Tell him or her to “hit the table” when they hear a sound.
- Put a puzzle together, one piece at a time, every time they hear a sound.
Significance of Early Detection of Hearing Loss

Early detection of hearing loss is significant because:

- Ear infections may cause deterioration of hearing if allowed to become chronic. Prompt treatment of ear infections (otitis media) can reduce the risk of hearing loss.

- Speech, language and hearing problems can be reduced during critical learning periods in the primary grades.

- Learning disabilities which would interfere with a child's schooling can be prevented or reduced.

- The child can be spared the social and emotional trauma of hearing impairment.

- Environmentally induced (high frequency) losses can be detected early enough for education to prevent continuing exposure to conditions causing the loss.

Referral Sources

If the local school system has an audiologist, the student should first be referred to this professional for threshold testing. Local health departments, private practice audiologists, physicians, speech and hearing centers and universities may also be resources.
Hearing Screening Referral  
(Sample Form)

Name of Student ____________________________ Date of Birth ________________

Homeroom _________________________________ Grade ______________________

School _________________________________ Date of Referral _____________

Dear Parent:

The hearing screening service provided as part of the School Health Program has been completed. Results of your child’s hearing test indicate the need for further evaluation and medical examination. The findings of the school hearing screening test are recorded on the back of this letter.

Since prolonged hearing loss can affect learning potential, it is important to have your child’s hearing examined by a physician as soon as possible. Please return this form to the school when the exam has been completed.

Thank you for your cooperation. If you have any questions or I can be of service, please contact me at the number listed below.

______________________________________
School Nurse

______________________________________
Telephone Number

Please return this form to the school nurse listed above.
## Findings: School Hearing Screening Test

### I. Results of 1st School Screening

**Date:** 
**Calibration:** ANSI

<table>
<thead>
<tr>
<th>HEARING STATUS</th>
<th>Left Ear</th>
<th>Right Ear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### II. Results of 2nd School Screening

**Date:** 
**Calibration:** ANSI

<table>
<thead>
<tr>
<th>HEARING STATUS</th>
<th>Left Ear</th>
<th>Right Ear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1000</td>
<td></td>
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<tr>
<td>2000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### III. Results of Hearing Examination:

**Date:** ____________
**Hearing Test:** ________________
**Calibration:** ANSI

<table>
<thead>
<tr>
<th>HEARING STATUS</th>
<th>Left Ear</th>
<th>Right Ear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>8000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pure Tone Average DB loss (1000-2000-4000):**

- Diagnosis or explanation: __________________________
- Plan of treatment: __________________________
- Recommendations for school: __________________________
- Signature of Examiner__________________________  Phone # ___________
Guidelines on Supervision of Hearing Screenings

According to G.S. 90-304 (a) (3); April 1, 2005, the following are necessary to supervise a hearing screening. For further reference, contact:

BOARD OF EXAMINERS
FOR SPEECH AND LANGUAGE PATHOLOGIST AND AUDIOLOGISTS
Post Office Box 16885, Greensboro, North Carolina 27416-0885
Telephone (336) 272-1828  Fax (336) 272-4353
www.ncboeslpa.org

.0212 Supervision of Hearing Screening
(a) The Board of Examiners for Speech and Language Pathologists and Audiologists interprets the words "audiometric screening" used in G.S.90-294(c)(6) and (f) as the presentation of pure tone stimuli at fixed intensity using pass/fail criteria requiring no interpretation by the person administering the screening. Objective methods of screening auditory function based upon new technology may be used subject to the conditions specified in this Rule.
(b) Fixed-intensity, pure tone audiometric screening performed within the context of an individual speech-language evaluation or assessment is within the scope of practice of licensed speech and language pathologists, and by extension allowed for registered speech-language pathology assistants, provided that it can be demonstrated that the licensee or registered assistant has received formal instruction and practicum in audimetric screening as part of his or her training program.
(c) Licensed speech and language pathologists, registered speech-language pathology assistants, and unlicensed persons may perform screenings of hearing sensitivity and auditory function on the general public or specific populations provided that the individuals performing such screenings have been properly trained by a licensed audiologist or physician in the specific techniques for that screening and provided that supervision of the screening program is formally vested in a licensed audiologist or physician.
(d) Screening programs using objective or technology-based hearing screening techniques in place of traditional fixed-frequency, pure tone audiometry (for example, automated auditory brainstem response tests, otoacoustic emission screening instruments, microprocessor audiometers, etc.), even though such
techniques and instruments may yield a pass/fail indication, require the oversight and supervision of a licensed audiologist or physician.

(e) The Board of Examiners for Speech and Language Pathologists and Audiologists interprets the word "supervision" in G. S. §90-294(c) (6) and (f) to include the following elements:

(1) Selecting the appropriate calibrated screening instrument to be used for the target population;

(2) Providing sufficient initial and refresher training in the specific screening methods and instruments to be used to ensure that the screeners have sufficient knowledge of the screening methods, understand the limitations of the screening program, and can demonstrate proper operation of the equipment;

(3) Assuring that records are maintained describing the training received by the screeners, the names of attendees, the nature of any evaluation and any referral made;

(4) Providing sufficient evaluation of the test site for ambient sound and to ensure that the screeners are following the screening protocol; and

(5) Reviewing samples of screening records to confirm that the screening has conformed to the program standards.

(f) Licensed speech and language pathologists and registered speech language pathology assistants shall not instruct others in the techniques of hearing screening or supervise hearing screening programs. These aspects of a hearing screening program are within the scope of practice of licensed audiologists and physicians.

History note: Authority G.S. 90-304(a) (3);
Eff. April 1, 2005
Dental Screening

Purpose

The purpose of a dental health screening program is multifaceted and includes:

- Identification of students with dental treatment needs;
- Assurance that all students have the opportunity for professional dental evaluation in a dental office;
- Increased awareness of the importance of good oral health;
- Identification of types, extent, patterns of dental disease;
- Increased awareness of the importance of developing and practicing good oral hygiene habits; and
- Familiarization of students, teachers and parents with available services.

One challenge is to identify the students with high disease experience and to assure education and preventive services for them. In addition, it is important to generate an awareness of, and demand for, dental sealants among physicians, nurses, dentists and parents. Nurses play a vital role in identifying students with health problems. The partnership between nurses and dental professionals offers great benefits for children.

Recommendations

School health programs should have the responsibility for facilitating dental screening, referral and follow-up for students in selected grades in cooperation with public health dental staff.

Procedure

The screening should be completed by the public health dental hygienist based on approved manuals and procedures of the North Carolina Oral Health Section or one of the dental programs sponsored by a local health department. All screenings should offer an education component. A school nurse may be asked to assist with the referral and follow-up phase. Public health dentists and dental hygienists may be contacted by calling the local health department. If information is not available at the health department, contact the Oral Health Section at 919-707-5480.

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3 This section reviewed and revised by N.C. Division of Public Health Oral Health Section
Available Resources for Oral Health

The program of the North Carolina Oral Health Section is based on prevention and education with the majority of the staff based in the field to provide as many direct services to residents as possible. School children still suffer from dental disease with considerable variation from community to community.

Dental public health staff conduct a variety of program activities. All program activities include educational components to modify the behavior patterns of individuals to improve their oral health habits through dietary change, tooth brushing and flossing. Service components are:

- **Screening:**
  Dental screening, referral and follow-up by dental public health staff targeted primarily toward children in kindergarten and fifth grades.

- **Prevention:**
  Limited preventive clinical services with the provision of dental sealants as a top priority. Dental public health staff, working as teams, offer sealant promotion projects in schools.
  Fluoride Mouthrinse Program for targeted schools with students at greater risk for dental decay. The 2003 – 2004 N. C. School Oral Health Survey showed that the dental health of students from lower SES (socio-economic status) who participated in the Fluoride Mouthrinse Program was nearly equivalent to that of students from higher SES who did not participate in the Fluoride Mouthrinse Program.

- **Dental Health Education**
  Dental health education and information presented to children, both individually and in groups, regarding appropriate dietary habits, consumerism, injury prevention, disease prevention, oral hygiene practices, and professional dental care practices.
  Dental health educational information presented to a variety of adults, both individually and in groups. Specific target groups include health professionals, civic clubs, older adults, parents and teachers. Screening and referral programs may be available depending on the availability of staff and privately-practicing dentists.
  The Oral Health Section web site that provides resources for teachers, other health professionals and consumers:
  http://www.communityhealth.dhhs.state.nc.us
Vision Screening

Regulations

According to G.S. 130A-440.1, every student entering kindergarten in public schools shall obtain a vision screening in accordance with the vision screening standards adopted by the vision commission. Children who fail the vision screening must receive a comprehensive eye examination. A comprehensive eye examination consists of: Measurement of vision acuity, ocular alignment and mobility, depth perception (stereopsis), fusion, slit lamp examination, exam of ocular surfaces and refraction and dilation. Vision screening is a required element of the mandated North Carolina Kindergarten Health Assessment completed by the primary care physician.

Recommendations for Vision Screenings

In North Carolina, school screenings are the principal means of performing vision screenings, after the age of kindergarten entry. Vision screening should be accomplished annually for children in kindergarten and grades 1, 2, 3, 4, 5 and once in the middle school years according to the 1995 recommendation of the North Carolina Pediatric Vision Screening Task Force, convened by the (then) N.C. Division of Maternal and Child Health. To improve vision screening, the task force concluded that N.C. should move to a system of training and certifying health care professionals and school based volunteers who routinely participate in childhood vision screening. Another task force was convened in 2004 to review the recommendations. The task force reaffirmed the 1994 report and added stereo acuity (stereopsis) to the recommended screening protocol.

Vision screening should also be considered on all students who: are new to the school system, are in special education programs, failed a screening during the previous years, failed academically the previous year, demonstrate possible vision problems or are referred by teachers or parents. The number of children mass screened should take into consideration the extent of personnel available to provide for adequate follow-up activities for those students referred.

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This section reviewed and revised by Prevent Blindness North Carolina
Purpose

Visual acuity has particular educational significance because of the obvious relationship to learning. One in four school aged children has a vision problem significant enough to affect their learning. Uncorrected vision problems, such as amblyopia and strabismus, can worsen over time and result in permanent vision loss. Most eye problems in children can be corrected if they are detected and treated early. Screening for distance acuity is considered by authorities to be the single most important test of visual ability with proven reliability in detecting all of the above conditions. Nearsightedness is the most common refractive error in six year olds.

Recommendations

- When school systems implement mass vision screening programs, school nurses should have the responsibility for organizing the programs and for assessing the in-service education needs of teachers and other school staff.
- With the exception of developmentally-delayed children, trained volunteers may be used for initial mass screening.
- Training for vision screening should be carried out by Prevent Blindness North Carolina (PBNC). When training by PBNC is not available, vision screeners must follow the PBNC recommendations as promoted by the N.C. Division of Public Health, Children & Youth Branch, School Health Unit, until such training can be arranged.
- Mass vision screenings should include an assessment of:
  1) observable signs and symptoms of eye problems and
  2) distance visual acuity for each eye.

Vision screening must include both near and distance acuity prior to ruling out a sensory deficit as the primary cause of an achievement discrepancy that results in placement in EC with a category of Specific Learning Disability.

Additional screening guidelines, details regarding vision screening certification workshops, charts, and financial resources available for obtaining follow-up treatment can be found at Prevent Blindness NC, www.preventblindness.org/nc or 1-800-543-7839.
Distance Visual Acuity Screening

Equipment

Distance acuity charts should be chosen based on the child’s ability and charts should have a 20/25 line. The most challenging test a child is able to accomplish should be used. Below are suggested distance visual acuity charts and the grades for which they are recommended.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Chart</th>
</tr>
</thead>
<tbody>
<tr>
<td>K and 1st grade</td>
<td>10 ft HOTV</td>
</tr>
<tr>
<td>2nd grade and up</td>
<td>10 ft Snellen (Sloan)</td>
</tr>
</tbody>
</table>

Procedure

**Step 1: Set up the screening area**
- Choose a room free of distractions with adequate lighting and enough space for the required 10 feet for the regulation 10 foot HOTV or Snellen chart.
- Place the chart on the wall with the passing line at eye level of the student.
- Mark a line on the floor 10 feet from the chart
- Student stands with heels on the line (or sits in a chair with the back legs of the chair on the line)

**Step 2: Greet the Child and Observe for Appearance, Behavior and Complaints**
- Ask the student’s name, age, grade and if they wear glasses.
- If the student has glasses or contacts, test with the corrective lenses (Be sure to record the results stating he was wearing glasses or contacts)
- Determine the appropriate chart based on the student’s educational ability/grade level.
- Determine passing criteria based on the child’s age.
- Look for any appearance, behavior, or complaint/signs of possible vision problems.
Step 3:
Start by:

**Practicing**
- Explain the letters/characters to be used and ensure the child understands how to respond.
- With both eyes unoccluded, have the child name the letters on the starting line (one line above the passing line.)
- Use the HOTV card to play a “matching game” if the child is unable to name the letters/symbols.
- Demonstrate how to use the occluder. Do not put pressure on the covered eye, as this can cause temporary blurring of the vision. Make sure that the eye under the occluder is relaxed and open, not squinting. Be sure the student cannot “peek” or see around the occluder. (A clean paper cup is a good alternative occluder.)

### Step 4: Begin Testing
- Have child occlude left eye and begin reading on starting line (one line above passing line).
- Proceed down the chart to the 20/20 line if possible.
- Watch for squinting, tilting the head or peeking from behind the occluder.
- To pass a line, the child must correctly identify one more than half of the symbols on the line.
- Record acuity as the smallest line the child was able to pass.
- Occlude the right eye and repeat the process.
- If the child fails the starting line, begin screening at the top of the chart and move down to the smallest line the child passes.

### Step 5: Refer the following:
- Any observable signs and symptoms of vision problems (redness, discharge, swelling, misalignment, jiggling, squinting, protruding, drooping) or student complaints (headaches, blurry vision, double vision, sensitivity to light)
- Failing acuity score in either eye

<table>
<thead>
<tr>
<th>Age:</th>
<th>Passing</th>
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<tbody>
<tr>
<td>4 &amp; 5 Years Old</td>
<td>20/40 or better in each eye</td>
</tr>
<tr>
<td>6 Years &amp; Older</td>
<td>20/30 or better in each eye (HOTV) OR 20/32 or better in each eye (Snellen)</td>
</tr>
</tbody>
</table>
A visual acuity difference of two or more lines between eyes, even if within the passing range
Acuity is 20/20 in one eye and 20/30 (or 20/32) or worse in the other eye
Acuity is 20/25 in one eye and 20/40 or worse in the other eye
• Record both pass and fail results as well as follow-up efforts
• Re-screen within two weeks those children who fail or are untestable on initial mass screening prior to initiating a referral for a professional eye examination

Alternative Tests for Distance Visual Acuity

In some cases, it may be helpful to utilize a symbol chart for screening very young, non-English speaking, or otherwise hard-to-screen children. The HOTV or LEA Symbol charts are acceptable alternatives. If the child is unable to name the letters/symbols, the screening may be done as a “matching game”.

Students Wearing Glasses

Students wearing glasses or contact lenses are screened with prescribed correction and documented on the student’s health record (e.g., “20/40 with glasses). If known, document the date of last professional eye examination, date of last correction, and date of the next scheduled exam.

This information, and observations by the screener, are important in determining the need for a referral. Sometimes a child under regular care will not be able to pass the screening test, but has the best possible correction. On the other hand, a child who has not been seen by an eye doctor in over a year may need to be seen. The results of the screening should be discussed with the parent in order to determine the appropriateness of a referral.

Near-Point Testing

Near vision acuity testing should be administered on an as needed basis for two distinct purposes: 1) to determine if a child is having difficulty viewing objects at a close range or 2) to test as part of the evaluation of a student identified or referred for Exceptional Children programs. The Rosenbaum Pocket Near Vision Screening card or LEA Symbols Card are recommended.

• Choose a quiet area free from distractions and clutter.
• Hold the card 14 inches from the child’s eyes.
• Conduct the test binocularly (both eyes unoccluded)
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• Instruct the child to wear prescription lenses, if applicable.
• Instruct the child to read the numbers or characters on the starting line for that child’s age.
• To pass a line, the child must correctly identify one more than half of the symbols on the line.
• Record acuity as the smallest line the child was able to pass.

EC (Exceptional Child) evaluation may require testing of each eye individually in addition to a binocular acuity.

Testing Procedures for Assessing Ocular Alignment

Cover Test

The Cover Test may be used to assess ocular alignment (strabismus).

• Tell the student what you are going to do.
• Have the student fixate on a target about 10 feet behind you with both eyes open.
• Cover one eye with a hand-held occluder or a cupped hand. Do not touch the student’s eye.
• Watch the uncovered eye for any movement of fixation. (Movement may be observed in towards the nose, out toward the ear, up or down.)
• Remove the cover to see if the first eye has deviated.
• If there is no apparent misalignment of either eye, move the cover back and forth between the 2 eyes, waiting about 1 to 2 seconds between movements.
• If misalignment of either eye occurs, referral for treatment is indicated. This movement must be observed more than once; it must be consistent.

Corneal Light Reflection Test

Corneal Light Reflection Test may also be used to detect misalignment for students in grades K and 1.

• Tell the student what you are going to do. Ask the student to focus on the examiner’s face.
• Using a penlight held about 2 feet from the student’s face, direct the light toward the student’s eye.
• Observe the dots of light reflected back to you from his/her pupils.
If the student’s eyes are straight, the two dots of light will be in the same place on both pupils or they will be both slightly toward the nose side of the pupil, symmetrically.

If the dot of light is off center in one pupil, or they are not symmetrical (parallel), this indicates misalignment and a referral should be made.

Corneal light reflection test is a “pass” if the dots of light are centered in each pupil or are slightly toward the nose side, equally distant in both eyes.

Optional Types of Vision Screening

Other types of vision screening that might be done for students include:

a. Color Discrimination
b. Stereopsis (mandated by G.S. 130A-440.1 as part of kindergarten entry screening; optional for other grade levels.)

Stereopsis screening is mandated within the above General Statute and documented on the Kindergarten Health Assessment form issued by NC Division of Public Health and Department of Public Instruction. Stereopsis screening is recommended as “best practice” by Prevent Blindness NC and other organizations up to age nine.

Optional screenings might be used as part of visual assessments for high-risk students, such as those being evaluated for possible placement in special education programs or as part of re-screening for student who fail the initial screening. These optional screenings do not need to be done routinely for all students or as part of a mass screening program. The optional types of vision screening tools will provide information on how to score and record test results.

The most current information about vision screening and children’s eye problems, as well as screening information may be found at the following website:

www.preventblindness.org/nc
Children’s Vision Screening Program Referral Letter

Child’s Name: __________________________________________________________

Age                              Sex                                 Date

Address

City                                                                           Zip                                        Phone #

Dear Parent:

A recent vision screening indicates that your child may be experiencing some vision difficulty. Although these results are not a diagnosis and do not necessarily mean that glasses or treatment is needed, we urge you to make an appointment now and take your child to an eye doctor to determine if there is a vision problem. Your child’s vision screening indicated the following:

- Child did not pass the distance vision test: Right: 20/___  Left: 20/______
- There was a two-line difference between the eyes: Right: 20/___ Left: 20/___
- A sign or symptom of a problem was observed:_______________________________
- Child did not pass the near vision test:    Binocular: 20/_______
- Child did not pass the color vision test.
- Child did not pass the stereopsis screening.

Please give this form to the eye care professional when you take your child in for an examination. This information will help the doctor understand the reason for this referral. If you have any questions or concerns regarding this vision referral, please contact me at the telephone number listed below.

School Nurse / Screener (Please Print) School Nurse/Screener Signature

School Name                                                            School Address

Telephone Number City                                   State              Zip

► Please take this form to the eye doctor and have them complete the reverse side.
Examiner’s Report Form

Attending Doctor:

This child’s vision was recently screened at school, and a professional eye examination was recommended based on the results of the screening. Please complete the report form and return it to the school nurse at the address indicated on the reverse side of this document.

Child’s Name: __________________________________________

Date of Birth: _____/______/______ Date of Examination: ______________

Visual Acuity:

Distance:    Right 20/_______ Left 20/_______
Near:       Binocular: 20/________

Diagnosis:

☐ Amblyopia
☐ Muscle Imbalance
   (Specify)_______________________________________________
☐ Refractive Error: ☐ Myopia ☐ Hyperopia ☐ Astigmatism
☐ Other (Specify)__________________________________________
☐ No Problem Detected

Treatment:

☐ Glasses Prescribed: ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time (Specify)________
☐ Other (Specify)__________________________________________
☐ Follow-Up Care Recommended

Examiner’s Name __________________________________________

Address __________________________________________________

Phone Number ____________________________________________

Consent of Parent/Guardian: I agree that the above information may be released to the school system for the purpose of providing educational services to my child.
Date_________ Parent/Guardian Signature _______________________

Referral Criteria
20/50 or worse in either eye for a 4 or 5 year old
20/40 or worse in either eye for 6 years and older
2 line difference in visual acuity between the eyes
Failed Stereopsis Screening

Examiner’s Report Form

School Health Program Manual – January 2010
N.C. Division of Public Health – Children & Youth Branch – School Health Unit
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Blood Pressure Screening

Blood pressure screening should be conducted once during middle school and once during high school on all students. This screening should be held in conjunction with a health lesson that identifies risk factors associated with hypertension and cardiovascular disease. All students and staff who present with signs and symptoms that indicate need should have their blood pressure status assessed and monitored. Blood pressure measurement should be included as part of the complete health assessment of any child.

Rationale

▪ Mortality due to hypertension and heart disease in North Carolina is among the highest in the nation.

▪ Early identification, followed by successful treatment, may prevent heart disease, stroke and kidney failure.

▪ Elevated blood pressure may be an early indication of the presence of other serious health conditions that need further medical evaluation.

▪ Screening presents an excellent opportunity for health promotion education and counseling related to cardiovascular health with a population of emerging adults.

Recommendations

▪ School nurses may organize and implement, in collaboration with others, a blood pressure assessment program that includes screening and education of risk factors associated with hypertension and cardiovascular disease.

▪ Screening should be conducted in a quiet environment free from noises and building sounds.

▪ Necessary equipment includes stethoscope and sphygmomanometer (mercury or aneroid) and correct cuff size: child, adult, large adult.

▪ Sphygmomanometers should be checked frequently for calibration to ensure their accuracy and reliability.

▪ Screening may be accomplished as a collaborative community effort with health departments, the Red Cross, the American Heart Association, and others.
Use of trained volunteers is appropriate for initial mass screening, as long as they are given general information on hypertension and its relationship to cardiovascular disease and instructed in appropriate procedures.

The school nurse may elect to do initial screening or monitor and supervise volunteers. An individual assessment should be conducted by the nurse for all students with elevated blood pressures.

**Preparation**

- Prepare students for screening activity by explaining procedure.
- Allow sufficient time (five minutes) before screening procedure to allow students to rest from any physical or anxiety-provoking activity.
- Schedule screening for blood pressure during a time other than, or immediately following, physical education class.

**Procedure**

- Have students assume an erect but comfortable sitting position with both feet flat on the floor.
- Fully expose the **right** upper arm, making certain sleeves are not constricting the arm. If it is necessary to use the left arm, indicate this when recording reading.
- Rest the student's elbow and forearm on a supportive surface at heart level with the palm turned upward.
- Select the appropriate compression cuff: proper cuff size is essential for accurate readings. An oversized cuff may produce an erroneously low reading, whereas an undersized cuff may give an erroneously high result. The cuff used should cover 75 percent of the upper arm but not encroach on the antecubital fossa. The inflatable bladder of the cuff should be long enough to encircle the arm (with or without overlap).
- Wrap the deflated cuff snugly and evenly around the arm. Smooth, snug application of the cuff will produce even pressure and thereby an accurate reading. The midline of the bladder should be placed one to two inches above the brachial artery.
Palpate the radial pulse while inflating the cuff to estimate the systolic pressure.

Place stethoscope earplugs in ears with ear tips turned forward.

Locate the brachial artery with your fingers and lightly hold the diaphragm of the stethoscope directly over the pulsating artery.

Rapidly inflate the cuff 30 mm above estimated systolic pressure.

Deflate the cuff slowly to drop at about two to three mm Hg/second, listening throughout the entire range of deflation until 10 mm Hg below the level of diastolic reading.

**Phase I:** The period marked by the first appearance of faint, clear tapping sounds which gradually increase in intensity.

**Phase II:** The period during which a murmur of swishing quality is heard.

**Phase III:** The period during which sounds are crisper and increase in intensity.

**Phase IV:** The period marked by the distinct, abrupt muffling of sound so that a soft, blowing quality is heard.

**Phase V:** The point at which sounds disappear.

Record the systolic pressure at the point where the initial tapping sound is heard for at least two consecutive beats.

Record the diastolic readings in infants and children up to age twelve at Phase IV.

Record the diastolic reading in children twelve years of age and older at Phase V.

After diastolic pressure is heard, deflate cuff rapidly and completely. Once you have begun to deflate the cuff, never reinflate. Deflate the bladder completely before inflating.
In the event the sounds are inaudible, the following action may be taken to augment the sounds:

- Rapidly inflate the cuff to decrease the amount of blood trapped in the forearm, thus increasing the loudness of sounds.
- Elevate the arm for 30 seconds, inflate the cuff while the arm is elevated, lower the arm to heart level, and deflate the cuff per procedure.
- Instruct the patient to open and close the fist rapidly 10 times after the cuff is inflated above systolic level.

Record systolic and diastolic pressures on the student's health record.

- If either the systolic or diastolic reading is higher than the recommended normal levels, allow student to rest about 15 minutes and re-check. If elevation persists, the student should be scheduled for further assessment using the referral criteria which follow.

**Recommended Referral Criteria**

Blood pressure referrals for children 3 to 18 years should be made only in accordance with the classification chart established by the National Heart, Lung and Blood Institute Task Force on Blood Pressure Control in Children, 2004, and endorsed in the website of the American Academy of Pediatrics. These standards represent the 95th to 99th and >99th percentiles for blood pressure in populations and provide criteria for referral.

Because of the labile nature of the blood pressure in children, measurements that are in the 95th--99th percentile should be repeated at least three times at different visits under circumstances in which apprehension and anxiety are minimized. The average of these three measurements is then used to determine if referral is necessary.

**Criteria**

✔ Immediate referral if child's blood pressure measurement falls in 99th percentile on any single occasion. Serial measurement and medical evaluation should be done by the physician.
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✓ Refer all students whose average blood pressure measurement (taken on three different occasions) is between 95th –99th percentiles.

✓ For adults, a referral should be made if the average systolic pressure is over 140 or if the diastolic is over 90 when taken on two separate occasions.

Continued Monitoring

Group counseling might be effective if there are a number of students with blood pressure elevations.

Continued monitoring should be provided when requested by the health care provider or when the need is identified by the school nurse.

A sample blood pressure screening referral form follows.
Blood Pressure Screening Referral Form

(Sample Form)

Dear Parent:

Blood pressure screening is one of the preventive health services provided by the School Health Program in this district. Your son/daughter’s class was recently screened as part of a health awareness initiative.

It is recommended that he/she be seen by a physician because his/her blood pressure was elevated at three different times. The readings are as follows:

<table>
<thead>
<tr>
<th>Date of Screening</th>
<th>Blood Pressure Reading</th>
<th>Arm Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. _______________</td>
<td>______________________</td>
<td>Rt. _____ Lt. _____</td>
</tr>
<tr>
<td>2. _______________</td>
<td>______________________</td>
<td>Rt. _____ Lt. _____</td>
</tr>
<tr>
<td>3. _______________</td>
<td>______________________</td>
<td>Rt. _____ Lt. _____</td>
</tr>
</tbody>
</table>

Please have ______________ examined by his/her doctor. Ask the doctor to complete the lower portion of this form and return to the school nurse by ______________.

Nurse ___________________________ Phone ___________________________

School ___________________________ Date of Referral ___________________________

Physician’s Report of Blood Pressure Examination

Name of Student ____________________________

Examination Findings:

Recommendations and/or treatment:

Do you wish to have this student’s blood pressure monitored at school?

No: ____ Yes: _____ If yes, how often ______________________

Physician’s Name: ___________________________ Signature ___________________

Office Phone: ___________________________ Date: ___________________

Please return this form to the school nurse listed above.
North Carolina School Health Program Manual

Section E
School Health Services

Blood Pressure Screening

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TABLE 3. BP Levels for Boys by Age and Height Percentile

<table>
<thead>
<tr>
<th>Age, y</th>
<th>BP Percentile</th>
<th>Percentile of Height</th>
<th>Percentile of Height</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5th</td>
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The 90th percentile is 1.28 SD, the 95th percentile is 1.645 SD, and the 99th percentile is 2.326 SD over the mean.

For research purposes, the SDs in Table B1 allow one to compute BP Z scores and percentiles for boys with height percentiles given in Table 3 (i.e., the 5th, 10th, 25th, 50th, 75th, 90th, and 95th percentiles). These height percentiles must be converted to height Z scores given by: 5th = 1.28; 10th = 1.645; 25th = 0.68; 50th = 0; 75th = -0.68; 90th = -1.28; and 95th = -1.645, and then computed according to the methodology in steps 2 through 4 described in Appendix B. For children with height percentiles other than these, follow steps 1 through 4 as described in Appendix B.
### Table 4. BP Levels for Girls by Age and Height Percentile

The 90th percentile is 1.28 SD, the 95th percentile is 1.645 SD, and the 99th percentile is 2.326 SD over the mean. For research purposes, the SDs in Table B1 allow one to compute BP Z scores and percentiles for girls with height percentiles given in Table 4 (ie, the 5th, 10th, 25th, 50th, 75th, 90th, and 95th percentiles). These height percentiles must be converted to height percentiles by: 5% for 1st, 10th, 25th percentiles; 25% for 5th percentile; 50% for 50th percentile; 75% for 75th percentile; 90% for 90th percentile; and 95% for 95th percentile.

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<th>DBP, mm Hg</th>
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<td>27</td>
<td>50th</td>
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* The 90th percentile is 1.28 SD, the 95th percentile is 1.645 SD, and the 99th percentile is 2.326 SD over the mean. For research purposes, the SDs in Table B1 allow one to compute BP Z scores and percentiles for girls with height percentiles given in Table 4 (ie, the 5th, 10th, 25th, 50th, 75th, 90th, and 95th percentiles). These height percentiles must be converted to height percentiles by: 5% for 1st, 10th, 25th percentiles; 25% for 5th percentile; 50% for 50th percentile; 75% for 75th percentile; 90% for 90th percentile; and 95% for 95th percentile.
Follow-Up of Suspected Health Problems

An appraisal procedure is of value only if the student with the identified problem receives necessary treatment and optimum correction. If the results of screening tests or health assessments suggest that a health problem is present, follow-up is necessary. Follow-up is the term used to describe the various processes used in caring for the child’s defects or problems from the time they are first identified until the time that recommended care has been received by the child. Follow-up includes enlisting the cooperation of the student's parents in the referral and treatment process.

Follow-up can be described as the process, through communication, by which various individuals or agencies undertake responsibility to assure that action is taken to meet identified problems. The process can be initiated by telephone, written communications, or through personal conferences with students and parents (at school or in the home).

The nurse providing or coordinating health services within the school is the appropriate professional to institute the follow-up process. When a student is referred to the nurse for a suspected health problem, the nurse assesses the health status of the child through various mechanisms:

- Screening results
- Health history
- Review of developmental evaluation(s)
- Nutritional assessment
- Physical assessment
- Review of immunization status
- Review of reports such as physical therapy, speech or psychological exams

When a health problem is identified, the nurse contacts the parent to discuss the problem and possible choices for referral. Methods of referral will vary depending upon community resources. It is essential that the nurse is knowledgeable of the resources in the community. The local health department can be a valuable source of referral information for the nurse.

Adequate follow-up of health problems is dependent upon a coordinated working relationship between school personnel, parents, students, private medical providers, and other community agencies. Students will then be ready to benefit from the educational settings and reach their optimal potential.

Most parents are willing to assume the responsibility for their children's health care needs. However, some are not convinced of the need for a referral and others may not be able to
provide those resources. Factors causing a parent to delay seeking care are varied and could include: lack of understanding of the health impact, both present and future; financial inability; denial of the health problem; indifference; lack of access to health care; past experiences with health care providers that were unpleasant or inefficient; etc. In the interest of the child, the nurse should work with these parents to help them plan for their children’s health care needs. This can be done by establishing a relationship of mutual trust and by demonstrating through his/her actions empathy and support of the family.

In the event that the family does not follow up a suspected health problem that presents a significant health or academic concern, the school nurse, as an advocate for the child, should refer the matter to the school student assistance team or other school-based intervention service. The nurse and/or team, following school system policy, may consider initiating a report of suspected neglect with county Child Protective Services.

For the legal protection of the nurse and other school staff, it is extremely important for all involved in the referral and follow-up process to document the findings of health assessments or health services that have been performed, as well as parent conferences, referrals, follow-up contacts, and evidence of recommended care received by the child. (Documentation may be on Student’s Permanent Health Record or an individual health record for the student.)
Reports of School Health Programs

For accountability of a school health program, data is essential. Data is helpful to reveal work loads and accomplishments, to point out program needs or evidence of those needs being met, and to stimulate the development of long-and short-range program objectives. School health program managers and others should occasionally complete a self-assessment of their program. A tool for that task follows. Another school health program self-assessment tool is located in the CDC’s School Health Index. For more information, contact your regional school health nurse consultant.

Superintendents and other administrators appreciate periodic or special reports of the school health services being provided in their district. These reports are most helpful if they include a data section and a narrative section. The End of Year Report, a report submitted to the N.C. Division of Public Health, is a uniform method of recording and reporting data and outcomes of the school health program. The data collected throughout the year should be evaluated to plan for future services and to meet identified health needs.

Since 2004, when the N.C. School Nurse Funding Initiative (SNFI) was enacted, the reporting system has served also to document activities toward measurable outcomes. The SNFI Work Plan allows program planning with an emphasis on these six core areas:

1. Control of communicable disease
2. Assurance of appropriate immunizations
3. Care planning for students with special health care needs
4. Auditing medications
5. Screening and securing care for identified health problems
6. Delivering mandated activities, such as enforcement of health examinations required for school entry, compliance with state laws, and others.

The SNFI Annual Report documents fulfillment of the work plan.

Contact your regional school nurse consultant for a copy of the current End of Year Report form, the SNFI Work Plan, or the SNFI Annual Report form.
## North Carolina School Health Program Manual

### Section E Chapter 6
School Health Services Reports of School Health Programs

County ___________________________ LEA ___________________________

Date ____________________________

Progress scale: (4) Implemented; (3) Developed; not implemented; (2) Being considered; (1) Activity conducted without policy, protocol or written procedure; (0) No policies or activities in place.

### Assessment of School Health Program

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<td>Nurse ratio per school</td>
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<td>Employing agency: LEA, HD, Hospital</td>
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<td>Is there an MOA with HD?</td>
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<td>Reviewed with SN annually?</td>
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<td>Is your workspace adequate? (include all schools)</td>
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<td>▪ equipment</td>
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<td>▪ telephone for confidential conversations</td>
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<td>▪ a place to isolate those with communicable diseases</td>
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<td>Did you have an opportunity to participate in writing or updating your job description?</td>
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### North Carolina School Health Program Manual

**Section E**

**Chapter 6**

**School Health Services**

**Reports of School Health Programs**

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<td>How do you determine in-service needs of health staff and school personnel?</td>
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<td>What is your procedure for compiling health services data?</td>
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<td>Are confidentiality rules including rights of access to individual health records observed as required by law?</td>
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<td>Provision for emergency care: (first aid, fire and disaster plan, etc.)</td>
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<td>Student health appraisals and physical assessment according to policy for:</td>
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<td>Students involved in athletic competition</td>
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<td>Students referred by parents and/or school personnel</td>
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<td>Is there a School Health Services Procedure Manual?</td>
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### Criteria

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<td>• Development of IHPs, 504 Plans</td>
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<td>• Write health-related goals for student’s IEP</td>
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<td>• School based committee meetings</td>
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<td>• Home/Hospital visits</td>
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<td>• Provide staff in-service</td>
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<td>• Participate in Medicaid reimbursement for nursing services</td>
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<td>What is your relationship with other support staff?</td>
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<td>What structured programs (meetings) do you attend?</td>
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<td>Staff development?</td>
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</table>

Does the School Health Services Program undergo periodic evaluation and revision?

What are your training or in-service needs?

Recommended steps to be taken:
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Guidelines for Handling Student Health Records

Each school administrative unit should maintain a cumulative record folder for each student attending its schools. The cumulative record folder should contain the Student’s Permanent Health Record or the Local Education Agency (LEA)’s substitute for that form. (See Appendix III, Forms)

All cumulative record folders should be kept in locked filing cabinets in an area designated by the principal. Once the student no longer attends a school within the LEA, the health record is merged with the cumulative folder and kept with those records.

Students with chronic or ongoing health conditions or those needing in depth nursing documentation should have an individual student health record established and maintained by the school nurse. It should be separate from the cumulative folder and should be kept in locked filing cabinets in the nurse’s office. Access is limited to school nurses, substitute school nurses or other health care staff; additional school staff with a “need to know” as determined by the principal in consultation with the nurse, may also access health records.

Records in school health programs serve administrative and educational purposes in addition to medical purposes. Administrative health records show which children have received mandated immunizations and examinations. Injury reports are also administrative records. School health records serve an educational purpose when the findings from a medical evaluation could indicate a need to make accommodations in the student’s instructional needs.

An individual health record holds data for care of individual children when the school assumes responsibility for health supervision of students. Clinical records include all aspects of nursing care: assessment, planning (including decisions on what outcomes are desired), implementation and evaluation (including information on the extent to which outcomes were achieved.). Both positive and negative findings are documented. Health records indicate health-based recommendations for special management or observation of students while they are in the school.

The Family Educational Rights and Privacy Act (FERPA) of 1974 mandates specific safeguards regarding the confidentiality of and access to student records. (See Appendix II) Parents (or students 18 and over) have access to all records maintained by the LEA, including health records.
School health nurses that are employed by other agencies may have access to the student record if the following criteria are addressed:

1. The agency employing the school nurse and local school system (e.g., school board or administrator) specify in a written Memorandum of Agreement (MOA):
   - That the nurse is an agent for the school while providing school nursing service; and
   - Therefore is considered among "school officials" with access.

2. The nurse is acting in this official capacity when requesting access. The nurse may also maintain individual health records on a student, but they should be stored at the school in a secure location. These records become part of the official LEA records and should be archived once a student graduates or leaves the school system, per LEA procedures.
The Storage of Student/Employee Health Information

Students
The Family Educational Rights and Privacy Act, also known as FERPA or The Buckley Amendment, governs the collection, maintenance, and dissemination of student education records. The Act does not address whether all student information should be maintained in a single file or whether it can be maintained in separate files depending upon the nature of the contents. We believe that it is proper to maintain separate files for sensitive health information – items such as health care plans, treatment protocols, and medical authorizations.

For example, student health information should be kept in a safe, locked record storage that is separate from the student’s other school records. The principal may share student health information with persons who have (1) direct guidance, teaching or supervisory responsibility for the student, and (2) a specific need to know in order to protect the safety of the student or others. Access to sensitive health information should be limited to persons who meet those two criteria. The information should be available to these persons on a daily basis in the event that the need to access it should arise.

We recommend that you follow these procedures while the student remains enrolled in your school system. Once the student departs from the school, it is appropriate to merge this information with any copy of the cumulative record that you keep for records maintenance purposes. If the student transfers to another school system, best practice is to forward the original student records to the new system and retain a copy if your policy is to keep information on students who transfer.

Employees

Employee personnel files are confidential pursuant to G.S. 115C-319. However, 115C-320 makes certain exceptions by permitting access to confidential information to four categories of persons: the employee; the superintendent and other supervisory personnel; members of the local board of education and the board’s attorney; and a party by authority of a subpoena or proper court order.

Because of the potential for the inadvertent release of confidential, sensitive health information from an employee’s file, we believe that it is also proper and advised to house this information separately from the regular personnel file.

1 Prepared by Harry Wilson, legal counsel, State Board of Education and N. C. Department of Public Instruction, 2004. Reviewed and approved by Katie Cornetto, Staff Attorney, N.C. Board of Education, September 2010
INTRODUCTION

One of the most challenging responsibilities of school nurses is managing the many types of student health records, both paper and electronic. They include documents such as immunization records, screening records, progress notes, physician orders, physical examination records, medication and treatment logs, individualized health care plans, emergency health care plans, third party medical records, consent forms, Medicaid and other insurance billing forms, and flow charts.

School health records provide the mechanism for a school nurse to communicate information to students, families, the school multidisciplinary team, emergency personnel, other health care providers, and school nurse substitutes. Data from school health records can be used to show evidence of student health problems that should be addressed. Data can also be used for evaluation of school health programs, quality assurance, and evaluation of program outcomes. School health records are transferred to new school sites when a student progresses to other buildings within a district or moves to another district. It is important for school districts to have policies and procedures regarding the types, maintenance, protection, access, retention, destruction, and confidentiality of student health records. State laws and regulations may dictate these policies and procedures (Harrigan, 2002). As society and the health care system are moving from paper to electronic technology, so too is the school health office. Technology currently in use to receive and transmit student health information includes:

- Answering machines
- Cellular and cordless telephones
- E-mail via computer
- Facsimile machine (fax)
- Personal digital assistant (PDA)
- Voice mail

BACKGROUND

The following areas are considered when examining a school health records system:

- The foundation and rationale for any school health records system should be based on who needs the information, what information they need for the benefit of the student, and who has the expertise to interpret the records (National Association of State School Nurse Consultants, 2000; Schwab & Gelfman, 2001).
• School health records are maintained for purposes of communication, legal evidence, research, education, quality assurance monitoring, statistics, accrediting/licensing, and reimbursement (Schwab, Panettieri, & Bergren, 1998).

• In keeping with medical record requirements, school health records are cumulative and chronological, and errors are not changed, rather recorded on the appropriate date (Schwab & Gelfman, 2001).

• Management of student health records includes their generation, maintenance, protection, disclosure, and destruction. Privacy, confidentiality, and consent are related to record management. (NASN, 2002).

• Paper records are generally kept in locked files. Some school staff will need immediate access to some health information, such as that in emergency care plans, 504 plans, IEPs, and written instructions for care providers (Schwab & Gelfman, 2001).

• Laws governing school health records include the Federal Family Education Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) as well as individual state laws (Bergren, 2001c).

• Computer databases that provide comprehensive student health records and health office logs are available. These are enhanced by nurses using personal computers linked to a network of computers in a building or district. Some school nurses serving multiple buildings use notebook computers to carry from school to school and connect to the network while in each building (Schwab & Gelfman, 2001).

• Fax machines are widely used for transmitting health information. In schools, fax machines streamline accessing such records as immunizations, parental permissions, doctor’s orders, clinic records, and pharmacy communications regarding medications (Bergren, 2001b).

• PDAs augment computers by sharing information with them. Some school nurses find PDAs useful for digital data collection and retrieval. Student health data is collected during screenings or accessed during emergencies on the school campus. Information is uploaded onto the school nurse’s computer at a later time (Suszka-Hildebrandt, 2001).

• E-mail has become a standard method of communicating in the school setting among staff in and outside of the school district. E-mail is self-documenting and can be retained in a paper or electronic health record at the time of the exchange, eliminating the need for additional notation. The original message is preserved into a file by downloading (Bergren, 2001a).
RATIONALE

Health information in either paper or electronic form must be confidential, secure, accessible only by authorized staff, and protected from loss or destruction (Bergren, 2001b). Information transmitted via the newer technologies is different from paper records in that it can be fairly easily misdirected, intercepted, rerouted, and read by recipients for whom it is not intended (Bergren, 2001a). Because of this, new methods of security must be undertaken.

ROLE OF THE SCHOOL NURSE

School nurses need to address the many issues surrounding student health records in the school health office. Ensuring the security and privacy of both electronic and paper records is of utmost importance. In addition, school nurses must know the relevant federal and state laws, regulations, and guidelines about school health record maintenance, protection, disclosure, and destruction. In addressing these issues, school nurses should evaluate school district policies and procedures, initiate changes if indicated, and educate staff, students, and parents (NASN, 2002).

Electronic records and their transmission pose potential problems that school nurses must address. Special provisions must be established to protect electronic health records and student privacy in the school district. The specific method of storing student health data determines the particular opportunities for abuse of its integrity, so school nurses should be involved on the school district technology team to give input on the need for privacy. Additionally, school nurses should be able to describe the security measures taken by the school district to protect student confidentiality (Schwab & Gelfman, 2001).

Computers have streamlined record keeping for many school nurses. Along with the convenience comes the need to protect both on-screen and stored information. The use of secure passwords, programs to thwart hackers, and screen savers, as well as several areas of access for the student health data base and a policy of never leaving the computer unattended when student health data is accessible or viewable, is necessary for security. Computer software should have over-write protection and multi-level access if multiple health office employees will be entering data (Schwab & Gelfman, 2001).

Informed consent should be obtained before using e-mail for transmissions from the health office. Consent forms should describe the school district security and the expected response time, and explain that transmissions will be placed in the student’s health file. The school nurse should assist the school district in establishing a policy for the type of information that may be sent via e-mail. Messages with identifiable health information should be encrypted.

Additional security measures regarding e-mail include precautions to prevent misdirected e-mail; password-protected screen savers; never forwarding messages without permission of parent, health provider, or student; and prohibiting sharing of health office e-mail accounts or
passwords with anyone. A confidentiality statement should be written on all e-mail messages involving students (Bergren, 2001a).

When faxing, school nurses should include a cover page that states the confidentiality and limited use of student health information. To protect student confidentiality when faxing documents, the school nurse should fax only when mail will not suffice, transmit only requested information, keep faxes short, and obtain proper authorization. The fax machine should be located in a secure area of the school where it can be monitored by authorized staff. School nurses need to know what their individual state laws specify regarding whether a fax document can be used instead of the original signed paper document for doctors orders and prescriptions (Bergren, 2001b). School nurses utilizing technology in the health office need to emphasize to their school administrators the importance of keeping student health information secure and private. The school technology team should provide assistance in explaining what is needed and how it can be implemented. Funding for security measures might be obtained through the school parent organization or a community service organization.

REFERENCES

July 2004
National Association of School Nurses, Inc.
www.nasn.org
School Nurse Issues Regarding Confidentiality of Health Information

Position Statement
National Association of State School Nurse Consultants

Position

The National Association of State School Nurse Consultants (NASSNC) supports the rights of students to be respected and have personal health issues and information dealt with in a private manner. NASSNC believes all health information must be treated as confidential in accordance with federal and state law, the standards of school nursing practice and the code of professional ethics. In education settings, school nurses share confidential information only when it is educationally relevant for a student's academic progress, necessary to address a student's potential emergency and health care needs, essential to ensure the safety of the student, other students and school personnel, and other situations specific by law. The provisions of the federal Family Educational Rights and Privacy Act (FERPA) guides school nurses making decisions on when to divulge student health information.

Rationale

All students have health issues that must be handled in a confidential manner. Students are entitled, by federal and state law, to attend public school and may require nursing and health services in order to maximize their learning potential and remain safe in school. Breach of confidentiality violates trust, is unethical, and may be subject to legal sanctions or civil remedies.

Generally, student health information may not be shared with parties outside the school without informed consent of the student’s parent or guardian or if the student is 18 years old, as governed by federal and state law. However, FERPA “permits the disclosure of education records, without consent, to appropriate parties in connection with an emergency, if knowledge of the information is necessary to protect the health or safety of the student or other individuals.” FERPA also permits sharing student health information in schools with school staff who have a legitimate educational interest. The school nurse uses professional judgment to determine which health conditions pertain to a student’s learning and safety. The school nurse must balance the privacy rights of the student and family with need to share information.

Definitions

Standards are a set of criteria with expected behaviors or course of action. Practice standards are applied to a specific profession, such as school nursing. Standards are substantiated by a body of knowledge, legal authority and/or code of ethics. There can be social or legal consequences for infractions.

Student Health Information may include: a health history, recent injuries, immunizations, records of routine screenings, medical and behavioral diagnoses and interventions, health care provider orders
including medications and treatments, nursing assessments, diagnoses and intervention plans, and/or documentation of emergency situations.

Summary

The National Association of State School Nurse Consultants believes student health information must be treated in a confidential manner protecting the privacy rights of individuals. NASSNC believes this information should be shared only when educationally relevant to a student's academic progress, necessary for providing health services including emergency care, or essential to ensure the safety of students and school personnel.

References


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Organizations: Health Promotion, Health Support

Advocates for Youth
2000 M Street NW, Suite 750, Washington, DC 20036
202-419-3420
www.advocatesforyouth.org

American Nurses Association
8515 Georgia Avenue – Suite 400
Silver Springs, MD 20910
800-274-4262
www.nursingworld.org

American National Red Cross
2025 E Street, NW, Washington, DC 20006
800-257-7575
www.redcross.org

American Public Health Association
800 I Street N.W., Washington, DC 20001-3710
202-777—APHA
www.apha.org

American School Health Association
PO Box, 708 Kent, OH 44240
www.ashaweb.org

Case Management Project of North Carolina
www.cmpnc.org

Children’s Defense Fund
25 East Street, NW, Washington, DC 20001
Phone: 800-233-1200
www.childrensdefense.org
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Resources, References, Resolutions & Position Statements

Item #1 Organizations

Children’s Hospital Boston
Project School Care
300 Longwood Avenue, Boston, MA 02115
617-355-6000
www.childrenshospital.org

FAPE (Free, Appropriate, Public Education)
www.fape.org/pubs

Federation for Children with Special Needs, Inc.
1135 Tremont Street, Suite 420, Boston, MA 02120
617-236-7210
800-331-0688
www.fcsn.org

Food Allergy and Anaphylaxis Network
11781 Lee Jackson Highway, Suite 160
Fairfax, VA 22033
800-929-4040
www.foodallergy.org

Medline Plus
U.S. DHHS, National Library of Medicine
U.S. DHHS, National Institutes of Health

National Association of School Nurses
8484 Georgia Avenue, Suite 420
Silver Spring, MD 20910
1-240-821-1130
1-866-627-6767
www.nasn.org

National Maternal and Child Health Clearinghouse
Health Resources and Services Administration Information Center
P. O. Box 2910
Merrifield, VA 22116
Toll Free: 1-888-275-4772
www.hrsa.gov

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| National Safety Council  
1121 Spring Lake Drive  
Itasca, IL 60143-3201  
630-285-1121  
[www.nsc.org](http://www.nsc.org) |

| North Carolina Action for Children  
1300 St. Mary’s Street, Suite 500  
Raleigh, N.C. 27605-1276  
Phone: 919-834-7299  
[www.ncchild.org](http://www.ncchild.org) |

| North Carolina Board of Nursing  
3724 Nation Drive  
Glenwood Place Office Complex  
Camden Building, Suite 201  
(Mailing Address) PO Box 2129, Raleigh, NC 27602-2129  
919-782-3211  
Email: [email@ncbon.com](mailto:email@ncbon.com)  
[www.ncbon.com](http://www.ncbon.com) |

| North Carolina Diabetes Prevention and Control Branch  
[www.ncdiabetes.org](http://www.ncdiabetes.org) |

| North Carolina Department of Public Instruction  
North Carolina Public Schools  
301 N. Wilmington St.  
Raleigh, NC 27601  
[www.ncpublicschools.org](http://www.ncpublicschools.org) |

| North Carolina Healthy Schools  
[www.nchealthyschools.org](http://www.nchealthyschools.org) |

| North Carolina Immunization Branch  
Division of Public Health  
[www.immunizenc.com](http://www.immunizenc.com) |
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North Carolina Institute of Government
CB# 3330, Knapp Building, UNC-Chapel Hill, NC 27599-3330
919-966-5381
http://ncinfo.iog.unc.edu

North Carolina Lions Foundation
PO Box 39, Sherrills Ford, NC 28673
828-478-2135
www.nclf.org

North Carolina Nurses Association
103 Enterprise Street, Raleigh, NC 27602-2025
919-821-4250
800-626-2153
www.ncnurses.org

North Carolina Public Health Association
7424 Chapel Hill Road, Suite 102
Raleigh, N.C. 27607
919-828-6201
www.ncpha.com

North Carolina Safe Kids
N.C. Department of Insurance
Raleigh, NC
http://www.ncdoi.com/OSFM/safekids/default.asp
http://ncsafekids.org/

N.C. School Health Training Center
Dr. Donna Breitenstein, Director
NC Comprehensive School Health Training Center
P. O. Box 32047
Appalachian State University
Boone, N.C. 28608
Email: breitenstein@appstate.edu
www.ncshtc.appstate.edu
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Planned Parenthood Federation of America, Inc.
434 W. 33rd Street, New York, NY 10001
www.plannedparenthood.org

School Nurse Association of North Carolina
www.snanc.org

SEARCH INSTITUTE
The Banks Building
615 First Avenue, NE, Suite 125, Minneapolis, MN 55413
800-888-7828
www.search-institute.org

The Center for Health and Health Care in Schools
www.healthinschools.org

U.S. Department of Agriculture
Accommodating Children with Special Dietary Needs in the School Nutrition Programs
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Use of Abbreviations and Symbols

The use of abbreviations and symbols in charting is a useful timesaver, but the practice can lead to confusion and serious mistakes. Any abbreviations and symbols used in a practice setting must be shared and understood by all who have a need to know. Each school district should adopt its own list of common abbreviations and symbols, and any “short cuts” in charting that are not on that list, must be avoided.

The Joint Commission, also known as the Joint Commission on Accreditation of Healthcare Organizations, recommends that the following abbreviations and symbols never be used in charting. In addition, the following page contains a list of commonly misused symbols, which each practice setting may also decide to prohibit from use.

The Joint Commission
Official “Do Not Use” List

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Mistaken for “0” (zero), the number “4” (four) or “cc”</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number 10 (ten)</td>
<td>Write “International Unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd (daily)</td>
<td>Mistaken for each other</td>
<td>Write “daily”</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d, qod (every other day)</td>
<td>Period after the Q mistaken for “1” and the “O” mistaken for “1”</td>
<td>Write “every other day”</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg)</td>
<td>Decimal point is missed</td>
<td>Write X mg</td>
</tr>
<tr>
<td>Lack of leading zero (.X mg)</td>
<td>Decimal point is missed</td>
<td>Write 0.X mg</td>
</tr>
<tr>
<td>MS, MSO₄ and MgSO₄</td>
<td>Confused for one another Can mean morphine sulfate or magnesium sulfate</td>
<td>Write “morphine sulfate” or Write “magnesium sulfate”</td>
</tr>
</tbody>
</table>

2 Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.
3 Exception: A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.
### Also to be avoided

Additional Abbreviations, Acronyms and Symbols

(For possible future inclusion in the official “Do Not Use” List)

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<tr>
<td>&gt; (greater than)</td>
<td>Misinterpreted as the number “7” or the letter “L”</td>
<td>Write “greater than”</td>
</tr>
<tr>
<td>&lt; (less than)</td>
<td>Confused for one another</td>
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<tr>
<td>Abbreviations for drug names</td>
<td>Misinterpreted due to similar abbreviations for multiple drugs</td>
<td>Write drug names in full</td>
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<tr>
<td>Apothecary units</td>
<td>Unfamiliar to many practitioners</td>
<td>Use metric units</td>
</tr>
<tr>
<td>@</td>
<td>Mistaken for the number “2” (two)</td>
<td>Write “at”</td>
</tr>
<tr>
<td>cc</td>
<td>Mistaken for U (units) when poorly written</td>
<td>Write “mL” (preferred)</td>
</tr>
<tr>
<td>µg</td>
<td>Mistaken for mg (milligrams) resulting in one thousand-fold overdose</td>
<td>Write “mcg” or “micrograms”</td>
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# The YEAR 2010 AT A GLANCE

## January

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<td>National Radon Action Month</td>
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<tr>
<td>Thyroid Awareness Month</td>
<td>4-10 National Folic Acid Awareness Week</td>
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<td>5 Give Kids A Smile Day</td>
<td>5 National Wear Red Day</td>
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<td>7 - 13 National Sleep Awareness Week®</td>
<td>8 - 12 National School Breakfast Week</td>
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<td>15 - 21 Brain Awareness Week</td>
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N.C. Division of Public Health – Children & Youth Branch – School Health Unit
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**May**

| American Stroke Month                           | Better Hearing and Speech Month                           |          |
| Clean Air Month                                 | Electromagnetic Sensitivity Awareness Month              |          |
| Healthy Vision Month                            | Hepatitis Awareness Month                                |          |
| Lupus Awareness Month                           | Lyme Disease Awareness Month                             |          |
| Melanoma/Skin Cancer Detection and Prevention Month | Mental Health Month                                    |          |
| National Arthritis Awareness Month              | National Asthma and Allergy Awareness Month              |          |
| National Bike Month                             | National Celiac Disease Awareness Month                  |          |
| National High Blood Pressure Education Month    | National Neurofibromatosis Month                         |          |
| National Osteoporosis Awareness and Prevention Month | National Physical Fitness and Sports Month              |          |
| National Teen Pregnancy Prevention Month        | Older Americans Month                                    |          |
| Sturge-Weber Awareness Month                   | Tuberous Sclerosis Awareness Month                       |          |
| Ultraviolet Awareness Month                     | Multiple Chemical Sensitivity Month                      |          |
| 1 - 7 National Physical Education and Sport Week | 2 - 8 Children's Mental Health Awareness Week            |          |
| 2 - 8 North American Occupational Safety and Health Week | 3 - 7 National Mental Health Counseling Week       |          |
| 3 Melanoma Monday                               | 8 Cornelia de Lange Syndrome Awareness Day                |          |
| 9 - 15 Food Allergy Awareness Week              | 9 - 15 National Alcohol- and Other Drug-Related Birth Defects Week |          |
| 10 - 16 National Stuttering Awareness Week      | 10 National Women's Check-up Day                         |          |
| 12 Fibromyalgia Awareness Day                   | 18 HIV Vaccine Awareness Day                             |          |

*School Health Program Manual – January 2010*

N.C. Division of Public Health – Children & Youth Branch – School Health Unit
# North Carolina School Health Program Manual

## Appendix I

### Resources, References

### Item #3

### Resolutions and Position Statements

### Health Observances

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<thead>
<tr>
<th>Date</th>
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<tr>
<td>19 February</td>
<td>National Asian and Pacific Islander HIV/AIDS Awareness Day</td>
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<td>National Employee Health and Fitness Day</td>
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<td>1 - 4 June</td>
<td>Fireworks Safety Month</td>
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<td>1 - 4 June</td>
<td>National Aphasia Awareness Month</td>
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<td>6 - 12 June</td>
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<td>Sun Safety Week</td>
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<td>14 - 22 June</td>
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<td>20 - 26 June</td>
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<td>27 - 5 July</td>
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<td>19 - 25 National Farm Safety &amp; Health Week</td>
<td>19 - 25 National Rehabilitation Awareness Celebration</td>
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N.C. Division of Public Health – Children & Youth Branch – School Health Unit
### National Spina Bifida Awareness Month

#### Resolutions and Position Statements

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Rapid response to emergencies can save lives.

North Carolina children deserve rapid, effective care for emergencies that occur in schools.

To make this care a reality we endorse:

1. Training all school staff to recognize a life threatening emergency, that is, a situation which endangers Airway, Breathing, or Circulation.

2. Training all staff to call 911 (Emergency Medical Services) when a life threatening emergency occurs.

3. Training all school staff to summon a school nurse upon recognizing a life threatening emergency and calling 911. If the school nurse is not available, summon designated trained, non-medical staff to provide emergency treatment.

Furthermore, the State of North Carolina allows school nurses as well as designated, trained non-medical personnel to administer epinephrine to individuals experiencing a life threatening allergic reaction. We endorse:

4. Encouraging schools to keep pre-filled epinephrine auto-injectors available for emergency use by school nurses or designated trained, non-medical staff.

Allergic Emergencies

1. School boards may authorize a school nurse employed by the school district and for whom the board is responsible to maintain an adequate supply of prefilled auto syringes of epinephrine with fifteen-hundreths (0.15) milligrams or three-tenths milligrams delivery at the school. The nurse shall recommend to the school board the number of prefilled epinephrine auto syringes that the school should maintain.

2. To obtain prefilled auto syringes for a school district, a prescription written by a licensed physician, a physician’s assistant, or nurse practitioner is required. For such prescriptions, the school district shall be designated as the patient, and the prescription shall be filled at a licensed pharmacy.

3. A school nurse shall have the discretion to use an epinephrine auto syringe on any individual the school nurse believes is having a life-threatening anaphylactic reaction based on the nurse’s training in recognizing an acute episode of an anaphylactic reaction.

The school nurse is allowed to delegate to trained school personnel the administration of epinephrine.
4. Trained non-medical staff authorized by the North Carolina Medical Care Commission shall have the discretion to use an epinephrine auto syringe on any individual he or she believes is having a life-threatening anaphylactic reaction based on their training in recognizing an acute episode of an anaphylactic reaction.

5. School physicians may execute standing orders and prescriptions for school nurses or designated trained, non-medical staff to use epinephrine when there are symptoms of anaphylaxis.

6. No school teacher, school administrator, or school health care personnel, or any other school personnel shall be liable for civil damages which may result from acts or omissions in the use of the epinephrine which may constitute ordinary negligence. This immunity does not apply to acts or omissions constituting gross negligence or willful or wanton conduct.

Sample Standing Orders

Administer, through intra-muscular (IM) route, an auto syringe prefilled with fifteen-hundredths (0.15) milligrams for a child less than 50 pounds or three-tenths (0.3) milligram epinephrine for any individual over 50 pounds. If unsure about the weight, the larger dose should be given.

Any individual treated for symptoms with epinephrine at school will be transferred to medical facility.

Endorsed by the NCPS at its executive meeting on Jan 16, 2009.
## North Carolina School Health Program Manual

### Appendix I Resources, References

| Item #4 | Resolutions and Position Statements | Epipens |

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POSITION STATEMENT

Standardized Nursing Languages

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the use of standardized nursing languages by school nurses will promote quality nursing care, validate the effectiveness of school nursing services, and promote research endeavors. Further, NASN believes school nurses should use the opportunity to contribute to the implementation, evaluation, and development of nursing languages relevant to school nursing. Finally, NASN supports the use of standardized nursing languages in school nursing practice, in electronic health records, and school nursing education programs.

HISTORY

Although nurses have always been an integral part of the health care system, their contributions have largely been invisible. In this era of accountability, it is essential that nurses be able to articulate their contributions to the health of the clients they serve. This is particularly essential for school nurses who work in educational settings where they may have difficulty articulating what contributions they make to the health and academic success of students. Such information can assist school nurses in justifying their positions in a time of budgetary constraints. It will also help school nurses provide the best care for children in the school setting.

Standardized nursing languages were developed to give the phenomena that represent the nursing process a name or label to make them visible. The School Nursing Scope and Standards of Practice specify the use of the nursing process in the planning, delivery, and evaluation of nursing care and the use of standardized language or recognized terminology to document the nursing diagnosis, the outcome, and the implementation of the plan in a retrievable form (NASN & ANA, 2005, pp. 11, 12, 16). Standardized nursing languages provide uniform nomenclature for the diagnosis, intervention, and evaluation components of the nursing process. In addition to naming diagnoses, interventions, and outcomes, nursing languages define each label and list factors describing the components of each. This standardization of terminology facilitates communication about care across settings, is useful in documentation and entering data into electronic health records, and is valuable in promoting research on the effectiveness or outcomes of care. Standardized nursing languages also have implications for competency evaluation, reimbursement for services, and curriculum design (Dochterman & Bulechek, 2004, p. 3). The use of standardized nursing languages has the potential to improve the quality of nursing care, guide policy, and assist nurses in clearly articulating how their actions contribute to positive health outcomes.

The North American Nursing Diagnosis Association International (NANDA I) defines nursing diagnosis as “a clinical judgment about individual, family, or community responses to actual or potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.” (NANDA I, 2005, p. 227). “Nursing diagnoses give nurses a standardized language to articulate the problems they encounter in their daily practice” (Denehy, 2004, p. 11). The NANDA classification has diagnoses for problems encountered in the school setting, as well as risk and wellness diagnoses appropriate for ambulatory clientele. The 2005 classification has 172 nursing diagnoses and a taxonomy that categorizes the diagnoses into 13 domains.

The Nursing Interventions Classification (NIC) is a classification of interventions that nurses perform in all settings and specialties. A nursing intervention is defined as "any treatment, based upon clinical judgment and knowledge, that a nurse performs to enhance client outcomes" (Dochterman & Bulechek, 2004, p. xxiii). “The interventions in NIC provide a standardized language for what nurses do and list specific activities that nurses can select in implementing the interventions” (Denehy, 2004, p. 14). NIC includes interventions for illness treatment, disease prevention, and health
promotion and can be used with individuals, families and communities. The 2004 classification has 514 interventions and a taxonomy that organizes the interventions into seven domains.

The Nursing Outcomes Classification (NOC) is a vocabulary to describe "An individual, family, or community state, behavior, or perception that is measured along a continuum in response to a nursing intervention(s)" (Moorhead, Johnson & Maas, 2004, p. xix). The outcomes offer a mechanism to evaluate the effectiveness of care by providing a list of indicators that relate to the outcomes of the care delivered. The standardized outcomes were developed to measure the effects of nursing interventions and can be used in all settings and with individuals, families, and communities. The 2004 classification lists 330 outcomes that are organized in a taxonomy with seven domains.

The Omaha System, an ANA recognized nursing language, has a Problem Classification Scheme with 42 general problems organized in four domains (Martin, 2005). The Intervention Scheme has four categories; then one of 76 targets is selected to focus care. There is a five-point problem rating scale for outcomes related to knowledge behavior, and status. The system is simple and brief, but provides little standardized language for interventions and none for outcomes. The three Omaha schemes, designed to be used together, have no coding structure needed for the EHR. The main contribution of the Omaha System is detailing the types of problems seen in community health; however, this research does not extend to the intervention or evaluation schemes or publications on its use and relevance to school nursing.

DESCRIPTION OF ISSUE

The American Nurses Association (1994) supports the development and use of standardized nursing languages for use in national nursing databases and the Nursing Minimum Data Set that includes the nursing elements of diagnoses, interventions, and outcomes. The use of standardized terminology facilitates communication about nursing practice, promotes research, and provides the language needed in electronic health records used to evaluate care, determine costs of care, and develop nursing databases needed to describe not only what nurses do but also the effectiveness of their actions. NANDA, NIC, and NOC are recognized as official nursing languages by the American Nurses Association (ANA) and are included in the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and the National Library of Medicine’s Metathesaurus. These classifications have developed a coding system that will facilitate their use in information systems similar to the use of the International Classification of Diseases (ICD-9 Codes), a classification of diseases and medical procedures that has a coding system used for documentation and reimbursement and Current Procedural Terminology (CPT), a set of codes, descriptions, and guidelines used describe procedures and services performed by physicians and other health care providers. Such classifications are needed to meet the federal mandate for most Americans to have electronic health records in 10 years (USDHHS, 2005) that will reduce medical errors, minimize paperwork, lower costs, and improve the quality of care.

Implementation of standardized nursing languages is expected to facilitate clinical, administrative, and policy decision-making (ANA, 1995). The NANDA, NIC, and NOC classifications represent the nursing process, are supported by research, and facilitate continuity of care across settings. Studies have demonstrated the relevance of these languages to school nursing (See Reference/Resource list). Although these languages were developed and are maintained independently, work is being done to illustrate how they can be linked together in practice (Dochterman & Jones, 2003; Gordon, 1998; Johnson, et al, 2005). NANDA, NIC, and NOC have the capability to describe the wide scope of school nursing practice and are the most appropriate standardized languages for school nursing practice and documentation.

Practicing in educational settings, school nurses’ image, identity, and value are vulnerable in this era of accountability. The use of standardized nursing languages can assist school nurses to uniformly describe children’s health status and the effectiveness of measures taken to improve their health and academic success. It will make school nursing practice visible and validate the complex nature of school nursing practice.
RATIONALE

The use of standardized nursing languages in school settings:

- Gives a name to what school nurses contribute to student health and academic success.
- Facilitates comprehensive uniform terminology that can be used in documentation.
- Provides standardized coded terminology required for electronic health records.
- Makes school nursing services visible to clients, families, educators, administrators, and the community and in nursing and health care data sets.
- Assists in the development of nursing databases that quantify school nursing practice.
- Advances nursing knowledge through identifying and evaluating nursing care.
- Promotes research on the effectiveness of school nursing services leading to evidence-based practice.
- Assists in determining the costs of school nursing services.
- Supports the National Association of School Nurses and the American Nurses Association’s Scope and Standards of Practice which specify the use of the nursing process in the planning, implementation, and evaluation of nursing care and the use of standardized languages in documentation.
- Promotes quality school nursing practice, research, and education.

The use of standardized nursing languages by school nurses will promote quality nursing care, validate the effectiveness of school nursing services, and promote research endeavors. School nurses have the opportunity to contribute to the implementation, evaluation, and development of nursing languages relevant to school nursing. The National Association of School Nurses supports the use of standardized nursing languages in school nursing practice, in school health software, and school nursing education programs.

References/Resources


Nursing Classification Systems: NANDA, NIC and NOC:
Adopted: June 2001
Revised: June 2006
Policy Statement—Guidance for the Administration of Medication in School

abstract

Many children who take medications require them during the school day. This policy statement is designed to guide prescribing health care professionals, school physicians, and school health councils on the administration of medications to children at school. All districts and schools need to have policies and plans in place for safe, effective, and efficient administration of medications at school. Having full-time licensed registered nurses administering all routine and emergency medications in schools is the best situation. When a licensed registered nurse is not available, a licensed practical nurse may administer medications. When a nurse cannot administer medication in school, the American Academy of Pediatrics supports appropriate delegation of nursing services in the school setting. Delegation is a tool that may be used by the licensed registered school nurse to allow unlicensed assistive personnel to provide standardized, routine health services under the supervision of the nurse and on the basis of physician guidance and school nursing assessment of the unique needs of the individual child and the suitability of delegation of specific nursing tasks. Any delegation of nursing duties must be consistent with the requirements of state nurse practice acts, state regulations, and guidelines provided by professional nursing organizations. Long-term, emergency, and short-term medications; over-the-counter medications; alternative medications; and experimental drugs that are administered as part of a clinical trial are discussed in this statement. This statement has been endorsed by the American School Health Association. 

Pediatrics 2009;124:1244–1251

INTRODUCTION

School boards and districts are responsible for policies and procedures for administration of medications to students who require them during the school day. The health circumstances that require medication are diverse. Medical advances have enabled many students with special health care needs or chronic health conditions to be included in classes with their peers.¹ Some schools struggle to balance the need for health care services for increasing numbers of children with special health care needs with the current resources available to provide those services.²–¹²

The presence in schools of a full-time licensed registered school nurse is strongly endorsed.¹³ Registered nurses (RNs) have the knowledge and skills required for the delivery of medication, the clinical knowledge of the student’s health, and the responsibility to protect the health

COUNCIL ON SCHOOL HEALTH

KEY WORDS
medications, school, unlicensed assistive personnel, delegate, self-administer

ABBREVIATIONS
RN—registered nurse
AAP—American Academy of Pediatrics
UAP—unlicensed assistive personnel
OTC—over-the-counter

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All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

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and safety of all students. The use of untrained school staff to administer medications to children with special health care needs creates risks, not only of medical liability for the school and the licensed registered school nurse but also of medication error for the student.14–16 To ensure the health and safety of students, all schools should have a full-time licensed RN who has the knowledge and skills required for the delivery of medication and the assessment of student health.17,18

This policy statement has been endorsed by the American School Health Association.

**TRAINED UNLICENSED ASSISTIVE PERSONNEL**

When a school nurse is not available at all times, the American Academy of Pediatrics (AAP), the National Association of School Nurses, and the American Nurses Association recommend trained and supervised unlicensed assistive personnel (UAP) who have the required knowledge, skills, and composition to deliver specific school health services under the guidance of a licensed RN. UAP duties are delegated by a licensed RN.19,20 Training and supervision of UAP are necessary for providing safe, accurate, and timely administration of medication. Delegation is a tool that may be used by the licensed registered school nurse to allow UAP to provide standardized routine health services under the supervision of the nurse and on the basis of physician guidance and school nursing assessment of the unique needs of the individual child and the suitability of delegation of specific nursing tasks. Any delegation of nursing duties must be consistent with the requirements of state nurse practice acts, state regulations, and guidelines provided by professional nursing organizations. Delegation of nursing duties is the responsibility of the certified licensed school nurse or licensed RN. The nurse determines which nursing services can be delegated and then selects, trains, and evaluates the performance of UAP; audits school medication records and documents; and conducts refresher classes throughout the school year.21–25 The training, certification, and supervision of UAP should be determined by national and state nursing organizations and state nurse practice laws. Delegation is an ongoing process and a management tool, not a once-a-year event.

UAP training is typically limited and specific for medication-administration tasks and cannot replace a nursing assessment. In most circumstances, a medication UAP should be an ancillary health office staff member (health assistant/aide) who is also trained in basic first aid and district health office procedures. On rare occasions when a member of the health office staff (RN, licensed practice nurse, or UAP health assistant/aide) is not available, other willing volunteer school staff may be trained by the licensed RN to assume specific limited tasks such as single-dose medication delivery or life-saving emergency medication administration. In those instances, it is important for school districts to identify and satisfactorily address medical liability issues for the school district, the nurse, and the voluntary nonmedical staff member who is serving temporarily as UAP.

**SCHOOL POLICY AND PROCEDURES**

Section 504 of the Rehabilitation Act and the Individuals With Disabilities Education Act (IDEA) provide protection for students with disabilities by requiring schools to make reasonable accommodations and to allow for safe inclusion of these students in school programs.26–28 These federal laws apply only to schools that receive federal funds, do not cover all students who require medications during the school day (eg, short-term needs), and are not specific about how administration of medications should be conducted in school. The AAP supports state laws, regulations, or standards that establish more specific policies for administration of medications that apply to all of the state’s school districts. State standards can limit discrepancies among school districts within the state and reduce confusion for parents and prescribing health care professionals. School boards and school superintendents are responsible for establishing policies and detailed procedures for the safe administration of medication in the school setting. When state standards are insufficient, school health professionals, consulting physicians, and school health councils can work with AAP chapters to promote improved state standards and assist with local policies and procedures. Individual school districts also might wish to seek legal advice as they assume the responsibility for giving medication during school hours and during activities at school before or after school hours. Liability coverage should be provided for the staff, including nurses, teachers, athletic staff, principals, superintendents, and members of the school board.15 Any student who must take medication during regular school hours should do so in compliance with all federal and state laws and school district policies.

Guidance for pediatricians, school physicians, and school health consultants is consistent with policy declarations of the National Association of School Nurses29 and the American Nurses Association.20 The following are recommendations for school districts in implementing medication-administration policies and procedures.29

- Protect student safety and prevent medication errors. Nursing services
at school, whether emergent, urgent, or routine, require the creation of a confidential, timely, and accurate record of the service provided.  

- Identify the licensed health professional (certified or registered school nurse or school physician) on the school staff who supervises and is responsible for the safe keeping and accessibility and administration of medications, including documentation and a system of accountability for students who carry and self-administer their medications.  

- Use a systematic review of documentation of medication administration records for quality improvement, especially to reduce medication errors and to verify controlled substance counts.  

- Create an ongoing training and certification program for UAP who perform specific nursing services when delegated and supervised by the licensed school RN or school physician.  

- Establish and follow effective communication systems that support the school’s nursing plan (individualized health plans, etc) and promote accurate implementation of the prescriber’s instructions for the medical management of a designated student’s health needs.  

- Require a written medication form, signed by the authorized prescriber and parent, with the name of the student, the drug, the dose, approximate time it is to be taken, and the diagnosis or reason the medication is needed. This requirement applies for all prescription medications.  

- Require written parental approval if over-the-counter (OTC) medications are permitted. Limit the duration that an OTC medication is administered at school.30 Use of OTC medications over an extended time period warrants an authorized prescriber’s oversight and authorization.  

- Protect student health information confidentiality as outlined in the Family Education Rights and Privacy Act31,32 and the Health Insurance Portability and Accountability Act.33  

- Train, delegate, and supervise appropriate UAP who have the knowledge and skills to administer or assist in the administration of medication to students when assessed to be appropriate by the supervising and delegating licensed registered school nurse or school physician in compliance with applicable state laws and regulations.  

- Permit responsible students to carry and self-administer emergency medications for those conditions authorized by school policies and regulations, which also describe students’/parents’ rights and responsibilities.34,35  

- Provide and encourage parents to provide spare life-saving medications in the health office for students who carry and self-administer emergency medications in the event that the life-saving medication cannot be located when a student is in need of the medicine.  

- Make provisions for secured and immediate access to emergency medications at school at all times, including before and after school hours and during students’ off-campus school-sponsored activities.35-38  

**ADMINISTRATION OF LONG-TERM MEDICATIONS**  

Long-term medications are those needed to manage a student’s symptoms or promote health over an extended period of time. Many students who require long-term medications are children with special health care needs whose school attendance and participation in school activities depend on the administration of the prescribed treatment. Asthma, attention-deficit/hyperactivity disorder, seizures, heart conditions, cerebral palsy, and diabetes mellitus are among the common conditions that require medication at school.40-42 Although not common, students infected with HIV may require multiple medications during the school day. In most cases, school nurses will develop individualized health plans for children with special health care needs.43  

School nurses should review all school medication orders, establish liaisons with the student’s health care professionals, administer medication, and/or provide effective training and supervision of UAP who are delegated to administer medication.13,44 Requests to administer nonstandard medications (eg, doses in excess of manufacturer guidelines; alternative, homeopathic, or experimental medications; nutritional supplements) do not have to be honored by a school nurse. However, a school nurse has a professional obligation to promptly record the request and resolve the conflict with the parent, the prescriber, and/or, when needed, the school physician.45  

**EMERGENCY AND URGENT MEDICATIONS**  

Emergency and urgent medications are often given by nonoral routes and are administered to initiate treatment or amelioration of a disease or condition that may be life-threatening or cause grave morbidity. The complexity and urgency of this intervention is the focus of the AAP policy statement “Medical Emergencies Occurring at School,”38 which describes prevention and mitigation of emergent events and stresses the role of the school nurse in providing this nursing service at school. The school nurse is the professional most likely to train school staff, to create a liaison with com-
munity emergency response teams and other health care professionals, and to assist, in coordination with the school physician, the school administration in development of policies and administrativeregulations concerning medical emergencies.\textsuperscript{17,34,36,37,46–48} State laws or regulations designate the roles and responsibilities of school staff in this situation. They may specifically limit or expand the role of UAP in emergency care settings. Some states have legislated authority to create protocols and procedures through which school staff are identified, trained, and certified to initiate medical care in a medically urgent or emergent situation and to address concerns of liability for nursing services provided under such conditions.\textsuperscript{40–51}

Immediate access to emergency medications (eg, autoinjectable epinephrine, albuterol, rectal diazepam, and glucagon) is a high priority and is crucial to the effectiveness of these lifesaving interventions. To maintain medication security and safety and provide for timely treatment, local procedures must specify where medications will be stored, who is responsible for the medication, who will regularly review and replace outdated medication, and who will carry the medication for field trips. In addition to unlicensed health office staff, other school staff may be trained, designated, and supervised as emergency UAP to be “first responders” to a student who experiences a medical emergency.

Schools also need an adequate supply of emergency medications in the event of a school lock-down or evacuation. Parent-supplied extra medication and/or school-supplied stock medications (including but not limited to autoinjectable epinephrine and albuterol inhalers) are among the emergency or urgent care medications that need to be available in these circumstances.\textsuperscript{37,38,52}

**SECURITY AND STORAGE OF MEDICATIONS**

All prescription medications brought to school should be in original containers appropriately labeled by the pharmacist or physician. Except for self-carry medications, they should be stored securely in accordance with manufacturer directions. Controlled substances must be double-locked.\textsuperscript{53} The school nurse, licensed practice nurse, or delegated, trained UAP must be available and have access to the medications at all times during the school day. All medications should be returned to the parents at the end of the school year or disposed of in accordance with existing laws, regulations, or standards. Care should be taken not to flush any drugs into the water system unnecessarily.

**STUDENT SELF-CARRYING AND SELF-ADMINISTRATION OF PRESCRIBED MEDICATIONS**

A responsible student should be permitted to carry medication for urgent or emergency need when it does not require refrigeration or security, according to policies determined by the school in accordance with laws, regulations, and standards.\textsuperscript{34,54} Controlled substances and those at risk of drug abuse or sale to others are not appropriate for self-carrying. The student’s personal health care professional, the parents, and the school nurse and school physician should collaboratively determine the ability of a student to appropriately self-administer the prescribed medication in a responsible and secure manner. School personnel must also permit the student to possess and take the medication once a determination has been made that the student is mature enough to carry and self-administer the medication. Some schools use self-administration agreements or have given a “medication pass” to students, verifying school permission for the student to carry and take medication. The student’s ability to appropriately self-administer the prescribed medication must be evaluated by the school nurse at regular intervals to ensure safety and correctness of administration. For elementary school–aged children, the self-administration of a dose of medication should be reported to school personnel as soon as the self-administered dose is given for documentation and assessment of need for additional assistance. Medications carried by students should be either on the person of the student, as in a dedicated “fanny pack,” or in possession of a supervising adult who will return the medication pack to the student as needed or when the student moves on to a new location. Medications should not be left unattended.

**OTC MEDICATIONS**

School administrators and health personnel should consider whether the benefits of administration of OTC medications outweigh the risks. Some states and school districts apply the same standards for OTC as for prescription medications. Others permit parent-recommended OTC medications or dietary supplements to be administered without a physician order. Either approach can be problematic. Providing parent-approved short-term medications, such as pain relievers, antiinflammatory medications, and antihistamines, for example, may provide symptomatic improvement for the student, which enables attendance for learning and causes less classroom disruption. However, this practice can result in liability for a school district, because nonprescribed medications have potential to cause harm or adverse effects that may impede learning. There are also issues of school safety and security of drug use (eg, sharing of medication between classmates when OTC medications are not stored in the school health office). On the other hand, the social realities of parents who work, often in jobs that do
not allow for medical leave to attend to their children’s illnesses, may require that they send their children to school with mild illnesses. It can be difficult to obtain physician authorization for OTC medications. Because of these realities, it may be necessary to consider allowing the administration of nonprescribed, parent-recommended medications for students during the school day on a short-term basis. The relative value of OTC medications for the specific population should guide policies. Cold and cough OTC medicines have not been shown to be effective in children younger than 6 years and are not appropriate for use at school without a physician order. When OTC medications are permitted, school physicians and school nurses should develop standing protocols or standing orders that support 1-time verbal parental permission for specific OTC medications (eg, acetaminophen and ibuprofen).

ADDITIONAL CIRCUMSTANCES

Alternative medications, such as herbal or homeopathic medications, are not tested by the US Food and Drug Administration for safety or effectiveness. Lack of safety information for these medications limits their appropriate use at school. State and district medication policies should be used for alternative medications. These medications should never be administered without a written physician order. State and district policies should also address experimental medications and medications administered at doses in excess of manufacturer guidelines.

RECOMMENDATIONS

Recommendations forPediatricians and Other ChildHealth Professionals

The AAP recommends that pediatricians and other prescribing pediatric health care professionals take the following actions when writing prescriptions for students:

1. Prescribe medications for administration at school only when necessary. Many short-term and long-term medications can be given before and after school.
2. Learn about local school nursing services, medication policies and forms, and self-administration procedures.
3. Write specific, clear, and detailed instructions on dated, standardized school medication forms. Consider that the “need to treat” may be delegated to UAP.
4. Carefully assess and declare in writing your recommendation concerning students’ self-carrying/self-administration on the basis of your patient demonstrating the appropriate developmental, physical, and intellectual capacity to self-carry and/or self-administer an emergency medication at school (see National Asthma Education and Prevention Program guidance).
5. Collaborate with school physicians and school nurses and encourage parental collaboration.
6. Promote student health by advocating for coordinated school health programs.
7. Advocate for improved communication systems among schools, families, and pediatricians that support medication-administration services for students at school.
8. Advocate for improved school medication data collection and reporting by schools and school nurses.
9. Participate on your district’s school health council. School health councils offer an opportunity for the development of collaborative liaisons among school administrators, licensed school health staff, and community health professionals.

Recommendations for Public Advocacy

The AAP recommends that pediatricians and other child health professionals and their state professional organizations take the following actions:

1. Participate on or support the creation of a district school health council to promote student health and improved communications in a coordinated school health program;
2. Work with state departments of health and/or education, state and local school boards, and school districts to ensure the development and funding of adequate school health program staffing and sound school medication policies and procedures as outlined in this statement; and
3. Support state laws, regulations, or standards that establish specific policies for the safe and effective administration of medications in schools that apply to all state school districts.

COUNCIL ON SCHOOL HEALTH EXECUTIVE COMMITTEE, 2008–2009

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Role of the School Nurse in Providing School Health Services

Council on School Health

ABSTRACT
The school nurse has a crucial role in the seamless provision of comprehensive health services to children and youth. Increasing numbers of students enter schools with chronic health conditions that require management during the school day. This policy statement describes for pediatricians the role of the school nurse in serving as a team member in providing preventive services, early identification of problems, interventions, and referrals to foster health and educational success. To optimally care for children, preparation, ongoing education, and appropriate staffing levels of school nurses are important factors for success. Recommendations are offered to facilitate the working relationship between the school nurse and the child’s medical home. This statement has been endorsed by the National Association of School Nurses.

SCHOOL NURSE DEFINITION
The National Association of School Nurses defines school nursing as:

A specialized practice of professional nursing that advances the well-being, academic success, and lifelong achievement of students. To that end, school nurses facilitate positive student responses to normal development; promote health and safety; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self-management, self-advocacy, and learning.1

BACKGROUND
After the child’s home, school represents the second most influential environment in a child’s life. As more students enter schools with health or mental health problems, pediatricians face the challenge of managing their care throughout the school day. The school nurse is the health care representative on site. An understanding of the school nurse’s role is essential to ensure coordinated care. There is a recognized relationship between health and learning, as there is between school nurse availability and student well-being and educational success.2–4 The role of the school nurse encompasses both health and educational goals.5–7 Students today may face family crises, homelessness, immigration, poverty, and violence, which increase both their physical and mental health needs. School nurses perform a critical role within the school health program by addressing the major health problems experienced by children. This role includes providing preventive and screening services, health education and assistance with decision-making about health, and immunization against preventable diseases. In addition, school nurses may provide interventions for acute and chronic illness, injuries and emergencies, communicable diseases, obesity, substance use and abuse, adolescent pregnancy, mental health, dental disease, nutrition, and sexually transmitted infections.8–13 School nurses need to be physically present in schools to address these responsibilities appropriately. Improved student outcomes result where schools have a full-time school nurse.3 Inadequate staffing threatens the school nurse’s role as medical home extender.

School nurses are well positioned to take the lead for the school system in partnering with school physicians, community physicians, and community organizations. They facilitate access to Medicaid and the State Children’s Health Insurance Program to help families and students enroll in state health insurance programs and may assist in finding a medical home for each student who needs one.

This policy statement has been endorsed by the National Association of School Nurses.

SCHOOL NURSE ROLE
The National Association of School Nurses identifies 7 core roles that the school nurse fulfills to foster child and adolescent health and educational success. The roles are overarching and are applicable to school nurses at all levels of practice, in all geographic settings, and with all clients.
1. The school nurse provides direct care to students. The school nurse provides care for injuries and acute illness for all students and long-term management of students with special health care needs. Responsibilities include assessment and treatment within the scope of professional nursing practice, communication with parents, referral to physicians, and provision or supervision of prescribed nursing care. An individualized health care plan is developed for students with chronic conditions, and when appropriate, an emergency plan is developed to manage potential emergent events in the school setting (e.g., diabetes, asthma). Ideally, this health plan is aligned with the management plan directed by the child’s pediatrician and regularly updated through close communication. The school nurse is responsible for management of this plan and communication about the plan to all appropriate school personnel.

The school nurse has a unique role in provision of school health services for children with special health needs, including children with chronic illnesses and disabilities of various degrees of severity. Children with special health needs are included in the regular school classroom setting as authorized by federal and state laws. As a leader of the school health team, the school nurse must assess the student’s health status, identify health problems that may create a barrier to educational progress, and develop a health care plan for management of the problems in the school setting. The school nurse ensures that the student’s individualized health care plan is part of the individualized education plan (IEP). When appropriate, and that both plans are developed and implemented with full team participation, which includes the student, family, and pediatrician.

2. The school nurse provides leadership for the provision of health services. As the health care expert within the school, the school nurse assesses the overall system of care and develops a plan for ensuring that health needs are met. Responsibilities include development of plans for responding to emergencies and disasters and confidential communication and documentation of student health information.

3. The school nurse provides screening and referral for health conditions. Health screenings can decrease the negative effects of health problems on education by identifying students with potential underlying medical problems early and referring them for treatment as appropriate. Early identification, referral to the medical home, and use of appropriate community resources promote optimal outcomes. Screening includes but is not limited to vision, hearing, and BMI assessments (as determined by local policy).

4. The school nurse promotes a healthy school environment. The school nurse provides for the physical and emotional safety of the school community by monitoring immunizations, ensuring appropriate exclusion for infectious illnesses, and reporting communicable diseases as required by law. In addition, the school nurse provides for the safety of the environment by participating in environmental safety monitoring (playgrounds, indoor air quality, and potential hazards). The school nurse also participates in implementation of a plan for prevention and management of school violence, bullying, disasters, and terrorism events. The school nurse may also coordinate with school counselors in developing suicide prevention plans. In addition, if a school determines that drug testing is a part of its program, school nurses should be included in school district and community planning, implementation, and ongoing evaluation of this testing program.

5. The school nurse promotes health. The school nurse provides health education by providing health information to individual students and groups of students through health education, science, and other classes. The school nurse assists on health education curriculum development teams and may also provide programs for staff, families, and the community. Health education topics may include nutrition, exercise, smoking prevention and cessation, oral health, prevention of sexually transmitted infections and other infectious diseases, substance use and abuse, immunizations, adolescent pregnancy prevention, parenting, and others. School nurses also promote health in local school health councils.

6. The school nurse serves in a leadership role for health policies and programs. As a health care expert within the school system, the school nurse is a leader in the development and evaluation of school health policies. These policies include health promotion and protection, chronic disease management, coordinated school health programs, school wellness policies, crisis/disaster management, emergency medical condition management, mental health protection and intervention, acute illness management, and infectious disease prevention and management.

7. The school nurse is a liaison between school personnel, family, health care professionals, and the community. The school nurse participates as the health expert on the IEP and 504 teams. IEP teams identify the special education needs of students; 504 teams plan for reasonable accommodations for students’ special needs that impact their educational programs. As the case manager for students with health problems, the school nurse ensures that there is adequate communication and collaboration among the family, physicians, and providers of community resources. This is a crucial interface for the pediatrician and the school nurse to ensure consistent, coordinated care. The school nurse also works with community organizations and primary care physicians to make the community a healthy place for all children and families.

**SCHOOL NURSE ACTIVITIES**

The range of school health services varies by school district. The following health services are the minimum
that should be offered, according to the American Academy of Pediatrics (AAP) manual School Health: Policy and Practice:19

- Assessment of health complaints, medication administration, and care for students with special health care needs;
- A system for managing emergencies and urgent situations;
- Mandated health screening programs, verification of immunizations, and infectious disease reporting; and
- Identification and management of students’ chronic health care needs that affect educational achievement.

The AAP recognizes the need for appropriate management of student health conditions in its policy statement, “Guidelines for Administration of Medication in School.”20 It also recognizes the need for policies for emergency medical situations that can occur in school and the school nurse’s role in developing and implementing these policies.21,22 The school nurse serves as an extension of traditional community health services, ensuring continuity, compliance, and professional supervision of care within the school setting.

SCHOOL HEALTH SERVICES TEAM

The school nurse functions as a leader and the coordinator of the school health services team. The team may also include a school physician, licensed practical nurses, health aides and clerical staff, school counselors, school psychologists, school social workers, and substance abuse counselors. The health team may also expand to create a coordinated school health team that integrates health services, health education, physical education, nutrition services, counseling/psychological/social services, healthy school environment, health promotion for staff, and family/community involvement.23 Occupational therapists, physical therapists, and speech-language pathologists may also be part of the school health team. A pediatrician often fills the school physician role, because pediatricians are knowledgeable about general pediatrics, school health, and adolescent health. School physicians review guidelines, policies, and programs related to health care in schools. In some schools, a pediatric or family nurse practitioner functions as the school nurse and may provide additional services. Unlicensed assistive personnel (unlicensed individuals who are trained to perform as an assistant to the licensed nurse) may be part of the school health services team. Although they may possess state certification in medication administration as a nursing assistant or other nursing tasks, they must be trained and supervised by the school nurse in accordance with state nurse practice laws to perform delegated nursing tasks. Under this approach, the school nurse has the responsibility to decide which nursing tasks may be delegated and to whom within the school setting, in accordance with state laws and regulations.

Some schools may have a school-based health center in or adjacent to the school, which may provide primary care and psychosocial services. The school nurse coordinates the activities of the school health services team with the child’s primary care physician and/or with the school-based health center to provide continuity of care and prevent duplication of services.

PROFESSIONAL PREPARATION FOR SCHOOL NURSES

The AAP supports the goal of professional preparation for all school nurses and recommends the use of appropriately educated and selected school nurses to provide school health services. The National Association of School Nurses has determined that the minimum qualifications for the professional school nurse should include licensure as a registered nurse and a baccalaureate degree from an accredited college or university. There should be a process by which additional certification or licensure for the school nurse is established by the appropriate state board. The AAP supports national certification of school nurses by the National Board for Certification of School Nurses.24

CONCLUSION

The AAP supports having a full-time school nurse in every school as the best means of ensuring a strong connection with each student’s medical home. Interim steps toward achieving this ideal can be made by achieving the Healthy People 2010 goal, which states that districts should employ at least 1 nurse per 750 students, with variation, depending on the community and student population.25 Schools with high percentages of students with special health needs would require more intensive ratios of nurse to students; for example, 1 nurse per 225 students when students require daily professional nursing services or interventions, and 1 nurse per 125 when students have complex health needs.26 The presence of the school nurse in every school allows the school physician to work most efficiently in providing the coordinated care that each student requires.

The AAP recommends and supports the continued strong partnership among school nurses, school physicians, other school health personnel, and pediatricians. These partners serve the health of children and youth best by facilitating the development of a coordinated school health program, facilitating access to a medical home for each child,27 and integrating health, education, and social services for children at the community level. School nurses, as part of a coordinated school health program, contribute to meeting the needs of the whole child and supporting their success in school.28

RECOMMENDATIONS

1. Pediatricians should establish a working relationship with the school nurses who care for their patients with chronic conditions to ensure that individual patients’ health plans are executed effectively within the school. In addition, pediatricians’ communications with school nurses concerning their patients should be sufficiently clear and detailed to guide school nurses in overseeing the care of individual children.
2. Pediatricians can offer direct support of school nurses by serving on school wellness policy committees, school health advisory committees, emergency preparedness committees, or other school-related decision-making bodies. In addition, local physicians may be asked to consult on or assist in writing school health-related policies.

3. School-based screening for vision, hearing, or other conditions may require coordination between local physicians and the school nurse to ensure students are referred for additional evaluation and treatment, and for communication with students, families, school administration, and the community.

4. Pediatricians should play an active role in supporting the availability and continuing education of the school nurse. This role may encompass updates on new AAP recommendations and research findings that would keep the school nurse’s practice as aligned as possible with current AAP policy.

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Appendix I
Resolutions and Position Statements
AAP Role of School Nurse

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Delegation of Immunization Administration to UAP in Declared State or National Emergencies or Federal/State DHHS or CDC Initiated Mass Immunization Campaigns

Position Statement for RN and LPN Practice

Declared State or National Emergencies or Federal/State DHHS or CDC Initiated Mass Immunization Campaigns may require the immunization of large numbers of citizens in a short, designated period of time. It may, at such times, be necessary and appropriate for Licensed Nurses (RN and LPNs) to delegate the task of immunization administration, consistent with agency policies and procedures, by any appropriate route, to unlicensed assistive personnel (UAP) as part of timely, effective mass immunization programs. The UAP assisting in such programs may include any unlicensed personnel, regardless of title, who participate in mass immunization activities through the delegation process.

Consistent with G.S. 90-171.20 (7) & (8), nursing law permits the delegation of tasks to unlicensed assistive personnel by the RN and LPN.

In order for the RN or LPN to delegate activities to UAP the following criteria listed in Administrative Code Rule 21 NCAC 36.0221(b) must be met:

"Tasks may be delegated to an unlicensed person which:
(1) frequently recur in the daily care of a client or group of clients;
(2) are performed according to an established sequence of steps;
(3) involve little or no modification from one client-care situation to another;
(4) may be performed with a predictable outcome; and
(5) do not inherently involve ongoing assessment, interpretation, or decision-making which cannot be logically separated from the procedures(s) itself."

The RN or LPN may only delegate technical aspects of immunization administration to UAP in these State or National Emergencies or Campaigns.

The licensed nurse (RN or LPN) may not delegate the professional judgment or decision-making responsibility to UAP which includes:

(1) recognizing side effects;
(2) recognizing toxic effects;
(3) recognizing allergic reactions;
(4) recognizing immediate desired effects;
(5) recognizing unusual and unexpected effects;
(6) recognizing changes in client’s condition that contraindicates administration of the immunization;
(7) anticipating those effects which may rapidly endanger a client’s life or well-being; and making judgments and decisions concerning actions to take in the event such untoward effects occur. [21 NCAC 36 .0221 (c)].

The RN or LPN delegating immunization administration must, therefore, remain available to the UAP on site to address any issues identified in pre-administration screening of the client and for the ongoing assessment and evaluation of the client as indicated by the situation and by RN or LPN Scope of Practice.

The RN retains responsibility and accountability for comprehensive assessment and evaluation of the client as defined in Administrative Code Rule 21 NCAC 36 .0224 (b) and (e) “Components of Practice for the Registered Nurse.” The RN has the overall responsibility and accountability for educating the UAP in appropriate administration techniques and for then assessing the capabilities of the UAP to include validation of their competence (i.e., qualifications, knowledge, and skills) in carrying out the technical role.
of immunization administration. In addition, the RN is responsible for delegating appropriately and providing the UAP with ongoing supervision, teaching, and evaluation as defined in Administrative Code Rule 21 NCAC 36 .0224 (i) and (j).

The LPN participates in the assessment and evaluation of the client as defined in Administrative Code Rule 21 NCAC 36 .0225 (b) and (e) “Components of Practice for the Licensed Practical Nurse.” The LPN is accountable for her/his decision to delegate immunization administration to a qualified UAP previously educated and validated as competent by an RN. The LPN oversees the performance of the UAP, verifying that tasks have been performed as delegated to the UAP and in accordance with the established standards of practice and as defined in 21 NCAC 36.0225 (d).

The continuum of the process of immunization begins with the initiation of the immunization order based on client need and ends with the re-evaluation of the client’s needs related to the immunization regimen. The immunization order shall be a valid Standing Order from the identified medical authority for the mass immunization event, usually the local health department Medical Director or the State Health Director.

Collection of screening data using an approved form for the purpose of pre-administration screening and the task of direct immunization administration are the only aspects of the continuum that may be carried out by the appropriately qualified UAP according to the policies and procedures of the agency. Within this framework, the actual task of giving immunizations to a client is considered a technical activity that does not require the professional judgment of a licensed nurse. Thus, the performance of this technical task may be delegated to an appropriately qualified UAP. However, any on-going assessment, interpretation, and decision-making required relative to clients receiving immunizations must be carried out by the RN or LPN within their respective Scope of Practice. Accountability for any professional judgments or decision-making surrounding immunization administration (e.g., deciding when to refer specific client issues to a physician or deciding when to withhold an immunization due to screening "flags") is the responsibility of the RN or LPN and may not be delegated to the UAP.

THIS POSITION STATEMENT IS LIMITED FOR USE ONLY IN “DECLARED STATE OR NATIONAL EMERGENCIES OR FEDERAL/STATE DHHS OR CDC INITIATED MASS IMMUNIZATION CAMPAIGNS,” NOT FOR USE IN ROUTINE IMMUNIZATION ADMINISTRATION.

For any questions, please contact the Practice Consultants at the North Carolina Board of Nursing at 919-782-3211 ext 244.
North Carolina School Health Program Manual

Appendix I Resources, References Item #8
Resolutions and Position Statements
___________________________________________________
NCBON Immunizations by UAP

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SUMMARY OF THE POSITION:

It is the position of the National Association of School Nurses (NASN) that supervision and evaluation of school nurses based upon standards of professional school nursing practice is essential.

HISTORY:

Historically, school nurses were rarely or ineffectively evaluated by supervisors who had little or no knowledge and understanding of the school nurse role. School systems began including professional support personnel in their evaluation process in response to both public pressure and state mandates. The National Association of School Nurses responded to the need for an evaluation tool for school nurses by first developing, *An Evaluation Guide for School Nursing Practice: Designed for Self and Peer Review* to be used in conjunction with the 1983 edition of, *Standards of School Nursing Practice*. More recently, *Job Performance Evaluation Guidelines for School Nurses* was developed (Ackerman, 1995). Most current is the publication of *School Nursing: Scope and Standards of Practice*, jointly published by the National Association of School Nurses and the American Nurses Association in 2005.

DESCRIPTION OF ISSUE:

In order to meet students’ health needs and to function effectively with school and community team members, School nurses need supervision and evaluation to maintain and improve competence in this independent practice. School nurses have the right to performance evaluations that promote excellence in school nursing practice (Tustin, et al., 2002). Best practice requires that this supervision and evaluation be performed by a registered professional School nurse.

A distinction needs to be made between supervision in the context of employee performance and employment law and supervision in the context of nursing practice and nursing law. In the employment context, supervision may include responsibility to direct or oversee, hire and fire, adjust salaries, or ensure a performance evaluation is done, even though direct input may come from sources other than the supervisor. In the nursing context, supervision is related to the scope of nursing practice as defined by the state’s nurse practice act (Schwab & Pohlman, 2002). It is likewise necessary to “educate school administrators in regard to the laws that regulate school nurse practice” (NASN, 2006a)

RATIONALE:

School nurses are accountable through licensure, under nurse practice acts, for nursing judgments and actions. However, functions performed by school nurses that do not require a nursing license fall under the non-nurse supervisor’s authority as outlined by the employer (Schwab & Pohlman, 2002).

Individual school nurse performance may be enhanced through development of a professional portfolio and/or evaluation of competencies as a part of a performance evaluation. With a professional portfolio featuring current
practice and a working plan for professional growth, School nurses are accountable for achieving their own learning objectives and enhancing their own practice (Trossman, 1999; Oermann, 2002). Competencies

- provide direction about what is needed to practice as a school nurse,
- depict the knowledge, skills, and attitudes necessary for the school nurse
- provide a way to measure professional growth, and
- furnish a framework for performance appraisal (Bobo, Adams, & Cooper, 2002).

Evaluations should be formalized and occur at regular intervals to assess both the professional and the program development of the school nurse. In districts without school nurse administrators, self-evaluation through use of an individual portfolio and assessment of competencies or by contracting with a school nurse supervisor in another school district for the nursing component of an evaluation is recommended. School nurses without nurse administrators can take a leadership role in assisting their administration in developing a tool that includes the non-nurse component and self-evaluation component of the performance evaluation.

CONCLUSION:

Enhanced student health and safety and continuous improvement of individual school nursing practice is the ultimate goal of supervision and evaluation (Tustin, Canham, Berridge, Braden, & Starksl, 2002).

References/Resources:


Adopted: July 1970
North Carolina School Health Program Manual

Appendix I Resources, References Item #9
Resolutions and Position Statements

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NASN Statement on Supervision/Evaluation

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Joint Statement on Delegation
American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN)

Introduction
There is more nursing to do than there are nurses to do it. Many nurses are stretched to the limit in the current chaotic healthcare environment. Increasing numbers of people needing healthcare combined with increasing complexity of therapies create a tremendous demand for nursing care. More than ever, nurses need to work effectively with assistive personnel. The abilities to delegate, assign, and supervise are critical competencies for the 21st century nurse.

In 2005, both the American Nurses Association and the National Council of State Boards of Nursing adopted papers on delegation. Both papers presented the same message: delegation is an essential nursing skill. This joint statement was developed to support the practicing nurse in using delegation safely and effectively.

Terminology
Although there is considerable variation in the language used to talk about delegation, ANA and NCSBN both defined delegation as the process for a nurse to direct another person to perform nursing tasks and activities. NCSBN describes this as the nurse transferring authority while ANA calls this a transfer of responsibility. Both mean that a registered nurse (RN) can direct another individual to do something that that person would not normally be allowed to do. Both papers stress that the nurse retains accountability for the delegation.

Both papers define assignment as the distribution of work that each staff member is responsible for during a given work period. The NCSBN uses the verb "assign" to describe those situations when a nurse directs an individual to do something the individual is already authorized to do, e.g., when an RN directs another RN to assess a patient, the second RN is already authorized to assess patients in the RN scope of practice.

Both papers consider supervision to be the provision of guidance and oversight of a delegated nursing task. ANA refers to on-site supervision and NCSBN refers to direct supervision, but both have to do with the physical presence and immediate availability of the supervising nurse. The ANA refers to off-site supervision, and NCSBN refers to indirect supervision. Both have to do with availability of the supervising nurse through various means of written and verbal communication.

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1 ANA and NCSBN have different constituencies. The constituency of ANA is state nursing associations and member RNs. The constituency of NCSBN is state boards of nursing and all licensed nursing. Although for the purpose of collaboration, this joint paper refers to registered nurse practice, NCSBN acknowledges that in many states LPN/VNs have limited authority to delegate.

2 ANA defines supervision to be the active process of directing, guiding, and influencing the outcome of an individual’s performance of a task. Similarly, NCSBN defines supervision as the provision of guidance or direction, oversight, evaluation and follow-up by the licensed nurse for the accomplishment of a delegated nursing task by assistive personnel. Individuals engaging in supervision of patient care should not be construed to be managerial supervisors on behalf of the employer under federal labor law.
Joint Statement on Delegation
American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN)

Policy Considerations
- State nurse practice acts define the legal parameters for nursing practice. Most states authorize RNs to delegate.
- There is a need and a place for competent, appropriately supervised nursing assistive personnel in the delivery of affordable, quality health care.
- The RN assigns or delegates tasks based on the needs and condition of the patient, potential for harm, stability of the patient’s condition, complexity of the task, predictability of the outcomes, abilities of the staff to whom the task is delegated, and the context of other patient needs.
- All decisions related to delegation and assignment are based on the fundamental principles of protection of the health, safety and welfare of the public.

Principles of Delegation
- The RN takes responsibility and accountability for the provision of nursing practice.
- The RN directs care and determines the appropriate utilization of any assistant involved in providing direct patient care.
- The RN may delegate components of care but does not delegate the nursing process itself. The practice pervasive functions of assessment, planning, evaluation and nursing judgment cannot be delegated.
- The decision of whether or not to delegate or assign is based upon the RN’s judgment concerning the condition of the patient, the competence of all members of the nursing team and the degree of supervision that will be required of the RN if a task is delegated.
- The RN delegates only those tasks for which she or he believes the other health care worker has the knowledge and skill to perform, taking into consideration training, cultural competence, experience and facility/agency policies and procedures.
- The RN individualizes communication regarding the delegation to the nursing assistive personnel and client situation and the communication should be clear, concise, correct and complete. The RN verifies comprehension with the nursing assistive personnel and that the assistant accepts the delegation and the responsibility that accompanies it.
- Communication must be a two-way process. Nursing assistive personnel should have the opportunity to ask questions and/or for clarification of expectations.
- The RN uses critical thinking and professional judgment when following the Five Rights of Delegation, to be sure that the delegation or assignment is:
  1. The right task
  2. Under the right circumstances
  3. To the right person
  4. With the right directions and communication; and
  5. Under the right supervision and evaluation.
- Chief Nursing Officers are accountable for establishing systems to assess, monitor, verify and communicate ongoing competence requirements in areas related to delegation.
There is both individual accountability and organizational accountability for delegation. Organizational accountability for delegation relates to providing sufficient resources, including:
- Sufficient staffing with an appropriate staff mix
- Documenting competencies for all staff providing direct patient care and for ensuring that the RN has access to competence information for the staff to whom the RN is delegating care
- Organizational policies on delegation are developed with the active participation of all nurses, and acknowledge that delegation is a professional right and responsibility.

Delegation Resources
Both the ANA and NCSBN have developed resources to support the nurse in making decisions related to delegation. Appendix A of this paper provides the ANA Principles of Delegation. Appendix B presents the NCSBN decision tree on delegation that reflects the four phases of the delegation process articulated by the NCSBN.

Delegation in Nursing Education
Both the ANA and the NCSBN acknowledge that delegation is a skill that must be taught and practiced for nurses to be proficient in using it in the delivery of nursing care. Nursing schools should provide students with both didactic content and the opportunity to apply theory in a simulated and realistic context. Nursing curricula must include competencies related to delegation. RNs are educated and mentored on how to delegate and supervise others. The effective use of delegation requires a nurse to have a body of practice experience and the authority to implement the delegation.

Delegation in NCLEX®
The NCLEX-RN® Examination Test Plan includes competencies related to delegation.

Delegation in the Provision of Nursing Care
The ANA paper outlines some basic elements for the nurse that is essential to form the foundation for delegation, including:
1. Emphasis on professional nursing practice;
2. Definition of delegation, based on the nurse practice act and rules/regulations;
3. Review of specific sections of the law and regulations regarding delegation;
4. Emphasis on tasks/functions that cannot be delegated or cannot be routinely delegated;
5. Focus on RN judgment for task analysis and the decision whether or not to delegate;
6. Determination of the degree of supervision required for delegation;
7. Identification of guidelines for lowering risk related to delegation;
8. Development of feedback mechanisms to ensure that a delegated task is completed and to receive updated data to evaluate the outcome.
The NCSBN paper discusses these elements as part of the preparation to delegate. The NCSBN paper also articulates the following steps of the delegation process:

- **Assess and plan** the delegation, based on the patient needs and available resources.
- **Communicate** directions to the delegate including any unique patient requirements and characteristics as well as clear expectations regarding what to do, what to report, and when to ask for assistance.
- **Surveillance and supervision** of the delegation, including the level of supervision needed for the particular situation and the implementation of that supervision, including follow-up to problems or a changing situation.
- **Evaluation and feedback** to consider the effectiveness of the delegation, including any need to adjust the plan of care.

Delegation skills are developed over time. Nursing employers need to recognize that a newly licensed nurse is a novice who is still acquiring foundational knowledge and skills. In addition, many nurses lack the knowledge, the skill and the confidence to delegate effectively, so ongoing opportunities to enforce the theory and apply the principles of delegation is an essential part of employment orientation and staff development.

Many nurses are reluctant to delegate. This is reflected in NCSBN research findings and a review of the literature as well as anecdotal accounts from nursing students and practicing nurses. There are many contributing factors, ranging from not having had educational opportunities to learn how to work with others effectively to not knowing the skill level and abilities of nursing assistive personnel to simply the work pace and turnover of patients. At the same time, NCSBN research shows an increase in the complexity of the nursing tasks performed by assistive personnel. With the demographic changes and resultant increase in the need for nursing services, plus the nursing shortage, nurses need the support of nursing assistive personnel.

**Conclusions**
The topic of delegation has never been timelier. Delegation is a process that, used appropriately, can result in safe and effective nursing care. Delegation can free the nurse for attending more complex patient care needs, develop the skills of nursing assistive personnel and promote cost containment for the healthcare organization. The RN determines appropriate nursing practice by using nursing knowledge, professional judgment and the legal authority to practice nursing. RNs must know the context of their practice, including the state nurse practice act and professional standards as well as the facility/organization’s policies and procedures related to delegation. Facing a shortage of epic proportions, the nursing community needs to plan how we can continue to accomplish nursing care while assuring the public access to safe, competent nursing care. RNs are urged to seek guidance and appropriate direction from supervisors or mentors when considering decisions about delegation. Mastering the skill and art of delegation is a critical step on the pathway to nursing excellence.

**Attachments:**
Attachment A: ANA Principles of Delegation
Attachment B: NCSBN Decision Tree – Delegation to Nursing Assistive Personnel
Appendix A
American Nurses Association Principles for Delegation

The following principles have remained constant since the early 1950s.

**Overarching Principles:**
- The nursing profession determines the scope of nursing practice.
- The nursing profession defines and supervises the education, training and utilization for any assistant roles involved in providing direct patient care.
- The RN takes responsibility and accountability for the provision of nursing practice.
- The RN directs care and determines the appropriate utilization of any assistant involved in providing direct patient care.
- The RN accepts aid from nursing assistive personnel in providing direct patient care.

**Nurse-related Principles:**
- The RN may delegate elements of care but does not delegate the nursing process itself.
- The RN has the duty to answer for personal actions relating to the nursing process.
- The RN takes into account the knowledge and skills of any individual to whom the RN may delegate elements of care.
- The decision of whether or not to delegate or assign is based upon the RN’s judgment concerning the condition of the patient, the competence of all members of the nursing team and the degree of supervision that will be required of the RN if a task is delegated.
- The RN delegates only those tasks for which she or he believes the other health care worker has the knowledge and skill to perform, taking into consideration training, cultural competence experience and facility/agency policies and procedures.
- The RN uses critical thinking and professional judgment when following The Five Rights of Delegation:
  1. Right task
  2. Right circumstances
  3. Right person
  4. Right directions and communication
  5. Right supervision and evaluation (NCSBN 1995)
- The RN acknowledges that there is a relational aspect to delegation and that communication is culturally appropriate and the person receiving the communication is treated respectfully.
- Chief nursing officers are accountable for establishing systems to assess, monitor, verify and communicate ongoing competence requirements in areas related to delegation, both for RNs and delegates.
- RNs monitor organizational policies, procedures and position descriptions to ensure there is no violation of the nurse practice act, working with the state board of nursing if necessary.
Joint Statement on Delegation
American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN)

Organization-related Principles:

- The organization is accountable for delegation through the allocation of resources to ensure sufficient staffing so that the RN can delegate appropriately.
- The organization is accountable for documenting competencies for all staff providing direct patient care and for ensuring that the RN has access to competency information for staff to whom the RN is delegating patient care.
- Organizational policies on delegation are developed with the active participation of all nurses (staff, managers and administrators).
- The organization ensures that the education needs of nursing assistive personnel are met through the implementation of a system that allows for nurse input.
- Organizations have policies in place that allow input from nurses indicating that delegation is a professional right and responsibility.
Appendix B National Council of State Boards of Nursing
Decision Tree for Delegation to Nursing Assistive Personnel

Step One – Assessment and Planning

Are there laws and rules in place that support the delegation?  

NO

Is the task within the scope of the delegating nurse?  

NO

Do not delegate

YES

Has there been assessment of the client needs?  

NO

Assess client needs and then proceed to a consideration of delegation

YES

Is the delegating nurse competent to make delegation decisions?  

NO

Do not delegate until can provide and document additional education, then reconsider delegation; otherwise do not delegate

YES

Is the task consistent with the recommended criteria for delegation to nursing assistive personnel (NAP)? Must meet all the following criteria:
- Is within the NAP range of functions
- Frequently recurs in the daily care of a client or group of clients;
- Is performed according to an established sequence of steps;
- Involves little or no modification from one client-care situation to another;
- May be performed with a predictable outcome;
- Does not inherently involve ongoing assessment, interpretation, or decision-making which cannot be logically separated from the procedure(s) itself; and
- Does not endanger a client’s life or well-being

NO

Do not delegate

YES

Does the nursing assistive personnel have the appropriate knowledge, skills and abilities (KSA) to accept the delegation?

NO

Do not delegate until evidence of education and validation of competency available, then reconsider delegations; otherwise do not delegate

YES

Does the ability of the NAP match the care needs of the client?
Joint Statement on Delegation
American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN)

**Step Two – Communication**

*Communication must be a two-way process*

**The nurse:**
- Assesses the assistant’s understanding
  - How the task is to be accomplished
  - When and what information is to be reported, including
    - Expected observations to report and record
    - Specific client concerns that would require prompt reporting
  - Individualizes for the nursing assistive personnel and client situation
  - Addresses any unique client requirements and characteristics, and clear expectations of:
  - Assesses the assistant’s understanding of expectations, providing clarification if needed.
  - Communicates his or her willingness and availability to guide and support assistant.
  - Assures appropriate accountability by verifying that the receiving person accepts the delegation and accompanying responsibility

**The nursing assistive personnel:**
- Ask questions regarding the delegation and seek clarification of expectations if needed
- Inform the nurse if the assistant has not done a task/function/activity before, or has only done infrequently
- Ask for additional training or supervision
- Affirm understanding of expectations
- Determine the communication method between the nurse and the assistive personnel
- Determine the communication and plan of action in emergency situations.

**Documentation:** Timely, complete and accurate documentation of provided care
- Facilitates communication with other members of the healthcare team
- Records the nursing care provided.
Step Three – Surveillance and Supervision
The purpose of surveillance and monitoring is related to nurse’s responsibility for client care within the context of a client population. The nurse supervises the delegation by monitoring the performance of the task or function and assures compliance with standards of practice, policies and procedures. Frequency, level and nature of monitoring vary with needs of client and experience of assistant.

<table>
<thead>
<tr>
<th>The nurse considers the:</th>
<th>The nurse determines:</th>
<th>The nurse is responsible for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Client’s health care status and stability of condition</td>
<td>▪ The frequency of onsite supervision and assessment based on:</td>
<td>▪ Timely intervening and follow-up on problems and concerns. Examples of the need for intervening include:</td>
</tr>
<tr>
<td>▪ Predictability of responses and risks</td>
<td>▪ Needs of the client</td>
<td>▪ Alertness to subtle signs and symptoms (which allows nurse and assistant to be proactive, before a client’s condition deteriorates significantly).</td>
</tr>
<tr>
<td>▪ Setting where care occurs</td>
<td>▪ Complexity of the delegated function/task/activity</td>
<td>▪ Awareness of assistant’s difficulties in completing delegated activities.</td>
</tr>
<tr>
<td>▪ Availability of resources and support infrastructure.</td>
<td>▪ Proximity of nurse’s location</td>
<td>▪ Providing adequate follow-up to problems and/or changing situations is a critical aspect of delegation.</td>
</tr>
<tr>
<td>▪ Complexity of the task being performed.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Step Four – Evaluation and Feedback**
Evaluation is often the forgotten step in delegation.

In considering the effectiveness of delegation, the nurse addresses the following questions:
- Was the delegation successful?
  - Was the task/function/activity performed correctly?
  - Was the client’s desired and/or expected outcome achieved?
  - Was the outcome optimal, satisfactory or unsatisfactory?
  - Was communication timely and effective?
  - What went well; what was challenging?
  - Were there any problems or concerns; if so, how were they addressed?
- Is there a better way to meet the client need?
- Is there a need to adjust the overall plan of care, or should this approach be continued?
- Were there any “learning moments” for the assistant and/or the nurse?
- Was appropriate feedback provided to the assistant regarding the performance of the delegation?
- Was the assistant acknowledged for accomplishing the task/activity/function?
North Carolina School Health Program Manual

Appendix I  Resources, References  Item #10
Resolutions and Position Statements  Join Statement on Delegation

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POSITION STATEMENT

Caseload Assignments

HISTORY

Determining staffing for school nurses is generally a local function (Costante, 2001). Thus, caseload assignments for school nurses vary greatly throughout the United States. Historically, the federal government and the National Association of School Nurses (NASN) have recommended a school nurse-to-student ratio of 1:750 (U.S. Department of Health and Human Services, 2000). Previous versions of this position statement have also recommended a school nurse-to-student ratio of 1:225 in mainstreamed special education populations, 1:125 in severely chronically ill or developmentally disabled populations, and based on individual needs in medically fragile populations (Harrigan, 2002). Expectations for school nursing services vary depending upon state mandates and local school district and school attitudes toward school health services. But generally school nursing practice has been focused on a defined set of specific tasks, such as screenings, first aid, and immunization compliance. Many school nurses have been, and continue to be, evaluated by the tasks they complete and the frequency with which these tasks are performed (Selekman & Guilday, 2003).

DESCRIPTION OF ISSUE

A task-oriented role definition no longer describes the impact school nurses have on individual students and the school community (Selekman & Guilday, 2003). School nurses now need to have expertise in clinical nursing, communication, surveillance, education, advocacy, and leadership in order to ensure that all students’ health needs are addressed. Changing populations in the schools are impacting the nature and scope of nursing services required. The school nurse is the most appropriate person to oversee the coordinated school health program. As part of coordinated school health the school nurses role includes assessing student health status, identifying health problems that have an impact on health and learning, delivering emergency care, administering medications, performing health care procedures, providing wellness programs, advocating for children and families, as well as providing health counseling and health education. School nursing further involves planning, developing, managing, and evaluating health care services to children in an educational setting and encompasses working with the families of the students and the community in which the student resides (Guilday, 2000).

The school nurse-to-student ratio affects the delivery of school nursing services. Caseload assignments are influenced by multiple factors, such as:

- Mandatory functions
- School district goals and objectives
- Educational preparation of the school nurse
- Geographic location and number of buildings assigned to the nurse
- Social, economic and cultural status of the community
- Special health problems within the student population
- Mobility of the people in the community
- Reimbursement opportunities
- Licensed or unlicensed assistive personnel
- Presence or absence of a school-based clinic
- Job description, model of service delivery
- Accessibility to medical care
- Student populations with Individualized Educational Plans, Individualized Health Care Plans, or 504 Plans
School nurse-to-student ratios in many schools indicate that teachers cannot always depend on the school nurse to be available in case of a medical emergency (Barrett, 2001). Additionally, some students’ health needs may not be safely met by a nurse who has simultaneous responsibility for hundreds of other students (Costante, 2001) or who needs to cover schools at disparate sites.

Research has shown that nurses with a baccalaureate degree are more likely to use interventions that facilitate health promotion and disease prevention activities and are more likely to involve families and communities. These activities are vital to the establishment of a coordinated school health program. Nurses without baccalaureate degrees report using more interventions that focus on the physical needs of the students (Guilday, 2000). School nurses with advanced preparation as a nurse practitioner or in other fields bring additional skills to the school setting.

RATIONALE

All students have a right to have their health needs safely met while in the school setting. School nurse-to-student ratios need to be set to ensure that each student is afforded appropriate preventative, health promotion, early identification, and intervention services (Costante, 2001).

CONCLUSION

It is the position of the National Association of School Nurses that school districts should provide a full-time professionally prepared registered nurse all day, every day in each building (NASN, 2003). Also recommended is additional school nurse staff to accommodate other student health needs including, but not limited to, special education evaluations, nursing services included in IEPs, nursing services for students with 504 Plans, and schools with large populations and large numbers of students with mental or social concerns.

NASN recommends minimum ratios of nurses to students depending on the needs of the student populations:

- 1:750 for students in the general population,
- 1:225 in the student populations that may require daily professional school nursing services or interventions,
- 1:125 in student populations with complex health care needs, and
- 1:1 may be necessary for individual students who require daily and continuous professional nursing services.
References/Resources:


Adopted: June 1972
North Carolina School Health Program Manual

Appendix I Resources, References Item #11
Resolutions and Position Statements

NASN Statement on Caseload Assignment

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# Medical Statement for Students with Special Nutritional Needs for School Meals

*School District*  
*Address*  
*Phone*  
*Contact*

## Part A (To be completed by Parent/Guardian)

<table>
<thead>
<tr>
<th>Name of Student: (Last) ___________________ (First) _______________________ (Middle) ____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student ID # ____________________ School _____________________ Grade ______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Will student eat breakfast at school?</th>
<th>Will student eat lunch at school?</th>
<th>Will the student eat snack in the after school program?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Parent/Guardian: __________________________ ____________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address: ___________________________ City: __________________ State/Zip: __________</td>
</tr>
<tr>
<td>Phone number(s): ___________________________ (W) __________________ __________ (H) __________________ __________ (Cell)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does the child have an identified disability?</th>
<th>If the child does not have an identified disability, does the child have special nutritional or feeding needs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

If Yes, describe the major life activities affected by the disability:

If Yes, have a licensed physician complete Part B of this form and sign it.

<table>
<thead>
<tr>
<th>signature of parent/guardian</th>
<th>printed name</th>
<th>telephone number</th>
<th>date</th>
</tr>
</thead>
</table>

## Part B Diet Order (To be completed by Physician)

Specify any dietary restrictions or special diet:

List any foods that cause food allergies or intolerances that should be avoided:

If student has life threatening allergies, check appropriate box(es): ☐ ingestion ☐ contact ☐ inhalation

Designate consistency requirements for food:

Designate consistency requirement for liquids:

Blenderized Liquid ☐ Puree ☐ ☐ Thin ☐ Nectar-thick ☐

Mechanical Soft ☐ Soft ☐ ☐ Honey-thick ☐ Spoon-thick ☐

For any special diet, list specific foods to be omitted and suggested substitutions; You may attach a separate page with additional information.

<table>
<thead>
<tr>
<th>a. Foods To Be Omitted</th>
<th>b. Suggested Substitutions</th>
</tr>
</thead>
</table>

Indicate any other comments about the child’s eating or feeding patterns:

<table>
<thead>
<tr>
<th>signature of physician/medical authority*</th>
<th>printed name</th>
<th>telephone number</th>
<th>date</th>
</tr>
</thead>
</table>

* A licensed physician’s signature is required for participants with a disability. For participants without a disability, a licensed physician or medical authority must sign the form.

## Part C (To be completed by Child Nutrition Services)

Child Nutrition Services Notes:

<table>
<thead>
<tr>
<th>CN Administrator Signature:</th>
<th>Date:</th>
<th></th>
</tr>
</thead>
</table>
Appendix I  Resources, References  Item #13
Resolutions and Position Statements
DPI School Meals Consultants

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### NORTH CAROLINA IMMUNIZATION BRANCH REGIONAL NURSE CONSULTANTS

**Regional Immunization Nursing Consultants (RINs)**

<table>
<thead>
<tr>
<th>Gina Holland</th>
<th>Sheree Smith, interim</th>
<th>Tammy Pentony</th>
<th>Elizabeth Draper (temporarily covering for Elaine Thomas)</th>
<th>Beth Meadows (Field Supervisor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5601 Six Forks Road 1917 Mail Service Center Raleigh, NC 27699-1917</td>
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<td>5601 Six Forks Road 1917 Mail Service Center Raleigh, NC 27699-1917</td>
<td>5601 Six Forks Road 1917 Mail Service Center Raleigh, NC 27699-1917</td>
<td></td>
</tr>
<tr>
<td>(Ph)828-652-8939</td>
<td>(Ph) 919-663-3854</td>
<td>(Ph) 910-893-1036</td>
<td>(Ph) 919-707-5575</td>
<td>(Ph) 252-224-1282</td>
</tr>
<tr>
<td>(Fax)828-652-3499</td>
<td>(Fax) 919-663-3976</td>
<td>(Fax) 910-893-1046</td>
<td>(Fax) 919-870-4826</td>
<td>(Fax) 252-224-1219</td>
</tr>
<tr>
<td>(Cell)828-606-5817</td>
<td>(Cell) 919-218-0929</td>
<td>(Cell) 919-218-5215</td>
<td>(Cell) 919-218-0851</td>
<td>(Cell) 252-808-5250</td>
</tr>
<tr>
<td><a href="mailto:gina.holland@dhhs.nc.gov">gina.holland@dhhs.nc.gov</a></td>
<td><a href="mailto:sheree.smith@dhhs.nc.gov">sheree.smith@dhhs.nc.gov</a></td>
<td><a href="mailto:tammy.pentony@dhhs.nc.gov">tammy.pentony@dhhs.nc.gov</a></td>
<td><a href="mailto:elizabeth.draper@dhhs.nc.gov">elizabeth.draper@dhhs.nc.gov</a></td>
<td><a href="mailto:beth.meadows@dhhs.nc.gov">beth.meadows@dhhs.nc.gov</a></td>
</tr>
</tbody>
</table>

Sheree Smith, Nurse Consultant - Contact for new providers and clinical education visits.

5601 Six Forks Road, 1917 Mail Service Center, Raleigh NC 27699-1917. (Phone) 919-663-3854 (Cell) 919-218-0929 (Fax) 919-663-3976

### Counties

- **Allegheny**
- **Alamance**
- **Durham**
- **Anson**
- **Beaufort**
- **Alexander**
- **Cabarrus**
- **Franklin**
- **Brunswick**
- **Camden**
- **Caswell**
- **Granville**
- **Chatham**
- **Carteret**
- **Catawba**
- **Halifax**
- **Columbus**
- **Chowan**
- **Gaston**
- **Harnett**
- **Cumberland**
- **Craven**
- **Guilford**
- **Hertford**
- **Duplin**
- **Curtisuck**
- **Iredell**
- **Johnston**
- **Hoke**
- **Dare**
- **Lincoln**
- **Lee**
- **Montgomery**
- **Gates**
- **Mecklenburg**
- **Martin**
- **Moore**
- **Greene**
- **Orange**
- **Nash**
- **New Hanover**
- **Hyde**
- **Randolph**
- **Northampton**
- **Pender**
- **Jones**
- **Rockingham**
- **Person**
- **Richmond**
- **Lenoir**
- **Rowan**
- **Tyrrell**
- **Robeson**
- **Onslow**
- **Union**
- **Vance**
- **Sampson**
- **Pamlico**
- **Yadkin**
- **Wake**
- **Scotland**
- **Pasquotank**
- **Warren**
- **Stanly**
- **Perquimans**
- **Washington**
- **Wayne**
- **Pitt**
- **McDowell**
- **Wilson**

*Temporarily assigned county

*Temporarily assigned county

Effective 2/19/10
<table>
<thead>
<tr>
<th>Holly Kiel</th>
<th>Ashley Luck</th>
<th>Isabel Reynolds (Regional Immunization Consultant Supervisor)</th>
<th>Vicki Ransom</th>
<th>Becky Houston Batchelor</th>
</tr>
</thead>
<tbody>
<tr>
<td>5601 Six Forks Road, 1917 Mail Service Center Raleigh, NC 27699-1917</td>
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<td>5601 Six Forks Road, 1917 Mail Service Center Raleigh, NC 27699-1917</td>
</tr>
<tr>
<td>(Ph) 828-694-1611</td>
<td>(Ph) 336-882-3176</td>
<td>(Ph) 910-938-7466</td>
<td>(Ph) 919-707-5572</td>
<td>(Ph) 252-568-5529</td>
</tr>
<tr>
<td>(Fax) 828-694-1604</td>
<td>(Fax) 336-882-3339</td>
<td>(Fax) 910-938-7496</td>
<td>(Fax) 919-870-4824</td>
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<td>(Cell) 828-553-7754</td>
<td>(Cell) 336-813-4158</td>
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<td>(Cell) 919-218-5545</td>
<td>(Cell) 252-206-6189</td>
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<tr>
<td><a href="mailto:holly.kiel@dhhs.nc.gov">holly.kiel@dhhs.nc.gov</a></td>
<td><a href="mailto:ashley.luck@dhhs.nc.gov">ashley.luck@dhhs.nc.gov</a></td>
<td><a href="mailto:isabel.reynolds@dhhs.nc.gov">isabel.reynolds@dhhs.nc.gov</a></td>
<td><a href="mailto:vicki.ransom@dhhs.nc.gov">vicki.ransom@dhhs.nc.gov</a></td>
<td><a href="mailto:becky.houston@dhhs.nc.gov">becky.houston@dhhs.nc.gov</a></td>
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</tbody>
</table>

ALEXANDER ALAMANCE | BLADEN CHATHAM | BEAUFORT 
AVERY ALLEGHANY | BRUNSWICK DURHAM | BERTIE 
BUNCOMBE ANSON CARTERET FRANKLIN CAMDEN 
BURKE ASHE COLUMBUS GRANVILLE CHOWAN 
Caldwell Cabarrus Cumberland Halifax CRAVEN 
CATAWBA CASWELL NEW HANOVER HARNETT CURRITUCK 
CHEROKEE DAVIDSON ONSLOW HOKE DARE 
CLAY DAVE PENDER LEE DUPLIN 
CLEVELAND FORSYTH Sampson MOORE EDGECOMBE 
GASTON GUILFORD PERSON GATES 
GRAHAM MONTGOMERY ROBESON GREENE 
HAYWOOD ORANGE SCOTLAND HERTFORD 
HENDERSON RANDOLPH VANCE HYDE 
IREDELL RICHMOND WAKE JOHNSTON 
JACKSON ROCKINGHAM WARREN JONES 
LINCOLN ROWAN LENOIR 
MACON STANLY MARTIN 
MADISON STOKES NASH 
MCDOWELL SURRY 
MECKLENBURG UNION PAMLICO 
MITCHELL WATAUGA PASQUOTANK 
POLK WILKES PERQUIMANS 
RUTHERFORD YADKIN PITT 
SWAIN TYRRELL 
TRANSYLVANIA WASHINGTON 
YANCEY WAYNE WILSON 

Revised February 1, 2010
School Nurse Evaluation Tool

Preface
As with the Job Description, the Evaluation Tool must be individualized to fit the needs of the system and the individual nurse. Job descriptions and evaluations will vary based on the number of schools, complexity of student needs, and other criteria individual to each system.

Introduction
The purpose of the evaluation process is to ensure accountability, high quality services, and professional growth. The evaluation process includes data obtained from multiple sources including observations, interviews, document analysis, and personal/professional goals. Performance standards are based on the school nurse’s job description, NC Nurse Practice Act, and Best Practice as defined in Scope and Standards of School Nursing Practice.

School nurses are frequently the only healthcare provider in the school. They work independently and are responsible for planning, implementing, coordinating, monitoring outcomes and evaluating school health services that:

- Maximize the quantity of in-class time by reducing the incidence of health-related absenteeism
- Eliminate or minimize health problems which impair learning and future academic/social success
- Promote the highest degree of independent functioning as possible
- Promote student, staff and community awareness of and participation in healthy behaviors

A performance evaluation is completed annually. It is recommended that interim evaluations be completed during the first year of employment. More frequent reviews may be indicated if performance needs improvement.

When supervising and evaluating school nurses, a distinction needs to be made between supervision in the context of general employee performance and supervision of nursing practice/nursing law. In both cases, it may be necessary for the evaluator to get input from other sources.

1 Adopted by Professional Practice & Standards Committee of School Nurse Association of North Carolina, January 29, 2009
Non-nurse supervisors may evaluate the general employee performance of the nurse using non-nursing evaluative measures.

A Registered Nurse (RN) supervisor may evaluate both nursing practice and general employee performance.

When using this evaluation tool:

- Non-nurse supervisors may complete Accountability, pages 1 and 2 and Professional Goals, page 9.
- RN supervisors may complete all sections of the Evaluation Tool.
- In the absence of a RN to perform the evaluation, a peer evaluation by another RN is recommended. This evaluation should include an audit of at least one of the school nurse’s cases to see that all components are practiced appropriately.
Rating Tool/Explanations
Using the School Nurse Job Description (SNANC, 2006) evaluate utilizing the ratings below.

(4) Exceeds Expectations

Performance is consistently high. Nursing practice is demonstrated at a high level. Nurse seeks to expand scope of competencies and undertakes additional appropriate responsibilities.

(3) Meets Expectations

Performance within this function area consistently meets adequate/acceptable standards and may occasionally exceed the major functions and standards of the position. Nurse maintains an adequate scope of competencies and performs additional responsibilities as assigned.

(2) Needs Improvement

Performance meets some position requirements and standards but does not meet the major, most important requirements and/or standards and needs improvement. Nurse requires supervision and assistance to maintain an adequate scope of competencies and/or sometimes fails to perform additional responsibilities as assigned. Corrective action is in place and the nurse is activating this plan.

(1) Fails to Meet Expectations

Performance within this function area is consistently inadequate or unacceptable and most practice areas require considerable improvement to fully meet minimum expectations. Nurse requires close and frequent supervision in the performance of most or all responsibilities. Corrective action is in place but the nurse fails to make adequate progress in response to the plan.

References

School Nursing: Scope and Standards of Practice, American Nurses Association, Silver Spring, MD 2005

School Nurse Appraisal Instruments, Orange County Public School System, March 2008
School Nurse Evaluation Tool

<table>
<thead>
<tr>
<th>Employee Name:</th>
<th>Supervisor Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Title:</td>
<td>Supervisor Title:</td>
</tr>
<tr>
<td>Division/Section:</td>
<td>Division/Section:</td>
</tr>
<tr>
<td>Time in Position:</td>
<td>Review Period Begin Date:</td>
</tr>
<tr>
<td>Primary School Assignment:</td>
<td>Review Period End Date:</td>
</tr>
<tr>
<td>Date:</td>
<td>Type of Review:</td>
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</tbody>
</table>

**Documentation** is a requirement of professional nursing practice. It is expected that documentation includes all phases of the nursing process & should be considered in each of the evaluation sections below. All client documentation must be in an individually retrievable format.

**Client** is used to reflect the diversity of school nursing practice and may be a student, the student and family as a unit, the school population, or the school community, including faculty and staff.

**Appraisal Rating Scale:**
1. Above Standard
2. At Standard
3. Below Standard
4. Unsatisfactory
## General Job Expectations

### Adheres to assigned work schedule

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Provides work schedule to supervisor and all assigned schools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Notifies school and supervisor of changes in schedule</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 Reports on time &amp; remains for assigned time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4 Utilizes time effectively</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5 Uses leave time appropriately and follows procedures</td>
<td></td>
<td></td>
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</tbody>
</table>

### Communication

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
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</thead>
<tbody>
<tr>
<td>2.1 Speaks at level of client</td>
<td></td>
<td></td>
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<tr>
<td>2.2 Establishes positive rapport with staff &amp; client</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3 Keeps principal &amp; supervisor appropriately informed</td>
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</tbody>
</table>

### Customer Service

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Positive attitude</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2 Team player</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3 Courteous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4 Anticipates needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5 Demonstrates flexibility</td>
<td></td>
<td></td>
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</tbody>
</table>
North Carolina School Health Program Manual

Appendix I Resources, References Item #16
Resolutions and Position Statements
SNANC School Nurse Evaluation Tool

Professional Conduct

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<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>4.1 Professional attire (dress code &amp; good hygiene practices)</td>
<td></td>
<td></td>
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<tr>
<td>4.2 Maintains client confidentiality</td>
<td></td>
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</table>

List other requirements of individual agency

<table>
<thead>
<tr>
<th>Competencies</th>
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<th>Comments</th>
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</table>

Standards of Care

Standard 1: Assessment
The school nurse collects comprehensive data pertinent to the client’s health or situation.

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Collect data based on the client’s immediate condition or anticipated needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Compares and contrasts clinical findings with normal and abnormal variations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 Uses appropriate evidence-based assessment techniques and instruments in collecting data</td>
<td></td>
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</tbody>
</table>
### Standard 2: Diagnosis

The school nurse analyzes the assessment data to determine the diagnoses or issues.

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>2.1 Validates issues with the client</td>
<td>1 2 3 4</td>
<td></td>
</tr>
</tbody>
</table>

### Standard 3: Outcomes Identification

The school nurse identifies expected outcomes for a plan individualized to the client or situation.

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>3.1 Involves client in identifying resources, timeframe and criteria to develop expected outcomes that are culturally appropriate</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>3.2 Define and create outcome measurements specific to each setting and client</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>3.3 Documents expected outcomes in measurable goals</td>
<td>1 2 3 4</td>
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</tbody>
</table>

### Standard 4: Planning

The school nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>4.1 Develops an individualized healthcare plan with appropriate strategies for health promotion and disease prevention (e.g., EAP, IHP, health components of IEP and 504)</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>4.2 Plan intervention/strategies in collaboration with other members of the interdisciplinary team</td>
<td>1 2 3 4</td>
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</tbody>
</table>
Standard 5: Implementation
The school nurse implements the identified plan

Standard 5A: Coordination of Care
The school nurse coordinates care delivery

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>5A.1 Utilize the plan to coordinate health teaching/counseling to other members of the school team</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>5A.2 Delegate and teach special health care and procedures according to stated policies, protocols or regulations</td>
<td>1 2 3 4</td>
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</tbody>
</table>

Standard 5B: Health Teaching and Health Promotion
The school nurse provides health education and employs strategies to promote health and a safe environment

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
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<tbody>
<tr>
<td>5B.1 Acts as the primary resource person regarding health education</td>
<td></td>
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<tr>
<td>5B.2 Provides general health education related to the individual client and/or groups at large through direct instruction or expert consultation</td>
<td></td>
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<tr>
<td>5B.3 Promotes self-care and safety through the education of the individual client and/or school community regarding health issues</td>
<td></td>
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<tr>
<td>5B.4 Promotes health principles through the Coordinated School Health Program</td>
<td></td>
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</tbody>
</table>
Standard 5C: Consultation
The school nurse provides consultation to influence the identified plan, enhance the abilities of others and effect change.

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<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
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<tbody>
<tr>
<td>5C.1 Uses data, information and student response to care to make recommendations for change</td>
<td>1 2 3 4</td>
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</table>

Standard 6: Evaluation
The school nurse evaluates progress towards attainment of outcomes.

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<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>6.1 Monitor the progress of clients toward desired results and identified outcomes</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>6.2 Review the health status of clients at specified intervals</td>
<td>1 2 3 4</td>
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<tr>
<td>6.3 Revise the plan, as needed</td>
<td>1 2 3 4</td>
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</table>

Standards of Professional Performance

Standard 7: Quality of Practice
The school nurse systematically enhances the quality and effectiveness of nursing practice.

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>7.1 Incorporates new knowledge to initiate changes in school nursing practice if desired outcomes are not achieved</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>7.2 Participates in quality improvement activities. Identify, collect, analyze, formulate recommendations and implement activities to improve school nursing practice</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>7.3 Obtain and maintain national school nurse certification</td>
<td>1 2 3 4</td>
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</table>
### Standard 8: Education

The school nurse attains knowledge and competency that reflects current school nursing practice.

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<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
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<tbody>
<tr>
<td>8.1 Maintains clinical skills and knowledge of professional issues appropriate to school nursing practice</td>
<td>1</td>
<td></td>
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<tr>
<td>8.2 Demonstrates a commitment to lifelong learning through ongoing educational activities</td>
<td>2</td>
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<tr>
<td>8.3 Maintains professional records that provide evidence of competency including formal and independent learning activities</td>
<td>3</td>
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</table>

### Standard 9: Professional Practice Evaluation

The school nurse evaluates one’s own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules and regulations.

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>9.1 Engages in self-evaluation of practice, identifying areas of strength as well as areas in which professional development would be beneficial</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>9.2 Obtains informal feedback regarding one’s own practice from clients, peers, professional colleagues, and others</td>
<td>2</td>
<td></td>
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<tr>
<td>9.3 Takes action to achieve goals identified during the evaluation process</td>
<td>3</td>
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</tbody>
</table>
Standard 10: Collegiality
The school nurse interacts with, and contributes to the professional development of, peers and school personnel as colleagues.

<table>
<thead>
<tr>
<th>Competencies</th>
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<tbody>
<tr>
<td>10.1 Shares knowledge and skills with peers and colleagues</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>10.2 Interacts with peers and colleagues to enhance one’s own professional school nursing practice</td>
<td>2</td>
<td></td>
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<tr>
<td>10.3 Participates in appropriate professional organizations in a membership or leadership capacity</td>
<td>3</td>
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</table>

Standard 11: Collaboration
The school nurse collaborates with the client, the family, school staff and others in the conduct of school nursing practice.

<table>
<thead>
<tr>
<th>Competencies</th>
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<tbody>
<tr>
<td>11.1 Work in partnership with clients, families and healthcare providers to effect change and generate positive outcomes</td>
<td>1</td>
<td></td>
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</table>

Standard 12: Ethics
The school nurse integrates ethical provisions in all areas of practice.

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
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<tbody>
<tr>
<td>12.1 Delivers care in a manner that preserves and protects client autonomy, confidentiality, dignity and rights, and being sensitive to diversity in the school setting</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
### Standard 13: Research
The school nurse integrates research findings into practice.

<table>
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<tr>
<th>Competencies</th>
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<th>Comments</th>
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<tbody>
<tr>
<td>13.1 Utilizes the best available evidence, including research findings, to guide practice decisions</td>
<td>1</td>
<td></td>
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<tr>
<td>13.2 Actively participates in research activities at various levels appropriate to the school nurse’s education and position</td>
<td>2</td>
<td></td>
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</table>

### Standard 14: Resource Utilization
The school nurse considers factors related to safety, effectiveness, cost and impact on practice in the planning and delivery of school nursing services.

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
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<tbody>
<tr>
<td>14.1 Assists the client and family in identifying and securing appropriate and available services to address health-related needs</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>14.2 Evaluates factors such as safety, effectiveness, availability, and cost/benefits when choosing options that will result in the same expected outcome</td>
<td>4</td>
<td></td>
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</tbody>
</table>

### Standard 15: Leadership
The school nurse provides leadership in the professional practice setting and the profession.

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
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<tbody>
<tr>
<td>15.1 Directs the coordination of care across settings and among caregivers, including oversight of licensed and</td>
<td>2</td>
<td></td>
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</tbody>
</table>
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**Appendix I**  
Resources, References  
Item #16  
Resolutions and Position Statements  
SNANC School Nurse Evaluation Tool

<table>
<thead>
<tr>
<th>Competencies</th>
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<tbody>
<tr>
<td>unlicensed personnel in any assigned or delegated tasks as permitted by state nurse practice acts</td>
<td></td>
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<tr>
<td>15.2 Displays the ability to define a clear vision, the associated goals and a plan to implement and measure progress</td>
<td></td>
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<tr>
<td>15.3 Demonstrates knowledge of the philosophy and mission of the school district and professional school nursing practice</td>
<td></td>
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<tr>
<td>15.4 Serves in key roles in the school and work settings by participating on committees, councils, etc.</td>
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**Standard 16: Program Management**  
The school nurse manages school health services.

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Rating</th>
<th>Comments</th>
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<tbody>
<tr>
<td>16.1 Conducts ongoing school health needs assessments to identify current health problems and identify the need for new programs</td>
<td></td>
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</tr>
<tr>
<td>16.2 Implements needed health programs, policies and procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.3 Orients, trains, documents competency, supervises and evaluates health assistants and UAPs (unlicensed assistive personnel) as appropriate to the school setting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Personal/Professional Goals:

References

School Nursing: Scope and Standards of Practice, American Nurses Association, Silver Spring, MD 2005

School Nurse Appraisal Instruments, Orange County Public School System, March 2008
A listing by regional consultant.

**NORTHWEST**

Alexander, Alleghany, Ashe, Avery, Burke, Caldwell, Catawba, Davidson, Davie, Elkin City, Winston-Salem/Forsyth, Hickory City, Iredell-Statesville, Mooresville City, Mount Airy City, Lexington City, Newton-Conover City, Stokes, Surry, Thomasville, Watauga, Wilkes, Yadkin.

**Contact**

Bill Rynn
Johnson J. Hayes Federal Building
207 West Main Street, Room 238
Wilkesboro, NC 28697

**Phone**

336.667.6059

**Fax**

336.667.6377

**WEST**

Asheville City, Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

**Contact**

Johnny Westall
Western Carolina University
151 Outreach Center
Cullowhee, NC 28723-9093

**Phone**

828.227.2085

**Fax**

828.227.7041

**SOUTHWEST**

Anson, Cabarrus, Cleveland, Gaston, Hoke, Kannapolis City, Kings Mountain City, Lincoln, Charlotte-Mecklenburg, Montgomery, Moore, Richmond, Rowan-Salisbury, Scotland, Shelby City, Stanly, Union

**Contact**

Nancy Johnson
UNC-Charlotte
9201 University City Blvd.
College of Education, Room 152
Charlotte, NC 28223-0001

**Phone**

704.687.8824

**Fax**

704.687.6484
### CENTRAL

<table>
<thead>
<tr>
<th>Contact</th>
<th>Phone</th>
<th>Fax</th>
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</thead>
<tbody>
<tr>
<td>Mary Hutchens</td>
<td>919.807.3313</td>
<td>919.807.3243</td>
</tr>
</tbody>
</table>

Contact Phone Fax
Mary Hutchens
Exceptional Children Division
Department of Public Instruction
6356 Mail Service Center
Raleigh, NC 27699-6356

### NORTHEAST
Beaufort, Bertie, Camden, Edenton-Chowan, Currituck, Dare, Edgecombe, Gates, Halifax, Hertford, Hyde, Martin, Northampton, Elizabeth City/Pasquotank, Perquimans, Pitt, Roanoke Rapids City, Tyrrell, Weldon City, Washington

<table>
<thead>
<tr>
<th>Contact</th>
<th>Phone</th>
<th>Fax</th>
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<tbody>
<tr>
<td>Tracy A. Riddle</td>
<td>252.328.1519</td>
<td>252.328.1523</td>
</tr>
</tbody>
</table>

Contact Phone Fax
Tracy A. Riddle
College of Education
East Carolina University
Ragsdale Building, Room 112
Greenville, NC 27858-4353

### SOUTHEAST
Bladen, Brunswick, Carteret, Clinton City, Columbus, Craven, Cumberland, Duplin, Greene, Jones, Lenoir, New Hanover, Onslow, Pamlico, Pender, Robeson, Sampson, Wayne, Whiteville City

<table>
<thead>
<tr>
<th>Contact</th>
<th>Phone</th>
<th>Fax</th>
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</thead>
<tbody>
<tr>
<td>Jessica Swencki</td>
<td>910.672.1624</td>
<td>910.672.1629</td>
</tr>
</tbody>
</table>

Contact Phone Fax
Jessica Swencki
School of Education
Fayetteville State University
1200 Murchison Road
Fayetteville, NC 28301-4298

### CHARTER SCHOOLS
Provides consultation services and technical assistance to staff at the charter schools located throughout the state.

<table>
<thead>
<tr>
<th>Contact</th>
<th>Phone</th>
<th>Fax</th>
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</thead>
<tbody>
<tr>
<td>Consultants for Charter Schools</td>
<td>919.807.3319</td>
<td>919.807.3243</td>
</tr>
</tbody>
</table>

Consultants for Charter Schools
Rebecca Dowless
Exceptional Children Division
Department of Public Instruction
6356 Mail Service Center
Raleigh, NC 27699-6356
By Region

http://www.ncpublicschools.org/ec/directory/region?&print=true

3/9/2010
Why are schools getting money from Medicaid?
The Individuals with Disabilities Education Improvement Act (IDEA) says Medicaid will pay for some Individual Education Program (IEP) services. The law encourages school systems to recover cost of certain services provided to Medicaid-eligible children. Financial resources help schools teach children.

How do schools use the money they receive from Medicaid?
Each local school system determines how the money is used. Many schools use money from Medicaid to fund training, equipment, or materials to support programs for children. NC Department of Public Instruction (NCDPI) encourages schools to use Medicaid dollars for Exceptional Children programs.

IDEA references - [34 CFR §§300.9 and 300.154]
FERPA reference - [20 U.S.C. § 1232g; 34 CFR Part 99]

What will Medicaid pay for in schools?
School systems can recover cost for medically-related services included in the student’s IEP. Some school services Medicaid pays for include: audiology; nursing services; occupational therapy; physical therapy; speech therapy; psychological and counseling services.

Do schools need parental consent to recover cost from Medicaid?
Schools are required by the Family Educational Rights and Privacy Act (FERPA) and IDEA to get informed parent consent before releasing personal information about students. Parents need to understand why and when schools provide information about their child to the state Medicaid agency. Schools need parental consent to help offset the cost of required IEP services.

When schools recover cost from Medicaid, will it cost our family anything?
No. Schools cannot require parents to pay for services a child requires at school. Schools cannot use Medicaid benefits if it lowers lifetime coverage, results in cost for other services that would be covered, increases the family’s cost, causes the family to lose benefits, or puts the family at risk of losing benefits.

Does this process change services my child will receive at school or in the community?
No. Schools must provide all IEP services even if the school does not recover cost from Medicaid. Medicaid services received outside of school are authorized separately from IEP services. If outside services have been affected, families are encouraged to contact their local EC Director.

Where can I get more information about this?
Contact your Exceptional Children (EC) Director the NCDPI Medicaid Consultants

DIVISION OF EXCEPTIONAL CHILDREN
6356 MAIL SERVICE CENTER
RALEIGH, NC 27699-6356
Medicaid Consultants:
Laurie Ray: 919-636-1827
Lauren Hohman: 919-843-4466
www.ncpublicschools.org/ec/medicaid/
# North Carolina School Health Program Manual

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CERTIFICATION OF SCHOOL NURSES

SECTION 7.41. (a) G.S. 115C-315 is amended by adding the following new subsection to read:

“(d1) Certification for School Nurses. – Notwithstanding any other provision of law or rule, school nurses employed in the public schools prior to July 1, 1998, shall not be required to be nationally certified to continue employment. School nurses not certified by the American Nurses’ Association or the National Association of School Nurses shall continue to be paid based on the noncertified nurse salary range as established by the State Board of Education.” (2001)

1 The proper names of the two national associations which offer school nurse certification are National Board for Certification of School Nurses (NBCSN) and American Nurses Credentialing Center (ANCC).
North Carolina School Health Program Manual  
General Statutes, State Policies, and Administrative Code  
Appendix II  
Item #1  
School Nurse Certification and Salary

NORTH CAROLINA STATE BOARD OF EDUCATION  
Policy Manual

Policy Identification  
Priority: Twenty-First Century Systems  
Category: Public School Employee Salary Schedules  
Policy ID Number: TCS-T-000

Policy Title: 16 NCAC 1A.0005 Policy regarding the NC Public School Personnel Salary Schedules and Manual

Current Policy Date: 06/04/2009


Statutory Reference: GS 115C-12(9)a

Administrative Procedures Act (APA) Reference Number and Category: 16 NCAC 1A.0005

The Department provides state salary funds to LEAs in accordance with the State Salary Schedule for Public School Personnel and State Salary Conversion Tables, which the SBE adopts annually.

Please refer to the NC Public School Personnel Salary Schedule Manual. This manual and the schedules are available from the:

NC Department of Public Instruction  
Division of School Business  
Information Analysis & Reporting  
6334 Mail Service Center  
Raleigh, NC  27699-6334

Questions regarding the NC Public School Personnel Salary Schedule Manual and the schedules should be directed to: (919) 807-3708

The NC Public School Personnel Salary Schedule Manual is also available from the following link: http://www.ncpublicschools.org/docs/fbs/finance/salary/salarymanual.pdf.
STATE SALARY MANUAL 2009-2010
N.C. STATE BOARD OF EDUCATION
SECTION D
TEACHER AND STUDENT SERVICES 2

I. All Teacher and Student Services Personnel

A. DAILY RATE OF PAY

The following employees have their daily rate of pay based on 22 days regardless of the number of week days in the month of service

- all teachers,

- all student services personnel, and

- all employees in split position where one of the positions is based on a 22-day daily rate.

EXAMPLE: An employee serves 50% of the day as a teacher (22-day basis) and 50% of the day as an assistant principal (actual number of days in month basis). This employee’s daily rate is calculated on 22 days per month.

B. SALARY BASIS

1. Teachers, guidance counselors, school social workers, and media coordinators

Those employed with the Public Schools of North Carolina are assigned a salary on the appropriate classroom teacher salary schedule according to the class level of their license, experience level, and area of assignment. (See APPENDIX C for Salary Schedules)

2. Audiologists, school psychologists, and speech-language pathologists

Those employed with the Public Schools of North Carolina are paid on the "M" teacher salary schedule, with 5 years of experience on the "M" teacher salary schedule corresponding to 0 years of experience as an audiologist, school psychologist or speech-language pathologist.

2 N.C. Department of Public Instruction, State Salary manual 2009-2010, Section D, Teacher and Student Services, excerpted for references to school nurse certification and salary. Complete school employee salary information is available at the N.C. DPI website: http://sbepolicy.dpi.state.nc.us/
language pathologist. (For exceptions, see Section D IV). (See APPENDIX C for Salary Schedules)

3. School Nurses

For the salary basis of school nurses, see Section D V.

C. SALARY SCHEDULE PLACEMENT

Certified salary at highest license level

Effective July 1, 2000, if an individual in a teaching or student services position holds at least one license area beyond the ‘A’ level then that individual’s salary is certified at his or her highest education level of licensure.

Rule: This rule applies even if the educator is assigned to an area other than the one with the highest-class level.

EXCEPTION: Salary certification for audiologists, speech-language pathologists, and school psychologists follows procedures in Section D IV.

D. ADVANCED DEGREE SUPPLEMENT

If an individual in a teaching or student services personnel position has earned an advanced or doctoral license s/he will receive an additional monthly supplement, of

- $126 per month for an advanced license and
- $253 per month for both an advanced license and a doctorate license.

Effective Date For Salary Purposes

For salary purposes, degrees above the bachelor’s level that are earned

- on or after April 1 of the current school year will become effective July 1 of the upcoming school year or
- prior to April 1 of the current school year will become effective in the same pay period as the license effective date.

EXAMPLE: The license area effective date of a doctorate degree is 12/17 (as shown on the Employment Inquiry screen). For salary purposes, this doctorate degree will be effective in the 6th pay period. All December paychecks should reflect the pay increase.
B. NON-EDUCATIONAL MASTER’S DEGREE AND APPLICATION FOR ‘M’ SUPPLEMENTAL SALARY

Effective July 1, 1993, the Licensure Section began authorizing salary payments on the class 'M' teacher license for teachers who hold a master’s degree in a non-teaching area and the degree is directly relevant to the teacher’s area of assignment.

Effective July 1, 2003, a list of individuals by LEA who are currently on the "M" salary schedule can be viewed on the website. It is the LEA’s responsibility to review the web page and send the list to Licensure for any additions or deletions. For new employees who hold a master’s degree in a non-teaching education or for a current employee whose area of assignment changes, a Form G - Request for Authorization of Graduate Salary must be submitted. If Licensure grants approval, the form is forwarded to the Information Analysis and Support Section for salary assignment. This information must be submitted early in the new school year for proper placement on the "M" salary schedule.

Note: The list can be viewed from the Licensure and Salary Info Center or the Non-Public Professional Experience Info Center.

IV. Student Services Personnel

A. STUDENT SERVICES PERSONNEL POSITIONS AND BUDGET CODES

Included in the student services personnel category are:

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V. Other Certified Personnel

A. OVERVIEW

Other certified personnel are employed in positions within job classifications requiring professional certification as prescribed by the State Board of Education. These positions do not require a professional license issued by the Licensure Section and are not required

- to complete an approved education program or
- to achieve a specified minimum score on the National Teacher’s Examination/Praxis Examination.

B. SCHOOL NURSE

Effective July 1, 2002, school nurses employed in the public schools prior to July 1, 1998, shall not be required to be nationally certified to continue employment. Therefore, all school nurses employed since July 1, 1998 are required to be certified by either

- the American Nurses’ Association (ANA) or
- the National Association of School Nurses (NASN).

2. Salary basis

Nationally certified school nurses who are employed in the public schools as nurses shall be paid on the classroom teacher’s ‘M’ salary schedule according to their years of experience. Since the Licensure Section does not currently license school nurses, LEAs will assign years of experience for their nationally certified school nurses following the licensure rules used for determining non-teaching experience for workforce development health occupations.

Non-nationally certified school nurses should be paid within the non-certified nurse salary range.

3 Information regarding source of certification in DPI Salary Manual is scheduled to be updated for the next publication of the Salary Manual. Correct source of national school nurse certification is National Board for Certification of School Nurses (NBCSN) or American Nurses Credentialing Center (ANCC). No new certification applications are accepted by ANCC. School nurses currently certified in school nursing by ANCC may re-certify only. NBCSN accepts applications for new and renewal certification.
3. ABCs incentive bonus

The ABCs incentive bonus given to teachers and student services personnel in schools that either meet or exceed the student performance goals are also applicable to nationally certified school nurses, but not to non-certified school nurses.

4. Budget code

Budget code 5840-xxx-139 should be used to code the nationally certified school nurses.

Budget code 5840-xxx-148 should be used to code the non-certified school nurses.

5. Daily rate of pay

Nationally certified school nurses are paid based on 22 days regardless of the number of weekdays in the month of service.

Non-certified school nurses whose term of employment is exactly 10 months (220 days) will be paid based on 22 days in a month. Those non-certified school nurses whose term of employment is not exactly 10 months (220 days) will be paid based on the actual number of workdays in a month (20, 21, 22, or 23).

6. Employing non-certified school nurses

LEAs may employ, if necessary, non-certified nurses. However, they must be hired with the stipulation that they become nationally certified within three years of their hire date.

Rule: Until national certification is attained, their salary shall be assigned according to the non-certified nurse ranges.
School Nurse Certification and Salary

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Child Protective Services

§ 7B-101 Definitions
As used in this Subchapter, unless the context clearly requires otherwise, the following words have the listed meanings:

(1) Abused Juveniles – any juvenile less than 18 years of age whose parent, guardian, custodian, or caretaker;
   a. Inflicts or allows to be inflicted upon the juvenile a serious physical injury by other than accidental means;
   b. Creates or allows to be created a substantial risk of serious physical injury to the juvenile by other than accidental means;
   c. Uses or allows to be used upon the juvenile cruel or grossly inappropriate procedures or cruel or grossly in appropriate devices to modify behavior;
   d. Commits, permits, or encourages the commission of a violation of the following laws by, with, or upon the juvenile: first degree rape, as provided in G.S. 14-27.2; second degree rape as provided in G.S. 14-27.3; first degree sexual offense as provided in G.S. 14-27-4; second degree sexual offense, as provided in G.S. 14.27.5; sexual act by custodian, as provided in G.S. 14.27.7 crime against nature as provided in G.S.. 14-177, incest, as provided in G.S. 14-178, preparation of obscene photographs, photographs, slides or motion pictures of the juvenile, as provided G.S. 14-190.5; employing or permitting the juvenile to assist in a violation of the obscenity laws as provided in G.S. 14-190.6; dissemination of obscene material to the juvenile as provided in G.S.14-910.7 and G.S. 14-190.8; displaying or disseminating material harmful to the juvenile as provided in G.S. 14-190.14 and G.S. 14-190.15; first and second degree sexual exploitation of the juvenile as provided in G.S. 14-190.16 and G.S. 14-190.17 promoting the prostitution of the juvenile as provided in G.S. 14-190-18; and taking indecent liberties with the juvenile as provided in G.S. 14-202-1.
   e. Creates or allows to be created serious emotional damage to the juvenile; serious emotional damage is evidenced by a juvenile’s severe anxiety, depression, withdrawal or aggressive behavior toward himself or others; or
   f. Encourages, directs, or approves of delinquent acts involving moral turpitude committed by the juvenile.

(3) Caretaker – Any person other than a parent, guardian, or custodian who has responsibility for the health and welfare of
a juvenile in a residential setting. A person responsible for a juvenile’s health and welfare means a stepparent, foster parent, an adult member of the juvenile’s household, an adult relative entrusted with the juvenile’s care, any person such as a house parent or cottage parent who has primary responsibility for supervising a juvenile’s health and welfare in a residential child care facility or residential educational facility, or any employee or volunteer of a division, institution, or school operated by the Department of Health and Human Services. “Caretaker” also means any person who has the responsibility for the care of a juvenile in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes and includes any person who has the approval of the care provider to assume responsibility for the juveniles under the care of the care provider. Nothing in this subdivision shall be construed to impose a legal duty of support under Chapter 50 or Chapter 110 of the General Statutes. The duty imposed upon a caretaker as defined in this subdivision shall be for the purpose of this Subchapter only.

(8) Custodian – The person or agency that has been awarded legal custody of a juvenile by a court or a person, other than parents or legal guardians, who has assumed the status and obligation of a parent without being awarded the legal custody of a juvenile by a court.

(9) Dependent Juvenile – A juvenile in need of assistance or placement because the juvenile has no parent, guardian, or custodian responsible for the juvenile’s care or supervision or whose parent, guardian, or custodian, is unable to provide for the care or supervision and lacks an appropriate alternative child care arrangement.

(14) Juvenile – A person who has not reached the person’s eighteenth birthday and is not married, emancipated, or a member of the armed services of the United States.

(15) Neglected Juvenile – A juvenile who does not receive proper care, supervision, or discipline from the juvenile’s parent, guardian, custodian, or caretaker; or who has been abandoned; or who is not provided necessary medical care; or who is not provided necessary remedial care; or who lives in an environment injurious to the juvenile’s welfare; or who has been placed for care or adoption in violation of law. In determining whether a juvenile is a neglected juvenile, it is relevant whether that juvenile lives in a home where another juvenile has died as a result of suspected abuse or neglect or lives in a home where another juvenile has been subjected to abuse or neglect by an adult who regularly lives in the home. (2005)
§ 7B-300. Protective services. Screening of Abuse and Neglect Complaints
The director of the department of social services in each county of the State shall establish protective services for juveniles alleged to be abused, neglected, or dependent. Protective services shall include the screening of reports, the performance of an assessment using either a family assessment response or an investigative assessment response, casework, or other counseling services to parents, guardians, or other caretakers as provided by the director to help the parents, guardians, or other caretakers and the court to prevent abuse or neglect, to improve the quality of child care, to be more adequate parents, guardians, or caretakers, and to preserve and stabilize family life. The provisions of this Article shall also apply to child care facilities as defined in G.S. 110-86. (2005)

§ 7B-301. Duty to report abuse, neglect, dependency, or death due to maltreatment.
Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, as defined by G.S. 7B-101, or has died as the result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found. The report may be made orally, by telephone, or in writing. The report shall include information as is known to the person making it including making it including the name and address of the juvenile; the name and address of the juvenile's parent, guardian, or caretaker; the age of the juvenile; the names and ages of other juveniles in the home; the present whereabouts of the juvenile if not at the home address; the nature and extent of any injury or condition resulting from abuse, neglect, or dependency; and any other information which the person making the report believes might be helpful in establishing the need for protective services or court intervention. If the report is made orally or by telephone, the person making the report shall give the person's name, address, and telephone number. Refusal of the person making the report to give a name shall not preclude the department's assessment of the alleged abuse, neglect, dependency, or death as a result of maltreatment.

Upon receipt of any report of sexual abuse of the juvenile in a child care facility, the director shall notify the State Bureau of Investigation within 24 hours or on the next work day. If sexual abuse in a child care facility is not alleged in the initial report, but during the course of the assessment there is reason to suspect that sexual abuse has occurred, the director shall immediately notify the State Bureau of Investigation. Upon notification that sexual abuse may have occurred in a child care facility, the State Bureau of Investigation may form a task force to investigate the report. (2005)
§ 7B-302. Assessment by director; access to confidential information; notification of person making the report.

(a) When a report of abuse, neglect, or dependency is received, the director of the department of social services shall make a prompt and thorough assessment, using either a family assessment response or an investigative assessment response, in order to ascertain the facts of the case, the extent of the abuse or neglect, and the risk of harm to the juvenile, in order to determine whether protective services should be provided or the complaint filed as a petition. When the report alleges abuse, the director shall immediately, but no later than 24 hours after receipt of the report, initiate the assessment. When the report alleges neglect or dependency, the director shall initiate the assessment within 72 hours following receipt of the report. When the report alleges abandonment, the director shall immediately initiate an assessment, take appropriate steps to assume temporary custody of the juvenile, and take appropriate steps to secure an order for nonsecure custody of the juvenile. The assessment and evaluation shall include a visit to the place where the juvenile resides, except when the report alleges abuse or neglect in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes. When a report alleges abuse or neglect in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes, a visit to the place where the juvenile resides is not required. When the report alleges abandonment, the assessment shall include a request from the director to law enforcement officials to investigate through the North Carolina Center for Missing Persons and other national and State resources whether the juvenile is a missing child.

(a1) All information received by the department of social services, including the identity of the reporter, shall be held in strictest confidence by the department, except that:

(1) The department shall disclose confidential information to any federal, State, or local government entity or its agent in order to protect a juvenile from abuse or neglect. Any confidential information disclosed to any federal, State, or local government entity or its agent under this subsection shall remain confidential with the other government entity or its agent and shall only be redisclosed for purposes directly connected with carrying out that entity's mandated responsibilities.

(2) The information may be examined upon request by the juvenile's guardian ad litem or the juvenile, including a juvenile who has reached age 18 or been emancipated.

(3) A district or superior court judge of this State presiding over a civil matter in which the department of
social services is not a party may order the department to release confidential information, after providing the department with reasonable notice and an opportunity to be heard and then determining that the information is relevant and necessary to the trial of the matter before the court and unavailable from any other source. This subdivision shall not be construed to relieve any court of its duty to conduct hearings and make findings required under relevant federal law, before ordering the release of any private medical or mental health information or records related to substance abuse or HIV status or treatment. The department of social services may surrender the requested records to the court, for in camera review, if the surrender is necessary to make the required determinations.

A district or superior court judge of this State presiding over a criminal or delinquency matter shall conduct an in camera review prior to releasing to the defendant or juvenile any confidential records maintained by the department of social services, except those records the defendant or juvenile is entitled to pursuant to subdivision (2) of this subsection.

(5) The department may disclose confidential information to a parent, guardian, custodian, or caretaker in accordance with G.S. 7B-700 of this Subchapter.

(a2) If the director, at any time after receiving a report that a juvenile may be abused, neglected, or dependent, determines that the juvenile's legal residence is in another county, the director shall promptly notify the director in the county of the juvenile's residence, and the two directors shall coordinate efforts to ensure that appropriate actions are taken.

(b) When a report of a juvenile's death as a result of suspected maltreatment or a report of suspected abuse, neglect, or dependency of a juvenile in a noninstitutional setting is received, the director of the department of social services shall immediately ascertain if other juveniles live in the home, and, if so, initiate an assessment in order to determine whether they require protective services or whether immediate removal of the juveniles from the home is necessary for their protection. When a report of a juvenile's death as a result of maltreatment or a report of suspected abuse, neglect, or dependency of a juvenile in an institutional setting such as a residential child care facility or residential educational facility is received, the director of the department of social services shall immediately ascertain if other juveniles remain in the facility subject to the alleged perpetrator's care or supervision, and, if so, assess the circumstances of those
circumstances of those juveniles in order to determine whether they require protective services or whether immediate removal of those juveniles from the facility is necessary for their protection.

(c) If the assessment indicates that abuse, neglect, or dependency has occurred, the director shall decide whether immediate removal of the juvenile or any other juveniles in the home is necessary for their protection. If immediate removal does not seem necessary, the director shall immediately provide or arrange for protective services. If the parent, guardian, custodian, or caretaker refuses to accept the protective services provided or arranged by the director, the director shall sign a petition seeking to invoke the jurisdiction of the court for the protection of the juvenile or juveniles.

(d) If immediate removal seems necessary for the protection of the juvenile or other juveniles in the home, the director shall sign a petition that alleges the applicable facts to invoke the jurisdiction of the court. Where the assessment shows that it is warranted, a protective services worker may assume temporary custody of the juvenile for the juvenile's protection pursuant to Article 5 of this Chapter.

(d1) Whenever a juvenile is removed from the home of a parent, guardian, custodian, stepparent, or adult relative entrusted with the juvenile's care due to physical abuse, the director shall conduct a thorough review of the background of the alleged abuser or abusers. This review shall include a criminal history check and a review of any available mental health records. If the review reveals that the alleged abuser or abusers have a history of violent behavior against people, the director shall petition the court to order the alleged abuser or abusers to submit to a complete mental health evaluation by a licensed psychologist or psychiatrist.

(e) In performing any duties related to the assessment of the report or the provision or arrangement for protective services, the director may consult with any public or private agencies or individuals, including the available State or local law enforcement officers who shall assist in the assessment and evaluation of the seriousness of any report of abuse, neglect, or dependency when requested by the director. The director or the director's representative may make a written demand for any information or reports, whether or not confidential, that may in the director's opinion be relevant to the assessment or provision of protective services. Upon the director's or the director's representative's request and unless protected by the attorney-client privilege, any public or private agency or individual shall provide access to and copies of this confidential information and these records to the extent permitted by federal law and regulations. If a custodian of criminal investigative information or records believes that release of the information will jeopardize the right of the State to prosecute a defendant or the right of a defendant to receive a fair trial or will undermine an ongoing or future investigation, the custodian shall provide a written demand to the director or the director's representative.
undermine an ongoing or future investigation, it may seek an order from a court of competent jurisdiction to prevent disclosure of the information. In such an action, the custodian of the records shall have the burden of showing by a preponderance of the evidence that disclosure of the information in question will jeopardize the right of the State to prosecute a defendant or the right of a defendant to receive a fair trial or will undermine an ongoing or future investigation. Actions brought pursuant to this paragraph shall be set down for immediate hearing, and subsequent proceedings in the actions shall be accorded priority by the trial and appellate courts.

(f) Within five working days after receipt of the report of abuse, neglect, or dependency, the director shall give written notice to the person making the report, unless requested by that person not to give notice, as to whether the report was accepted for assessment and whether the report was referred to the appropriate State or local law enforcement agency.

(g) Within five working days after completion of the protective services assessment, the director shall give subsequent written notice to the person making the report, unless requested by that person not to give notice, as to whether there is a finding of abuse, neglect, or dependency, whether the county department of social services is taking action to protect the juvenile, and what action it is taking, including whether or not a petition was not a petition was filed. The person making the report shall be informed of procedures necessary to request a review by the prosecutor of the director's decision not to file a petition. A request for review by the prosecutor shall be made within five working days of receipt of the second notification. The second notification shall include notice that, if the person making the report is not satisfied with the director's decision, the person may request review of the decision by the prosecutor within five working days of receipt. The person making the report may waive the person's right to this notification, and no notification is required if the person making the report does not identify himself to the director.

(h) The director or the director's representative may not enter a private residence for assessment purposes without at least one of the following:

(1) The reasonable belief that a juvenile is in imminent danger of death or serious physical injury.

(2) The permission of the parent or person responsible for the juvenile's care.

(3) The accompaniment of a law enforcement officer who has legal authority to enter the residence.

(4) An order from a court of competent jurisdiction. (2009)

§ 7B-303 Interference with Assessment
(a) If any person obstructs or interferes with an assessment required by G.S. 7B-302, the director may file a
petition naming that person as respondent and requesting an order directing the respondent to cease the obstruction or interference. The petition shall contain the name and date of birth and address of the juvenile who is the subject of the assessment; shall include a concise statement of the basis for initiating the assessment; shall specifically describe the conduct alleged to constitute obstruction of or interference with the assessment; and shall be verified.

(b) For the purposes of this section, obstruction of or interference with an assessment means refusing to disclose the whereabouts of the juvenile, refusing to allow the director to have personal access to the juvenile, refusing to allow the director to observe or interview the juvenile in private, refusing to allow the director access to confidential information and records upon request pursuant to G.S. 7B-302, refusing to allow the director to arrange for an evaluation of the juvenile by a physician or other expert, or other conduct that makes it impossible for the director to carry out the duty to assess the juvenile’s condition.

(c) Upon filing of the petition, the court shall schedule a hearing to be held not less than five days after service of the petition and summons on the respondent. Service of the petition and summons and notice of hearing shall be made as provided by the Rules of Civil Procedure on the respondent; the juvenile’s parent, guardian, custodian, or caretaker; and any other person determined by the court to be a necessary party. If at the hearing on the petition the court finds by clear, cogent and convincing evidence that the respondent, without lawful excuse, has obstructed or interfered with an assessment required by G.S. 7B-302, the court may order the respondent to cease such obstruction or interference. The burden of proof shall be on the petitioner.

(d) If the director has reason to believe that the juvenile is in need of immediate protection or assistance, the director shall so allege in the petition and may seek an ex parte order from the court. If the court, from the verified petition and any inquiry the court makes of the director, finds probable cause to believe both that the juvenile is at risk of immediate harm and that the respondent is obstructing or interfering with the director’s ability to assess the juvenile’s condition, the court may enter an ex parte order directing the respondent to cease the obstruction or interference. The order shall be limited to provisions necessary to enable the director to conduct an assessment sufficient to determine whether the juvenile is in need of immediate protect or
immediate protect or assistance. Within 10 days after the entry of an ex parte order under this subsection, a hearing shall be held to determine whether there is good cause for the continuation of the order or the entry of a different order. An order entered under this subsection shall be served on the respondent along with a copy of the petition, summons, and notice of hearing.

(e) The director may be required at a hearing under this section to reveal the identity of any person who made a report of suspected abuse, neglect, or dependency as required by G.S. 7B-301.

(f) An order entered pursuant to this section is enforceable by civil or criminal contempt as provided in Chapter 5A of the General Statutes.

§ 7B-306. Review by Prosecutor
The prosecutor shall review the director’s determination that a petition should not be filed within 20 days after the person making the report is notified. The review shall include conferences with the person making the report, the protective services worker, the juvenile, if practicable, and other persons known to have pertinent information about the juvenile or the juvenile’s family. At the conclusion of the conferences, the prosecutor may affirm the decision made by director, may request the appropriate local law enforcement agency to investigate the allegations, or may direct the director to file a petition. (1999)

(a) If the director finds evidence that a juvenile may have been abused as defined by G.S. 7B-101, the director shall make an immediate oral and subsequent written report of the findings to the district attorney or the district attorney’s designee and the appropriate local law enforcement agency within 48 hours after receipt of the report. The local law enforcement agency shall immediately, but no later than 48
48 hours after receipt of the information, initiate and coordinate a criminal investigation with the protective services assessment being conducted by the county department of social services. Upon completion of the investigation, the district attorney shall determine whether criminal prosecution is appropriate and may request the director or the director’s designee to appear before a magistrate.

If the director receives information that a juvenile may have been physically harmed in violation of any criminal statute by any person other than the juvenile’s parent, guardian, custodian, or caretaker, the director shall make an immediate oral and subsequent written report of that information to the district attorney or the district attorney’s designee and to the appropriate local law enforcement agency within 48 hours after receipt of the information. The local law enforcement agency shall immediately, but no later than 48 hours after receipt of the information, initiate a criminal investigation. Upon completion of the investigation, the district attorney shall determine whether criminal prosecution is appropriate.

If the report received pursuant to G.S. 7B-301 involves abuse or neglect of a juvenile in child care, the director shall notify the Department of Health and Human Services within 24 hours or on the next working day of receipt of the report.

(b) If the director finds evidence that a juvenile has been abused or neglected as defined by G.S. 7B-101 in a child care facility, the director shall immediately so notify the Department of Health and Human Services and, in the case of sexual abuse, the State Bureau of Investigation, in such a way as does not violate the law guaranteeing the confidentiality of the records of the department of social services.

(c) Upon completion of the assessment, the director shall give the Department written notification of the results of the assessment required by G.S. 7B-302. Upon completion of an assessment of sexual abuse in a child care facility, the director shall also make written notification of the results of the assessment to the State Bureau of Investigation.

The director of the department of social services shall submit a report of alleged abuse, neglect, or dependency cases or child fatalities that are the result of alleged maltreatment to the central registry under the policies adopted by the Social Services Commission. (2005)

§ 7B-310. Privileges Not Grounds for Failing to Report or for Excluding Evidence

No privilege shall be grounds for any person or institution failing to report that a juvenile may have been abused, neglected, or dependent, even if the knowledge or suspicion is acquired in an official
official professional capacity, except when the knowledge or suspicion is gained by an attorney from the attorney’s client during representation only in the abuse, neglect or dependency case. No privilege except the attorney-client privilege shall be grounds for excluding evidence of abuse, neglect, or dependency in any judicial proceeding (civil, criminal, or juvenile) in which a juvenile’s abuse, neglect, or dependency is in issue nor in any judicial proceeding resulting from a report submitted under this Article, both as this privilege relates to the competency of the witness and to the exclusion of confidential communications. (1999)

§ 7B-311. Central registry; responsible individuals list.
(a) The Department of Health and Human Services shall maintain a central registry of abuse, neglect, and dependency cases and child fatalities that are the result of alleged maltreatment that are reported under this Article in order to compile data for appropriate study of the extent of abuse and neglect within the State and to identify repeated abuses of the same juvenile or of other juveniles in the same family. This data shall be furnished by county directors of social services to the Department of Health and Human Services and shall be confidential, subject to rules adopted by the Social Services Commission providing for its use for study and research and for other appropriate disclosure. Data shall not be used at any hearing or court proceeding unless based upon a final judgment of a court of law.
(b) The Department shall also maintain a list of responsible individuals identified by county directors of social services as the result of investigative assessment responses. The Department may provide information from this list to child caring institutions, child placing agencies, group home facilities, and other providers of foster care, child care, or adoption services that need to determine the fitness of individuals to care for or adopt children.
(c) It is unlawful for any public official or public employee to knowingly and willfully release information from either the central registry or the responsible individuals list to a person who is not authorized to receive the information. It is unlawful for any person who is authorized to receive information from the central registry or the responsible individuals list to release that information to an unauthorized person. It is unlawful for any person who is not authorized to receive information from the central registry or the responsible individuals list to access or attempt to access that information. A person who commits an offense described in this subsection is guilty of a Class 3 misdemeanor.
(d) The Social Services Commission shall adopt rules regarding the operation of the central registry and responsible individuals list, including: (1) Procedures for filing data.
(2) Procedures for notifying a responsible individual of a determination of abuse or serious neglect.
(3) Procedures for correcting and expunging information.
(4) Determining persons who are authorized to receive information from the responsible individuals list.
(5) Releasing information from the responsible individuals list to authorized requestors.
(6) Gathering statistical information.
(7) Keeping and maintaining information placed in the registry and on the responsible individuals list.
(8) A definition of "serious neglect". (1979, c. 815, s. 1; 1993, c. 516, s.11; 1997-443, s. 11A.118(a); 1998-202, s. 6; 1999-456, s. 60; 2005-399, s. 2.)
§130A-134 Reportable Diseases and Conditions
The Commission shall establish by rule a list of communicable diseases and communicable conditions to be reported (1987).

§130A-136 School Principals and Child-Care Operators to Report
A principal of a school and an operator of a child-care facility, as defined in G.S. 110-86(3), who has reason to suspect that a person within the school or child-care facility has a communicable disease or communicable condition declared by the Commission to be reported, shall report information required by the commission to the local health director of the county or district in which the school or facility is located (1997).

§130A-142 Immunity of Persons Who Report
A person who makes a report pursuant to the provisions of this Article shall be immune from any civil or criminal liability that might otherwise be incurred or imposed as a result of making that report (1987).

§130A-143 Confidentiality of Records
All information and records, whether publicly or privately maintained, that identify a person who has AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions of this Article shall be strictly confidential. This information shall not be released or made public except under the following circumstances:
(1) Release is made of specific medical or epidemiological information for statistical purposes in a way that no person can be identified;
(2) Release is made of all or part of the medical record with the written consent of the person or persons identified or their guardian;
(3) Release is made to health care personnel providing medical care to the patient;
(4) Release is necessary to protect the public health and is made as provided by the Commission in its rules regarding control measures for communicable diseases and conditions;
(5) Release is made pursuant to other provisions of this Article;
(6) Release is made pursuant to subpoena or court order. Upon request of the person identified in the record, the record shall be reviewed in camera. In the trial, the trial judge may, during the taking of testimony concerning such information, exclude from the courtroom all persons except the officers of the court, the parties and those engaged in the trial of the case;
(7) Release is made by the Department or a local health department to a court or a law enforcement official for the purpose of...
of enforcing the provisions of this Article or Article 22 of this Chapter; or investigating a terrorist incident using nuclear, biological, or chemical agents. A law enforcement official who received the information shall not disclose it further, except (i) when necessary to enforce this Article or Article 22 of this Chapter, or when necessary to conduct an investigation of a terrorist incident using nuclear, biological, or chemical agents, or (ii) when the Department or a local health department seeks the assistance of the law enforcement official in preventing or controlling the spread of the disease or condition and expressly authorizes the disclosure as necessary for that purpose;

(8) Release is made by the Department or a local health department to another federal, state or local public health agency for the purpose of preventing or controlling the spread of a communicable disease or communicable condition;

(9) Release is made by the Department for bona fide research purposes. The Commission shall adopt rules providing for the use of the information for research purposes;

(10) Release is made pursuant to G.S. 130A-144(b); or

(11) Release is made pursuant to any other provisions of law that specifically authorize or require the release of information or records related to AIDS (2002).

§130A-144 Investigation and Control Measures

(a) The local health director shall investigate, as required by the Commission, cases of communicable diseases and communicable conditions reported to the local health director pursuant to this Article.

(b) Physicians and persons in charge of medical facilities or laboratories shall, upon request and proper identification, permit a local health director or the State Health Director to examine, review, and obtain a copy of medical or other records in their possession or under their control which the State Health Director or a local health director determines pertain to the (i) diagnosis, treatment, or prevention of a communicable disease or communicable condition for a person infected, exposed, or reasonably suspected of being infected or exposed to such a disease or condition, or (ii) the investigation of a known or reasonably suspected outbreak of a communicable disease or communicable condition.

(c) A physician or a person in charge of a medical facility or laboratory who permits examination, review or copying of medical records pursuant to subsection (b) shall be immune from any civil or criminal liability that otherwise might be incurred or imposed as a result of complying with a request made pursuant to subsection (b).

(d) The attending physician shall give control measures prescribed by the
Commission to a patient with a communicable disease or communicable condition and to patients reasonably suspected of being infected or exposed to such a disease or condition. The physician shall also give control measures to other individuals as required by rules adopted by the Commission.

(e) The local health director shall ensure that control measures prescribed by the Commission have been given to prevent the spread of all reportable communicable diseases or communicable conditions and any other communicable disease or communicable condition that represents a significant threat to the public health. The local health department shall provide, at no cost to the patient, the examination and treatment for tuberculosis disease and infection and for sexually transmitted diseases designated by the Commission.

(f) All persons shall comply with control measures, including submission to examinations and tests, prescribed by the Commission subject to the limitations of G.S. 130A-148.

(g) The Commission shall adopt rules that prescribe control measures for communicable diseases and conditions subject to the limitations of G.S. 130A-148. Temporary rules prescribing control measures for communicable diseases and conditions shall be adopted pursuant to G.S. 150B-13.

(h) Anyone who assists in an inquiry or investigation conducted by the State Health Director for the purpose of evaluating the risk of transmission of HIV or Hepatitis B from an infected health care worker to patients, or who serves on an expert panel established by the State Health Director for that purpose, shall be immune from civil liability that otherwise might be incurred or imposed for any acts or omissions which result from such assistance or service, provided that the person acts in good faith and the acts or omissions do not amount to gross negligence, willful or wanton misconduct, or intentional wrongdoing. This qualified immunity does not apply to acts or omissions which occur with respect to the operation of a motor vehicle. Nothing in this subsection provides immunity from liability for a violation of G.S.130A-143.

(2004)

10A NCAC 41A .0201 Control Measures – General

(a) Except as provided in Rules of this Section, the recommendations and guidelines for testing, diagnosis, treatment, follow-up, and prevention of transmission for each disease and condition specified by the American Public Health Association in its publication, Control of Communicable Diseases Manual shall be the required control measures. Control of Communicable Diseases Manual is hereby incorporated by reference including subsequent amendments.

(b) In interpreting and implementing the specific control measures adopted in Paragraph (a), of this Rule, and in devising control measures for outbreaks designated by the State Health Director and for communicable diseases and conditions for which a specific control measure is not provided by this Rule, the following principles shall be used:

1. Control measures shall be those which can reasonably be expected to decrease the risk of transmission and which are consistent with recent scientific and public health information.

2. For diseases or conditions transmitted by the airborne route, the control measures shall require physical isolation for the duration of infectivity.

3. For diseases or conditions transmitted by the fecal-oral route, the control measures shall require exclusions from situations in which transmission can be reasonably expected to occur, such as work as a paid or voluntary food handler or attendance or work in a day-care center for the duration of infectivity.

4. For diseases or conditions transmitted by sexual or the blood-borne route, control measures shall require prohibition of donation of blood, tissue, organs, or semen, needle-sharing, and sexual contact in a manner likely to result in transmission for the duration of infectivity.

(c) Persons with congenital rubella syndrome, tuberculosis, and carriers of Salmonella typhi and hepatitis B who change residence to a different local health department jurisdiction shall notify the local health director in both jurisdictions.

(d) Isolation and quarantine orders for communicable diseases and communicable conditions for which
control measures have been established shall require compliance with applicable control measures and shall state penalties for failure to comply. These isolation and quarantine orders may be no more restrictive than the applicable control measures.

(e) An individual enrolled in an epidemiologic or clinical study shall not be required to meet the provisions of 10A NCAC 41A .0201 -.0209 which conflict with the study protocol if:

(1) the protocol is approved for this purpose by the State Health Director because of the scientific and public health value of the study, and
(2) the individual fully participates in and complete the study.

(f) A determination of significant risk of transmission under this Subchapter shall be made only after consideration of the following factors, if known:

(1) The type of body fluid or tissue;
(2) The volume of body fluid or tissue;
(3) The concentration of pathogen;
(4) The virulence of the pathogen; and
(5) The type of exposure, ranging from intact skin to non-intact skin, or mucous membrane.

(g) The term “household contacts” as used in this Subchapter means any person residing in the same domicile as the infected person. (2003)

10A NCAC 41A .0202 Control Measures – HIV

The following are the control measures for the Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) infection:

(1) Infected persons shall:
(a) refrain from sexual intercourse unless condoms are used; exercise caution when using condoms due to possible condom failure;
(b) not share needles or syringes, or any other drug-related equipment, paraphernalia, or works that may be contaminated with blood through previous use;
(c) not donate or sell blood, plasma, platelets, other blood products, semen, ova, tissues, organs, or breast milk;
(d) have a skin test for tuberculosis;
(e) notify future sexual intercourse partners of the infection;
(f) if the time of initial infection is known, notify persons who have been sexual intercourse and needle partners since the date of infection; and,
(g) if the date of initial infection is unknown, notify persons who have been sexual intercourse and needle partners for the previous year.

(2) The attending physician shall:
(a) give the control measures in Item (1) of this Rule to infected patients, in accordance with 10A NCAC 41A.0210;
(b) if the attending physician knows the
the identity of the spouse of an HIV-infected patient and has not, with the consent of the infected patient, notified and counseled the spouse, the physician shall list the spouse on a form provided by the Division of Public Health and shall mail the form to the Division; the Division shall undertake to counsel the spouse. The attending physician’s responsibility to notify exposed and potentially exposed persons is satisfied by fulfilling the requirements of Sub-Items (2)(a) and (b) of this Rule;

(c) advise infected persons concerning clean-up of blood and other body fluids;
(d) advise infected persons concerning the risk of perinatal transmission and transmission by breast-feeding.

(4) The attending physician of a child who is infected with HIV and who may pose a significant risk of transmission in the school or day care setting because of open, oozing wounds or because of behavioral abnormalities such as biting shall notify the local health director. The local health director shall consult with the attending physician and investigate the following circumstances:

(a) If the child is in school or scheduled for admission and the local health director determines that there may be significant risk of transmission, the local health director shall consult with an interdisciplinary committee, which shall include school personnel, a medical expert, and the child’s parent or guardian to assist in the investigation and determination of risk. The local health director shall notify the superintendent or private school director of the need to appoint such an interdisciplinary committee.

(i) If the superintendent or private school director establishes such a committee within three days of notification, the local health director shall consult with this committee.

(ii) If the superintendent or private school director does not establish such a committee within three days of notification, the local health director shall establish such a committee.

(b) If the child is in school or scheduled for admission and the local health director determines, after consultation with the committee, that a significant risk of transmission exists, the local health director shall:

(i) notify the parents;
(ii) notify the committee;
(iii) assist the committee in determining whether an adjustment can be made to the student’s school program to eliminate significant risks of transmission.

(iv) determine if an alternative educational setting is necessary to protect the public health;

(v) instruct the superintendent or private school director concerning protective measures to be implemented in the alternative educational setting developed by school personnel; and

(vi) consult with the superintendent or
private school director to determine which school personnel directly involved with the child need to be notified of the HIV infection in order to prevent transmission and ensure that these persons are instructed regarding the necessity for protecting confidentiality.

(c) If the child is in day care and the local health director determines that there is a significant risk of transmission, the local health director shall notify the parents that the child must be placed in an alternate child care setting that eliminates the significant risk of transmission.

(4) When health care workers or other persons have a needlestick or nonsexual non-intact skin or mucous membrane exposure to blood or body fluids that, if the source were infected with HIV, would pose a significant risk of HIV transmission, the following shall apply:

(a) When the source person is known:
   (i) The attending physician or occupational health care provider responsible for the exposed person, if other than the attending physician of the person whose blood or body fluids is the source of the exposure, shall notify the attending physician of the source that an exposure has occurred. The attending physician of the source person shall discuss the exposure with the source and unless the source is already known to be infected, shall test the source for HIV infection without consent unless it reasonably appears that the test cannot be performed without endangering the safety of the source person or the person administering the test. If the source administering the test. If the source person cannot be tested, an existing specimen, if one exists, shall be tested.

   The attending physician of the exposed person shall be notified of the infection status of the source.

   (ii) The attending physician of the exposed person shall inform the exposed person about the infection status of the source, offer testing for HIV infection as soon as possible after exposure and at reasonable intervals up to one year to determine whether transmission occurred, and, if the source person was HIV infected, give the exposed person the control measures listed in Sub-Items (1)(a) through (c) of this Rule. The attending physician of the exposed person shall instruct the exposed person regarding the necessity for protecting confidentiality.

(b) When the source person is unknown, the attending physician of the exposed person shall inform the exposed person of the risk of transmission and offer testing for HIV infection as soon as possible after exposure and at reasonable intervals up to one year to determine whether transmission occurred.

   (c) A health care facility may release the name of the attending physician of a source person upon request of the attending physician of an exposed person.

(5) The attending physician shall notify the local health director when the physician, in good faith, has reasonable cause to suspect a patient infected with HIV is not following or cannot follow control measures and is thereby causing a
significant risk of transmission. Any other person may notify the local health director when the person, in good faith, has reasonable cause to suspect a person infected with HIV is not following control measures and is thereby causing a significant risk of transmission.

(6) When the local health director is notified pursuant to Item (5) of this Rule, of a person who is mentally ill or mentally retarded, the local health director shall confer with the attending mental health physician or mental health authority and the physician, if any, who notified the local health director to develop a plan to prevent transmission.

(7) The Division of Public Health shall notify the Director of Health Services of the North Carolina Department of Correction and the prison facility administrator when any person confined in a state prison is determined to be infected with HIV. If the prison facility administrator, in consultation with the Director of Health Services, determines that a confined HIV-infected person is not following or cannot follow prescribed control measures, thereby presenting a significant risk of HIV transmission, the administrator and the Director shall develop and implement jointly a plan to prevent transmission, including making recommendations to the unit housing classification committee.

(8) The local health director shall ensure that the health plan for local jails include education of jail staff and prisoners about HIV, how it is transmitted, and how to avoid acquiring or transmitting this infection.

(9) Local health departments shall provide counseling and testing for HIV infection at no charge to the patient. Third party payors may be billed for HIV counseling and testing when such services are provided and the patient provides written consent.

(10) HIV pre-test counseling is not required. Post-test counseling for persons infected with HIV is required, must be individualized, and shall include referrals for medical and psychosocial services and control measures.

(11) A local health department or the Department may release information regarding an infected person pursuant to G.S. 130A-143(3) only when the local health department or the Department has provided direct medical care to the infected person and refers the person to or consults with the health care provider to whom the information is released.

(12) Notwithstanding Rule .0201(d) of this Section, a local or state health director may require, as a part of an isolation order issued in accordance with G.S. 130A-145, compliance with a plan to assist the individual to comply with control measures. The plan shall be designed to meet the specific needs of the individuals and may include one or more of the following available and appropriate services.

(a) substance abuse counseling and treatment;
(b) mental health counseling and treatment; and

(c) education and counseling sessions about HIV, HIV transmission, and behavior change required to prevent transmission.

(13) The Division of Public Health shall conduct a partner notification program to assist in the notification and counseling of partners of HIV infected persons.

(14) Every pregnant woman shall be offered HIV testing by her attending physician at her first prenatal visit and in the third trimester. The attending physician shall test the pregnant woman for HIV infection, unless the pregnant woman refuses to provide informed consent pursuant to G.S. 130A-148(h). If there is no record at labor and delivery of an HIV test result during the current pregnancy for the pregnant woman, the attending physician shall inform the pregnant woman that an HIV test will be performed, explain the reasons for testing, and the woman shall be tested for HIV without consent using a rapid HIV test unless it reasonably appears that the test cannot be performed without endangering the safety of the pregnant woman or the person administering the test. If the pregnant woman cannot be tested, an existing specimen, if one exists that was collected within the last 24 hours, shall be tested using a rapid HIV test. The attending physician must provide the woman with the test results as soon as possible. However, labor and delivery providers who do not currently have the capacity to perform rapid HIV testing are not required to use a rapid HIV test until January 1, 2009.

(15) If an infant is delivered by a woman with no record of the result of an HIV test conducted during the pregnancy and if the woman was not tested for HIV during labor and delivery, the fact that the mother has not been tested creates a reasonable suspicion pursuant to G.S. 130A-148(h) that the newborn has HIV infection and the infant shall be tested for HIV. An infant born in the previous 12 hours shall be tested using a rapid HIV test. However, providers who do not currently have the capacity to perform rapid HIV testing shall not be required to use a rapid HIV test until January 1, 2009.

(16) Testing for HIV may be offered as part of routine laboratory testing panels using a general consent which is obtained from the patient for treatment and routine laboratory testing, so long as the patient is notified that they are being tested for HIV and given the opportunity to refuse. (2007)

10A NCAC 41A .0203 Control Measures
-Hepatitis B

(a) The following are the control measures for hepatitis B infection. The infected persons shall:

(1) refrain from sexual intercourse unless condoms are used except when the partner is known to be infected with or immune to hepatitis B;

(2) not share needles or syringes;

(3) not donate or sell blood, plasma,
platelets, other blood products, semen, ova, tissues, organs, or breast milk.
(4) if the time of initial infection is known,
identify to the local health director all sexual intercourse and needle partners since
the date of infection; and, if the date of initial infection is unknown, identify
persons who have been sexual intercourse or needle partners during the previous six
months;
(5) for the duration of the infection, notify
future sexual intercourse partners of the infection, and refer them to their attending
physician or the local health director for control measures; and for the duration of
the infection, notify the local health director of all new sexual intercourse partners;
(6) Identify to the local health director all current household contacts;
(7) Be tested six months after diagnosis to
determine if they are chronic carriers, and when necessary to determine appropriate
control measurements for persons exposed pursuant to Paragraph (b) of this Rule;
(8) Comply with all control measures for hepatitis B infection specified in
Paragraph (a) of 10A NCAC 41A .0201, in those instances where such control measures do not conflict with other requirements of this Rule.
(b) The following are the control measures for persons reasonably suspected of being exposed:
(1) en a person has had a sexual intercourse exposure to hepatitis B infection, the person shall be tested;
(2) after testing, when a susceptible person has had sexual intercourse exposure to hepatitis B infection, the person shall be given a dose of appropriate for body weight of hepatitis B immune globulin and hepatitis B vaccination as soon as possible; hepatitis B immune globulin shall be given no later than two weeks after the last exposure;
(3) when a person is a household contact, sexual intercourse or needle sharing contact of a person who has remained infected with hepatitis B for six months or longer, the partner or household contact, if susceptible and at risk of continued exposure, shall be vaccinated against hepatitis B;
(4) when a health care worker or other person has a needle stick, non-intact skin, or mucous membrane exposure to blood or body fluids that, if the source were infected with the hepatitis B virus, would pose a significant risk of hepatitis B transmission, the following shall apply:
(A) when the source is known, the source person shall be tested for hepatitis B infection unless already known to be infected;
(B) when the source is infected with hepatitis B and the exposed person is:
(i) vaccinated, the exposed person shall be tested for anti-HBs and, if anti-HBs is unknown or less than ten milli-
International Units per ml, receive hepatitis
hepatitis B vaccination and hepatitis B immune globulin as soon as possible; hepatitis B immune globulin shall be given no later than seven days after exposure;

(ii) not vaccinated, the exposed person shall be given a dose appropriate for body weight of hepatitis B immune globulin immediately and begin vaccination with hepatitis B vaccine within seven days;

(C) when the source is unknown, the determination of whether hepatitis B immunization is required shall be made in accordance with current published Control of Communicable Diseases Manual and Centers for Disease Control and Prevention Guidelines.

(5) infants born to HbsAg-positive mothers shall be given hepatitis B vaccination and hepatitis B immune globulin within twelve hours of birth or as soon as possible after the infant is stabilized. Additional doses of hepatitis vaccine shall be given in accordance with current published Control of Communicable Diseases Manual and Centers for Disease Control and Prevention Guidelines. The infant shall be tested for the presence of HBsAg and anti-HBs within three to nine months after the last dose of the regular series of vaccine; if required because of failure to develop immunity after the regular series, additional doses shall be given in accordance with current published Control of Communicable Diseases Manual and Centers for Disease Control and Prevention guidelines.

(6) Infants born to mothers whose HBsAg status is unknown shall be given hepatitis B vaccine within 12 hours of birth and the mother tested. If the tested mother is found to be HbsAg-positive, the infant shall be given hepatitis B immune globulin as soon as possible and no later than seven days after birth.

(7) When an acutely infected person is a primary caregiver of a susceptible infant less than twelve months of age, the infant shall receive an appropriate dose of hepatitis B immune globulin and hepatitis vaccinations in accordance with current published Control of Communicable Diseases Manual and Centers for Disease Control and Prevention Guidelines.

(c) The attending physician shall advise all patients known to be at high risk, including injection drug users, men who have sex with men, hemodialysis patients, and patients who receive multiple transfusions of blood products, that they should be vaccinated against hepatitis B if susceptible. The attending physicians shall also recommend that hepatitis B chronic carriers receive Hepatitis A vaccine (if susceptible).

(d) The following persons shall be tested for and reported in accordance with 10A NCAC 41A.0101 if positive for hepatitis B infection:

(1) pregnant women unless known to be infected; and

(2) donors of blood, plasma, platelets, other blood products, semen, ova, tissues, or organs
(e) the attending physician of a child who is infected with Hepatitis B virus and who may pose a significant risk of transmission in the school or day care setting because of open, oozing wounds or because of behavioral abnormalities such as biting shall notify the local health director. The local health director shall consult with the attending physician and investigate the circumstances.

(f) if the child referred to in Paragraph (e) of this Rule is in school or scheduled for admission and the local health director determines that there may be a significant risk of transmission, the local health director shall consult with an interdisciplinary committee, which shall include school personnel, a medical expert, and the child’s parent or guardian to assist in the investigation and determination of risk. The local health director shall notify the superintendent or private school director of the need to appoint such an interdisciplinary committee. If the superintendent or private school director establishes such a committee within three days of notification, the local health director shall consult with this committee. If the superintendent or private school director does not establish such a committee within three days of notification, the local health director shall establish such a committee.

(g) If the child referred to in Paragraph (e) of this Rule is in day care and the local health director determines that there is a significant risk of transmission, the local health director shall notify the parents that the child must be placed in an alternate child care setting that eliminates the significant risk of transmission. (2003)
10A NCAC 41A .0204 Control Measures - Sexually Transmitted Diseases

(a) Local health departments shall provide diagnosis, testing, treatment, follow-up, and preventive services for syphilis, gonorrhea, chlamydia, nongonococcal urethritis, mucopurulent cervicitis, chancroid, lymphogranuloma venereum, and granuloma inguinale. These services shall be provided upon request and at no charge to the patient.

(b) Persons infected with, exposed to, or reasonably suspected of being infected with gonorrhea, chlamydia, non-gonococcal urethritis, and mucopurulent cervicitis shall:
(1) Refrain from sexual intercourse until examined and diagnosed and treatment is completed, and all lesions are healed;
(2) Be tested, treated, and re-evaluated in accordance with the STD Treatment Guidelines published by the U.S. Public Health Service. The recommendations contained in the STD Treatment Guidelines are the required control measures for testing, treatment, and follow-up for gonorrhea, chlamydia, non-gonococcal urethritis, and mucopurulent cervicitis, and are incorporated by reference including subsequent amendments and editions. However, urethral Gram stains may be used for diagnosis of males rather than gonorrhea cultures unless treatment has failed;
(3) Notify all sexual partners from 30 days before the onset of symptoms to completion of therapy that they must be evaluated by a physician or local health department.

c) Persons infected with, exposed to, or reasonably suspected of being infected with syphilis, lymphogranuloma venereum, granuloma inguinale, and chancroid shall:

(1) Refrain from sexual intercourse until examined and diagnosed and treatment is completed, and all lesions are healed;
(2) Be tested, treated, and re-evaluated in accordance with the STD Treatment Guidelines published by the U.S. Public Health Service. The recommendations contained in the STD Treatment Guidelines are the required control measures for testing, treatment, and follow-up for syphilis, lymphogranuloma venereum, granuloma inguinale, and chancroid, except that chancroid cultures are not required.
(3) Give names to a disease intervention specialist employed by the local health department or by the Division of Public Health for contact tracing of all sexual partners and others as listed in this Rule:
(A) for syphilis:
(i) congenital – parents and siblings;
(ii) primary - all partners from three months before the onset of symptoms to completion of therapy and healing of lesions;
(iii) secondary - all partners from six months before the onset of symptoms to
completion of therapy and healing of lesions; and
   (iv) latent - all partners from 12 months before the onset of symptoms to completion of therapy and healing of lesions and, in addition, for women with late latent, spouses and children;
   (B) for lymphogranuloma venereum:
      (i) if there is a primary lesion and no buboes, all partners from 30 days before the onset of symptoms to completion of therapy and healing of lesions; and
      (ii) if there are buboes all partners from six months before the onset of symptoms to completion of therapy and healing of lesions;
   (C) for granuloma inguinale - all partners from three months before the onset of symptoms to completion of therapy and healing of lesions; and
   (D) for chancroid - all partners from ten days before the onset of symptoms to completion of therapy and healing of lesions.

   (d) All persons evaluated or reasonably suspected of being infected with any sexually transmitted disease shall be tested for syphilis, encouraged to be tested confidentially for HIV, and counseled about how to reduce the risk of acquiring sexually transmitted disease, including the use of condoms.

   (e). All pregnant women shall be tested for syphilis, chlamydia and gonorrhea at the first prenatal visit. All pregnant women shall be tested for syphilis between 28 and 30 weeks of gestation and at delivery. Hospitals shall determine the syphilis serologic status of the mother prior to discharge of the newborn so that if necessary the newborn can be evaluated and treated as provided in (c) (2) of this rule. Pregnant women 25 years of age and younger shall be tested for Chlamydia and gonorrhea in the third trimester or at delivery if the woman was not tested in the third trimester.

   (f) Any woman who delivers a stillborn infant shall be tested for syphilis.

   (g) All newborn infants shall be treated prophylactically against gonococcal ophthalmia neonatorum in accordance with the STD Treatment Guidelines published by the U.S. Public Health Service. The recommendations contained in the STD Treatment Guidelines are the required prophylactic treatment against gonococcal ophthalmia neonatorum. (2008)
10A NCAC 41A .0205 Control Measures – Tuberculosis

(a) The local health director shall investigate all cases of tuberculosis disease and their contacts in accordance with the provisions of the Control of Communicable Diseases Manual, which is hereby incorporated by reference including subsequent amendments and editions. Copies of this publication may be purchased from the American Public Health Association, Publication Sales Department, PO Box 753, Waldorf, MD 20604 for a cost of $22.00 each plus $5.00 shipping and handling. A copy is available for inspection in the Division of Public Health, 1931 Mail Service Center, Raleigh, NC 27699-1931.

(b) The following persons shall be skin tested for tuberculosis and given appropriate clinical, microbiologic and x-ray examination in accordance with the “Diagnostic Standards and Classification of Tuberculosis in Adults and Children,” published by the American Thoracic Society. The recommendations contained in this reference shall be the required control measures for evaluation, testing, and diagnosis for tuberculosis patients, contacts and suspects, except as otherwise provided in this Rule and are incorporated by reference including subsequent amendments and additions:

(1) Household and other high priority contacts of active cases of pulmonary and laryngeal tuberculosis. For purposes of this Rule, a high priority contact is defined in accordance with the Centers for Disease Control and Prevention guidelines which are incorporated by reference in rule .0201 of this section. If the contact’s initial skin test is negative (0-4mm), and the case is confirmed by culture, a repeat skin test shall be performed 8 to 10 weeks after the exposure has ended;

(2) Persons reasonably suspected of having tuberculosis disease;

(3) Inmates in the custody of, and staff with direct inmate contact in, the Department of Corrections upon incarceration or employment, and annually thereafter;

(4) Patients and staff in long term care facilities upon admission or employment. The two-step skin test method shall be used if the individual has not had a documented tuberculin skin test within the preceding 12 months;

(5) Staff in adult day care centers providing care for persons with
with HIV infection or AIDS upon employment. The two-step skin test method shall be used if the individual has not had a documented tuberculin skin test within the preceding 12 months; and

(6) persons with HIV infection or AIDS.

A copy of "Diagnostic Standards and Classification of Tuberculosis in Adults and Children" is available by contacting the Division of Public Health, 1931 Mail Service Center, Raleigh, North Carolina 27699-1931 or by accessing the Centers for Disease Control and Prevention website: at http://www.cdc.gov/nchstp/tb/pubs/mmwrhtml/Maj_guide/cdc_ats_guidelines.htm.

(d) The attending physician or designee shall instruct all patients treated for tuberculosis regarding the potential side effects of the medications prescribed and prescribed medications, including instructions to promptly notify the physician or designee if side effects occur.

(e) Persons with active tuberculosis disease shall complete a standard multi-drug regimen, unless otherwise approved by the State Tuberculosis Medical Director or designee, and shall be managed using Directly Observed Therapy (DOT), which is the actual observation of medication ingestion by a health care worker (HCW).

(f) Persons with suspected or known active pulmonary or laryngeal tuberculosis who have sputum smears positive for acid fast bacilli are considered infectious and shall be managed using airborne precautions, including respiratory isolation, or isolation in their home, with no new persons exposed. These individuals are considered noninfectious and use of airborne precautions, including respiratory isolation or isolation in their home, may be discontinued when:

1. They have three consecutive sputum smears collected at least eight hours apart which are negative; and
2. They have been compliant on tuberculosis medications to which the organism is judged to be susceptible and there is evidence of clinical response to tuberculosis treatment.
(g) Persons with suspected or known active pulmonary or laryngeal tuberculosis who are initially sputum smear negative do not require respiratory isolation once they have been started on tuberculosis treatment. (2006)

10A NCAC 41A 0.206 Infection Control-Health Care Setting

(a) The following definitions shall apply throughout this Rule:

(1) “Health care organization” means hospital; clinic; physician; dentist; podiatrist; optometrist, or chiropractic office; home health agency; nursing home; local health department; community health center; mental health agency; hospice; ambulatory surgical center; urgent care center; emergency room; or any other health care provider that provides clinical care.

(2) “Invasive procedure” means entry into tissues, cavities, or organs or repair of traumatic injuries. The term includes the use of needles to puncture skin, vaginal and cesarean deliveries, surgery, and dental procedures during which bleeding occurs or the potential for bleeding exists.

(b) Health care workers, emergency responders, and funeral service personnel shall follow blood and body fluid precautions with all patients.

(c) Health care workers who have exudative lesions or weeping dermatitis shall refrain from handling patient care equipment and devices used in performing invasive procedures and from all direct patient care that involves the potential for contact of the patient, equipment, or devices with the lesion or dermatitis until the condition resolves.

(d) All equipment used to puncture skin, mucous membranes, or other tissues in medical, dental, or other settings must be disposed of in accordance with 10A NCAC 36B after use or sterilized prior to reuse.

(e) In order to prevent transmission of HIV and hepatitis B from health care workers to patients, each health care organization that performs invasive procedures shall implement a written infection control policy. The health care organization shall ensure that health care workers in its employ or who have staff privileges are trained in the principles of infection control and the practices required by the policy; require and monitor compliance with the policy; and update the policy as needed to prevent transmission of HIV and hepatitis B from health care workers to patients. The health care organization shall designate a staff member to direct these activities. The designated staff member in
staff member in each health care organization shall have completed a course in infection control approved by the Department. The course shall address:

(1) Epidemiologic principles of infectious disease;
(2) Principles and practice of asepsis;
(3) Sterilization, disinfection, and sanitation;
(4) Universal blood and body fluid precautions;
(5) Engineering controls to reduce the risk of sharp injuries;
(6) Disposal of sharps; and
(7) Techniques that reduce the risk of sharp injuries to health care workers.

The infection control policy required by this Rule shall address the following components that are necessary to prevent transmission of HIV and hepatitis B from infected health care workers to patients:

(1) Sterilization and disinfection, including a schedule for maintenance and microbiologic monitoring of equipment, the policy shall require documentation of maintenance and monitoring;
(2) Sanitation of rooms and equipment, including cleaning procedures, agents and schedules;
(3) Accessibility of infection control devices and supplies;
(4) Procedures to be followed in implementing 10A NCAC 41A.0202(4) and .0203(b)(4) when a health care provider or a patient has an exposure to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV or hepatitis B (2003).

10a NCAC 41A .0207 HIV and Hepatitis B Infected Health Care Workers

(a) The following definitions shall apply throughout this Rule:

(1) “surgical or obstetrical procedures” means vaginal deliveries or surgical entry into tissues, cavities, or organs. The term does not include phlebotomy, administration of intramuscular, intradermal, or subcutaneous injections; needle biopsies, needle aspirations; lumber punctures; angiographic procedures; endoscopic and bronchoscopic procedures; or placing or maintaining peripheral or central intravascular lines.

(2) “Dental procedure” means any dental procedure involving manipulation, cutting, or removal of oral or perioral tissues, including tooth structure during which bleeding occurs or the potential for bleeding exists. The term does not include the brushing of teeth.

(b) All health care workers who
perform surgical or obstetrical procedures or dental procedures and who know themselves to be infected with HIV or hepatitis B shall notify the State Health Director. Health care workers who assist in these procedures in a manner that may result in exposure of patients to their blood and who know themselves to be infected with HIV or hepatitis B shall also notify the State Health Director. The notification shall be made in writing to the Chief, Communicable Disease Control Branch, 1902 Mail Service Center, Raleigh, NC 27699-1902.

(c) The State Health Director shall investigate the practice of any infected health care worker and the risk of transmission to patients. The investigation may include review of pertinent medical and work records and consultation with health care professionals who may have information necessary to evaluate the clinical condition or practice of the infected health care worker. The attending physician of the infected health care worker shall be consulted. The State Health Director shall protect the confidentiality of the infected health care worker and may disclose the worker’s infection status only when essential to the conduct of the investigation or periodic reviews pursuant to Paragraph (h) of this Rule. When the health care worker’s infection status is disclosed, the State Health Director shall give instructions regarding the requirement for protecting confidentiality.

(d) If the State Health Director determines that there maybe a significant risk of transmission of HIV or hepatitis B to patients, the State Health Director shall appoint an expert panel to evaluate the risk of transmission to patients, and review the practice, skills, and clinical condition of the infected health care worker, as well as the nature of the surgical or obstetrical procedures or dental procedures performed and operative and infection control techniques used. Each expert panel shall include an infectious disease specialist, an infection control expert, a person who practices the same occupational specialty as the infected health care worker and, if the health care worker is a licensed professional, a representative of the appropriate licensure board. The panel may include other experts. The State Health Director shall consider for appointment recommendations from health care organizations and local societies of health care professionals.

(e) The expert panel shall review information collected by the State Health Director and shall submit a report to the State Health Director. The report shall include a summary of the investigation, the findings of the expert panel, and recommendations for control measures. The State Health Director shall consider the report and shall take appropriate action to control the transmission of HIV or hepatitis B to patients.
Health Director and may request that the State Health Director obtain additional information as needed. The State Health Director shall not reveal to the panel the identity of the infected health care worker. The infected health care worker and the health care worker’s attending physician shall be given an opportunity to present information to the panel. The panel shall make recommendations to the State Health Director that address the following:

(1) Restrictions that are necessary to prevent transmission from the infected health care worker to patients;

(2) Identification of patients that have been exposed to a significant risk of transmission of HIV or hepatitis B; and

(3) Periodic review of the clinical condition and practice of the infected health care worker.

(f) If, prior to receipt of the recommendations of the expert panel, the State Health Director determines that immediate practice restrictions are necessary to prevent an imminent threat to the public health, the State Health Director shall issue an isolation order pursuant to G.S. 130A-145. The isolation order shall require cessation or modification of some or all surgical or obstetrical procedures or dental procedures to the extent necessary to prevent an imminent threat to the public health. This isolation order shall remain in effect until an isolation order is issued pursuant to Paragraph (g) of this Rule or until the State Health Director determines the imminent threat to the public health no longer exists.

(g) After consideration of the recommendations of the expert panel, the State Health Director shall issue an isolation order pursuant to G.S. 130A-145. The isolation order shall require any health care worker who is allowed to continue performing surgical or obstetrical procedures or dental procedures to, within a time period specified by the State Health Director, successfully complete a course in infection control procedures, approved by the Department of Health and Human Resources, General Communicable Disease Control Branch, in accordance with 10A NCAC 41A.0206(e).

The isolation order shall require practice restrictions, such as cessation or modification of some or all surgical or obstetrical procedures or dental procedures, to the extent necessary to prevent a significant risk of transmission of HIV or hepatitis B to patients. The isolation order shall prohibit the performance of procedures that cannot be modified to avoid a significant risk of transmission. If the State Health Director determines that there has been a significant risk of transmission of HIV or hepatitis B to a patient, the State
hepatitis B to a patient, the State Health Director shall notify the patient or assist the health care worker to notify the patient.

(h) The State Health Director shall request the assistance of one or more health care professionals to obtain information needed to periodically review the clinical condition and practice of the infected health care worker who performs or assists in surgical or obstetrical procedures or dental procedures.

(i) An infected health care worker who has been evaluated by the State Health Director shall notify the State Health Director prior to a change in practice involving surgical or obstetrical procedures or dental procedures.

The infected health care worker shall not make the proposed change without approval from the State Health Director. If the State Health Director makes a determination in accordance with Paragraph (c) of this Rule that there is significant risk of transmission of HIV or hepatitis B to patients, the State Health Director shall appoint an expert panel in accordance with Paragraph (d) of this Rule. Otherwise, the State Health Director shall notify the health care worker that he or she may make the proposed change in practice.

(j) If practice restrictions are imposed on a licensed health care worker, a copy of the isolation order shall be provided to the appropriate licensure board. The State Health Director shall report violations of the isolation order to the appropriate licensure board. The licensure board shall report to the State Health Director any information about the infected health care worker that may be relevant to the risk of transmission of HIV or hepatitis B to patients.

10A NCAC 41A .0210 Duties of Attending Physicians

Immediately upon making a diagnosis of or reasonably suspecting a communicable disease or communicable condition for which control measures are provided in Rule .0201, .0202 or .0203 of this Section, the attending physician shall instruct the patient and any other person specified in those control measures to carry out those control measures and shall give sufficiently detailed instructions for proper compliance, or the physician shall request the local health director to give such instruction. When making the initial telephone report for diseases and conditions required to be reported within 24 hours, the physician shall inform the local health director of the control measures given.
10A NCAC 41A .0211 Duties of Other Persons

(a) The local health director may reveal the identity and diagnosis of a person with a reportable communicable disease or communicable condition or other communicable disease or communicable condition which represents a significant threat to the public health to those persons specified in Paragraph (b) when disclosure is necessary to prevent transmission in the facility or establishment for which they are responsible. The local health director shall ensure that all persons so notified are instructed regarding the necessity for protecting confidentiality.

(b) The following persons shall require that any person about whom they are notified pursuant to Paragraph (a) comply with control measures given by the local health director to prevent transmission in the facility or establishment:

(1) the principal of any private or public school;
(2) employers;
(3) superintendents or directors of all public or private institutions, hospitals, or jails; and
(4) operators of a child day care center, child day care home, or other child care providers.

(c) The provisions of Paragraphs (a) and (b) shall not apply with regard to gonorrhea, syphilis, chanroid, granuloma inguinale, lymphogranuloma venereum, chamydia, non-gonococcal urethritis, AIDS, and HIV infection. However, persons may be notified with regard to these diseases and conditions in accordance with 10 A NCAC 41A .0201, 0202 or 0203 of this Section (1991).
CHAPTER 41 – HEALTH: EPIDEMIOLOGY

SUBCHAPTER 41A – COMMUNICABLE DISEASE CONTROL

SECTION .0100 – REPORTING OF COMMUNICABLE DISEASES

10A NCAC 41A .0101 REPORTABLE DISEASES AND CONDITIONS

(a) The following named diseases and conditions are declared to be dangerous to the public health and are hereby made reportable within the time period specified after the disease or condition is reasonably suspected to exist:

1. acquired immune deficiency syndrome (AIDS) -7 days;
2. anthrax - immediately;
3. botulism - immediately;
4. brucellosis -7 days;
5. campylobacter infection -24 hours;
6. chancroid -24 hours;
7. chlamydial infection (laboratory confirmed) -7 days;
8. cholera -24 hours;
9. Creutzfeldt-Jakob disease - 7 days;
10. cryptosporidiosis - 24 hours;
11. cyclosporiasis - 24 hours;
12. dengue -7 days;
13. diphtheria -24 hours;
14. Escherichia coli, shiga toxin-producing -24 hours;
15. ehrlichiosis - 7 days;
16. encephalitis, arboviral -7 days;
17. foodborne disease, including but not limited to Clostridium perfringens, staphylococcal, and Bacillus cereus -24 hours;
18. gonorrhea -24 hours;
19. granuloma inguinale -24 hours;
20. Haemophilus influenzae, invasive disease -24 hours;
21. Hantavirus infection - 7 days;
22. Hemolytic-uremic syndrome - 24 hours;
23. Hemorrhagic fever virus infection - immediately;
24. hepatitis A -24 hours;
25. hepatitis B -24 hours;
26. hepatitis B carriage -7 days;
27. hepatitis C, acute - 7 days;
28. human immunodeficiency virus (HIV) infection confirmed -7 days;
29. influenza virus infection causing death in persons less than 18 years of age - 24 hours;
30. legionellosis -7 days;
31. leprosy - 7 days;
32. leptospirosis -7 days;
33. listeriosis - 24 hours;
34. Lyme disease -7 days;
Communicable Disease

(35) lymphogranuloma venereum -7 days;
(36) malaria -7 days;
(37) measles (rubeola) -24 hours;
(38) meningitis, pneumococcal -7 days;
(39) meningococcal disease -24 hours;
(40) monkeypox - 24 hours;
(41) mumps -7 days;
(42) nongonococcal urethritis -7 days;
(43) novel influenza virus infection; - immediately;
(44) plague - immediately;
(45) paralytic poliomyelitis -24 hours;
(46) psittacosis -7 days;
(47) Q fever -7 days;
(48) rabies, human -24 hours;
(49) Rocky Mountain spotted fever -7 days;
(50) rubella -24 hours;
(51) rubella congenital syndrome -7 days;
(52) salmonellosis -24 hours;
(53) severe acute respiratory syndrome (SARS) - 24 hours;
(54) shigellosis -24 hours;
(55) smallpox - immediately;
(56) Staphylococcus aureus with reduced susceptibility to vancomycin - 24 hours;
(57) streptococcal infection, Group A, invasive disease - 7 days;
(58) syphilis -24 hours;
(59) tetanus -7 days;
(60) toxic shock syndrome -7 days;
(61) trichinosis -7 days;
(62) tuberculosis -24 hours;
(63) tularemia - immediately;
(64) typhoid -24 hours;
(65) typhoid carriage (Salmonella typhi) -7 days;
(66) typhus, epidemic (louse-borne) -7 days;
(67) vaccinia - 24 hours;
(68) vibrio infection (other than cholera) - 24 hours;
(69) whooping cough -24 hours;
(70) yellow fever -7 days.
10A NCAC 41A .0102 METHOD OF REPORTING

(a) When a report of a disease or condition is required to be made pursuant to G.S. 130A-135 through 139 and 10A NCAC 41A .0101, with the exception of laboratories, which shall proceed as in Subparagraph (d), the report shall be made to the local health director as follows:

(1) For diseases and conditions required to be reported within 24 hours, the initial report shall be made by telephone, and the report required by Subparagraph (2) of this Paragraph shall be made within seven days.

(2) In addition to the requirements of Subparagraph (1) of this Paragraph, the report shall be made on the communicable disease report card or in an electronic format provided by the Division of Public Health and shall include the name and address of the patient, the name and address of the parent or guardian if the patient is a minor, and epidemiologic information.

(3) In addition to the requirements of Subparagraphs (1) and (2) of this Paragraph, forms or electronic formats provided by the Division of Public Health for collection of information necessary for disease control and documentation of clinical and epidemiologic information about the cases shall be completed and submitted for the following reportable diseases and conditions identified in 15A NCAC 19A .0101(a): acquired immune deficiency syndrome (AIDS); brucellosis; cholera; cryptosporidiosis; cyclosporiasis; E. coli 0157:H7 infection; ehrlichiosis; Haemophilus influenzae, invasive disease; Hemolytic-uremic syndrome/thrombotic thrombocytopenic purpura; hepatitis A; hepatitis B; hepatitis B carriage; hepatitis C; human immunodeficiency virus (HIV) confirmed; legionellosis; leptospirosis; Lyme disease; malaria; measles (rubella); meningitis, pneumococcal; meningococcal disease; mumps; paralytic poliomyelitis; psittacosis; Rocky Mountain spotted fever; rubella; rubella congenital syndrome; tetanus; toxic shock syndrome; trichinosis; tuberculosis; tularemia; typhoid; typhoid carriage (Salmonella typhi); vibrio infection (other than cholera); and whooping cough.

(4) Communicable disease report cards, surveillance forms, and electronic formats are available from the Division of Public Health, 1915 Mail Service Center, Raleigh, North Carolina 27699-1915, and from local health departments.
Communicable Disease

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10A NCAC 13P .0509 CREDENTIALING OF INDIVIDUALS TO ADMINISTER LIFESAVING TREATMENT TO PERSONS SUFFERING AN ADVERSE REACTION TO AGENTS THAT MIGHT CAUSE ANAPHYLAXIS

(a) To become credentialed by the North Carolina Medical Care Commission to administer epinephrine to persons who suffer adverse reactions to agents that might cause anaphylaxis, a person shall meet the following:

(1) Be 18 years of age or older; and
(2) successfully complete an educational program taught by a physician licensed to practice medicine in North Carolina or designee of the physician. The educational program shall instruct individuals in the appropriate use of procedures for the administration of epinephrine to pediatric and adult victims who suffer adverse reactions to agents that might cause anaphylaxis and shall include the following:

(A) definition of anaphylaxis;
(B) agents that might cause anaphylaxis and the distinction between them, including drugs, insects, foods, and inhalants;
(C) recognition of symptoms of anaphylaxis for both pediatric and adult victims;
(D) appropriate emergency treatment of anaphylaxis as a result of agents that might cause anaphylaxis;

(E) availability and design of packages containing equipment for administering epinephrine to victims suffering from anaphylaxis as a result of agents that might cause anaphylaxis;
(F) pharmacology of epinephrine including indications, contraindications, and side effects;
(G) discussion of legal implications of rendering aid; and
(H) instruction that treatment is to be utilized only in the absence of the availability of physicians or other practitioners who are authorized to administer the treatment.

(b) A credential to administer epinephrine to persons who suffer adverse reactions to agents that might cause anaphylaxis shall be issued by the North Carolina Medical Care Commission upon receipt of a completed application signed by the applicant and the physician who taught or was responsible for the educational program. Applications may be obtained from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707. All credentials shall be valid for a period of four years.

(c) This rule enables only those individuals who do not hold a North Carolina EMS credential and are not associated or affiliated with an EMS system, EMS agency, or emergency response provider, to provide care pending arrival of the emergency responders dispatched through a 911 center to an EMS event involving a person suffering an
Credentialing of Individuals to Administer Lifesaving treatment in Anaphylaxis

an anaphylactic reaction.

History Note: Authority G.S. 143-508(d)(11); 143-509(9);
Temporary Adoption Eff. January 1, 2003; January 1, 2002;
Eff. April 1, 2003;
Emancipation of Minors

G.S. 7B-3500  Who May Petition

Any juvenile who is 16 years of age or older and who has resided in the same county in North Carolina or on federal territory within the boundaries of North Carolina for six months next preceding the filing of the petition may petition the court in that county for a judicial decree of emancipation (1998).

G.S. 7B-3501  Petition

The petition shall be signed and verified by the petitioner and shall contain the following information:

1. The full name of the petitioner and the petitioner’s birth date, and state and county of birth;
2. A certified copy of the petitioner’s birth certificate;
3. The name and last known address of the parent, guardian, or custodian;
4. The petitioner’s address and length of residence at that address;
5. The petitioner’s reasons for requesting emancipation; and
6. The petitioner’s plan for meeting the petitioner’s needs and living expenses which plan may include a statement of employment and wages earned that is verified by the petitioner’s employer (1998).

G.S. 7B-3504  Considerations for Emancipation.

In determining the best interests of the petitioner and the need for emancipation, the court shall review the following considerations:

1. The parental need for the earnings of the petitioner;
2. The petitioner’s ability to function as an adult;
3. The petitioner’s need to contract as an adult or to marry;
4. The employment status of the petitioner and the stability of the petitioner’s living arrangements;
5. The extent of family discord which may threaten reconciliation of the petitioner with the petitioner’s family;
6. The petitioner’s rejection of parental supervision or support; and
7. The quality of parental supervision or support (1998).
Article 36  
§ 7B-3600  Judicial Authorization of Emergency Treatment; Procedure  

A juvenile in need of emergency treatment under Article 1A of Chapter 90 of the General Statutes, whose physician is barred from rendering necessary treatment by reason of parental refusal to consent to treatment, may receive treatment with court authorization under the following procedure:  

(1) The physician shall sign a written statement setting out:  

a. The treatment to be rendered and the emergency need for treatment;  

b. The refusal of the parent, guardian, custodian, or person who has assumed the status and obligation of a parent without being awarded legal custody of the juvenile by a court to consent to the treatment; and  

c. The impossibility of contacting a second physician for a concurring opinion on the need for treatment in time to prevent immediate harm to the juvenile.  

(2) Upon examining the physician’s written statement prescribed in subdivision (1) of this section and finding:  

a. That the statement is in accordance with this Article, and  

b. That the proposed treatment is necessary to prevent immediate harm to the juvenile. The court may issue a written authorization for the proposed treatment to be rendered.  

(3) In acute emergencies in which time may not permit implementation of the written procedure set out in subdivisions (1) and (2) of this section, the court may authorize treatment in person or by telephone upon receiving the oral statement of a physician satisfying the requirements of subdivision (1) of this section and upon finding that the proposed treatment is necessary to prevent immediate harm to the juvenile.  

(4) The court’s authorization for treatment overriding parental refusal to consent should not be given without attempting to offer the parent an opportunity to state the reasons for refusal; however, failure of the court to hear the parent’s objections shall not invalidate judicial authorization under this Article.  

(5) The court’s authorization for treatment under subdivisions (1) and (2) of this section shall be issued in duplicate. One copy shall be given to the treating physician and the other copy shall be attached to the physician’s written statement and filed as a juvenile proceeding in the office of the clerk of court.  

(6) The court’s authorization for treatment under subdivision (3) of this section shall be reduced to writing as soon as possible, supported by the physician’s written statement as prescribed by subdivision (1) of this section and shall be filed as prescribed by in subdivision (5) of this section.  

The court’s authorization for treatment under this Article shall have the same effect as parental consent for treatment.  

Following the court’s authorization for treatment and after giving notice to the juvenile’s parent, guardian, or custodian the court shall conduct a hearing in order to provide for payment for the treatment rendered. The court may order the parent or other responsible parties to pay the cost of treatment. If the court finds the parent is unable to pay the cost of treatment, the cost shall
treatment, the cost shall be a charge upon the county when so ordered. This Article shall operate as a remedy in addition to the provisions in G.S. 7B-903, 7B-2503, and 7B-2506. (1979,c.815, s.1; 1998-202,s.6.)
North Carolina School Health Program Manual

General Statutes, State Policies, and Administrative Code

Appendix II

Item #6

Emergency Medical Treatment Authorization

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Eye Safety Devices

§115C-166 Eye Protection Devices
Required in Certain Courses.

The governing board or authority of any public or private school or educational institution within the State, wherein shops or laboratories are conducted providing instructional or experimental programs involving:

(1) Hot solids, liquids or molten metals;
(2) Milling, sawing, turning, shaping, cutting, or stamping of any solid materials;
(3) Heat treatment, tempering, or kiln firing of any metal or other materials;
(4) Gas or electric arc welding;
(5) Repair or servicing of any vehicle; or
(6) Caustic or explosive chemicals or materials shall provide for and require that every student and teacher wear industrial-quality eye protective devices at all times while participating in any such program. These industrial-quality eye protective devices shall be furnished free of charge to the student and teacher (1981).

§115-167 Visitors to Wear Eye Safety Devices

Visitors to such shops and laboratories shall be furnished with and required to wear such eye safety devices while such programs are in progress (1981).
Eye Safety Devices

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§130A-440 Health Assessment Required

(a) Every child in this State entering kindergarten in the public schools shall receive a health assessment. The health assessment shall be made no more than 12 months prior to the date of school entry. No child shall attend kindergarten unless a health assessment transmittal form, developed pursuant to G.S. 130A-441, indicating that the child has received the health assessment required by this section, is presented to the school principal. The medical provider, or the parent, guardian, or person in loco parentis, must present a completed health assessment transmittal form to the principal of the school on or before the child’s first day of attendance. If a health assessment transmittal form is not presented on or before the first day, the principal shall present a notice of deficiency to the parent, guardian or responsible person. The parent, guardian, or responsible person shall have 30 calendar days from the first day of attendance to present the required health assessment transmittal form for the child. Upon termination of 30 calendar days, the principal shall not permit the child to attend the school until the required health assessment transmittal form has been presented.

(b) A health assessment shall include a medical history and physical examination with screening for vision and hearing and, if appropriate, testing for anemia and tuberculosis. Vision screening shall be conducted in accordance with G.S. 130A-440.1. The health assessment may also include dental screening and developmental screening for cognition, language, and motor function.

(c) The health assessment shall be conducted by a physician licensed to practice medicine, a physician’s assistant as defined in G.S. 90-18.1(a), a certified nurse practitioner, or a public health nurse meeting the Department’s Standards for Early Periodic Screening, Diagnosis, and Treatment.

(d) This Article shall not apply to children entering kindergarten in private church schools, schools of religious charter, or qualified nonpublic schools, regulated by Article 39 of Chapter 115C of the General Statutes (2006).


(a) Vision Screening Required for Children Entering Kindergarten. – Every child in this State entering kindergarten in the public schools, beginning with the 2007-2008 school year, shall obtain vision screening in accordance with vision screening standards adopted by the Governor’s Commission on Early Childhood Vision Care. Within 180 days of the start of the school year, the parent of the child shall present to the school principal or the principal’s designee certification that the child has, within the past 12 months, obtained vision screening conducted by a licensed physician,
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Kindergarten Health Assessment

optometrist, physician assistant, nurse practitioner, registered nurse, orthoptist, or a vision screener certified by Prevent Blindness North Carolina, or a comprehensive eye examination performed by an ophthalmologist or optometrist. The health assessment transmittal form required pursuant to G.S. 130A-440 qualifies as certification that the child has obtained the required vision screening. All providers conducting vision screening shall provide each parent in writing the results of the vision screening on forms bearing the signature of the provider supplied to the provider by the Governor's Commission on Early Childhood Vision Care. The provider shall also orally communicate this information to the parent and shall take reasonable steps to ensure that the parent understands the information communicated. In the instance where a child enters the first grade without having been enrolled in a kindergarten program requiring a vision screening, the requirements for vision screening under this subsection shall apply.

(a1) Comprehensive Eye Examination. – For children who receive and fail to pass a vision screening as required under subsection (a) of this section, a comprehensive eye examination is required. If a public school teacher, administrator, or other appropriate school personnel has reason to believe that a child enrolled in kindergarten through third grade is having problems with vision, the school personnel may recommend to the child's parent that the child have a comprehensive eye examination. Notification to the parent shall also inform the parent that funds may be available from the Governor's Commission on Early Childhood Vision Care to pay providers for the examination, including corrective lenses.

The comprehensive eye examination shall be conducted by a duly licensed optometrist or ophthalmologist. The comprehensive eye examination conducted pursuant to this section shall consist of a complete and thorough examination of the eye and shall include:

(1) Measurement of visual acuity;
(2) Ocular alignment and motility;
(3) Depth perception – stereopsis;
(4) Fusion;
(5) Slit lamp examination of the lid margins, conjunctivae, cornea, anterior chamber, iris, and crystalline lens;
(6) Examination of the ocular adnexa, the anterior segment, and pupils; and
(7) Cycloplegic refraction and dilated fundus examination.

Health assessment vision screening under G.S. 130A-440 is not a comprehensive eye examination for purposes of this section.

(b) Repealed by Session Laws 2006-240, s. 1(a), effective August 13, 2006.

(c) The results of a comprehensive eye examination conducted under this section shall be included on the comprehensive eye examination transmittal form developed by the Commission pursuant to G.S. 143B-216.75 and shall contain a summary of the comprehensive eye examination performed by the optometrist or ophthalmologist. Any treatment recommendations by the optometrist or ophthalmologist, such as
spectacles for schoolwork, shall appear in the summary and school health card. The provider shall present a signed transmittal form to the parent upon completion of the examination. The parent shall submit the transmittal form to the school in accordance with this section.

(d) Repealed by Session Laws 2006-240, s. 1(a), effective August 13, 2006.

(e) G.S. 130A-441, 130A-442, and 130A-443, pertaining to health assessments, apply to comprehensive eye examinations required under this section.

(f) No child shall be excluded from attending school for a parent's failure to obtain a comprehensive eye examination required under this section. If a parent fails or refuses to obtain a comprehensive eye examination or to provide the certification of a comprehensive eye examination, the school shall send a written reminder to the parent of required eye examinations and shall include information about funds that may be available from the Governor's Commission on Early Childhood Vision Care.

(g) In adopting standards for vision screening under this section and as required under G.S. 130A-440, the Commission shall take into account the resources necessary to comply with the standards and, if standards will require additional resources, shall mitigate the impact on resources without compromising vision screening effectiveness.

(h) As used in this section, the term "parent" means the parent, guardian, or person standing in loco parentis. (2005-276, s. 10.59F(g); 2005-345, s. 20(d); 2006-240, s. 1(a).)

§130A-441 Reporting

(a) Health assessment results shall be submitted to the school principal by the medical provider on health assessment transmittal forms developed by the Department and the Department of Public Instruction.

(b) Each school having a kindergarten shall maintain on file the health assessment results. The files shall be open to inspection by the Department, the Department of Public Instruction, or their authorized representatives and persons inspecting the files shall maintain the confidentiality of the files. Upon transfer of a child to another kindergarten, a copy of the health assessment results shall be provided upon request and without charge to the new kindergarten.

(c) Within 60 calendar days after the commencement of a new school year, the principal shall file a health assessment status report with the Department on forms developed by the Department and the Department of Public Instruction. The report shall document the number of children in compliance and not in compliance with G.S. 130A-440(a) (1993).

§130A-442 Religious Exemption

If the bona fide religious beliefs of the parent, guardian or person in loco parentis of a child are contrary to the health assessment requirements contained in this Article, this Article shall not apply to the child. Upon
child. Upon submission of a written statement of the bona fide religious beliefs and opposition to the health assessment requirements, the child may attend kindergarten without submitting a health assessment report. (1986)
General Statutes, State Policies, and Administrative Code
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Kindergarten Health Assessment

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§ 115C-323. Employee health certificate.

(a) Any person initially employed in a public school or reemployed in a public school after an absence of more than one school year shall provide to the superintendent a certificate certifying that the person does not have any physical or mental disease, including tuberculosis in the communicable form or other communicable disease, that would impair the person's ability to perform his or her duties effectively. A local board or a superintendent may require any school employee to take a physical examination when considered necessary.

Any public school employee who has been absent for more than 40 successive school days because of a communicable disease shall, before returning to work, provide to the superintendent a certificate certifying that the individual is free from any communicable disease.

(b) One of the following individuals shall prepare any certificate required under this section:

(1) A physician licensed to practice in North Carolina.

(2) A nurse practitioner approved under G.S. 90-18(14).

(3) A physician's assistant licensed to practice in North Carolina.

(c) Notwithstanding subsection (b) of this section, in the case of a person initially employed in a public school, any of the following who holds a current unrestricted license or registration in another state may prepare the certificate so long as evidence of that license or registration is on the certificate:

(1) A physician.

(2) A nurse practitioner.

(3) A physician's assistant.

(d) The certificate shall be prepared on a form supplied by the Superintendent of Public Instruction. The certificate shall be issued only after a physical examination has been conducted, at the time of the certification, in accordance with rules adopted by the Superintendent of Public Instruction, with approval of the Secretary of Health and Human Services. These rules may require an X-ray chest examination for all new employees of the public school system.

(e) It shall be the duty of the superintendent of the school in which the person is employed to enforce the provisions of this section. Any person violating any of the provisions of this section shall be guilty of a Class 1 misdemeanor. (1955, c. 1372, art. 17, s. 1; 1957, c. 1357, ss. 2, 14; 1973, c. 476, s. 128; 1975, c. 72; 1981, c. 423, s. 1; 1985 (Reg. Sess., 1986), c. 975, s. 20; 1991, c. 342, s. 4; 1993, c. 539, s. 886; 1994, Ex. Sess., c. 24, s. 14(c); 1997-443, s. 11A.50; 2001-118, s. 1.)
Section 1. LOCAL SCHOOL HEALTH ADVISORY COUNCIL

(a) Each school district shall establish and maintain a local School Health Advisory Council to help plan, implement, and monitor this policy as well as other health issues as part of the coordinated school health plan.

(b) The local School Health Advisory Council shall be composed of community and school representatives from the eight areas of a coordinated school health program mentioned in Section 4 (a), representatives from the local health department and school administration.

Section 2. PHYSICAL EDUCATION

(a) To address issues such as overweight, obesity, cardiovascular disease, and Type II diabetes, students enrolled in kindergarten through eighth grades are to participate in physical activity as part of the district’s physical education curriculum. Elementary schools should consider the benefits of and move toward having 150 minutes per week with a certified physical education teacher throughout the 180 day school year. Middle schools should consider the benefits of and move toward having 225 minutes per week of Healthful Living Education with certified health and physical education teachers throughout the 180-day school year.

(b) The physical education course shall be the environment in which students learn, practice and receive assessment on developmentally appropriate motor skills, social skills, and knowledge as defined in the North Carolina Healthful Living Standard Course of Study and foster support and guidance for being physically active. In order to meet enhanced goals, these classes should be the same class size as other regular classes.

Section 3. RECESS AND PHYSICAL ACTIVITY

Structured/unstructured recess and other physical activity (such as, but not limited to, physical activity time, physical education or intramurals) shall not be taken away from students as a form of punishment. In addition, severe and inappropriate exercise may not be used as a form of punishment for students.

A minimum of 30 minutes of moderate to vigorous physical activity shall be provided by schools for all K-8 students daily. This requirement can be achieved through a regular physical education class and/or through activities such as recess, dance, classroom energizers, or other curriculum-based physical activity programs. However, such use of this time should complement and
complement and not substitute for the physical education program.

(c) The physical activity required by this section must involve physical exertion of at least a moderate to vigorous intensity level and for a duration sufficient to provide a significant health benefit to students.

Section 4. COORDINATED SCHOOL HEALTH PROGRAMS (CSHP)

(a) The State Board of Education shall make available to each school district a coordinated school health model designed to address health issues of children. The program must provide for coordinating the following eight components:

1. Safe environment;
2. Physical education;
3. Health education;
4. Staff wellness;
5. Health services;
6. Mental and social health;
7. Nutrition services; and
8. Parental/family involvement.

(b) The North Carolina Department of Public Instruction shall notify each school district of the availability of professional development opportunities and provide technical assistance in implementing coordinated school health programs at the local level.

(c) The physical activity required by this section must involve physical exertion of at least a moderate to vigorous intensity level and for a duration sufficient to provide a significant health benefit to students.

Section 5. THIS POLICY SHALL BE FULLY IMPLEMENTED BY THE 2006-2007 SCHOOL YEAR.

(a) Each local school district shall develop an action plan prepared in collaboration with the local School Health Advisory Council to assist in the implementation of the policy. This action plan shall identify steps that need to be taken each year to fully implement the policy by the 2006-2007 school year and shall include a review and appropriate modification of existing physical education curricula.

(b) Action plans shall be submitted to the North Carolina Department of Public Instruction by July 15, 2004.

(c) Progress reports shall be submitted to the North Carolina Department of Public Instruction by July 15, 2005 and 2006.

(d) Beginning July 15, 2007, each local school district in collaboration with the local School Health Advisory Council shall prepare a report annually which will include the minutes of physical education and/or healthful living, physical activity received by students in each school within the district. Indicators that will mark successful implementation and evidences of completion shall be a part of the plan.

This report shall be completed by July 15th each year and remain on file for a period of 12 months to be provided upon request of the North Carolina Department of Public Instruction and local boards of education.

(f) Progress reports and the annual reports shall also include any other information that may be recommended from the State Board of Education’s Ad Hoc Committee studying implementation of the physical education and Healthful Living programs in kindergarten through eighth grades.
Guidelines for the Development and Implementation of Individual Diabetes Care Plans and to require Local Boards of Education To Implement These Guidelines

(Also known as Senate Bill 911)

G.S. 115C-47 is amended adding a new subdivision found in 115C-12 s.(31) To Adopt Guidelines for Individual Diabetes Care Plans.

§ 115C-12. Powers and duties of the Board generally.
The general supervision and administration of the free public school system shall be vested in the State Board of Education. The State Board of Education shall establish policy for the system of free public schools, subject to laws enacted by the General Assembly. The powers and duties of the State Board of Education are defined as follows:
(31) To Adopt Guidelines for Individual Diabetes Care Plans. – The State Board shall adopt guidelines for the development and implementation of individual diabetes care plans. The State Board shall consult with the North Carolina Diabetes Advisory Council established by the Department of Health and Human Services in the development of these guidelines. The State Board also shall consult with local school administrative unit employees who have been designated as responsible for coordinating their individual unit's efforts to comply with federal regulations adopted under Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794. In its development of these guidelines, the State Board shall refer to the guidelines recommended by the American Diabetes Association for the management of children with diabetes in the school and day care setting and shall consider recent resolutions by the United States Department of Education's Office of Civil Rights of investigations into complaints alleging discrimination against students with diabetes.

The guidelines adopted by the State Board shall include:
a. Procedures for the development of an individual diabetes care plan at the written request of the student's parent or guardian, and involving the parent or guardian, the student's health care provider, the student's classroom teacher, the student if appropriate, the school nurse if available, and
other appropriate school personnel.
b. Procedures for regular review of
an individual care plan.
c. Information to be included in a
diabetes care plan, including the
responsibilities and appropriate
staff development for teachers
and other school personnel, an
emergency care plan, the
identification of allowable
actions to be taken, the extent to
which the student is able to
participate in the student's
diabetes care and management,
and other information necessary
for teachers and other school
personnel in order to offer
appropriate assistance and
support to the student. The State
Board shall ensure that the
information and allowable
actions included in a diabetes
care plan as required in this
subdivision meet or exceed the
American Diabetes Association's
recommendations for the
management of children with
diabetes in the school and day
care setting.
d. Information and staff
development to be made
available to teachers and other
school personnel in order to
appropriately support and assist
students with diabetes.

The State Board shall ensure that these
guidelines are updated as necessary and
shall ensure that the guidelines and any
subsequent changes are published and
disseminated to local school
administrative units.

This act is effective when it becomes
law. The guidelines under Section 1 of
this act shall be adopted no later than
January 15, 2003, and shall be
implemented under Section 2 of this act
beginning with the 2003-2004 school
year. (2002)

§ 15C-375.3. Guidelines to support and
assist students with diabetes.
(Amendment adopted 2009)

Local boards of education and
boards of directors of charter schools
shall ensure that the guidelines adopted
by the State Board of Education under
G.S. 115C-12(31) are implemented in
schools in which students with diabetes
are enrolled. In particular, the boards
shall require the implementation of the
procedures set forth in those guidelines
for the development and implementation
of individual diabetes care plans. The
boards also shall make available
necessary information and staff
development to teachers and school
personnel in order to appropriately
support and assist students with diabetes
in accordance with their individual
diabetes care plans. Local boards of
education and boards of directors of
charter schools shall report to the State
Board of Education annually, on or
before August 15, whether they have
students with diabetes enrolled and
provide information showing
General Statutes, State Policies, and Administrative Code

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Students with Diabetes

compliance with the guidelines adopted by the State Board of Education under G.S. 115C-12(31). These reports shall be in compliance with the federal Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g. (2005-22, s. 3(a), (b); 2009-563, s. 1.)
Students with Diabetes

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Article 25A.

Special Medical Needs of Students.

§ 115C-375.1. To provide some medical care to students.

It is within the scope of duty of teachers, including substitute teachers, teacher assistants, student teachers, or any other public school employee when authorized by the board of education or its designee, (i) to administer any drugs or medication prescribed by a doctor upon written request of the parents, (ii) to give emergency health care when reasonably apparent circumstances indicate that any delay would seriously worsen the physical condition or endanger the life of the pupil, and (iii) to perform any other first aid or lifesaving techniques in which the employee has been trained in a program approved by the State Board of Education. No employee, however, shall be required to administer drugs or medication or attend lifesaving techniques programs.

Any public school employee, authorized by the board of education or its designee to act under (i), (ii), or (iii) above, shall not be liable in civil damages for any authorized act or for any omission relating to the act unless the act amounts to gross negligence, wanton conduct, or intentional wrongdoing.

At the commencement of each school year, but before the beginning of classes, and thereafter as circumstances require, the principal of each school shall determine which persons will participate in the medical care program. (2005-22, s. 2(b); 2006-264, ss. 57(a), (c).)
Medical Care to Students by School Personnel

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§ 90-21.1 When Physician May Treat Minor Without Consent of Parent, Guardian or Person in loco parentis

It shall be lawful for any physician licensed to practice medicine in North Carolina to render treatment to any minor without first obtaining the consent and approval of either the father or mother of said child, or any person acting as guardian, or any person standing in loco parentis to said child where:

1. The parent or parents, the guardian, or a person standing in loco parentis to said child cannot be located or contacted with reasonable diligence during the time within which said minor needs to receive the treatment herein authorized, or

2. Where the identity of the child is unknown, or where the necessity for immediate treatment is so apparent that any effort to secure approval would delay the treatment so long as to endanger the life of said minor, or

3. Where an effort to contact a parent, guardian, or person standing in loco parentis would result in a delay that would seriously worsen the physical condition of said minor, or

4. Where the parents refuse to consent to a procedure, and the necessity for immediate treatment is so apparent that the delay required to obtain a court order would endanger life or seriously worsen the physical condition of the child. No treatment shall be administered to a child over the parent’s objection as herein authorized unless the physician shall first obtain the opinion of another physician licensed to practice medicine in the State of North Carolina that such procedure is necessary to prevent immediate harm to the child.

Provided, however, that the refusal of a physician to use, perform or render treatment to a minor without consent of the minor’s parent, guardian, or person standing in the position of loco parentis, in accordance with this Article, shall not constitute grounds for a civil action or criminal proceedings against such physician (1977).

§90-21.2 “Treatment” Defined

The word “treatment” as used in G.S. 90-21.1 is hereby defined to mean any medical procedure or treatment, including X-rays, the administration of drugs, blood transfusions, use of anesthetics, and laboratory or other diagnostic procedures employed by or ordered by a physician licensed to practice medicine in the State of North Carolina that is used, employed, or ordered to be used or employed commensurate with the exercise of reasonable care and equal to the standards of medical practice normally employed in the community where said physician administers treatment to said minor (1965)
§90-21.3 Performance of Surgery on Minor; Obtaining Second Opinion as to Necessity

The word “treatment” as defined in G.S. 90-21.2 shall also include any surgical procedure which in the opinion of the attending physician is necessary under the terms and conditions set out in G.S. 90.21.1; provided, however, no surgery shall be conducted upon a minor as herein authorized unless the surgeon shall first obtain the opinion of another physician licensed to practice medicine in the State of North Carolina that said surgery is necessary under the conditions set forth in G.S. 90.21.1; provided further, that in any emergency situation that shall arise in a rural community, or in a community where it is impossible for the surgeon to contact any other physician for the purpose of obtaining his opinion as to the necessity for immediate surgery, it shall not be necessary for the surgeon to obtain approval from another physician before performing such surgery as is necessary under the terms and conditions set forth in G.S. 90.21.1 (1965)

§90.21.4 Responsibility, Liability and Immunity of Physicians

(a) Any physician licensed to practice medicine in North Carolina providing health services to a minor under the terms, conditions and circumstances of this Article shall not be held liable in any civil or criminal action for providing such services without having obtained permission from the minor’s parent, legal guardian, person standing in loco parentis, or a legal custodian other than a parent when granted specific authority in a custody order to consent to medical or psychiatric treatment. The physician shall not be relieved on the basis of this Article from liability for negligence in the diagnosis and treatment of a minor.

(b) The physician shall not notify a parent, legal guardian, person standing in loco parentis, or a legal custodian other than a parent when granted specific authority in a custody order to consent to medical, or psychiatric treatment, without the permission of the minor, concerning the medical health services set out in G.S. 90.21.5(a), unless the situation in the opinion of the attending physician indicates that notification is essential to the life or health of the minor. If a parent, legal guardian, person standing in loco parentis, or a legal custodian other than a parent when granted specific authority in a custody order to consent to medical or psychiatric treatment contacts the physician concerning the treatment or medical services being provided to the minor, the physician may give information (1985)

§90.21.5 Minor’s Consent Sufficient for Certain Medical Health Services

(a) Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for

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the prevention, diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130A-135 (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 1 of Chapter 122C of the General Statutes except as provided in G.S. 122C-222. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-222.

(b) Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child (1986).
Article 1 B: Medical Malpractice Actions

§90.21.11 Definitions

As used in this Article, the term “health care provider” means without limitation any person who pursuant to the provisions of Chapter 90 of the General Statutes is licensed, or is otherwise registered or certified to engage in the practice of or otherwise performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, psychology; or a hospital or a nursing home or any other person who is legally responsible for the negligence of such person, hospital or nursing home; or any other person acting at the direction or under the supervision of any of the foregoing persons, hospital, or nursing home (bold added).

As used in this Article, the term “medical malpractice action” means a civil action for damages for personal injury or death arising out of the furnishing or failure to furnish professional services in the performance of medical, dental, or other health care (1995).

§90.21.12 Standard of Health Care

In any action for damages for personal injury or death arising out of the furnishing or failure to furnish professional services in the performance of medical, dental, or other health care, the defendant shall not be liable for the payment of damages unless the trier of the facts is satisfied by the greater weight of the evidence that the care of such health care provider was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act giving rise to the cause of action (1975).

§90.21.13 Informed Consent to Health Care Treatment or Procedure

(a) No recovery shall be allowed against any health care provider upon the grounds that the health care treatment was rendered without the informed consent of the patient or other person authorized to give consent for the patient where:

(1) The action of the health provider in obtaining the consent of the patient or other person authorized to give consent for the patient was in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities; and

(2) A reasonable person, from the information provided by the health care provider under the circumstances, would have a general understanding of the procedures or treatments and of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments which are recognized and followed by other health care providers engaged in the same field of practice in the same or similar communities; and

(3) A reasonable person, under all the circumstances, would have a general understanding of the procedures or treatments and of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments which are recognized and followed by other health care providers engaged in the same field of practice in the same or similar communities.
surrounding circumstances, would have undergone such treatment or procedure had he been advised by the health care provider in accordance with the provisions of subdivisions (1) and (2) of this section.

(b) A consent which is evidenced in writing and which meets the foregoing standards, and which is signed by the patient or other authorized person, shall be presumed to be a valid consent. This presumption, however, may be subject to rebuttal only upon proof that such consent was obtained by fraud, deception or misrepresentation of a material fact. A consent that meets the foregoing standards, that is given by a patient, or other authorized person, who under all the surrounding circumstances has capacity to make and communicate health care decisions, is a valid consent.

(c) The following persons, in the order indicated, are authorized to consent to medical treatment on behalf of a patient who is comatose or otherwise lacks capacity to make or communicate health care decisions:

(1) A guardian of the patient’s person, or a general guardian with powers over the patient’s person, appointed by a court of competent jurisdiction pursuant to Article 5 of Chapter 35A of the General Statutes; provided that, if the patient has a health care agent appointed pursuant to a valid health care power of attorney, the health care agent shall have the right to exercise the authority to the extent granted in the health care power of attorney and to the extent provided in G.S. 32A-19(b) unless the Clerk has suspended the authority of that health care agent in accordance with G.S. 35A-1208(a);

(2) A health care agent appointed pursuant to a valid health care power of attorney, to the extent of the authority granted;

(3) An attorney-in-fact, with powers to make health care decisions for the patient, appointed by the patient pursuant to Article 1 or Article 2 of Chapter 32A of the General Statutes, to the extent of the authority granted;

(4) The patient’s spouse;

(5) A majority of the patient’s reasonably available parents and children who are at least 18 years of age;

(6) A majority of the patient’s reasonably available siblings who are at least 18 years of age; or

(7) An individual who has an established relationship with the patient, who is acting in good faith on behalf of the patient, and who can reliably convey the patient’s wishes.

(c1) If none of the persons listed under subsection (c) of this section is reasonably available, then the patient’s attending physician, in the attending physician’s discretion, may provide health care treatment without the consent of the patient or other person authorized to consent for the patient if there is confirmation by a physician other than the patient’s attending physician of the patient’s condition and the necessity for treatment; provided, however, that confirmation of the patient’s condition and the necessity for treatment are not required if the delay in obtaining the confirmation would endanger the life or seriously worsen the condition of the patient.

(d) No action may be maintained against any health care provider upon any guarantee,
warranty or assurance as to the result of any medical, surgical or diagnostic procedure or treatment unless the guarantee, warranty or assurance, or some note or memorandum thereof, shall be in writing and signed by the provider or by some other person authorized to act for or on behalf of such provider.

(e) In the event of any conflict between the provisions of this section and those of G.S. 35A-1245, 90-21.17, and 90-322, Articles 1A and 19 of Chapter 90, and Article 3 of Chapter 122C of the General Statutes, the provisions of those sections and Articles shall control and continue in full force and effect (2007).

§90.21.14 First Aid or Emergency Treatment: Liability Limitation
(a) Any person, including a volunteer medical or health care provider at a facility of a local health department as defined in G.S. 130A-2 or at a non-profit community health center or a volunteer member of a rescue squad, who receives no compensation for his services as an emergency medical care provider, who renders first aid or emergency health care treatment to a person who is unconscious, ill, or injured.

(1) When the reasonably apparent circumstances require prompt decisions and actions in medical or other health care, and

(2) When the necessity of immediate health care treatment is so reasonably apparent that any delay in the rendering of the treatment would seriously worsen the physical condition or endanger the life of the person, shall not be liable for damages for injuries alleged to have been sustained by the person or for damages for the death of the person alleged to have occurred by reason of an act or omission in the rendering of the treatment unless it is established that the injuries were or the death was caused by gross negligence, wanton conduct or intentional wrongdoing on the part of the person rendering the treatment.

(b) Nothing in this section shall be deemed or construed to relieve any person from liability for damages for injury or death caused by an act or omission on the part of such person while rendering health care services in the normal and ordinary course of his business or profession. Services provided by a volunteer health care provider who receives no compensation for his services and who renders first aid or emergency treatment to members of athletic teams are deemed not to be in the normal and ordinary course of the volunteer health care provider’s business or profession.

(c) In the event of any conflict between the provisions of this section and those of G.S. 20-166(d), the provisions of G.S. 20-166(d), shall control and continue in full force and effect (2001).
North Carolina School Health Program Manual

General Statutes, State Policies, and Administrative Code

Appendix II  Item #14

_______________________________________________________________

Medical Malpractice

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§ 8-53 Communications Between Physician and Patient

No person, duly authorized to practice physic or surgery, shall be required to disclose any information which he may have acquired in attending a patient in a professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as a surgeon, and no such information shall be considered public records under G.S. 132-1. Confidential information obtained in medical records shall be furnished only on the authorization of the patient, or if deceased, the executor, administrator, or, in the case of unadministered estates, the next of kin. Any resident or presiding judge in the district, either at the trial or prior thereto, or the Industrial Commission pursuant to law may, subject to G.S. 8-53.6, compel disclosure if in his opinion disclosure is necessary to a proper administration of justice. If the case is in district court the judge shall be a district court judge, and if the case is in superior court the judge shall be a superior court judge (1983).

§ 8-53.1 Physician-patient and nurse privilege; limitations.

(a) Notwithstanding the provisions of G.S. 8-53 and G.S. 8-53.13, the physician-patient or nurse privilege shall not be a ground for excluding evidence regarding the abuse or neglect of a child under the age of 16 years or regarding an illness of or injuries to such child or the cause thereof in any judicial proceeding related to a report pursuant to the North Carolina Juvenile Code, Chapter 7B of the General Statutes of North Carolina.

(b) Nothing in this Article shall preclude a health care provider, as defined in G.S. 90-21.11, from disclosing information pursuant to G.S. 90-21.20B. (1965, c. 472, s. 2; 1971, c. 710, s. 2; 1981, c. 469, s. 24; 1998-202, s. 13(b); 2004-186, s. 16.2; 2006-253, s. 18; 2007-115, s. 4.)

§ 8-53.4 School Counselor Privilege

No person certified by the State Department of Public Instruction as a school counselor and duly appointed or designated as such by the governing body of a public school system within this State or by the head of any private school while within this State shall be competent to testify in any action, suit, or proceeding concerning any information acquired in rendering counseling services to any student enrolled in such public school system or private school, and which information was necessary to enable him to render counseling services; provided, however, that this section shall not apply where the student in open court waives the privilege conferred. Any resident or presiding judge in the district in which the action is pending may compel disclosure, either at the trial or prior thereto, in his opinion disclosure is necessary to a proper administration of justice. If the case is in district court the judge shall be the district court judge, and if the case is in superior court the judge shall be a superior court judge (1983).
§115C-401 School Counseling Inadmissible Evidence
Information given to a school counselor to enable him to render counseling services may be privileged as provided G.S. 8-53.4 (1981).
Physician – Patient Communications

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Nursing Practice Act

§90-171.19 Legislative Findings
The General Assembly of North Carolina finds that mandatory licensure of all who engage in the practice of nursing is necessary to ensure minimum standards of competency and to provide the public safe nursing care.

§90-171.20 Definitions
As used in this Article, unless the context required otherwise;
(1) “Board” means the North Carolina Board of Nursing.
(2) “Health care provider” means any licensed health care professional and any agent or employee of any health care institution, health care insurer, health care professional school, or a member of any allied health profession. For purposes of this Article, a person enrolled in a program that prepares the person to be a licensed health care professional or an allied health professional shall be deemed a health care provider.
(3) “License” means a permit issued by the Board to practice nursing as a registered nurse or as a licensed practical nurse, including a renewal thereof.
(4) “Nursing” is a dynamic discipline which includes the assessing, caring, counseling, teaching, referring and implementing of prescribed treatment in the maintenance of health, prevention and management of illness, injury, disability or the achievement of a dignified death. It is ministering to, assisting and sustained, vigilant and continuous care of those acutely or chronically ill, supervising patients during convalescence and rehabilitation; the supportive and restorative care given to maintain the optimum health level of individuals, groups and communities; the supervision, teaching and evaluation of those who perform or are preparing to perform these functions; and the administration of nursing programs and nursing services.
(5) “Nursing program” means any educational program in North Carolina offering to prepare persons to meet the educational requirements for licensure under this Article.
(6) “Person” means an individual, corporation, partnership, association, unit of government, or other legal entity
(7) The “practice of nursing by a registered nurse” consist of the following ten components:
   (a) Assessing the patient’s physical and mental health including the patient’s reaction to illnesses and treatment regimens.
   (b) Recording and reporting the results of the nursing assessment.
   (c) Planning, initiating, delivering, and evaluating appropriate nursing acts.
   (d) Teaching, assigning, delegating to or supervising other personnel in implementing the treatment regimen.
   (e) Collaborating with other health care providers in determining the appropriate health care for a patient but, subject to the provisions of G.S. 90-182, not prescribing a medical treatment regimen or making a medical diagnosis, except under supervision of
of a licensed physician.

(f) Implementing the treatment and pharmaceutical regimen prescribed by any person authorized at State law to prescribe the regimen.

(g) Providing teaching and counseling about the patient’s health.

(h) Reporting and recording the plan for care, nursing care given, and the patient’s response to that care.

(i) Supervising, teaching and evaluating those who perform or are preparing to perform nursing functions and administering nursing programs and nursing services.

(j) Providing for the maintenance of safe and effective nursing care, whether rendered directly or indirectly.

(8) The “practice of nursing by a licensed practical nurse” consists of the following seven components.

(a) Participating in the assessment of the patient’s physical and mental health, including the patient’s reaction to illnesses and treatment regimens.

(b) Recording and reporting the results of the nursing assessment.

(c) Participating in implementing the health care plan developed by the registered nurse and/or prescribed by any person authorized by State law to prescribe such a plan, by performing tasks assigned or delegated by and performed under the supervision or under orders or directions of a registered nurse, physician licensed to practice medicine, dentist, or other person authorized by State law to provide the supervision.

(c1) assigning or delegating nursing interventions to other qualified personnel under the supervision of the registered nurse.

(d) Participating in the teaching and counseling of patients as assigned by a registered nurse, physician, or other qualified professional licensed to practice North Carolina.

(e) Reporting and recording the nursing care rendered and the patient’s response to that care.

(f) Maintaining safe and effective nursing care, whether rendered directly or indirectly.

(2001)

21 NCAC 36 .0221 LICENSE REQUIRED

(a) No cap, pin, uniform, insignia or title shall be used to represent to the public, that an unlicensed person is a registered nurse or a licensed practical nurse as defined in G.S. 90-171.43.

(b) The repetitive performance of a common task or procedure which does not require the professional judgment of a registered nurse or licensed practical nurse shall not be considered the practice of nursing for which a license is required. Tasks that may be delegated to the Nurse Aide I and Nurse Aide II shall be established by the Board of Nursing pursuant to 21 NCAC 36 .0403. Tasks may be delegated to an unlicensed person which:

(1) frequently recur in the daily care of a client or group of clients;

(2) are performed according to an established sequence of steps;
(3) involve little or no modification from one client-care situation to another;
(4) may be performed with a predictable outcome; and
(5) do not inherently involve ongoing assessment, interpretation, or decision-making which cannot be logically separated from the procedure(s) itself.

Client-care services which do not meet all of these criteria shall be performed by a licensed nurse.

c) The registered nurse or licensed practical nurse shall not delegate the professional judgment required to implement any treatment or pharmaceutical regimen which is likely to produce side effects, toxic effects, allergic reactions, or other unusual effects; or which may rapidly endanger a client's life or well-being and which is prescribed by a person authorized by state law to prescribe such a regimen. The nurse who assumes responsibility for implementing a treatment or pharmaceutical regimen shall be accountable for:

(1) recognizing side effects;
(2) recognizing toxic effects;
(3) recognizing allergic reactions;
(4) recognizing immediate desired effects;
(5) recognizing unusual and unexpected effects;
(6) recognizing changes in client's condition that contraindicates continued administration of the medication;
(7) anticipating those effects which may rapidly endanger a client's life or well-being; and
(8) making judgments and decisions concerning actions to take in the event such untoward effects occur.

d) When health care needs of an individual are incidental to the personal care needs of the individual, nurses shall not be accountable for care performed by clients themselves, their families or significant others, or by caretakers who provide personal care to the individual.

e) Pharmacists may administer drugs in accordance with 21 NCAC 46 .2507.(2004)

21 NCAC 36 .0224 COMPONENTS OF NURSING PRACTICE FOR THE REGISTERED NURSE

(a) The responsibilities which any registered nurse can safely accept are determined by the variables in each nursing practice setting. These variables include:

(1) the nurse’s own qualifications including:
   (A) basic educational preparation; and
   (B) knowledge and skills subsequently acquired through continuing education and practice;
(2) the complexity and frequency of nursing care needed by a given client population;
(3) the proximity of clients to personnel;
(4) the qualifications and number of staff;
(5) the accessible resources; and
(6) established policies, procedures, practices, and channels of communication which lend support to the types of nursing services offered.

(b) Assessment is an on-going process and consists of the determination of nursing care needs based upon collection and interpretation of data relevant to the health status of a client, group or community.

(1) Collection of data includes:
   (A) obtaining data from relevant sources regarding the biophysical, psychological, social and cultural factors of the client's life and the influence these factors have on health status, including:
      (i) subjective reporting;
      (ii) observations of appearance and behavior;
      (iii) measurements of physical structure and physiological functions;
      (iv) information regarding available resources; and
   (B) verifying data collected.

(2) Interpretation of data includes:
   (A) analyzing the nature and inter-relationships of collected data; and
   (B) determining the significance of data to client's health status, ability to care for self, and treatment regimen.

(3) Formulation of a nursing diagnosis includes:
   (A) describing actual or potential responses to health conditions. Such responses are those for which nursing care is indicated, or for which referral to medical or community resources is appropriate; and
   (B) developing a statement of a client problem identified through interpretation of collected data.

(c) Planning nursing care activities includes identifying the client's needs and selecting or modifying nursing interventions related to the findings of the nursing assessment. Components of planning include:
   (1) prioritizing nursing diagnoses and needs;
   (2) setting realistic, measurable goals and outcome criteria;
   (3) initiating or participating in multidisciplinary planning;
   (4) developing a plan of care which includes determining and prioritizing nursing interventions; and
   (5) identifying resources based on necessity and availability.

(d) Implementation of nursing activities is the initiating and delivering of nursing care according to an established plan, which includes, but is not limited to:
   (1) procuring resources;
   (2) implementing nursing interventions and medical orders consistent with 21 NCAC 36.0221(c) and within an environment conducive to client safety;
(3) prioritizing and performing nursing interventions;
(4) analyzing responses to nursing interventions;
(5) modifying nursing interventions; and
(6) assigning, delegating and supervising nursing activities of other licensed and unlicensed personnel consistent with Paragraphs (a) and (i) of this Rule, G.S. 90-171.20(7)d and (7)i, and 21 NCAC 36 .0401.

(e) Evaluation consists of determining the extent to which desired outcomes of nursing care are met and planning for subsequent care. Components of evaluation include:

(1) collecting evaluative data from relevant sources;
(2) analyzing the effectiveness of nursing interventions; and
(3) modifying the plan of care based upon newly collected data, new problem identification, change in the client's status and expected outcomes.

(f) Reporting and Recording by the registered nurse are those communications required in relation to all aspects of nursing care.

(1) Reporting means the communication of information to other persons responsible for, or involved in, the care of the client. The registered nurse is accountable for:

(A) directing the communication to the appropriate person(s) and consistent with established policies, procedures, practices and channels of communication which lend support to types of nursing services offered;
(B) communicating within a time period which is consistent with the client's need for care;
(C) evaluating the responses to information reported; and
(D) determining whether further communication is indicated.

(2) Recording means the documentation of information on the appropriate client record, nursing care plan or other documents. This documentation must:

(A) be pertinent to the client's health care;
(B) accurately describe all aspects of nursing care including assessment, planning, implementation and evaluation;
(C) be completed within a time period consistent with the client's need for care;
(D) reflect the communication of information to other persons; and
(E) verify the proper administration and disposal of controlled substances.

(g) Collaborating involves communicating and working cooperatively with individuals whose services may have a direct or indirect effect upon the client's health care and includes:

(1) initiating, coordinating, planning and implementing nursing or multidisciplinary approaches for the client's care;
(2) participating in decision-making and in cooperative goal-directed efforts;
(3) seeking and utilizing appropriate resources in the referral process; and
(4) safeguarding confidentiality.

(h) Teaching and Counseling clients is the responsibility of the registered nurse, consistent with G.S. 90-171.20(7)g.  
(1) Teaching and counseling consist of providing accurate and consistent information, demonstrations and guidance to clients, their families or significant others regarding the client's health status and health care for the purpose of:
   (A) increasing knowledge;
   (B) assisting the client to reach an optimum level of health functioning and participation in self care; and
   (C) promoting the client's ability to make informed decisions.

(2) Teaching and counseling include, but are not limited to:
   (A) assessing the client's needs, abilities and knowledge level;
   (B) adapting teaching content and methods to the identified needs, abilities of the client(s) and knowledge level;
   (C) evaluating effectiveness of teaching and counseling; and
   (D) making referrals to appropriate resources.

(i) Managing the delivery of nursing care through the on-going supervision, teaching and evaluation of nursing personnel is the responsibility of the registered nurse as specified in the legal definition of the practice of nursing and includes, but is not limited to:
   (1) continuous availability for direct participation in nursing care, onsite when necessary, as indicated by client's status and by the variables cited in Paragraph (a) of this Rule;
   (2) assessing capabilities of personnel in relation to client status and plan of nursing care;
   (3) delegating responsibility or assigning nursing care functions to personnel qualified to assume such responsibility and to perform such functions;
   (4) accountability for nursing care given by all personnel to whom that care is assigned and delegated; and
   (5) direct observation of clients and evaluation of nursing care given.

(j) Administering nursing services is the responsibility of the registered nurse as specified in the legal definition of the practice of nursing in G.S. 90-171.20 (7)i, and includes, but is not limited to:
   (1) identification, development and updating of standards, policies and procedures related to the delivery of nursing care;
   (2) implementation of the identified standards, policies and procedures to promote safe and effective nursing care for clients;
   (3) planning for and evaluation of the nursing care delivery system; and
management of licensed and unlicensed personnel who provide nursing care consistent with Paragraphs (a) and (i) of this Rule and which includes:

(A) appropriate allocation of human resources to promote safe and effective nursing care;

(B) defined levels of accountability and responsibility within the nursing organization;

(C) a mechanism to validate qualifications, knowledge and skills of nursing personnel;

(D) provision of educational opportunities related to expected nursing performance; and

(E) validation of the implementation of a system for periodic performance evaluation.

(k) Accepting responsibility for self for individual nursing actions, competence and behavior is the responsibility of the registered nurse, which includes:

(1) having knowledge and understanding of the statutes and rules governing nursing;

(2) functioning within the legal boundaries of registered nurse practice; and

(3) respecting client rights and property, and the rights and property of others.

(2002)

21 NCAC 36 0225 COMPONENTS OF NURSING PRACTICE FOR THE LICENSED PRACTICAL NURSE

(a) The licensed practical nurse shall accept only those assigned nursing activities and responsibilities, as defined in Paragraphs (b) through (i) of this Rule, which the licensee can safely perform. That acceptance shall be based upon the variables in each practice setting which include:

(1) the nurse's own qualifications in relation to client need and plan of nursing care, including:

(A) basic educational preparation; and

(B) knowledge and skills subsequently acquired through continuing education and practice;

(2) the degree of supervision by the registered nurse consistent with Paragraph (d) (3) of this Rule;

(3) the stability of each client's clinical condition;

(4) the complexity and frequency of nursing care needed by each client or client group;

(5) the accessible resources; and

(6) established policies, procedures, practices, and channels of communication which lend support to the types of nursing services offered.
(b) Assessment is an on-going process and consists of participation in the determination of nursing care needs based upon collection and interpretation of data relevant to the health status of a client.
   
   (1) Collection of data consists of obtaining data from relevant sources regarding the biophysical, psychological, social and cultural factors of the client's life and the influence these factors have on health status, according to structured written guidelines, policies and forms, and includes:
      (A) subjective reporting;
      (B) observations of appearance and behavior;
      (C) measurements of physical structure and physiologic function; and
      (D) information regarding available resources.
   
   (2) Interpretation of data is limited to:
      (A) participation in the analysis of collected data by recognizing existing relationships between data gathered and a client's health status and treatment regimen; and
      (B) determining a client's need for immediate nursing interventions based upon data gathered regarding the client's health status, ability to care for self, and treatment regimen consistent with Paragraph (a)(6) of this Rule.
   
(c) Planning nursing care activities includes participation in the identification of client's needs related to the findings of the nursing assessment. Components of planning include:
   
   (1) participation in making decisions regarding implementation of nursing intervention and medical orders and plan of care through the utilization of assessment data;
   
   (2) participation in multidisciplinary planning by providing resource data; and
   
   (3) identification of nursing interventions and goals for review by the registered nurse.
   
(d) Implementation of nursing activities consists of delivering nursing care according to an established health care plan and as assigned by the registered nurse or other person(s) authorized by law as specified in G.S. 90-171.20 (8)(c).
   
   (1) Nursing activities and responsibilities which may be assigned to the licensed practical nurse include:
      (A) procuring resources;
      (B) implementing nursing interventions and medical orders consistent with Paragraph (b) of this Rule and Paragraph (c) of 21 NCAC 36.0221 and within an environment conducive to client safety;
      (C) prioritizing and performing nursing interventions;
      (D) recognizing responses to nursing interventions;
      (E) modifying immediate nursing interventions based on changes in a client's status; and
(F) delegating specific nursing tasks as outlined in the plan of care and consistent with Paragraph (d)(2) of this Rule, and 21 NCAC 36.0401.

(2) The licensed practical nurse may participate, consistent with 21 NCAC 36.0224(d)(6), in implementing the health care plan by assigning nursing care activities to other licensed practical nurses and delegating nursing care activities to unlicensed personnel qualified and competent to perform such activities and providing all of the following criteria are met:

(A) validation of qualifications of personnel to whom nursing activities may be assigned or delegated;

(B) continuous availability of a registered nurse for supervision consistent with 21 NCAC 36.0224(i) and Paragraph (d)(3) of this Rule;

(C) accountability maintained by the licensed practical nurse for responsibilities accepted, including nursing care given by self and by all other personnel to whom such care is assigned or delegated;

(D) participation by the licensed practical nurse in on-going observations of clients and evaluation of clients' responses to nursing actions; and

(E) provision of supervision limited to the validation that tasks have been performed as assigned or delegated and according to established standards of practice.

(3) The degree of supervision required for the performance of any assigned or delegated nursing activity by the licensed practical nurse when implementing nursing care is determined by variables which include, but are not limited to:

(A) educational preparation of the licensed practical nurse, including both the basic educational program and the knowledge and skills subsequently acquired by the nurse through continuing education and practice;

(B) stability of the client's clinical condition, which involves both the predictability and rate of change. When a client's condition is one in which change is highly predictable and would be expected to occur over a period of days or weeks rather than minutes or hours, the licensed practical nurse participates in care with minimal supervision. When the client's condition is unpredictable or unstable, the licensed practical nurse participates in the performance of the task under close supervision of the registered nurse or other person(s) authorized by law to provide such supervision;

(C) complexity of the nursing task which is determined by depth of scientific body of knowledge upon which the action is based and by the task's potential threat to the client's well-being. When a task is complex, the licensed practical nurse participates in the performance of
of the task under close supervision of the registered nurse or other person(s) authorized by law to provide such supervision;

(D) the complexity and frequency of nursing care needed by a given client population;

(E) the proximity of clients to personnel;

(F) the qualifications and number of staff;

(G) the accessible resources; and

(H) established policies, procedures, practices and channels of communication which lend support to the types of nursing services offered.

(e) Evaluation, a component of implementing the health care plan, consists of participation in determining the extent to which desired outcomes of nursing care are met and in planning for subsequent care. Components of evaluation by the licensed practical nurse include:

(1) collecting evaluative data from relevant sources according to written guidelines, policies and forms;

(2) recognizing the effectiveness of nursing interventions; and

(3) proposing modifications to the plan of care for review by the registered nurse or other person(s) authorized by law to prescribe such a plan.

(f) Reporting and recording are those communications required in relation to the aspects of nursing care for which the licensed practical nurse has been assigned responsibility.

(1) Reporting means the communication of information to other persons responsible for or involved in the care of the client. The licensed practical nurse is accountable for:

(A) directing the communication to the appropriate person(s) and consistent with established policies, procedures, practices and channels of communication which lend support to types of nursing services offered;

(B) communicating within a time period which is consistent with the client's need for care;

(C) evaluating the nature of responses to information reported; and

(D) determining whether further communication is indicated.

(2) Recording means the documentation of information on the appropriate client record, nursing care plan or other documents. This documentation must:

(A) be pertinent to the client's health care including client's response to care provided;

(B) accurately describe all aspects of nursing care provided by the licensed practical nurse;

(C) be completed within a time period consistent with the client's need for care;

(D) reflect the communication of information to other persons; and
(E) verify the proper administration and disposal of controlled substances.

(g) Collaborating involves communicating and working cooperatively in implementing the health care plan with individuals whose services may have a direct or indirect effect upon the client's health care. As delegated by the registered nurse or other person(s) authorized by law, the licensed practical nurse's role in collaborating in client care includes:

1. participating in planning and implementing nursing or multidisciplinary approaches for the client's care;
2. seeking and utilizing appropriate resources in the referral process; and
3. safeguarding confidentiality.

(h) "Participating in the teaching and counseling" of clients as assigned by the registered nurse, physician or other qualified professional licensed to practice in North Carolina is the responsibility of the licensed practical nurse. Participation includes:

1. providing accurate and consistent information, demonstrations, and guidance to clients, their families or significant others regarding the client's health status and health care for the purpose of:
   A. increasing knowledge;
   B. assisting the client to reach an optimum level of health functioning and participation in self care; and
   C. promoting the client's ability to make informed decisions.
2. collecting evaluative data consistent with Paragraph (e) of this Rule.

(i) Accepting responsibility for self for individual nursing actions, competence and behavior which includes:

1. having knowledge and understanding of the statutes and rules governing nursing;
2. functioning within the legal boundaries of licensed practical nurse practice; and
3. respecting client rights and property, and the rights and property of others. (2002)
Nursing Practice Act

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§115C-402 Student Records; Maintenance; Contents; Confidentiality

(a) The official record of each student enrolled in North Carolina public schools shall be permanently maintained in the files of the appropriate school after the student graduates, or should have graduated, from high school unless the local board determines that such files may be filed in the central office or other location designated by the local board for that purpose.

(b) The official record shall contain, as a minimum, adequate identification data including date of birth, attendance data, grading and promotion data, and such other factual information as may be deemed appropriate by the local board of education having jurisdiction over the school wherein the record is maintained. Each student’s official record also shall include notice of any suspension for a period of more than 10 days or of any expulsion under G.S. 115C-391 and the conduct for which the student was suspended or expelled. The superintendent or the superintendent’s designee shall expunge from the record the notice of suspension or expulsion if the following criteria are met:

(1) One of the following persons makes a request for expungement:
   a. The student’s parent, legal guardian, or custodian.
   b. The student, if the student is at least 16 years old or is emancipated.

(2) The student either graduates from high school or is not expelled or suspended again during the two-year period commencing on the date of the student’s return to school after the expulsion or suspension.

(3) The superintendent or the superintendent’s designee determines that the maintenance of the record is no longer needed to maintain safe and orderly schools.

(d) Each local board’s policy on student
records shall include information on the procedure for expungement under subsection (b) of this section.

(e) The official record of each student is not a public record as the term “public record” is defined by G.S. 132-1. The official record shall not be subject to inspection and examination as authorized by G.S. 132-6.

(f) The actual address and telephone number of a student who is a participant in the Address Confidentiality Program established pursuant to Chapter 15C of the General Statutes shall be kept confidential from the public and shall not be disclosed except as provided in Chapter 15C of the General Statutes. (2002)

§115C-403. Flagging and Verification of Student Records; Notification of Law Enforcement Agencies

(a) Upon notification by a law enforcement agency or the North Carolina Center for Missing Persons of a child’s disappearance, the superintendent of a local school administrative unit or his designee shall flag or mark the record of any child who is currently or was previously enrolled in a school of that unit and who is reported as missing. The flag or mark shall be made in such a manner that when a copy of or information regarding the record is requested, school personnel are alerted to the fact that the record is that of a missing child.

Before providing a copy of the school record or other information concerning the child whose record is flagged pursuant to this section, the superintendent or his designee shall notify the agency that requested that the record be flagged of every inquiry made concerning the flagged record, and shall provide a copy to the agency of any written request for information concerning the flagged record.

(b) When any child transfer from one school system to another school system, the receiving school shall, within 30 days of the child’s enrollment, obtain the child’s record from the school from which the child is transferring. If the child’s parent, custodian or guardian provides a copy of the child’s record from the school from which the child is transferring, the receiving school shall, within 30 days of the child’s enrollment, request written verification of the school record by contacting the school or institution named on the transferring child’s record. Upon receipt of a request, the principal or the principal’s designee of the school from which the child is transferring shall not withhold the record or verification for any reason, except as is authorized under the Family Educational Rights and Privacy Act. Any information received indicating that the transferring child is a missing child shall be reported to the North Carolina Center for Missing Persons (1998).

§130A-12 Confidentiality of Records

All record containing privileged patient medical information, information protected by law, or information that is otherwise confidential shall be maintained in a manner that is consistent with the provisions of G.S. 130A-12. Any release of confidential information shall be in accordance with the provisions of G.S. 130A-12.

Appendix II #17-2
Record Maintenance and Confidentiality

protected under 45 Code of Federal Regulations Parts 160 and 164, and the information collected under the authority of Part 4 of Article 5 of this Chapter that are in the possession of the Department of Health and Human Services, the Department of Environment and Natural Resources, or local health departments shall be confidential and shall not be public records pursuant to G.S. 132-1 Information contained in the records may be disclosed only when disclosure is authorized or authorized or required by State or federal law. Notwithstanding G.S. 8-53 or G.S. 130A-143, the information contained in the records may be disclosed for purposes of treatment, payment, or health care operations. For purposes of this section, the terms “treatment,” “payment,” and “health care operations” have the meanings given those terms in 45 Code of Federal Regulations § 164.501. (2006)
§130A-236 Regulation of Sanitation in Schools

For the protection of the public health, the Commission shall adopt rules to establish sanitation requirements for public, private and religious schools. The rules shall address, but not be limited to, the cleanliness of floors, walls, ceilings, storage spaces and other areas; adequacy of lighting, ventilation, water supply, toilet and lavatory facilities; sewage collection, treatment and disposal facilities; and solid waste disposal. The Department shall inspect schools at least annually. The Department shall submit written inspection reports of public schools to the State Board of Education and written inspection reports of private and religious schools to the Department of Administration. (1993)

.2401 DEFINITIONS

The following definitions shall apply throughout this Section:
(1) "Central toilet" means a toilet which exits into a hallway or corridor and has more than one water closet.
(2) "Department" means the Department of Environment, Health, and Natural Resources and its authorized agents.
(3) "Home school" means a school as defined in G.S. 115C-563.
(4) "Principal" means the executive head of a school.
(5) "Private or religious school" means a school which is not supported by funds appropriated by the General Assembly of North Carolina, by the federal government, or through local governmental sources.
(6) "Public school" means a school supported by public funds appropriated by the General Assembly of North Carolina, by the federal government, and through local governmental sources.
(7) "Sanitarian" means a person authorized to represent the Department in enforcing the rules of this Section.
(8) "Superintendent" means the chief administrative head of a local school administrative unit.

.2402 INSPECTIONS
(a) An inspection of each school shall be made by the Department at least once a year to determine compliance with this Section.
(b) An inspection report shall be completed by the sanitarian upon completion of the inspection.
(c) If the conditions found at the time of the inspection of a public school are dangerous to the health of the students, or if an imminent hazard exists, the sanitarian shall notify the office of the local superintendent immediately by telephone or other direct means. A copy of the inspection report shall be immediately forwarded to the local and state superintendents.
(d) If the conditions found at the time of the inspection of a private or religious school are dangerous to the health of the students, or if an imminent hazard exists, the sanitarian shall notify the Office of Non-Public Education, 532 N. Wilmington Street, Raleigh, N.C. 27604, immediately by telephone or other direct means. A copy of the inspection report shall be immediately forwarded to that office.

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.2403 CLASSIFICATION
(a) Schools shall be classified as follows: schools which receive a score of at least 90 percent shall be classified A; schools which receive a score of at least 80 percent and less than 90 percent shall be classified B; schools which receive a score of at least 70 percent and less than 80 percent shall be classified C; and schools which receive a score of less than 70 percent shall be classified as unapproved. When the school is classified as unapproved, the sanitarian shall provide notification in accordance with Rule .2402(c) or (d) as appropriate. Grade cards shall not be posted in schools.
(b) The grading of schools shall be based on the standards of operation and construction as set forth in Rules .2405 through .2415 of this Section.

History Note: Statutory Authority G.S. 130A-236; Eff. January 1, 1986.

.2404 REINSPECTIONS
Upon request of the principal, a reinspection shall be made for the purpose of improving a classification. An unannounced inspection shall be made after the lapse of a reasonable period of time, not to exceed 30 days, from the date of the request.

History Note: Statutory Authority G.S. 130A-236; Eff. January 1, 1986.

.2405 WATER SUPPLY
(a) The water supply shall be from an approved source and shall be adequate and of a safe, sanitary quality.
(b) The water supply used shall be located, constructed, maintained, and operated in accordance with the Commission for Health
Services’ rules governing water supplies. Copies of 15A NCAC 18A .1700 and 15A NCAC 18C may be obtained from the Department. A sample of water from a private or public non-community water supply serving a school shall be collected by the sanitarian and submitted at least once a year to the Division of Laboratory Services or other laboratory certified by the Department to perform bacteriological examination.

(c) Backflow connections and cross-connections with unapproved water supplies are prohibited.
(d) Hot and cold running water under pressure shall be provided to food preparation areas, and any other areas in which water is required for operations and maintenance cleaning.
(e) The well house shall be kept clean and free of storage.

History Note: Statutory Authority G.S. 130A-236; 

.2406 DRINKING FOUNTAINS
(a) Drinking fountains shall be provided and installed as required by the North Carolina State Building Code.
Copies of the North Carolina State Building Code may be obtained from the North Carolina Department of Insurance, P.O. Box 26387, Raleigh, N.C. 27611.

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(b) Fountains shall be provided with adequate water pressure, properly regulated, kept clean and in good repair.

History Note: Statutory Authority G.S. 130A-236; 

.2407 SANITARY SEWAGE DISPOSAL
All sewage and other liquid wastes shall be disposed of in a public sewer system or, in the absence of a public sewer system, by an approved, properly operating sanitary sewage system.

History Note: Statutory Authority G.S. 130A-236; 

.2408 TOILET FACILITIES
(a) Toilet facilities shall be provided and installed as required by the North Carolina State Building Code. Copies of the North Carolina State Building Code may be obtained from the North Carolina Department of Insurance, P.O. Box 26387, Raleigh, N.C. 27611.

(b) Walls and ceilings of toilet facilities shall be constructed of non-absorbent, washable materials and shall be kept clean.
(c) Floors of toilet facilities shall be impervious and kept clean.
(d) Toilet fixtures shall be kept clean and in good repair.

History Note: Statutory Authority G.S. 130A-236; 
.2409 LA VATORY FACILITIES
(a) Lavatory facilities shall be provided and installed as required by the North Carolina State Building Code.

Copies of the North Carolina State Building Code may be obtained from the North Carolina Department of Insurance, P.O. Box 26387, Raleigh, N.C. 27611.

(b) Fixtures shall be kept clean and in good repair.

(c) Soap and individual towels or approved hand-drying devices shall be provided.

History Note: Statutory Authority G.S. 130A-236;

.2410 FLOORS: WALLS: AND CEILINGS
Floors, walls, and ceilings of all areas shall be kept clean and in good repair.

History Note: Statutory Authority G.S. 130A-236;
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.2411 STORAGE SPACES
Storage spaces and custodians' closets shall be kept clean and arranged so as to facilitate cleaning. All storage shall be at least 15 inches (38.1 centimeters) above the floor or otherwise arranged so as to permit thorough cleaning.

History Note: Statutory Authority G.S. 130A-236;

.2412 LIGHTING AND VENTILATION
(a) Lighting and ventilation shall be provided and installed as required by the North Carolina State Building Code.

Copies of the North Carolina State Building Code may be obtained from the North Carolina Department of Insurance, P.O. Box 26387, Raleigh, N.C. 27611.

(b) All windows and fixtures (grills, vents, blinds, drapes, lighting fixtures, etc.) shall be kept clean and in good repair.

History Note: Statutory Authority G.S. 130A-236;

.2413 DRESSING ROOMS AND SHOWERS
(a) Floors, walls, and ceilings shall be kept clean and in good repair.

(b) Floors, walls, and ceilings of shower areas shall be washable and non-absorbent.

(c) Showers shall be provided and installed as required by the North Carolina State Building Code. Copies of the North Carolina State Building Code may be obtained from the North Carolina Department of Insurance, P.O. Box 26387, Raleigh, N.C. 27611.

(d) All fixtures shall be kept clean and in good repair.

(e) Adequate facilities for storage of clothes and other personal items shall be provided and kept clean.

(f) A clean bath towel and soap shall be provided for each person using the showers.

(g) All bath towels shall be stored in a sanitary manner.

History Note: Statutory Authority G.S. 130A-236; Eff. January 1, 1986;
Amended Eff. September 1, 1990.
.2414 SOLID WASTE DISPOSAL
(a) Impervious, cleanable containers with lids, approved by the Department, shall be provided for the storage of solid waste.
(b) Solid waste containers shall be kept clean, in good repair, and emptied when full, but not less than once a week.
(c) All solid waste shall be disposed of in an approved landfill or by a method approved by the Department in accordance with state laws and rules.

.2415 PREMISES: MISCELLANEOUS
(a) The premises of the school under control of the principal shall be kept neat and clean at all times. Waste material, unnecessary articles, rubbish, litter, or garbage shall not be allowed to accumulate on the premises. There shall be no fly or mosquito breeding places, rodent harborages, or undrained areas on the premises.
(b) Pesticides and other toxic materials shall be used as directed on the label and handled and stored as to avoid health hazards.

.2416 REQUIREMENTS FOR HOME SCHOOLS
Home schools shall be exempt from this Section.

.2417 APPEALS PROCEDURE
Appeals concerning the interpretation and enforcement of the rules in this Section shall be made in accordance with G.S. 150B.

History Note: Statutory Authority G.S. 130A-236;
Eff. January 1, 1986;
N.C. School Children’s Health Act of 2006

In 2006 the North Carolina General Assembly ratified the School Children’s Health Act of 2006, Session Law 2006-143 requiring schools to protect children from certain toxic exposures at school, including:

- copper
- chromated arsenic from treated wood in playgrounds
- exposure to diesel emissions from school buses
- mold prevention and mitigation
- pesticides
- elemental mercury.

North Carolina General Statute 115-C was amended with four new subdivisions:

N.C. G.S. 115c-(47)

- (47)a, requires that school boards adopt policies that address pesticide use in schools. Parents, guardians, custodians, and school staff are to receive annual notification on the scheduled pesticide use on school property. Parents, guardians, custodians, and school staff are to be provided 72 hours notice prior to nonscheduled use of pesticides on school grounds. The notification requirements do not apply to: antimicrobial cleansers, disinfectants; self contained baits and crack and crevice treatments; and pesticide products in EPA toxicity class IV, “Relatively Nontoxic” (no signal word required on the product's label).

- (47)b, requires school boards to implement Integrated Pest Management (IPM) programs by October 1, 2011. IPM is a comprehensive approach to pest management that emphasizes prevention of pest infestations. Pest control is achieved by combinations of biological, physical, chemical, and cultural tactics that are low cost, environmentally sound, and socially acceptable. IPM provides a decision making process for determining if, when, and where pest suppression by use of pesticides is needed and what control tactics and methods are appropriate.
• **NCGS 115-C(48)**

Requires schools to develop guidelines for sealing or removal of arsenic treated wood on playgrounds and/or testing soils on school grounds for contamination by leaching of arsenic. Purchasing or accepting or Chromated Copper Arsenate treated wood for future use on school grounds is prohibited. Existing arsenic treated wood in playground equipment must be sealed or a timeline for removing existing arsenic treated wood on playgrounds must be implemented according to guidelines established under G.S. 115C-12(33). Schools are encouraged to test the soil on school grounds for contamination caused by the leaching of arsenic treated wood.

• **NCGS 115-C(49)**

Encourages school boards to remove and properly dispose of bulk elemental mercury, chemical mercury, and bulk mercury compounds used as teaching aids in science classrooms, not including barometers. Schools are prohibited the future use of bulk elemental mercury, chemical mercury compounds, and bulk mercury compounds used as teaching aids in science classrooms, not including barometers.

• **NCGS 115-C(50)**

Requires school boards to establish policies and procedures that reduce students’ exposure to diesel exhaust emissions resulting from unnecessary school bus idling, nose-to-tail parking, and inefficient route assignments.
OSHA Regulations

US DEPT. OF LABOR OSHA
REGULATIONS
Bloodborne Pathogens (Standards-29 CFR)

1910.1030 (a) Scope and Application. This section applies to all occupational exposure to blood or other potentially infectious materials as defined by paragraph (b) of this section.

(b) Definitions. For the purpose of this Section, the following shall apply:
Assistant Secretary means the Assistant Secretary of Labor for Occupational Safety and Health, or designated representative.
Blood means human blood, human blood components, and products made from human blood. Bloodborne Pathogens means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV). Clinical Laboratory means a workplace where diagnostic or other screening procedures are performed on blood or other potentially infectious materials. Contaminated means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface. Contaminated Laundry means laundry which has been soiled with blood or other potentially infectious materials or may contain sharps. Contaminated Sharps means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires. Decontamination means the use of physical or chemical means to remove, inactive, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use or disposal. Director means the Director of the National Institute for Occupational Safety and Health, U.S. Department of Health and Human Services; or designated representative. Engineering Controls means controls (e.g., sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needleless system) that isolate or remove the bloodborne pathogens hazard from the workplace.

Exposure Incident means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee’s duties. Handwashing Facilities means a facility providing an adequate supply of running potable water, soap and single towels or hot air drying machines. Licensed Healthcare Professional is a person whose legally permitted scope of practice allows him/her to independently perform the
perform the activities required by paragraph (f) 
Hepatitis B Vaccination and Post-exposure 
Evaluation and Follow-up. 

**HBV** means hepatitis B virus. **HIV** means 
human immunodeficiency virus. 

**Needleless systems** means a device that does 
not use needles for: 
(1) The collection of bodily fluids or 
withdrawal of body fluids after initial venous or 
arterial access is established; (2) The 
administration of medication or fluids; or (3) 
Any other procedure involving the potential for 
occupational exposure to bloodborne pathogens 
due to percutaneous injuries from contaminated 
sharps. 

**Occupational Exposure** means reasonably 
anticipated skin, eye, mucous membrane, or 
parenteral contact with blood or other 
potentially infectious materials that may result 
from the performance of an employee’s duties. 

**Other Potentially Infectious Materials** means 
(1) The following human body fluids; semen, 
vaginal secretions, cerebrospinal fluid, synovial 
fluid, pleural fluid, pericardial fluid, peritoneal 
fluid, amniotic fluid, saliva in dental 
procedures, any body fluid that is visibly 
contaminated with blood, and all body fluids in 
situations where it is difficult or impossible to 
differentiate between body fluids, (2) Any 
unfixed tissue or organ (other than intact skin) 
from a human (living or dead); and (3) HIV-
containing cell or tissue cultures, organ 
cultures, and HIV-or HBV containing culture 
medium or other solutions; and blood organs or 
and blood organs or other tissues from 
experimental animals infected with HIV or 
HBV. **Parenteral** means piercing mucous 
membranes or the skin barrier through such 
events as needlesticks, human bites, cuts and 
abrasions. 

**Personal Protective Equipment** is specialized 
clothing or equipment worn by an employee for 
protection against a hazard. General work 
clothes (e.g. uniforms, pants, shirts or blouses) 
not intended to function as protection against a 
hazard are not considered to be personal 
protective equipment. 

**Production Facility** means a facility engaged 
in industrial-scale large-volume or high 
concentration production of HIV or HBV. 

**Regulated Waste** means liquid or semi-liquid 
blood or other potentially infectious materials; 
contaminated items that would release blood or 
other potentially infectious materials in a liquid 
or semi-liquid state if compressed; items that 
are caked with dried blood or other potentially 
infectious material and are capable of releasing 
these materials during handling; contaminated 
sharps; and pathological and microbiological 
wastes containing blood or other potentially 
infectious materials. 

**Research Laboratory** means a laboratory 
producing or using research-laboratory-scale 
amounts of HIV or HBV. Research 
laboratories may produce high concentrations 
of HIV or HBV but not in the volume found in 
production facilities. 

**Sharps with engineered sharps injury**
protection means a nonneedle sharp or a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, with a built-in safety feature or mechanism that effectively reduces the risk of an exposure incident.

Source Individual means any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients, clients in institutions for the developmentally disabled, trauma victims, clients of drug and alcohol treatment facilities, residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.

Sterilize means the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

Universal Precautions is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

Work Practice Controls means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g. prohibiting recapping of needles by a two-handed technique).

(c) Exposure Control
(c)(1) Exposure Control Plan
(c)(1)(i) Each employer having an employee(s) with occupational exposure as defined by paragraph (b) of this section shall establish a written Exposure Control Plan designed to eliminate or minimize employee exposure.
(c)(1)(ii) The Exposure Control Plan shall contain at least the following elements:
(c)(1)(iiA) The exposure determination required by paragraph (c)(2).
(c)(1)(iiB) The schedule and method of implementation for paragraphs (d) Methods of Compliance, (e) HIV and HBV Research Laboratories and Production Facilities, (f) Hepatitis B Vaccination and Post-Exposure Evaluation and Follow-up, (g) Communication of Hazards to Employees, and (h) Record keeping; of this standard, and (c)(1)(iiC) The procedure for the evaluation of circumstances surrounding exposure incidents as required by paragraph (f)(3) (i) of this standard;
(c)(1)(iii) Each employer shall ensure that a copy of the Exposure Control Plan is accessible to employees in accordance with 29-CFR 1910.1020(e).
(c)(1)(iv) The Exposure Control Plan shall be reviewed and updated at least annually and whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure and to reflect new or revised employee positions with occupational exposure. The review and update of such plans...
plans shall also: (c)(1)(iv) (A) reflect changes in technology that eliminate or reduce exposure to bloodborne pathogens; and (c)(1)(iv) (B) document annually consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure.

(c)(1)(v) An employer, who is required to establish an Exposure Control Plan, shall solicit input from non-managerial employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls and shall document the solicitation in the Exposure Control Plan.

(c)(1)(vi) The Exposure Control Plan shall be made available to the Assistant Secretary and the Director upon request for examination and copying.

(c)(2) Exposure Determination

(i) Each employer who has an employee(s) with occupational exposure as defined by paragraph (b) of this section shall prepare an exposure determination. This exposure determination shall contain the following:

(c)(2)(iA) A list of all job classifications in which all employees in those job classifications have occupational exposure:

(c)(2)(iB) A list of job classifications in which some employees have occupational exposure, and (c)(2)(iC) A list of all tasks and procedures or groups of closely related task and procedures in which occupational exposure occurs and that are performed by employees in job classification listed in accordance with the provisions of paragraph (c)(2)(i)(B) of this standard.

(c)(2)(ii) This exposure determination shall be made without regard to the use of personal protective equipment.

(d) Methods of Compliance

(d)(1) General. Universal precautions shall be observed to prevent contact with blood or other potentially infectious materials. Under the circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

(d)(2) Engineering and Work Practice Controls

(d)(2)(i) Engineering and work practice controls shall be used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be used.

(d)(2)(ii) Engineering controls shall be examined and maintained or replaced on a regular schedule to ensure their effectiveness.

(d)(2)(iii) Employers shall provide handwashing facilities which are readily accessible to employees.

(d)(2)(iv) When provision of handwashing facilities is not feasible, employers shall ensure that employees are provided with adequate handwashing facilities at alternative locations such as the cafeteria or restroom and shall ensure that handwashing facilities are accessible to employees during breaks and work hours.

(d)(2)(v) Employers shall ensure that employees are provided with adequate handwashing facilities at alternative locations such as the cafeteria or restroom and shall ensure that handwashing facilities are accessible to employees during breaks and work hours.

(d)(2)(vi) Employers shall ensure that employees are provided with adequate handwashing facilities at alternative locations such as the cafeteria or restroom and shall ensure that handwashing facilities are accessible to employees during breaks and work hours.
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facilities is not feasible, the employer shall provide either an appropriate antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. When antiseptic hand cleaners or towelettes are used, hands shall be washed with soap and running water as soon as feasible.
(d)(2)(v) Employers shall ensure that employees wash their hands immediately or as soon as feasible after removal of gloves or other personal protective equipment.
(d)(2)(vi) Employers shall ensure that employees wash hands and any other skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or other potentially infectious materials.
(d)(2)(vii) Contaminated needles and other contaminated sharps shall not be bent, recapped, or removed except as noted in paragraphs (d)(2)(vii)(A) and (d)(2)(vii)(B) below. Shearing or breaking of contaminated needles is prohibited.
(d)(2)(viiA) Contaminated needles and other contaminated sharps shall not be bent, recapped or removed unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical or dental procedure.
(d)(2)(viiB) Such bending, recapping or needle removal must be accomplished through the use of a mechanical device or a one-handed technique.
(d)(2)(viii) Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly reprocessed. These containers shall be:
(D)(2)(vii)(A-D)puncture resistant; labeled or color-coded in accordance with this standard; leakproof on the sides and bottom; and in accordance with the requirements set forth in paragraph (d)(4)(ii)(E) for reusable sharps.
(d)(2)(ix) Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure.
(d)(2)(x) Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on countertops or bench tops where blood or other potentially infectious materials are present.
(d)(2)(xi) All procedures involving blood or other potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying, spattering and generation of droplets of these substances.
(d)(2)(xii) Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.
(d)(2)(xiii) Specimens of blood or other potentially infectious materials shall be placed in a container which prevents leakage during collection handling, processing, storage, transport, or shipping.
(d)(2)(xiii)(A) The container for storage,
transport, or shipping shall be labeled or color-coded according to paragraph (g)(1)(i) and closed prior to being stored, transported, or shipped. When a facility utilizes Universal Precautions in the handling of all specimens, the labeling/color-coding of specimens is not necessary provided containers are recognizable as containing specimens. This exemption only applies while such specimens/containers remain within the facility. Labeling or color-coding in accordance with paragraph (g)(1)(i) is required when such specimen containers leave the facility.

(d)(2)(xiii)(B) If outside contamination of the primary containers occurs, the primary container shall be placed within a second container which prevents leakage during handling, processing, storage, transport, or shipping and is labeled or color-coded according to the requirements of this standard. (d)(2)(xiii)(C) If the specimen could puncture the primary container, the primary container shall be placed within a secondary container which is puncture-resistant in addition to the above characteristics.

(d)(2)(xiv) Equipment which may become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary, unless the employer can demonstrate that decontamination of such equipment or portions of such equipment is not feasible.

(d)(2)(xiv)(A) A readily observable label in accordance with paragraph (g)(1)(i)(H) shall be attached to the equipment stating which portions remain contaminated.

(d)(2)(xiv)(B) The employer shall ensure that this information is conveyed to all affected employees, the servicing representative, and/or the manufacturer, as appropriate, prior to handling, servicing, or shipping so that appropriate precautions will be taken.

(d)(3) Personal Protective Equipment (See 1910.1030 (d) (3)
(d)(3)(i) Provision. When there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate personal protection equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields, or masks and eye protection, and mouthpieces, resuscitation bags, pocket masks, or other ventilation devices. Personal protective equipment will be considered “appropriate” only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee’s work clothes, street clothes, undergarments, skin, eyes, mouth or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

(d)(3)(ii) Use. The employer shall ensure that the employee uses appropriate personal protective equipment unless the employer shows that the employee temporarily and briefly declined to use personal protective
equipment when, under rare and extraordinary circumstances, it was the employee’s professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgment, the circumstances shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future.

(d)(3)(iii) Accessibility. The employer shall ensure that appropriate personal protective equipment in the appropriate sizes is readily accessible at the worksite or is issued to employees. Hypoallergenic gloves, glove liners, powderless gloves, or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.

(d)(3)(iv) Cleaning, Laundering, and Disposal. The employer shall clean, launder, and dispose of personal protective equipment required by paragraphs (d) and (e) of this standard, at no cost to the employee.

(d)(3)(v) Repair and Replacement. The employer shall repair or replace personal protective equipment as needed to maintain its effectiveness, at no cost to the employee.

(d)(3)(vi) If a garment(s) is penetrated by blood or other potentially infectious materials, the garment(s) shall be removed immediately or as soon as feasible.

(d)(3)(vii) All personal protective equipment shall be removed prior to leaving the work area.

(d)(3)(viii) When personal protective equipment is removed it shall be placed in an appropriately designated area or container for storage, washing, decontamination or disposal.

(d)(3)(ix) Gloves. Gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood, other potentially infectious materials, mucous membranes, and non-intact skin; when performing vascular access procedures except as specified in paragraph (d)(3)(ix)(D); and when handling or touching contaminated items or surfaces.

(d)(3)(ix)(A) Disposable (single use) gloves such as surgical or examination gloves, shall be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised.

(d)(3)(ix)(B) Disposable (single use) gloves shall not be washed or decontaminated for re-use.

(d)(3)(ix)(C) Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised. However, they must be discarded if they are cracked, peeling, torn, punctured, or exhibit other signs of deterioration or when their ability to function as
as a barrier is compromised.

(d)(3)(ix)(D) If an employer in a volunteer blood donation center judges that routine gloving for all phlebotomies is not necessary then the employer shall:

(1) Periodically reevaluate this policy;
(2) Make gloves available to all employees who wish to use them for phlebotomy;
(3) Not discourage the use of gloves for phlebotomy; and
(4) Require that gloves be used for phlebotomy in the following circumstances:
   (i) When the employee has cuts, scratches, or other breaks in his/her skin;
   (ii) When the employee judges that hand contamination with blood may occur, for example, when performing phlebotomy on an uncooperative source individual; and
   (iii) When the employee is receiving training in phlebotomy.

(d)(3)(x) **Masks, Eye Protection, and Face Shields.** Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin-length face shields, shall be worn whenever splashes, spray, spatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated.

(d)(3)(xi) **Gowns, Aprons, and Other Protective Body Clothing.** Appropriate protective clothing such as, but not limited to gowns, aprons, lab coats, clinic jackets, or similar outer garments shall be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated.

(d)(3)(xii) Surgical caps or hoods and/or shoe covers or boots shall be worn in instances when gross contamination can reasonably be anticipated (e.g., autopsies, orthopaedic surgery).

(d)(4) **Housekeeping**

(d)(4)(i) **General.** Employers shall ensure that the worksite is maintained in a clean and sanitary condition. The employer shall determine and implement an appropriate written schedule for cleaning and method of decontamination based upon the location within the facility, type of surface to be cleaned, type of soil present, and tasks or procedures being performed in the area.

(d)(4)(ii) All equipment and environmental and working surfaces shall be cleaned and decontaminated after contact with blood or other potentially infectious materials.

(d)(4)(ii)(A) Contaminated work surfaces shall be decontaminated with an appropriate disinfectant after completion of procedures; immediately or as soon as feasible when surfaces are overtly contaminated or after any spill of blood or other potentially infectious materials; and at the end of the work shift if the surface may have become contaminated since the last cleaning.

(d)(4)(ii)(B) Protective coverings, such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover
equipment and environmental surfaces shall be removed and replaced as soon as feasible when they become overtly contaminated or at the end of the work shift if they may have become contaminated during the shift.

(ii)(C) All bins, pails, cans, and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials shall be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

(ii)(D) Broken glassware which may be contaminated shall not be picked up directly with the hands. It shall be cleaned up using mechanical means, such as a brush, and dust pan, tongs, or forceps.

(ii)(E) Reusable sharps that are contaminated with blood or other potentially infectious materials shall not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

(d)(4)(iii) **Regulated Waste.**

(d)(4)(ii)(A) **Contaminated Sharps Discarding and Containment.**

(A)(1) Contaminated sharps shall be discarded immediately or as soon as feasible in containers that are: a. Closable; b. Puncture resistant; c. Leakproof on sides and bottom; and d. Labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard.

(A)(2) During use, containers for contaminated sharps shall be: a. Easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found (e.g., laundries); b. Maintained upright throughout use; and c. Replaced routinely and not be allowed to overfill.

(A)(3) When moving containers of contaminated sharps from the area of use, the containers shall be: closed immediately prior to removal or replacement to prevent spillage or protrusion on contents during handling, storage, transport, or shipping; placed in a secondary container if leakage is possible. The second container shall be: closable and constructed to contain all contents and prevent leakage during handling, storage, transport, or shipping and labeled or color-coded according to paragraph (g)(1)(i) of this standard.

(A)(4) Reusable containers shall not be opened, emptied, or cleaned manually or in any other manner which would expose employees to the risk of percutaneous injury.

(d)(4)(iii)(B) **Other Regulated Waste Containment**

(B)(1) Regulated waste shall be placed in containers which are: closable, constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping, labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard; and closed prior to removal to prevent spillage or protrusion of contents during handling, storage,
storage, transport, or shipping.

(B)(2) If outside contamination of the regulated waste container occurs, it shall be placed in a second container. The second container shall be: closable; constructed to contain all contents and prevent leakage of fluids during handling, storage, transport; or shipping labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard; and closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

(iii)(C) Disposal of all regulated waste shall be in accordance with applicable regulations of the US, States and Territories, and political subdivisions of States and Territories.

(d)(4)(iv) Laundry.

(iv)(A) Contaminated laundry shall be handled as little as possible with a minimum of agitation.

(iv)(A)(1) Contaminated laundry shall be bagged or containerized at the location where it was used and shall not be sorted or rinsed in the location of use.

(iv)(A)(2) Contaminated laundry shall be placed and transported in bags or containers labeled or color-coded in accordance with paragraph (g)(1)(i) of this standard.

1910.1030(f) Hepatitis B Vaccination and Post-exposure Evaluation and Follow-up

(f)(i) The employer shall make available the Hepatitis B vaccine and vaccination series to all employees who have occupational exposure and post-exposure evaluation and follow-up to all employees who have had an exposure incident.

(f)(ii) The employer shall ensure that all medical evaluations and procedures including the Hepatitis B vaccine and vaccination series and post-exposure evaluation and follow-up, including prophylaxis, are:

(ii)(A) Made available at no cost to the employee:

(ii)(B) Made available to the employee at a reasonable time and place;

(ii)(C) Performed by or under the supervision of a licensed physician or by or under the supervision of another licensed healthcare professional; and

(ii)(D) Provided according to recommendations of the US Public Health Service current at the time these evaluations and procedures take place, except as specified by this paragraph (f).

(f)(1)(iii) The employer shall ensure that all laboratory tests are conducted by an accredited laboratory at no cost to the employee


(f)(2)(i) Hepatitis B vaccination shall be made available after the employee has received the training required in paragraph (g)(2)(vii)(1) and within 10 working days of initial assignment to all employees who have occupational exposure unless the employee has previously received the complete Hepatitis
B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.

(2)(ii) The employer shall not make participation in a prescreening program a prerequisite for receiving Hepatitis B vaccination.

(2)(iii) If the employee initially declines Hepatitis B vaccination but at a later date while still covered under the standard decides to accept the vaccination, the employer shall make available Hepatitis B vaccination at that time.

(2)(iv) The employer shall assure that employees who decline to accept Hepatitis B vaccination offered by the employer sign the statement in Appendix A.

(2)(v) If a routine booster dose(s) of Hepatitis B vaccine is recommended by the US Public Health Service at a future date, such booster dose(s) shall be made available in accordance with section (f)(l)(ii).


Following a report of an exposure incident, the employer shall make immediately available to the exposed employee a confidential medical evaluation and follow-up, including the following elements:

(i) Documentation of the route(s) of exposure, and the circumstances under which the exposure incident occurred:

(ii) Identification and documentation of the source individual, unless the employer can establish that identification is infeasible or prohibited by state or local law;

(ii)(A) The source individual’s blood shall be tested as soon as feasible and after consent is obtained in order to determine HBV and HIV infectivity. If consent is not obtained, the employer shall establish that legally required consent cannot be obtained. When the source individual’s consent is not required by law, the source individual’s blood, if available, shall be tested and the results documented.

(ii)(B) When the source individual is already known to be infected with HBV or HIV, testing for the source individual’s known HBV or HIV status need not be repeated.

(ii)(C) Results of the source individual’s testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

(f)(3)(iii) Collection and testing of blood for HBV and HIV serological status;

(iii)(A) the exposed employee’s blood shall be collected as soon as feasible and tested after consent is obtained.

(iii)(B) If the employee consents to baseline blood collection, but does not give consent at that time for HIV serologic testing, the sample shall be preserved for at least 90 days. If, within 90 days of the exposure incident, the employee
employee elects to have the baseline sample tested, such testing shall be done as soon as feasible.

(f)(3)(iv) Post-exposure prophylaxis, when medically indicated, as recommended by the US Public Health Service;
(f)(3)(v) Counseling; and

1910.1030(f)(4) Information Provided to the Healthcare Professional.
(4)(i) The employer shall ensure that the healthcare professional responsible for the employee’s Hepatitis B vaccination is provided a copy of this regulation.
(4)(ii) The employer shall ensure that the healthcare professional evaluating an employee after an exposure incident is providing the following information:
(ii)(A) A copy of this regulation;
(ii)(B) A description of the exposed employee’s duties as they relate to the exposure incident;
(ii)(C) Documentation of the route(s) of exposure and circumstances under which exposure occurred;
(ii)(D) Results of the source individual’s blood testing, if available; and
(ii)(E) All medical records relevant to the appropriate treatment of the employee including vaccination status which are the employer’s responsibility to maintain.

1910.1030(f)(5) Healthcare Professional’s Written Opinion. The employer shall obtain and provide the employee with a copy of the evaluating healthcare professional’s written opinion within 15 days of the completion of the evaluation.

(f)(5)(i) The healthcare professional’s written opinion for Hepatitis B vaccination shall be limited to whether Hepatitis B vaccination is indicated for an employee and if the employee has received such vaccination
(f)(5)(ii) The healthcare professional’s written opinion for post-exposure evaluation and follow-up shall be limited to the following information:
(ii)(A) That the employee has been informed of the results of the evaluation; and
(ii)(B) That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.
(f)(5)(iii) All other findings or diagnoses shall remain confidential and shall not be included in the written report.

1910.1030(f)(6) Medical Record Keeping. Medical records required by this standard shall be maintained in accordance with paragraph (h)(1) of this section

1910.1030(g) Communication of Hazards to Employees
(g)(1) Labels and Signs
(g)(1)(i) Labels  
(i)(A) Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious material; and other containers used to store, transport, or ship blood or other potentially infectious materials, except as provided in paragraph (g)(1)(i)(E)(F), and G).

(i)(B) Labels required by this section shall include the following legend: BIOHAZARD (on orange label with the biohazard emblem)
(i)(C) These labels shall be fluorescent orange or orange-red or predominantly so, with lettering and symbols in contrasting color.
(i)(D) Labels shall be affixed as close as feasible to the container by string, wire, adhesive, or other method that prevents their loss or unintentional removal.
(i)(E) Red bags or red containers may be substituted for labels.
(i)(F) Containers of blood, blood components, or blood products that are labeled as to their contents and have been released for transfusion or other clinical use are exempted from the labeling requirements of paragraph (g).

(i)(G) Individual containers of blood or other potentially infectious materials that are placed in a labeled container during storage, transport, shipment or disposal are exempted from the labeling requirement.
(i)(H) Labels required for contaminated equipment shall be in accordance with this paragraph and shall also state which portions of the equipment remain contaminated.

(i)(I) Regulated waste that has been decontaminated need not be labeled or color-coded

1910.1030(g)(1)(ii) Signs  
(ii)(A) The employer shall post signs at the entrance to work areas specified in paragraph (e), HIV and HBV Research Laboratory and Production Facilities, which shall bear the following legend:

BIOHAZARD (on orange label with the biohazard emblem) and
(Example: Name of the Infectious Agent)
(Special requirements for entering the area)
(Example: Name, telephone number of the lab director or other responsible person).

(ii)(B) These signs shall be florescent orange-red or predominantly so, with lettering and symbols in a contrasting color.

1910.1030(g)(2) Information and Training  
(g)(2)(i) Employers shall ensure that all employees with occupational exposure participate in a training program which must be provided at no cost to the employee and during working hours.

(g)(2)(ii) Training shall be provided as follows:

(ii)(A) At the time of initial assignment to tasks
tasks where occupational exposure may take place:
(ii)(B) Within 90 days after the effective date of
the standard; and
(g)(2)(ii)(C) At least annually thereafter.
(g)(2)(iii) [ Reserved ]
(g)(2)(iv) Annual training for all employees
shall be provided within one year of their
previous training.
(g)(2)(v) Employers shall provide additional
training when changes such as modification of
tasks or procedures or institution of new tasks
or procedures affect the employee’s
occupational exposure. The additional training
may be limited to addressing the new exposures
created.
(g)(2)(vi) Material appropriate in content and
vocabulary to educational level, literacy, and
language of employees shall be used.
(g)(2)(vii) The training program shall contain at
a minimum the following elements:
(vii)(A) An accessible copy of the regulatory
text of this standard and an explanation of its
contents;
(vii)(B) A general explanation of the
epidemiology and symptoms of bloodborne
diseases;
(vii)(C) An explanation of the modes of
transmission of bloodborne pathogens;
(vii)(D) An explanation of the employer’s
exposure control plan and the means by which
the employee can obtain a copy of the written
plan;
(vii)(E) An explanation of the appropriate
methods for recognizing tasks and other
activities that may involve exposure to blood
and other potentially infectious materials;
(vii)(F) An explanation of the use and
limitations of methods that will prevent or
reduce exposure including appropriate
engineering controls, work practices and
personal protective equipment.
(vii)(G) Information on the types, proper use,
location, removal, handling, decontamination
and disposal of person protective equipment;
(vii)(H) An explanation of the basis for
selection of personal protective equipment;
(vii)(I) Information on the Hepatitis B vaccine,
including information on its efficacy, safety,
method of administration, the benefits of being
vaccinated, and that the vaccine and
vaccination will be offered free of charge;
(vii)(J) Information on the appropriate actions
to take and persons to contact in an emergency
involving blood or other potentially infectious
materials;
(vii)(K) An explanation of the procedure to
follow if an exposure incident occurs, including
the method of reporting the incident and the
medical follow-up that will be made available
(vii)(L) Information on the post-exposure
evaluation and follow up that the employer is
required to provide for the employee following
an exposure incident;
(vii)(M) An explanation of the signs and labels
and/or color-coding required by paragraph
(g)(l); and (g)(2)(vii);
(vii)(N) An opportunity for interactive questions and answers with the person conducting the training session.
(g)(2)(viii) The person conducting the training shall be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address.
(g)(2)(ix)(C) The employer shall provide a training program to employees who have no prior experience in handling human pathogens. Initial work activities shall not include the handling of infectious agents. A progression of work activities shall be assigned as techniques are learned and proficiency is developed. The employer shall assure that employees participate in work activities involving infectious agents only after proficiency has been demonstrated.

1910.1030(h) **Record Keeping**
(h)(1) Medical Records
(h)(1)(i) The employer shall establish and maintain an accurate record for each employee with occupational exposure, in accordance with 29 CFR 1910.1020.
(h)(1)(ii) This record shall include:
(ii)(A) The name and social security number of the employee;
(ii)(B) A copy of the employee’s Hepatitis B vaccination status including the dates of all the Hepatitis B vaccinations and any medical records relative to the employee’s ability to receive vaccination as required by paragraph (f)(2);
(ii)(C) A copy of all results of examinations, medical testing, and follow-up procedures as required by (f)(3);
(ii)(D) The employer’s copy of the healthcare professional’s written opinion as required by paragraph (f)(5); and
(ii)(E) A copy of the information provided to the healthcare professional as required by paragraphs (f)(4)(ii)(B),(C), and (D).
(h)(1)(iii) Confidentiality. The employer shall ensure that employee medical records required by paragraph (h)(1) are:
(iii)(A) Kept confidential;
(iii)(B) Not disclosed or reported without the employee’s express written consent to any person within or outside the workplace except as required by this section or as may be required by law.
(h)(1)(iv) The employer shall maintain the records required by paragraph (h) for at least the duration of employment plus 30 years in accordance with 29 CFR 1910.1020.
1910.1030(h)(2) **Training Records**
(h)(2)(i) Training records shall include the following information:
(i)(A) The dates of the training sessions;
(i)(B) The contents or a summary of the training sessions;
(i)(C) The names and qualifications of persons conducting the training; and
(i)(D) The names and job titles of all persons attending the training sessions.
(h)(2)(ii) Training records shall be maintained
for 3 years from the date on which the training occurred.

(h)(3) **Availability**

(h)(3)(i) The employer shall ensure that all records required to be maintained by this section shall be made available upon request to the Assistant Secretary and the Director for examination and copying.

(h)(3)(ii) Employee training records required by this paragraph shall be provided upon request for examination and copying to employees, to employee representatives, to the Director, and to the Assistant Secretary.

(h)(3)(iii) Employee medical records required by this paragraph shall be provided upon request for examination and copying to the subject employee, to anyone having written consent of the subject employee, to the Director and to the Assistant Secretary in accordance with 29 CFR 1910.1020

(h)(4) **Transfer of Records.**

(h)(4)(i) The employer shall comply with the requirements involving transfer of records set forth in 29 CFR 1910.1020(h)

(h)(4)(ii) If the employer ceases to do business and there is no successor employer to receive and retain the records for the prescribed period, the employer shall notify the Director, at least three months prior to their disposal and transmit them to the Director, if required by the Director to do so, within that three month period.

1910.1030(h)(5) **Sharps injury log**

(h)(5)(i) The employer shall establish and maintain a sharps injury log for the recording of percutaneous injuries from contaminated sharps. The information in the sharps injury log shall be recorded and maintained in such manner as to protect the confidentiality of the injured employee. The sharps injury log shall contain, at a minimum:

(h)(5)(i)(A) The type and brand of device involved in the incident,

(h)(5)(i)(B) The department or work area where the exposure incident occurred, and

(h)(5)(i)(C) An explanation of how the incident occurred.

(h)(5)(ii) The requirement to establish and maintain a sharps injury log shall apply to any employer who is required to maintain a log of occupational injuries and illnesses under 29 CFR 1904.

(h)(5)(iii) The sharps injury log shall be maintained for the period required by 29 CFR 1904.6.

1910.1030(i) **Dates**

(i)(1) Effective Date. The standard shall become effective on March 6, 1992.

(i)(2) The Exposure Control Plan required by paragraph (c) of this section shall be completed on or before May 5, 1992.

(i)(3) Paragraph (g)(2) Information and Training and (h) Record keeping shall take effect on or before June 4, 1992.

(i)(4) Paragraphs (d)(2) Engineering and Work Practice Controls, (d)(3) Personal Protective

1 Areas that do not pertain to School Health and Schools have been omitted. Bold format is not included in the federal document and has been done to facilitate recovery of specific topics.
2 The NC Administrative Code can be found at http://www.oah.state.nc.us/rules/
3 General Statutes of NC can be found at http://www.ncleg.net/
4 Bloodborne pathogens 1910.1030 can be found at www.osha.gov/Regulations (Standards-29) and www.nclabor.com
North Carolina School Health Program Manual

General Statutes, State Policies, and Administrative Code
App. II Item #19 OSHA Regulations

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Special Education

Part 1A. General Provisions.

§ 115C-106.1. State goal.
The goal of the State is to provide full educational opportunity to all children with disabilities who reside in the State. (1973, c. 1293, ss. 2-4; 1975, c. 563, ss. 1-5; 1977, c. 927, ss. 1, 2; 1979, 2nd Sess., c. 1295; 1981, c. 423, s. 1; 1997-443, s. 11A.47; 2006-69, s. 2.)

§ 115C-106.2. Purposes.
(a) The purposes of this Article are to (i) ensure that all children with disabilities ages three through 21 who reside in this State have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepares them for further education, employment, and independent living; (ii) ensure that the rights of these children and their parents are protected; and (iii) enable the State Board of Education and local educational agencies to provide for the education of all children with disabilities.

(b) In addition to the purposes listed in subsection (a) of this section, the purpose of this Article is to enable the State Board of Education and local educational agencies to implement IDEA in this State. If this Article is silent or conflicts with IDEA, and if IDEA has specific language that is mandatory, then IDEA controls.

(c) Notwithstanding any other section of this Article, the State Board of Education may set standards for the education of children with disabilities that are higher than those required by IDEA. (1973, c. 1293, ss. 2-4; 1975, c. 563, ss. 1-5; 1977, c. 927, ss. 1, 2; 1979, 2nd Sess., c. 1295; 1981, c. 423, s. 1; 1997-443, s. 11A.47; 2006-69, s. 2; 2007-292, s. 2.)

§ 115C-106.3. Definitions.
The following definitions apply in this Article:
(1) "Child with a disability" means a child with at least one disability who because of that disability requires special education and related services.
(2) "Disability" includes mental retardation; hearing impairment, including deafness; speech or language impairment; visual impairment, including blindness; serious emotional disturbance; orthopedic impairment; autism;
impairment; autism; traumatic brain injury; other health impairments, specific learning disability, or other disability as may be required to be included under IDEA. For a child ages three through seven, this term also includes developmental delay.

(3) "Dispute" means a disagreement between the parties.

(3a) "Educational services" means all of the following:

a. The necessary instructional hours per week in the form and format as determined by the child's IEP team and consistent with federal and State law. The instruction shall be delivered by an appropriately qualified teacher to the extent required by federal and State law, which requires a free appropriate public education and the opportunity for a sound basic education.

b. Related services included in the child's IEP.

c. Behavior intervention services designed to address the behavior violation that caused the disciplinary change of placement in order to prevent a recurrence.

(4) "Free appropriate public education" means special education and related services that:

a. Are provided at public expense, under public supervision and direction, and without charge;

b. Meet the standards of the State Board;

c. Include an appropriate preschool, elementary school, or secondary school education in the State; and

d. Are provided in conformity with an individualized education program.

(5) "Hearing officers" include administrative law judges as defined in G.S. 150B-2(1) and hearing review officers.

(5a) "Homebound instruction" means educational services provided to a student outside the school setting.


(7) "IEP Team" is as defined in IDEA.

(8) "Individualized education program" or "IEP" means a written statement for each child with a disability that is developed, reviewed, implemented, and revised consistent with IDEA and State law.

(9) "Infant or toddler with a disability" is as defined in IDEA.

(10) "Least restrictive environment" means to the maximum extent appropriate, children with disabilities are educated with children who are not disabled, and special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only when the nature of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

(11) "Local educational agency" includes any of the following that provides special education and related services to
to children with disabilities:

a. A local school administrative unit.
b. A charter school.
c. The Department of Health and Human Services.
d. The Department of Correction.
e. The Department of Juvenile Justice and Delinquency Prevention.
f. Any other State agency or unit of local government.

(12) "Mediation" means an informal process conducted by a mediator with the objective of helping parties voluntarily settle their dispute.

(13) "Mediator" means a neutral person who acts to encourage and facilitate a resolution of a dispute.

(14) "Parent" means:

a. A natural, adoptive, or foster parent;
b. A guardian, but not the State if the child is a ward of the State;
c. An individual acting in the place of a natural or adoptive parent, including a grandparent, stepparent, or other relative, and with whom the child lives;
d. An individual who is legally responsible for the child's welfare; or
e. A surrogate if one is appointed under G.S. 115C-109.2.

(15) "Party" or "Parties" means the local educational agency or the parents, or both.

(16) "Petition" means a request for a due process hearing as provided for under IDEA.

(17) "Preschool child with a disability" means a child with one or more disabilities who meets all of the following criteria:

a. Has reached his or her third birthday and whose parents have requested services from the public schools.
b. Is not eligible to enroll in public kindergarten.
c. Because of the disability, needs special education and related services in order to prepare the child to benefit from the educational programs provided by the public schools, beginning with kindergarten.

(18) "Related services" is as defined in IDEA.

(18a) "Residence" or "reside" means the place where a child with a disability is entitled to be enrolled in a North Carolina public school under G.S. 115C-366 except for the age requirements of that section. This definition shall not apply to children with disabilities who were (i) enrolled in a particular local school administrative unit on the last day of school for the 2006-2007 school year, or (ii) enrolled in and attending a school in a particular local school administrative unit on August 1, 2007, for the 2007-2008 school year for as long as they live within and are continuously enrolled in that local school administrative unit.

(19) "Rules" includes rules, policies, and procedures. Rules as defined in G.S. 150B-2(8a) shall be adopted in accordance with Article 2A of Chapter 150B of the General Statutes.
(20) "Special education" means specially designed instruction, at no cost to parents, to meet the unique needs of a child with a disability. The term includes instruction in physical education and instruction conducted in a classroom, the home, a hospital or institution, and other settings. (1977, c. 927, s. 1; 1981, c. 423, s. 1; 1983, c. 247, ss. 1, 2; 1983 (Reg. Sess., 1984), c. 1034, ss. 23, 24; 1985, c. 479, s. 26(a); 1985, c. 780, ss. 3, 4; 1989(Reg. Sess., 1990), c. 1003, s. 5; 1996, 2nd Ex. Sess., ch. 18, s. 18.24(b); 2006-69, s. 2; 2007-292, s. 1; 2007-429, s. 1.)

Part 1B. Provision of Free Appropriate Public Education

§ 115C-107.1. Free appropriate public education; ages.

(a) A free appropriate public education shall be made available to the following:

(1) All children with disabilities who reside in the State, who are the ages of three through 21, who have not graduated from high school, and who require special education and related services.

(2) Any child with a disability who is receiving special education and related services and who has not graduated from high school until the end of the school year in which that child reaches the age of 22.

(3) Children with disabilities who require special education and related services and who are suspended or expelled from school and entitled to continuing education services as provided in IDEA.

(b) A free appropriate public education is not required to be provided to infants and toddlers with disabilities. However, early intervention services shall be made available to these children under G.S. 143B-139.6A.

(c) If funds are made available, the State Board and the Secretary of Health and Human Services may adopt an agreement to allow the continuation of early intervention services for children with a disability who are at least three years old but before they enter kindergarten or are eligible to enter kindergarten. If an agreement is adopted under this subsection, then a free appropriate public education is not required to be provided to any child with a disability who continues to receive early intervention services in accordance with that agreement.
(d) Nothing in this Article requires a free appropriate public education to be made available to any individual aged 18 through 21 who, in the educational placement immediately before that individual's incarceration in an adult correctional facility, was not actually identified as being a child with a disability and did not have an IEP. (1977, c. 927, s. 1; 1981, c. 423, s. 1; 1989 (Reg. Sess., 1990), c. 1003, s. 5; 1997-443, s. 11A.118(a); 1998-202, s. 4(h); 2000-137, s. 4(k); 2006-69, s. 2.)

§ 115 115C-107.2. Duties of State Board of Education.
(a) The State Board of Education shall adopt rules to ensure that:

(1) The requirements of this Article and IDEA are met.
(2) All educational programs under the supervision of any local educational agency for children with disabilities meet all of the following requirements:
   a. The programs are under the general supervision of individuals in the State who are responsible for educational programs for children with disabilities.
   b. The programs meet the State Board's educational standards.
   c. With respect to homeless children, the programs meet the requirements of 20 U.S.C. § 1431, McKinney-Vento Homeless Assistance Act.
(b) The rules adopted under subsection (a) of this section shall include rules that:
(1) Establish standards for the programs of special education to be administered by local educational agencies and by the State Board.
(2) Ensure that children with disabilities are educated in the least restrictive environment.
(3) Ensure that local school administrative units make available special education and related services to all preschool children with disabilities whose parents request these services.
(4) Provide for public hearings, adequate notice of these hearings, and an opportunity for comment from the general public before the adoption of the rules required by this Article.
(5) Are required in order to receive federal funding under IDEA.
(6) Provide that, where a local educational agency finds that appropriate services are available from other public agencies or private organizations, the local educational agency may contract for those services rather than provide them directly.
(7) Enable local educational agencies to identify, evaluate, place, and make other educational decisions for children with disabilities.
(8) Provide procedural safeguards for children with disabilities and their parents.
(9) Designate a person in the Department of Public Instruction who is charged with receiving and responding to notices or other legal documents under Part 1D of this Article.
(10) Support and facilitate local educational agency and school-level system improvement designed to enable children with disabilities to meet the...
§ 115C-107.3. Child find.

(a) The Board shall require an annual census of all children with disabilities residing in the State, subdivided for "identified" and "suspected" children with disabilities, to be taken in each school year. Suspected children are those in the formal process of being evaluated or identified as children with disabilities. The census shall be conducted annually and shall be completed by October 15, submitted to the Governor and General Assembly and made available to the public by January 15 annually.

(b) In taking the census, the Board requires the cooperation, participation, and assistance of all local educational agencies. Therefore, each local educational agency shall cooperate and participate with and assist the Board in conducting the census.

(c) The census shall include the number of children identified and suspected with disabilities, their age, the nature of their disability, their county or city of residence, their local school administrative unit residence, whether they are being provided special educational or related services and if so by what local educational agency, the identity of each local educational agency having children with disabilities in its care, custody, management, jurisdiction, control, or programs, the number of children with disabilities being served by each local educational agency, and any other information or data that the Board requires. The census shall be of children with disabilities between the ages three through 21 but is not required to include children with disabilities that have graduated from high school. (1977, c. 927, s. 1; 1981, c. 423, s. 1; 1983, c. 247, ss. 3, 4; 1989, c. 585, s. 3; 1989 (Reg. Sess., 1990), c. 1003, s. 5; 1996, 2nd Ex. Sess., c. 18, ss. 18.24(c), (d); 1997-443, s. 11A.118(a); 1998-202, s. 4(g); 2000-137, s. 4(j); 2006-69, s. 2.)
§ 115C-107.6. Duties of local educational agencies.
   (a) Each local educational agency, in providing for the education of children with disabilities within its jurisdiction, must comply with IDEA and the rules adopted by the State Board under this Article. In addition, each local educational agency shall have in effect policies, procedures, and programs that are consistent with this Article, IDEA, and rules adopted by the State Board.
   (b) No child with disabilities shall be prevented from attending the public schools of the local educational agency in which the child resides or from which the child receives services or from attending any other public program of free appropriate public education based solely on the fact that the child has a disability. If it appears the child should receive a program of free appropriate public education in a program operated by or under the supervision of the Department of Health and Human Services or the Department of Juvenile Justice and Delinquency Prevention, the local school administrative unit shall confer with the appropriate Department of Health and Human Services or Department of Juvenile Justice and Delinquency Prevention staff for their participation and determination of the appropriateness of placement in that program and development of the child's individualized education program.
   (c) No matriculation or tuition fees or other fees or charges shall be required or asked of children with disabilities or their parents except those fees or charges that are required uniformly of all public school pupils. The provision of a free appropriate public education within the facilities of the Department of

NC 1500-2.4 Child with a disability
(a) General
(1) Child with a disability means a child evaluated in accordance with NC 1503-2 through NC 503-3 as having autism, deaf-blindness, deafness, developmental delay (applicable only to children ages three through seven), hearing impairment, intellectual disability, multiple disabilities, orthopedic impairment, other health impairment, serious emotional disability, specific learning disability, speech or language impairment, traumatic brain injury, or visual impairment (including blindness), and who, by reason of the disability, needs special education and related services.
(2) (i) If it is determined, through an appropriate evaluation under NC 1503-2 through NC1503-3, that a child has one of the disabilities identified in paragraph (a)(1) of this
this section, but only needs a related service and not special education, the child is not a child with a disability under IDEA.  

(ii) If the only service required by the child is speech language, it is considered special education rather than a related service and the child would be determined to be a child with a disability under paragraph (a)(1) of this section.

(b) Definitions of disability terms. The terms used in this definition of a child with a disability are defined as follows:

(1) Autism, sometimes called autism spectrum disorder, 

(i) means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects a child’s educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. 

(ii) Autism does not apply if a child’s educational performance is adversely affected primarily because the child has an emotional disability, as described in paragraph (b)(5) of this section. 

(iii) A child who manifests the characteristics of autism after age three could be identified as having autism if the criteria in paragraph (i) of this section are satisfied.

(2) Deaf-blindness means hearing and visual impairments that occur together, the combination of which causes such severe communication and other developmental and educational needs that they cannot be accommodated in special education programs solely for children with deafness or children with blindness.

(3) Deafness means a hearing impairment that is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification that adversely affects the child’s educational performance.

(4) Developmental delay means a child aged three through seven, whose development and/or behavior is delayed or atypical, as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas: physical development, cognitive development, communication development, social or emotional development, or adaptive development, and who, by reason of the delay, needs special education and related services.

(5) Serious emotional disability (hereafter referred to as emotional disability) 

(i) means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance:

(A) An inability to make educational progress that cannot be explained by intellectual, sensory, or health factors. 

(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers. 

(C) Inappropriate types of behavior or feelings under normal circumstances. 

(D) A general pervasive mood of unhappiness or depression.
(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

(ii) Serious emotional disability includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance under paragraph (b)(5)(i) of this section.

(6) Hearing impairment means an impairment in hearing, whether permanent or fluctuating, that adversely affects a child’s educational performance but that is not included under the definition of deafness in this section.

(7) Intellectual disability means significantly subaverage general intellectual functioning that adversely affects a child’s educational performance existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

(8) Multiple disabilities means two or more disabilities occurring together (such as intellectual disability-blindness, intellectual disability-orthopedic impairment, etc.), the combination of which causes such severe educational needs that they cannot be accommodated in special education programs solely for one of the impairments. Multiple disabilities does not include deaf-blindness.

(9) Orthopedic impairment means a severe physical impairment that adversely affects a child's educational performance. The term includes impairments caused by a congenital anomaly, impairments caused by disease (e.g., poliomyelitis, bone tuberculosis, etc.), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contractures, etc.).

(10) Other health impairment means having limited strength, vitality or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that--

(i) Is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, and Tourette’s Syndrome, etc.; and

(ii) Adversely affects a child's educational performance.

(11) Specific learning disability.

(i) General. Means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in the impaired ability to listen, think, speak, read, write, spell, or to do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia.

(ii) Disorders not included. Specific learning disability does not include learning problems that are primarily the result of visual, hearing, or motor disabilities, of mental retardation, of serious emotional disturbance, or of environmental, cultural, or economic disadvantage.

(12) Speech or language impairment means-

(i) A communication disorder, such as an impairment in fluency, articulation, language, or voice/resonance, that adversely affects a child's educational performance.
(ii) Language may include function of language (pragmatic), the content of language (semantic), and the form of language (phonologic, morphologic, and syntactic systems).

(iii) A speech or language impairment may result in a primary disability or it may be secondary to other disabilities.

(13) Traumatic brain injury means an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. Traumatic brain injury applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech. Traumatic brain injury does not apply to brain injuries that are congenital or degenerative, or to brain injuries induced by birth trauma.

(14) Visual impairment including blindness means an impairment in vision that, even with correction, adversely affects a child's educational performance. The term includes both partial sight and blindness. A visual impairment is the result of a diagnosed ocular or cortical pathology.

**NC 1505-2.2 Definitions**

As used in NC 1505-2.2 through NC 1505-2.16--

(a) Destruction means physical destruction or removal of personal identifiers from information so that the information is no longer personally identifiable.

(b) Education records means the type of records covered under the definition of "education records" in 34 CFR part 99 (the regulations implementing the Family Educational Rights and Privacy Act of 1974, 20 U.S.C. 1232g (FERPA)).

(c) Participating agency means any agency or institution that collects, maintains, or uses personally identifiable information, or from which information is obtained, under Part B of the IDEA.

**NC 1505-2.3 Notice to parents**

(a) The SEA must give notice that is adequate to fully inform parents about the requirements of NC 1501-4.3, including--

(1) A description of the extent that the notice is given in the native languages of the various population groups in the State;

(2) A description of the children on whom personally identifiable information is maintained, the types of information sought, the
the methods the SEA intends to use in gathering the information (including the sources from whom information is gathered), and the uses to be made of the information;
(3) A summary of the policies and procedures that LEAs must follow regarding storage, disclosure to third parties, retention, and destruction of personally identifiable information; and
(4) A description of all of the rights of parents and children regarding this information, including the rights under FERPA and implementing regulations in 34 CFR part 99.
(b) Before any major identification, location, or evaluation activity, the notice must be published or announced in newspapers or other media, or both, with circulation adequate to notify parents throughout the State of the activity.

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(Authority: 20 U.S.C. 1412(a)(8); 1417(c); 34 CFR 300.612)
NC 1505-2.4 Access rights

(a) Each LEA must permit parents to inspect and review any education records relating to their children that are collected, maintained, or used by the LEA under these Policies. The LEA must comply with a request without unnecessary delay and before any meeting regarding an IEP, or any hearing pursuant to NC 1504-1.8 or NC 1504-2.1 through NC 1504-2.3, or resolution session pursuant to NC 1504-1.11 and in no case more than 45 days after the request has been made.

(b) The right to inspect and review education records under this section includes--
(1) The right to a response from the LEA to reasonable requests for explanations and interpretations of the records;
(2) The right to request that the LEA provide copies of the records containing the information if failure to provide those copies would effectively prevent the parent from exercising the right to inspect and review the records; and
(3) The right to have a representative of the parent inspect and review the records.
(c) An LEA may presume that the parent has authority to inspect and review records relating to his or her child unless the LEA has been advised that the parent does not have the authority under applicable State law governing such matters as guardianship, separation, and divorce.
(Authority: 20 U.S.C. 1412(a)(8); 1417(c); 34 CFR 300.613)

NC 1505-2.5 Record of access
Each LEA must keep a record of parties obtaining access to education records collected, maintained, or used under Part B of the IDEA (except access by parents and authorized employees of the LEA), including the name of the party, the date access was given, and the purpose for which the party is authorized to use the records.

(Authority: 20 U.S.C. 1412(a)(8); 1417(c); 34 CFR 300.614)
NC 1505-2.6 Records on more than one child
If any education record includes information on more than one child, the parents of those
children have the right to inspect and review only the information relating to their child or to be informed of that specific information.

(Authority: 20 U.S.C. 1412(a)(8); 1417(c); 34 CFR 300.615)

NC 1505-2.7 List of types and locations of information
Each LEA must provide parents on request a list of the types and locations of education records collected, maintained, or used by the LEA.

(Authority: 20 U.S.C. 1412(a)(8); 1417(c); 34 CFR 300.616)

NC 1505-2.8 Fees
(a) Each LEA may charge a fee for copies of records that are made for parents under these Policies if the fee does not effectively prevent the parents from exercising their right to inspect and review those records.

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(b) An LEA may not charge a fee to search for or to retrieve information under these Policies.

(Authority: 20 U.S.C. 1412(a)(8); 1417(c); 34 CFR 300.617)

NC 1505-2.9 Amendment of records at parent’s request
(a) A parent who believes that information in the education records collected, maintained, or used under these Policies is inaccurate or misleading or violates the privacy or other rights of the child may request the LEA that maintains the information to amend the information.

(b) The LEA must decide whether to amend the information in accordance with the request within a reasonable period of time of receipt of the request.

(c) If the LEA decides to refuse to amend the information in accordance with the request, it must inform the parent of the refusal and advise the parent of the right to a hearing under NC 1505-2.10.

(Authority: 20 U.S.C. 1412(a)(8); 1417(c); 34 CFR 300.618)

NC 1505-2.10 Opportunity for a hearing
The LEA must, on request, provide an opportunity for a hearing to challenge information in education records to ensure that it is not inaccurate, misleading, or otherwise in violation of the privacy or other rights of the child.

(Authority: 20 U.S.C. 1412(a)(8); 1417(c); 3 CFR 300.619)

NC 1505-2.11 Result of hearing
(a) If, as a result of the hearing, the LEA decide that the information is inaccurate, misleading or otherwise in violation of the privacy or other rights of the child, it must amend the information accordingly and so inform the parent in writing.

(b) If, as a result of the hearing, the LEA decides that the information is not inaccurate, misleading, or otherwise in violation of the privacy or other rights of the child, it must inform the parent of the right to place in the records it maintains on the child a statement commenting on the information or setting forth any reasons for disagreeing with the decision of the LEA.

(c) Any explanation placed in the records of the child under this section must--
(1) Be maintained by the LEA as part of the records of the child as long as the record or contested portion is maintained by the LEA; and
(2) If the records of the child or the contested portion is disclosed by the LEA to any party, the explanation must also be disclosed to the party.

(Authority: 20 U.S.C. 1412(a)(8); 1417(c); 34 CFR 300.620)

**NC 1505-2.12 Hearing procedures**

A hearing held under NC 1505-2.10 must be conducted according to the procedures under 34 CFR 99.22.

(Authority: 20 U.S.C. 1412(a)(8); 1417(c); 34 CFR 300.621)

**NC 1505-2.13 Consent**

(a) Parental consent must be obtained before personally identifiable information is disclosed to parties, other than officials of participating agencies in accordance with paragraph (b)(1) of this section, unless the information is contained in educational records, and the disclosure is authorized without parental consent under 34 part CFR 99.

(b) (1) Except as provided in paragraphs (b)(2) and (b)(3) of this section, parental consent is not required before personally identifiable information is released to officials of participating agencies for purposes of meeting a requirement of this part.

(2) Parental consent or the consent of the eligible child who has reached the age of majority under State law, must be obtained before personally identifiable information is released to officials of participating agencies providing or paying for transition services in accordance with NC 1503-4.2(b)(3).

(3) If a child is enrolled or is going to enroll in a private school that is not located in the LEA of the parent’s residence, parental consent must be obtained before any personally identifiable identifiable information about the child is released between the officials in the LEA where the private school is located and officials in the LEA of the parent’s residence.

(Authority: 20 U.S.C. 1412(a)(8); 1417(c); 34 CFR 300.622)

**NC 1505-2.14 Safeguards**

(a) Each LEA must protect the confidentiality of personally identifiable information at collection, storage, disclosure, and destruction stages.

(b) One official at each LEA must assume responsibility for ensuring the confidentiality of any personally identifiable information.

(c) All persons collecting or using personally identifiable information must receive training or instruction regarding the State’s policies and procedures under NC 1501-4.3 and 34 CFR part 99.

(d) Each LEA must maintain, for public inspection, a current listing of the names and positions of those employees within the agency who may have access to personally identifiable information.

(Authority: 20 U.S.C. 1412(a)(8); 1417(c); 34 CFR 300.623)

**NC 1505-2.15 Destruction of information**

(a) The LEA must inform parents when personally identifiable information collected, maintained, or used under these Policies is no longer needed to provide educational services to the child.

(b) The information must be destroyed at the request of the parents. However, a permanent record of a student’s name, address, and phone number, his or her grades, attendance record, classes attended, grade level completed, and year completed may be maintained without time limitation.
(c) The LEA shall inform parents that the personally identifiable information to be destroyed may be needed by the parent or the child for social security benefits, legal defense, or other purposes. At the parent’s request, a copy of the record shall be provided.

(Authority: 20 U.S.C. 1412(a)(8); 1417(c); 34 CFR 300.624)

§ 115C-149. Policy. Chemically dependent children excluded from provisions of Article 9.

The General Assembly of North Carolina hereby declares that the policy of the State is to ensure that an appropriate education is provided for drug and alcohol addicted children; however, drug and alcohol addicted children are not "children with disabilities" within the meaning of G.S. 115C-106.3(1) unless because of some other condition they meet that definition. (1989, c. 316, s. 1; 2006-69, s. 3(c.).)

Reference: Resources used for this section include the General Assembly Web Site which can be found at [www.ncleg.net](http://www.ncleg.net) and the publication entitled “Policies Governing Services for Children With Disabilities.” This publication can be found on-line at [www.ncpublicschools.org/ec/policy](http://www.ncpublicschools.org/ec/policy).
§ 115C-407. Policy prohibiting tobacco use in school buildings, grounds, and at school-sponsored events

(a) Not later than August 1, 2008, local boards of education shall adopt, implement, and enforce a written policy prohibiting at all times the use of any tobacco product by any person in school buildings, in school facilities, on school campuses, and in or on any other school property owned or operated by the local school administrative unit. The policy shall further prohibit the use of all tobacco products by persons attending a school-sponsored event at a location not listed in this subsection when in the presence of students or school personnel or in an area where smoking is otherwise prohibited by law.

(b) The policy shall include at least all of the following elements:

(1) Adequate notice to students, parents, the public, and school personnel of the policy.

(2) Posting of signs prohibiting at all times the use of tobacco products by any person in and on school property.

(3) Requirements that school personnel enforce the policy.

(c) The policy may permit tobacco products to be included in instructional or research activities in public school buildings if the activity is conducted or supervised by the faculty member overseeing the instruction or research and the activity does not include smoking, chewing, or otherwise ingesting the tobacco product.

(d) The North Carolina Health and Wellness Trust Fund Commission shall work with local boards of education to provide assistance with the implementation of this policy including providing information regarding smoking cessation and prevention resources. Nothing in this section, G.S. 143-595 through G.S. 143-601, or any other section prohibits a local board of education from adopting and enforcing a more restrictive policy on the use of tobacco in school buildings, in school facilities, on school campuses, or at school-related or school-sponsored events, and in or on other school property.

(2003-421, s. 1; 2007-236, s. 1.)
The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.

FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level. Students to whom the rights have transferred are "eligible students."

Parents or eligible students have the right to inspect and review the student's education records maintained by the school. Schools are not required to provide copies of records unless, for reasons such as great distance, it is impossible for parents or eligible students to review the records. Schools may charge a fee for copies.

Parents or eligible students have the right to request that a school correct records which they believe to be inaccurate or misleading. If the school decides not to amend the record, the parent or eligible student then has the right to a formal hearing. After the hearing, if the school still decides not to amend the record, the parent or eligible student has the right to place a statement with the record setting forth his or her view about the contested information.

Generally, schools must have written permission from the parent or eligible student in order to release any information from a student's education record. However, FERPA allows schools to disclose those records, without consent, to the following parties or under the following conditions (34 CFR § 99.31):

- School officials with legitimate educational interest;
- Other schools to which a student is transferring;
- Specified officials for audit or evaluation purposes;
- Appropriate parties in connection with financial aid to a student;
- Organizations conducting certain studies for or on behalf of the school;
- Accrediting organizations;
- To comply with a judicial order or lawfully issued subpoena;
- Appropriate officials in cases of health and safety emergencies; and
- State and local authorities, within a juvenile justice system, pursuant to specific State law.

Schools may disclose, without consent, "directory" information such as a student's name, address, telephone number, date and place of birth, honors and awards, and dates
of attendance. However, schools must tell parents and eligible students about directory information and allow parents and eligible students a reasonable amount of time to request that the school not disclose directory information about them. Schools must notify parents and eligible students annually of their rights under FERPA. The actual means of notification (special letter, inclusion in a PTA bulletin, student handbook, or newspaper article) is left to the discretion of each school.

For additional information or technical assistance, you may call (202) 260-3887 (voice). Individuals who use TDD may call the Federal Information Relay Service at 1-800-877-8339.

Or you may contact us at the following address:

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, D.C. 20202-5920

Legislative History of Major FERPA Provisions

The Family Educational Rights and Privacy Act of 1974 ("FERPA"), § 513 of P.L. 93-380 (The Education Amendments of 1974), was signed into law by President Ford on August 21, 1974, with an effective date of November 19, 1974, 90 days after enactment. FERPA was enacted as a new § 438 of the General Education Provisions Act (GEPA) called "Protection of the Rights and Privacy of Parents and Students," and codified at 20 U.S.C. § 1232g. It was also commonly referred to as the "Buckley Amendment" after its principal sponsor, Senator James Buckley of New York. FERPA was offered as an amendment on the Senate floor and was not the subject of Committee consideration. Accordingly, traditional legislative history for FERPA as first enacted is unavailable.

Senators Buckley and Pell sponsored major FERPA amendments that were enacted on December 31, 1974, just four months later, and made retroactive to its effective date of November 19, 1974. These amendments were intended to address a number of ambiguities and concerns identified by the educational community, including parents, students, and institutions. On December 13, 1974, these sponsors introduced the major source of legislative history for the amendment, which is known as the "Joint Statement in Explanation of Buckley/Pell Amendment" ("Joint Statement"). See Volume 120 of the Congressional Record, pages 39862-39866.

Congress has amended FERPA a total of nine times in the nearly 28 years since its enactment, as follows:

P.L. 93-568, Dec. 31, 1974, effective Nov. 19, 1974 (Buckley/Pell Amendment)
P.L. 96-46, Aug. 6, 1979 (Amendments to Education Amendments of 1978)
P.L. 96-88, Oct. 17, 1979
FERPA is a "Spending Clause" statute enacted under the authority of Congress in Art. I, § 8 of the U.S. Constitution to spend funds to provide for the general welfare. ("No funds shall be made available under any applicable program..." unless statutory requirements are met.)

I. Covered institutions

Initially, FERPA applied to "any State or local educational agency, any institution of higher education, any community college, any school, agency offering a preschool program, or any other educational institution." The 1974 amendments substituted the term "educational agency or institution," defined as "any public or private agency or institution which is the recipient of funds under any applicable program."

The 1994 IASA amendments extended the right to inspect and review to education records maintained by State educational agencies, whose records are not otherwise subject to FERPA. Modification of inaccurate records that SEAs receive from educational agencies and institutions still takes place at the local level.

II. Covered records

As first enacted, FERPA provided parents with the right to inspect and review "any and all official records, files, and data directly related to their children, including all material that is incorporated into each student's cumulative record folder, and intended for school use or to be available to parties outside the school or school system, and specifically including, but not necessarily limited to, identifying data, academic work completed, level of achievement (grades, standardized achievement test scores), attendance data, scores on standardized intelligence, aptitude, and psychological tests, interest inventory results, health data, family background information, teacher or counselor ratings and observations, and verified reports of serious or recurrent behavior patterns." The 1974 amendments substituted the term "education records" for the "laundry list" of records subject to FERPA.

"Education records" was defined in the 1974 amendments as "those records, files, documents, and other materials which contain information directly related to a
student; and are maintained by an educational agency or institution or by a person acting for such agency or institution."

Four categories of records were excluded:

1) records in the sole possession of instructional, supervisory, and administrative personnel; 2) records of a law enforcement unit which are kept apart from "education records," are maintained solely for law enforcement purposes, and are not made available to persons other than law enforcement officials of the same jurisdiction, provided that personnel of a law enforcement unit do not have access to "education records"; 3) records of employees who are not also in attendance; and 4) physician, psychiatrist, or psychologist treatment records for eligible students.

The conferees stated their intention that the Department interpret the term "treatment" narrowly to limit the exemption for such records to those similar to those enumerated, and not remedial educational records made or maintained by education professionals. They also stated they did not intend to disrupt existing parental and student rights to confidentiality. Conference Report No. 93-1409, Joint Explanatory Statement of the Committee of Conference, for P.L. 93-568.

At the request of the Secretary of Education, Congress amended the "law enforcement unit exception" in 1992 to eliminate the unworkable and unintended results of the prohibition on sharing education records with the law enforcement unit. The exclusion now applies to "records maintained by a law enforcement unit of the educational agency or institution that were created by that law enforcement unit for the purpose of law enforcement."

As originally enacted, all FERPA rights transfer from parents to students who are 18 years old or attending postsecondary institutions. The term "eligible students" is regulatory.

Rights of Parents and Eligible Students

I. Right to Inspect and Review/Right to Access Education Records

Parents have the right to inspect and review the education records of their children. In the 1974 amendments, Congress clarified that when a record or data pertains to more than one child, parents "have the right to inspect and review only such part of such material or document as relates to such student or to be informed of the specific information contained in such part of such material."

The 1974 amendments limited the right to inspect and review records so that postsecondary students do not have access to 1) financial records of their parents, and 2) confidential letters of recommendation placed in records before January 1, 1975, or
II. Right to Challenge the Content of Education Records

Parents originally had the right to a hearing to challenge the content of records to insure they are not "inaccurate, misleading, or otherwise in violation of the privacy or other rights of students" and to provide an opportunity for the "correction or deletion of any such inaccurate, misleading or otherwise inappropriate data." The 1974 amendments strengthened this right by prohibiting the Department from making funds available to an agency or institution unless parents are provided an opportunity for a hearing. This amendment also gave parents the right to insert a written explanation regarding the contents of the records. The 1994 IASA amendments limited challenges to the violation of the "privacy rights of students," deleting the reference to "other rights." The purpose was to ensure that parents do not attempt to use FERPA to enforce rights under other laws, such as the Individuals with Disabilities Education Act (IDEA).

The 1994 IASA amendments also added a new subsection (h) regarding treatment of disciplinary records, which states that nothing in FERPA prohibits an agency or institution from including in a student's records appropriate information regarding disciplinary actions taken against the student for "conduct that posed a significant risk to the safety or well-being of that student, other students, or other members of the school community," or from disclosing that information to teachers and other school officials who have legitimate educational interest in the student's behavior.

III. Right to Consent to the Disclosure of Education Records

As originally enacted, covered institutions could not have a policy of permitting the release of personally identifiable records or files (or personal information contained therein)(§1232g(b)(1)), or a policy or practice of furnishing, in any form, any personally identifiable information contained in personal school records (§1232g(b)(2)), unless there is written consent from parents specifying records to be released, reasons for release, and parties to whom records may be released. The 1974 amendments clarified that agencies and institutions may not have "a policy or practice of permitting the release of [or providing access to] education records (or personally identifiable information contained
Exception to the "Prior Written Consent" Rule

As first enacted, FERPA contained five exceptions to the prior written consent rule for disclosures to:

1. Other school officials, including teachers within the educational institution or local educational agency who have legitimate educational interests. The 1974 amendments clarified that the agency or institution determines which school officials have "legitimate educational interests." The 1994 IASA amendments added a requirement that the specific educational interests of the child for whom consent would otherwise be required are included among legitimate educational interests of school officials.

The 1994 amendments also clarified that nothing in FERPA prohibited an agency or institution from disclosing information about disciplinary actions taken against students to teachers and school officials, including those in other schools, who have legitimate educational interests in the behavior of the student. The No Child Left Behind Act amended the Elementary and Secondary Education Act to require each State to provide an assurance to the Secretary that it has a procedure in place to facilitate the transfer of disciplinary records regarding a student's suspension or expulsion to any elementary or secondary school where the student is enrolled or intends to enroll.
2. Officials of other schools or school systems in which the student intends to enroll, upon condition that the student's parents be notified of the transfer, receive a copy of the record if desired, and have an opportunity for a hearing to challenge the content of the record. The 1974 amendments added "seeks or" before "intends to enroll."

3. Authorized representatives of (i) the Comptroller General of the U.S.; (ii) the Secretary; (iii) an administrative head of an education agency (as defined in section 409 of GEPA) (deleted after reorganization of the Department); or (iv) State educational authorities.

As first enacted, FERPA provided that these recipients may have access to records "which may be necessary in connection with the audit and evaluation of Federally-supported education programs, or in connection with the enforcement of the Federal legal requirements which relate to such programs" provided that, except when collection of personally identifiable data is specifically authorized by Federal law, "data collected by such officials with respect to individual students shall not include information (including social security numbers) which would permit the personal identification of such students or their parents after the data so obtained has been collected." The final clause was amended on December 31, 1974, to read: "any data collected by such officials shall be protected in a manner which will not permit the personal identification of students and their parents by other than those officials, and such personally identifiable data shall be destroyed when no longer needed for such audit, evaluation, and enforcement of Federal legal requirements."

On August 6, 1979, Congress clarified that FERPA does not "prohibit State and local educational officials from having access to student or other records which may be necessary in connection with the audit and evaluation of any federally or State supported education program or in connection with the enforcement of the Federal legal requirements which relate to any such program," subject to the conditions on redisclosure set forth elsewhere in the statute. The legislative history explains that this amendment corrects an "anomaly" caused by the Department's interpretation of FERPA as precluding State auditors from requesting student records in order to conduct State audits of local and State-supported programs.

The 1998 Higher Education Amendments added a provision that also allows disclosure to authorized representatives of "the Attorney General for law enforcement purposes" under the same conditions as apply to the Secretary under this provision, as described above.

4. Appropriate officials in connection with a student's application for, or receipt of, financial aid. The conferees of the 1974 Amendments stated their intention that this exception should allow the use of social security numbers in connection with a
student's application for, or receipt of, financial aid.

5. Designees of a judicial order or any lawfully issued subpoena, upon condition that parents and students are notified in advance of compliance by the educational institution or agency. The 1994 IASA amendments added a new, related exception for law enforcement purposes that allows agencies and institutions to disclose information to designees of a Federal grand jury subpoena without first notifying parents or students, and to designees in any other subpoena issued for a law enforcement purpose with notice to parents or students at the discretion of the court or other issuing agency.

The 1974 amendments added five additional exceptions to the prior written consent rule:

6. State and local officials or authorities to whom such information is specifically required to be reported or disclosed pursuant to State statute adopted prior to November 19, 1974 ("grandfather clause"). The Joint Statement explained that in establishing a minimum Federal standard for record confidentiality and access, FERPA was not intended to preempt the States’ authority in the field. Accordingly, States may further limit the number or type of State or local officials who will continue to have access or provide parents and students with greater access to records than under FERPA.

The 1994 IASA amendments eliminated the "grandfather clause" and substituted an exception for disclosure to State and local officials in connection with the State's juvenile justice system under specified conditions.

7. Organizations conducting studies for, or on behalf of, educational agencies or institutions for the purpose of developing, validating or administering predictive tests, administering student aid programs, and improving instruction, if such studies are conducted in such a manner as will not permit the personal identification of students and their parents by persons other than representatives of such organizations and such information will be destroyed when no longer needed for the purpose for which it is conducted.

The Senate amendment permitted access for testing purposes if the "information will not permit the identification of any person by the organization receiving such information." The House amendment, which was adopted, provides that this exemption for such agencies as the College Entrance Examination Board or the Educational Testing Service will allow representatives of those organizations to have access to personally identifiable information under the conditions stated. Conference Report No. 93-1409.

The 1994 IASA amendments added that if an organization conducting studies fails to destroy information in violation of the requirements, the educational agency or
institutions may not permit access to that organization for not less than five years.

8. Accrediting organizations in order to carry out their accrediting functions.

9. Parents of dependent students as defined in the Internal Revenue Code.

10. Appropriate persons in connection with an emergency, if the knowledge of such information is necessary to protect the health or safety of the student or other persons. The Joint Statement explains: "In order to assure that there are adequate safeguards on this exception, the amendments provided that the Secretary shall promulgate regulations to implement this subsection. It is expected that he will strictly limit the applicability of this exception."

In 1990, Congress enacted the Campus Security Act, which added a new exception to the prior written consent rule:

11. Postsecondary institutions may disclose to an alleged victim of any crime of violence (as defined in U.S. Code Title 18, § 16) the results of any disciplinary proceeding conducted by the institution against the alleged perpetrator of the crime, regardless of the outcome of the proceeding. Congress amended this provision in the Higher Education Amendments of 1998 by including "nonforcible sex offenses" and clarifying that only "final results" may be disclosed (i.e., name of student perpetrator, violation committed, and sanction imposed. Written consent is still required to disclose the name of any other student).

The following new exception was also added in the 1998 HEA amendments.

12. Postsecondary institutions may disclose the final results of any disciplinary proceeding for a crime of violence (as defined above) or nonforcible sex offense to anyone, including members of the general public, if the institution determines that the student committed a violation of its rules or policies with respect to the crime.

13. The 1998 HEA amendments also added a new exception that allows institutions of higher education to disclose to a parent or legal guardian information regarding a student's violation of any law or institutional rule or policy governing the use or possession of alcohol or a controlled substance if the student is under 21 and the institution determines that the student has committed a disciplinary violation with respect to the use or possession.

Since 1998 Congress has enacted two additional exceptions to the statutory prior consent rule:

14. The 2000 Campus Sex Crimes Prevention Act added a new subsection (b)(7) to the statute to ensure that an educational institution may disclose information concerning registered sex offenders provided to it under State sex offender registration and community notification programs.
15. The USA Patriot Act of 2001 added a new subsection (j) that allows the U.S. Attorney General to apply for an ex parte court order requiring an educational agency or institution to allow the Attorney General to collect and use education records relevant to investigations and prosecutions of specified crimes or acts of terrorism (domestic or international). The Attorney General must certify that there are specific facts giving reason to believe that the records are likely to contain the required information. An educational agency or institution that in good faith produces records in accordance with the court's order is not liable to any person for that production.

The 2001 USA Patriot Act excludes from the recordkeeping requirement disclosures in response to a court's ex parte order based upon the Attorney General's certification regarding terrorism investigations and prosecutions.

II. Redisclosure of records

As first enacted, FERPA provided that personal information from covered records could only be transferred to a third party on the condition that the recipient would not permit any other party to have access without a parent's written consent. The 1994 IASA amendments added that if a third party recipient permits access to education records without prior written consent (except in compliance with a subpoena or court order), the educational agency or institution may not permit access to that party for not less than five years.

III. Notification of rights

As first enacted, FERPA required the recipient of funds to inform parents and eligible students of their rights. The 1994 IASA amendments changed the term to "effectively informs" to ensure that agencies and institutions carry out this requirement in a way that ensures that parents and students actually receive notice.
Administrative Requirements Applicable to the Department

As originally enacted, FERPA required the Department to issue regulations to protect privacy rights of students and families in connection with any surveys or data-gathering activities conducted, assisted, or authorized by the Department. These activities must also be authorized by law. The 1994 IASA amendments directed the Department to adopt or identify appropriate regulations within 8 months.

Any action to terminate Federal financial assistance may be taken only if the Secretary finds that there has been a failure to comply, and compliance cannot be secured voluntarily.

In accordance with the statute, the Secretary has designated an office and review board within the Department to investigate, process, review and adjudicate FERPA violations and complaints of alleged FERPA violations.

The 1974 amendments prohibit the regionalization of the enforcement of FERPA by providing that, except for the conduct of hearings, none of the functions of the Secretary may be carried out in any regional offices of the Department.

Sources:
www.ed.gov/policy/gen/guid/fpco/ferpa/index
www.ed.gov/policy/gen/guid/fpco/ferpa/leg-history

For other information on confidentiality of school records visit www.nasn.org home page, tab “policy & advocacy” and look for section labeled “content by category” and select “Confidentiality.”
Family Educational Rights and Privacy Act (FERPA)

Final Rule

34 CFR Part 99

Section-by-Section Analysis

December 2008

Under FERPA, 20 U.S.C. § 1232g, a parent or eligible student has a right to inspect and review the student’s education records and to seek to have them amended in certain circumstances. A parent or eligible student must also provide a signed and dated written consent before an educational agency or institution discloses personally identifiable information from education records. Exceptions to this requirement are set forth in § 99.31(a).

FERPA applies to any “educational agency or institution” that receives funds under any program administered by the Department. See 34 CFR § 99.1(a). This includes all public K-12 school districts and virtually all postsecondary institutions, public or private. For ease of reference, this document uses the terms school or institution, school district or district, college, institution of higher education, and postsecondary institution, as appropriate, in place of “educational agencies and institutions.” We have noted all changes from the Notice of Proposed Rulemaking (NPRM) that was published in the Federal Register on March 24, 2008 (73 FR 15574). For the purposes of this document, when we refer to “current” regulations we mean the FERPA regulations that are in effect until January 8, 2009.

§ 99.3 Definitions

Attendance is defined currently to include attendance in person or by correspondence. (A “student” is defined as an individual who is or has been “in attendance” at an educational agency or institution and regarding whom the agency or institution maintains education records.) The final regulations add other situations in which students “attend” classes but are not physically present, including attendance by videoconference, satellite, Internet, or other electronic information and telecommunications technologies. This change will ensure that individuals who receive instruction through distance learning and other contemporary modalities are covered as “students” and, therefore, that their records are protected under FERPA. No changes from the NPRM.

**Directory information** is defined currently as information that would not generally be considered harmful or an invasion of privacy if disclosed. School districts and postsecondary institutions may disclose directory information without consent if they have given the parent or eligible student notice of the kinds of information they designate as directory information and an opportunity to opt out of directory information disclosures. The statute and current regulations specifically list some items as directory information, including a student’s name; address; telephone number; email address; photograph; date and place of birth; enrollment status; and major field of study. Neither the statute nor current regulations lists any items that may not be designated and disclosed as directory information.

**SSNs and student ID numbers.** Current regulations specify that a student’s Social Security Number (SSN) and student ID number are “personally identifiable information” (see below) but do not indicate whether these personal identifiers may be designated and disclosed as directory information. The final regulations specifically prohibit the disclosure of a student’s SSN as directory information; based on public comments, we modified the rule to allow student ID numbers to be disclosed as directory information if they qualify as electronic identifiers (discussed below). This will prevent districts and institutions from attaching these identifiers to students’ names on sign-in sheets in classrooms, health clinics, etc.; prevent schools from disclosing lists with these identifiers attached to students’ names, addresses, and other directory information; and prevent teachers from using them to post grades. This change is intended to help reduce the risk of unauthorized access to personal information and identity theft by ensuring that schools do not make these identifiers available publicly. School officials will still be able to use class lists with ID numbers but cannot make them available to students or parents. Teachers that still post grades publicly will have to use a code known only to the teacher and the student.

**Electronic personal identifiers.** Schools have indicated that the directories that support electronic information systems used to deliver certain student services, such as Web-based class registration, access to academic records and library resources, etc., require disclosure of the user name or other personal identifier, used by a student to gain access to these systems. Public key infrastructure (PKI) technology for encryption and digital signatures also requires wide dissemination of the sender’s public key, which is an identifier. The final regulations allow school districts and postsecondary institutions to designate these electronic personal identifiers as directory information, including student ID numbers, but only if the identifier functions essentially as a name, i.e., it is not used by itself to authenticate identity and cannot be used by itself to gain access to education records. A unique electronic identifier disclosed as directory information may be used to provide access to education records, but only when the identifier is combined with other authentication factors known only to the user, such as a...
secret password or personal identification number (PIN), or some other method or combination of methods to authenticate the user’s identity and ensure that the user is, in fact, a person authorized to access the records. This change will ensure that institutions can use advanced technologies to deliver student services and access to education records. As noted above, parents and eligible students can opt out of directory information disclosures; those that do will not be able to participate in student services that are delivered in this manner.

**Disclosure** is defined currently to mean permitting access to or the release, transfer, or other communication of personally identifiable information from education records to any party by any means. The final regulations exclude from “disclosure” returning an education record, or information from an education record, to the party identified as the provider or creator of the record. This will accomplish two things. First, a State consolidated record system can allow a school district or postsecondary institution to have access to information that that district or institution provided to the system without violating the statutory prohibition on redisclosure, 20 U.S.C. 1232g(b)(3). Second, it will help schools deal with falsified transcripts, letters of recommendation, and other documents they receive by allowing an institution that has received a questionable document to return it to the ostensible sender for verification. (This second problem is also addressed in changes to § 99.31(a)(2), discussed below.) In response to public comments, we clarify in the preamble to the final regulations that we have no authority to exclude from the term “disclosure” a school district’s or institution’s release or transfer of personally identifiable information from education records to its State longitudinal data system or to parties that agree to keep the information confidential, and that the final regulations do not authorize the release or transfer of education records to a student’s previous institution that is not identified as the source of those records. No changes from the NPRM.

**Education records** are currently defined as records that are directly related to a “student” and maintained by an “educational agency or institution” or by a party acting for the agency or institution. (The term “student” excludes individuals who have not been in attendance at the agency or institution.)

**Post-enrollment records.** Current regulations exclude records that only contain information about an individual after he or she is no longer a student at that school. This was intended to apply to fundraising and similar types of records related to alumni. Some schools, however, have mistakenly interpreted this provision to mean that any record created or received by the institution after a student is no longer enrolled, regardless of the subject matter, is not an “education record” under FERPA. For example, under this interpretation a settlement agreement maintained by a school district related to a discrimination, wrongful death, or other lawsuit brought by a parent after the student is no longer enrolled is not an “education record”
record” under FERPA and, therefore, could be subject to mandatory disclosure under an open records law or otherwise released without consent to anyone. The final regulations clarify that records that pertain to an individual’s previous attendance as a student are “education records” under FERPA regardless of when they were created or received by the institution. No changes from the NPRM.

Peer-grading (Owasso Indep. Sch. Dist. No. I-011 v. Falvo, 534 U.S. 426 (2002)). Under FERPA a school may not disclose a student’s grades to another student without the prior written consent of the parent or eligible student. “Peer-grading” is a common educational practice in which teachers require students to exchange homework assignments, tests, and other papers, grade one another’s work, and then either call out the grade or turn in the work to the teacher for recordation. Even though peer-grading results in students finding out each other’s grades, the U.S. Supreme Court in 2002 issued a narrow holding in Owasso that this practice does not violate FERPA because grades on students’ papers are not “maintained” under the definition of “education records” and, therefore, would not be covered under FERPA at least until the teacher has collected and recorded them in the teacher’s grade book, a decision consistent with the Department’s longstanding position on peer-grading. The Court rejected assertions that students were “parties acting for” an institution when they scored each other’s work and that the student papers were, at that stage, “maintained” within the meaning of FERPA. Among other considerations, the Court expressed doubt that Congress intended to intervene in such a drastic fashion with traditional State functions or that the “federal power would exercise minute control over specific teaching methods and instructional dynamics in classrooms throughout the country.” The final regulations create a new exception to the definition of “education records” that excludes grades on peer-graded papers before they are collected and recorded by a teacher. This change clarifies that peer-grading does not violate FERPA. No changes from the NPRM.

**Personally identifiable information.** This is discussed below under § 99.31(b).

**State auditor** is not defined in current regulations. Sections 99.31(a)(3) and 99.35 of the current regulations allow disclosure of education records to “State and local educational authorities” for audit and evaluation of State and Federally funded education programs, or for the enforcement of or compliance with Federal legal requirements that relate to those programs. Legislative history for Pub. L. 96-46 (1979), which added 20 U.S.C. § 1232g(b)(5) to FERPA, indicates that Congress intended to include State auditors within the statutory exception for “audits or evaluations.” H.R. Report 96-338 at 10, 14 (1979) and 125 Cong. Record S20327 (July 24, 1979) (statement of Sen. Pell). The amendment is ambiguous, however, because the statutory language does not actually mention “auditors” and refers only to “State and local educational officials.” We have been concerned about the potential breadth
breadth of these disclosures given the ambiguity of the statutory term and the lack of detail in the legislative history regarding which among many possible entities should be considered “State auditors.”

The proposed regulations addressed the issue by defining “State auditor” (§99.3) as a party under any branch of government with authority and responsibility under State law for conducting audits, and limited disclosures to “audits,” defined as “testing compliance with applicable laws, regulations, and standards” (§ 99.35(a)(3)). We proposed this narrow definition of “audit,” which would limit which entities would gain access to personally identifiable information in education records, in order to honor congressional intent without opening the door to potential abuses by a multitude of agencies seeking that information for their own purposes.

We received many comments opposing the proposed definition of “audits” because it would prevent auditors from conducting “performance audits” (i.e., evaluations of program efficiency and effectiveness), which are specifically included as professional services under the U.S. Comptroller’s Generally Accepted Government Auditing Standards (GAGAS). Simply expanding the definition of “audit” in the final regulations, however, would leave unaddressed our concern about the potential breadth of the term “State auditor,” which our research has shown could include a large number and variety of State officials and offices that perform a range of functions, depending on how the term is defined or interpreted. In addition to the range of possible offices, titles, and functions, we identified a number of important issues that would need to be addressed, such as whether a new definition should include only auditors who follow GAGAS and the consequences of excluding certain officials. Given these unresolved policy issues for which we do not have the benefit of public comment, and our legal concern over making a substantive change without public comment, we decided to remove the State auditor provisions from the final rule, continue to study the matter, and issue guidance or new regulations, as appropriate.

§ 99.5 Disclosures to parents and rights of students. Under current regulations, all rights of parents under FERPA, including the right to inspect and review education records, to seek to have education records amended in certain circumstances, and to consent to the disclosure of education records, transfer to the student once the student has reached 18 years of age or attends a postsecondary institution and thereby becomes an “eligible student.” Current regulations also provide that even after a student has become an “eligible student” under FERPA, postsecondary institutions (and high schools, for students over 18 years of age) may allow parents to have access to their child’s education records, without the student’s consent, in the following circumstances: the student is a dependent for Federal income tax purposes (§
§ 99.31(a)(8)); the disclosure is in connection with a health or safety emergency under the conditions specified in § 99.36 (i.e., if knowledge of the information is necessary to protect the health or safety of the student or other individuals (§ 99.31(a)(10))); and for postsecondary students, the student has violated any Federal, State or local law, or any rule or policy of the institution, governing the use or possession of alcohol or a controlled substance, if the institution determines that the student has committed a disciplinary violation regarding that use or possession and the student is under 21 at the time of the disclosure (§ 99.31(a)(15)).

The Department has been concerned that some colleges and other postsecondary institutions do not fully understand their options with regard to disclosing education records (or personally identifiable information from education records) of eligible students to their parents and continue to believe mistakenly that FERPA prevents them from releasing this information to parents under any circumstances, including a health or safety emergency. The final regulations clarify that disclosures to parents are permissible without the student’s consent under any of these three exceptions. That is, a school may disclose education records to a parent of a dependent student under any circumstance; this exception to the consent requirement is likely to cover the vast majority of traditional college students. Even if a student is not a dependent, a postsecondary institution may disclose education records to a student’s parent under the alcohol or controlled substance exception (§ 99.31(a)(15)) or in connection with a health or safety emergency (§ 99.31(a)(10)) under the circumstances set forth in § 99.36, discussed below. The change will help these institutions understand that while they may choose to follow a policy of not disclosing information to the parents of eligible students, FERPA does not prevent them from doing so in most circumstances. No changes from the NPRM.

§ 99.31(a)(1) School officials. Under current regulations, school districts and postsecondary institutions may allow “school officials, including teachers, within the agency or institution” to have access to students’ education records, without consent, if they have determined that the official has “legitimate educational interests” in the information. Under § 99.7, a district or postsecondary institution that discloses information under this exception must include in its annual FERPA notification for parents and students a specification of criteria for determining who constitutes a school official and what constitutes a legitimate educational interest. Disclosures to school officials with legitimate educational interests are not subject to the recordation requirements in § 99.32.

§ 99.31(a)(1)(i)(B) Outsourcing. Neither the statute nor current regulations addresses disclosure of education records without consent to non-employees retained to perform institutional services and functions. The final regulations expand the “school officials” exception to include contractors, consultants, volunteers, and other outside service providers...
used by a school district or postsecondary institution to perform institutional services and functions. A contractor (or other outside service provider) that is given access to education records under this provision must be under the direct control of the disclosing institution and subject to the same conditions on use and redisclosure of education records that govern other school officials (see § 99.33). In particular, the contractor must ensure that only individuals with legitimate educational interests (as determined by the district or institution, as appropriate) obtain access to personally identifiable information from education records it maintains (or creates) on behalf of the district or institution. Further, in accordance with § 99.33(a) and (b), the contractor may not redisclose personally identifiable information without consent unless the district or institution has authorized the redisclosure under a FERPA exception and the district or institution records the subsequent disclosure. A district or institution may not disclose education records to an outside service provider under this exception unless it has specified in its annual FERPA notification that it uses contractors, consultants, volunteers, etc. as school officials to provide certain institutional services and functions. A district’s or institution’s recordation of a disclosure to an outside service provider will not waive its failure to comply with the annual notification requirements for outside service providers.

This change is consistent with the Department’s longstanding guidance that FERPA does not require school districts and postsecondary institutions to provide all institutional services and functions on an in-house basis. As institutions have expanded the range of services they outsource, from traditional legal and debt collection services to fundraising, enrollment and degree verification, transcript distribution, and information technology (IT) services and more, the need to establish in regulations the conditions for these non-consensual disclosures has become critical. In addition to requiring the disclosing institution to have direct control over its outside service providers’ maintenance and use of education records, the regulations explain that disclosure is permitted under this exception only if the district or institution is outsourcing a service it would otherwise provide using employees. For example, postsecondary institutions may not use this exception to disclose education records, without consent, to a financial institution or insurance company that provides a good student discount on services that the institution would not otherwise provide. This will prevent uncontrolled designation of outside parties as “school officials” for marketing and other purposes for which non-consensual disclosure of education records is not authorized by statute.

In response to public comments, the preamble to the final regulations explains that State educational authorities that operate State longitudinal data systems are not “school officials” under this exception and that disclosures to these State systems generally fall under the “audit or evaluation” exception. The preamble also explains how a district or institution may disclose education records without consent to its own law enforcement unit under the school officials’
officials’ exception but not to outside police officers. We revised the regulations to clarify that the “direct control” requirement means control of the outside service provider’s maintenance and use of information from education records and is not intended to affect the outside party’s status as an independent contractor or render that party an employee under State or Federal law.

§ 99.31(a)(1)(ii) Controlling access to education records by school officials. Current regulations do not specify what steps, if any, a school district or postsecondary institution must take to enforce the “legitimate educational interests” requirement in the school officials’ exception. Parents and students have complained that school officials have unrestricted access to the education records of all students in a district’s or institution’s system, particularly in districts and institutions where records are maintained electronically. Institutions themselves have expressed uncertainty about what methods they should use to comply with this requirement when establishing or upgrading their recordkeeping systems.

The final regulations require school districts and postsecondary institutions to use “reasonable methods” to ensure that teachers and other school officials (including outside service providers) obtain access to only those education records -- paper or electronic -- in which they have legitimate educational interests. Many districts and postsecondary institutions already use physical or technological controls to protect education records against unauthorized access, such as locks on filing cabinets for paper records and software applications with role-based access controls for electronic records. Under the final regulations, districts and institutions may forego physical or technological controls and rely instead on administrative policies for controlling access to education records by school officials. Those that choose this method must ensure that their administrative policy is effective and that they remain in compliance with the legitimate educational interest requirement for accessing records. In particular, if a parent or eligible student alleges that a school official obtained access to the student’s records without a legitimate educational interest, the burden is on the district or institution to show that the school official had a legitimate educational interest in the information. In response to public comments, the preamble to the final regulations explains that the requirement for using “reasonable methods” applies whether an agency or institution uses physical, technological, or administrative controls to restrict access to education records by school officials.

The preamble to the NPRM suggested that districts and institutions should consider restricting or tracking access to education records by school officials to ensure that they remain in compliance with this requirement. (Recommendations for safeguarding education records from unauthorized access and disclosure outside the institution itself are discussed below.)
In terms of assessing the reasonableness of methods used to control access to education records by school officials, the preamble to the final regulations explains that the risk of unauthorized access means the likelihood that records may be targeted for compromise and the harm that could result. Methods are considered reasonable if they reduce the risk to a level commensurate with the likely threat and potential harm. The greater the harm that would result, the more protections a school or district must use to ensure that its methods are reasonable. For example, high-risk records, such as SSNs and other information that could be used for identity theft, should generally receive greater and more immediate protection than medium- or low-risk records, such as those containing only publicly available directory information. We note also that reasonableness depends ultimately on what are the usual and customary good business practices of similarly situated institutions, which, in turn, requires ongoing review and modification of methods and procedures as standards and technologies change.

Many institutions use software with role-based security features that limit an individual’s access to electronic records based on their professional responsibilities and, therefore, already comply with the final regulations. Those that do not will now have specific guidance for updating or upgrading the security of their recordkeeping systems as appropriate. No changes from the NPRM.

§ 99.31(a)(2) Student’s new school. Under current regulations, a school district or postsecondary institution may disclose education records, without consent, to officials of another school, school system, or postsecondary institution where a student “seeks or intends to enroll.” There has been uncertainty in the education community about whether the “seeks or intends to enroll” language in the statute and current regulations authorizes a district or institution to send, or continue sending, education records to a student’s new school once the student has actually enrolled. The final regulations clarify that the authority to disclose or transfer education records to a student’s new school does not cease automatically the moment a student has enrolled and continues to any future point in time so long as the disclosure is for purposes related to the student’s enrollment or transfer. In response to public comments, we explain in the preamble to the final regulations that this means that a school may disclose any records or information, including health and disciplinary records, that the school could have disclosed when the student was seeking or intending to enroll in the new school.

We also explain in the preamble to the final regulations that there are other Federal laws, such as the Individuals with Disabilities Education Act (IDEA), §504 of the Rehabilitation Act of 1973, and Title II of the Americans with Disabilities Act of 1990 (ADA), with different requirements that may affect the release of student information. For example, §504 generally prohibits postsecondary institutions from making pre-admission inquiries about an applicant’s
applicant’s disability status. However, after admission, §504 and Title II of the ADA do not prohibit institutions from obtaining information concerning a current student, including those with disabilities, from any school previously attended by the student in connection with an emergency and if necessary to protect the health or safety of a student or other persons under FERPA.

The clarification regarding the nature of the disclosure authority under this section will allow a student’s previous school to supplement, update, or correct any records it sent during the student’s application or transfer period. Combined with the changes to the definition of “disclosure” (described earlier) that allow a student’s new school to return a transcript or other document to the purported sender or creator of the record, this change will also allow a student’s previous school to identify any falsified or fraudulent records and explain the meaning of any records disclosed previously to the new school. No changes from the NPRM.

§ 99.31(a)(6) Organizations conducting studies. Current regulations restate the statutory provision that allows a school district or postsecondary institution to disclose personally identifiable information from education records, without consent, to organizations conducting studies “for, or on behalf of” the disclosing institution for purposes of developing, validating, or administering predictive tests; administering student aid programs; or improving instruction. (Note that under changes to § 99.35(b), discussed below, this exception now applies also to State educational agencies (SEAs) and State higher education authorities that receive education records without consent from school districts and postsecondary institutions under § 99.31(a)(3) for audit, evaluation, or enforcement purposes.) Under current regulations, information disclosed under this exception must be protected so that students and their parents cannot be personally identified by anyone other than representatives of the organization conducting the study, and must be destroyed when no longer needed for the study. Failure to destroy information in accordance with this requirement could lead to a five-year ban on the disclosure of information to that organization.

Current regulations do not explain what “for, or on behalf of” means. Organizations seeking to conduct independent research have asked for clarification about the circumstances in which personally identifiable information from education records may be disclosed without consent under this exception, and districts and institutions have asked whether they may use this exception even if they have no particular interest in the proposed study.

The final regulations require a school district or postsecondary institution that uses this exception to enter into a written agreement with the recipient organization that specifies the
purposes of the study. The written agreement must specify that information from education records may only be used to meet the purposes of the study stated in the written agreement and must contain the current requirements in § 99.31(a)(6) on redisclosure and destruction of information, as described above. In response to public comments, we revised the regulations to require that the written agreement must require the organization to conduct the study in a manner that does not permit personal identification of parents and students by anyone other than representatives of the organization with legitimate interests. The final regulations also require that the written agreement must specify the purpose, scope, and duration of the study and the information to be disclosed; require the organization to destroy or return all personally identifiable information when no longer needed for the purposes of the study; and specify the time period during which the organization must either destroy or return the information.

In response to public comments we added a new provision in the regulations stating that an agency or institution is not required to initiate research requests or agree with or endorse the conclusions or results of the study when disclosing information under this exception. However, the statutory language “for, or on behalf of” indicates that the disclosing district or institution agrees with the purposes of the study and retains control over the information from education records that is disclosed. The written agreement required under the regulations will help ensure that information disclosed under this exception is used only to meet the purposes of the study as stated in the agreement and that all redisclosure and destruction requirements are met.

We also explain in the preamble to the final regulations that although disclosure of personally identifiable information without consent is allowed for studies under this exception, we recommend that whenever possible agencies and institutions either release de-identified information or remove students’ names and SSNs to reduce the risk of unauthorized disclosure of personally identifiable information.

Applicability of this provision to SEAs and State higher educational authorities that redisclose personally identifiable information from education records on behalf of school districts and postsecondary institutions is discussed below under § 99.35(b).

§ 99.31(a)(9)(ii) Ex parte court orders under USA Patriot Act. Current regulations do not address amendments to FERPA under the USA Patriot Act, Pub. L. 107-56, which authorizes the U.S. Attorney General (or designee) to apply for an ex parte court order that allows the Attorney General to collect education records from an educational agency or institution, without the consent or knowledge of the student or parent, that are relevant to an investigation or prosecution of an offense listed in 18 U.S.C. 2332b(g)(5)(B) or an act of domestic or international terrorism specified in 18 U.S.C. 2331. Under the statutory amendment and final
amendment and final regulations, school districts and postsecondary institutions are allowed to make these disclosures without consent or notice to the parent or student that would otherwise be required under § 99.31(a)(9) of the regulations and without recording the disclosure under § 99.32(a). Note that the court order itself may instruct the district or institution not to notify the parent or student or record the disclosure of education records, or disclose the existence of the ex parte order to any party.

The district or institution that is served by the Attorney General with an ex parte court order under this exception should ensure that the order is facially valid, just as it does when determining whether to comply with other judicial orders and subpoenas under § 99.31(a)(9). It is not, however, required or authorized to examine the underlying certification of facts that the Attorney General is required to present to the court in the Attorney General’s application for the order. No changes from the NPRM.

§ 99.31(a)(16) Registered sex offenders. The Campus Sex Crimes Prevention Act (CSCPA), which is § 1601(d) of the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, created a new exception to the consent requirement in FERPA that allows school districts and postsecondary institutions to disclose information concerning registered sex offenders provided under State sex offender registration and campus community notification programs for institutions of higher education required under the Wetterling Act, 42 U.S.C. 14071. Under the Wetterling Act, States must require certain sex offenders to register their name and address with the State authority where the offender lives, works, or is enrolled as a student. States are also required to release relevant information necessary to protect the public concerning persons required to register under what are known as “community notification programs.”

CSCPA contains registration and notice requirements designed specifically for higher education campus communities, including a requirement that States collect information about a registered offender’s enrollment or employment at an institution of higher education, along with any change in enrollment or employment status at the institution, and make this information available promptly to a campus police department or other appropriate law enforcement agency. CSCPA also amended the Higher Education Act of 1965 (HEA) by requiring institutions of higher education to advise the campus community where it can obtain information about registered sex offenders provided by the State under the Wetterling Act, such as a campus law enforcement office, a local law enforcement agency, or a computer network address. While the FERPA amendment was made in the context of CSCPA’s amendments applicable to the higher education community, the Department determined that all agencies and institutions, including elementary and secondary schools and school districts,
school districts, are covered by the amendment. The regulations add a new exception that allows a school district or postsecondary institution to disclose without consent information it has received from a State under the Wetterling Act about a student who is required to register as a sex offender in the State. In response to comments, we removed the sentence stating that nothing in FERPA requires or encourages a school district or institution to collect or maintain information about registered sex offenders because it could be confusing and could discourage schools from disclosing relevant information about a registered sex offender in appropriate circumstances. Note that disclosures under this exception are required to comply with guidelines issued by the U.S. Attorney General for State community notification programs, which were published in the Federal Register on Jan. 5, 1999 (64 FR 572) and Oct. 25, 2002 (67 FR 65598).

§ 99.31(b) De-identification of information. Education records may be released without consent under FERPA if all personally identifiable information has been removed. The final regulations provide objective standards under which school districts, postsecondary institutions, SEAs, State higher education authorities, and any other party may release, without consent, education records, or information from education records, that has been de-identified through the removal of all “personally identifiable information” taking into account unique patterns of information about the student, whether through single or multiple releases, and other reasonably available information. The new standards apply to both individual, redacted records and statistical information from education records in both student level or microdata and aggregate form.

Under current regulations, personally identifiable information (PII) includes a student’s name and other direct personal identifiers, such as the student’s SSN or student number. PII also includes indirect identifiers, such as the name of the student’s parent or other family members; the student’s or family’s address, and personal characteristics or other information that would make the student’s identity easily traceable. The final regulations add biometric records to the list of personal identifiers that constitute PII, and add other indirect identifiers, such as date and place of birth and mother’s maiden name, as examples of identifiers that should be considered in determining whether information is personally identifiable. In response to public comments, the final regulations define “biometric record” to mean a record of one or more measurable biological or behavioral characteristics that can be used for automated recognition of an individual, including fingerprints, retina and iris patterns, voiceprints, DNA sequence, facial characteristics, and handwriting. The definition is based on National Security Presidential Directive 59 and Homeland Security Presidential Directive 24.
The final regulations remove from the definition of PII the reference to “other information that would make the student’s identity easily traceable” because the phrase lacked specificity and clarity, and possibly suggested a fairly low standard for protecting education records. In its place, the regulations add that PII includes “other information that, alone or in combination, is linked or linkable to a specific student that would allow a reasonable person in the school community, who does not have personal knowledge of the relevant circumstances, to identify the student with reasonable certainty.” This change brings the definition more in line with recent Office of Management and Budget (OMB) guidance to Federal agencies, with modifications tailored to the educational community. (See OMB M-07-16, “Safeguarding Against and Responding to the Breach of Personally Identifiable Information” at: http://www.whitehouse.gov/omb/memoranda/fy2007/m07-16.pdf.)

Under the final regulations, PII also includes “information requested by a person who the educational agency or institution reasonably believes knows the identity of the student to whom the education record relates.”

The definition of PII provides objective standards for districts, institutions, SEAs, State higher education authorities, and other parties that release information, either at will or in response to an open records request, to use in determining whether they may release information, including in special cases such as those involving well-known students or records that concern highly publicized incidents. In response to public comments, we clarify in the preamble to the final regulations that the disclosing party must look to local news, events, and media coverage in the “school community” in determining whether “other information” (i.e., information other than direct and indirect identifiers listed in the definition of PII), would make a particular record personally identifiable even after all direct identifiers have been removed. In regard to so-called targeted requests, the final regulations clarify that a party may not release information from education records if the requester asks for the record of a particular student, or if the party has reason to believe that the requester knows the identity of the student to whom the requested records relate. These standards for determining whether records contain PII also apply to the release of statistical information from education records, in particular small data cells that may identify students.

Under the final regulations a party that releases either redacted records or statistical information should also consider other information that is linked or linkable to a student, such as law enforcement records, published directories, and other publicly available records that could be used to identify a student, and the cumulative effect of disclosure of student data. In all cases, the disclosing party must determine whether the other information that is linked or linkable to an education record would allow a “reasonable person in the school community” to
community” to identify the student “with reasonable certainty.” (In response to public comment, we changed “school or its community” to “school community” to avoid confusion.) The regulations recognize that the risk of avoiding the disclosure of PII cannot be completely eliminated and is always a matter of analyzing and balancing risk so that the risk of disclosure is very low. The reasonable certainty standard in the new definition of PII requires such a balancing test.

In regard to statistical information from education records, the final regulations recognize that it is not possible to prescribe a single disclosure limitation method to apply in every circumstance to minimize the risk of disclosing PII. The preamble to the final regulations does, however, provide several examples of the kinds of statistical, scientific, and technological concepts used by the Federal statistical agencies that can assist parties in developing a sound approach to de-identifying information for release depending on what information has already been released and what other information is publicly available. The final regulations also codify the Department’s November 18, 2004, guidance to the Tennessee Department of Education by allowing a disclosing party to attach a code to properly de-identified student level information for education research, which would allow the recipient to match information received from the same source. (The recipient may not have access to any information about how the disclosing party generates and assigns a record code, or that would allow the recipient to identify a student based on the record code; certain other conditions apply.) A party that releases data under this provision must ensure that the identity of any student cannot be determined with reasonable certainty in this “coded data,” including assurances of sufficient cell and subgroup size, and the linking key that connects the code to student information cannot be shared with the requesting party. The Department believes that these standards establish an appropriate balance that facilitates educational research and accountability while preserving the privacy protections in FERPA. As noted above, the Department cannot specify in general which disclosure limitation methods should be used in any particular case. However, parties are directed to monitor releases of coded microdata to ensure that overlapping or successive releases do not result in data sets in which PII is disclosed.

§ 99.31(c) Identification and authentication of identity. The final regulations require a school district or postsecondary institution to use reasonable methods to identify and authenticate the identity of parents, students, school officials, and any other parties to whom they disclose education records. Current regulations do not address this issue. Authentication of identity is more complex for disclosure of electronic records as new methods and technologies are developed. Under the final regulations, districts and institutions may use PINs, passwords, personal security questions; “smart cards” and tokens; biometric indicators;
or other factors known or possessed only by the user, as appropriate. No changes from the NPRM.

§ 99.33 Redisclosure of education records. Current regulations prohibit recipients of education records, without prior written consent, from redisclosing personally identifiable information from the records unless the agency or institution disclosed the information with the understanding that the recipient may make further disclosures on its behalf under one of the exceptions in § 99.31 and the agency or institution records the redisclosure.

§ 99.35(b)(1) By Federal and State officials. Current regulations do not permit Federal and State officials that receive education records under §§ 99.31(a)(3) and 99.35 for audit, evaluation, and compliance and enforcement purposes to redisclose education records under the conditions of § 99.33(b). The final regulations permit these officials to redisclose education records under the same conditions that apply currently to other recipients of education records. For example, an SEA that has obtained education records for audit, evaluation, or compliance and enforcement purposes may redisclose the records for other qualifying purposes under § 99.31. These include forwarding records to a student’s new school district and to another official listed in § 99.31(a)(3) (such as the Secretary, or an SEA or State higher education authority) for another qualifying audit, evaluation, or compliance and enforcement purpose. This will facilitate the development of consolidated State data systems used for accountability and research purposes. The final regulations also allow State and Federal officials to redisclose education records under other exceptions listed in § 99.31(a), including disclosures to an accrediting agency; in connection with a health or safety emergency; and in compliance with a court order or subpoena. No changes from the NPRM.

§ 99.33(b)(2) Under court order or subpoena. The final regulations require an SEA or other party that rediscloses education records on behalf of an educational agency or institution in compliance with a court order or subpoena to comply with the parental notification requirements in § 99.31(a)(9)(ii) before it responds to the order or subpoena. We also revised the five-year penalty rule in § 99.33(e) so that if the Department determines that a third party, such as an SEA, does not notify the parent as required, the agency or institution may not allow that third party access to education records for at least five years.

§ 99.33(c) Clery Act. Under current regulations implementing the Jeanne Clery Disclosure of Campus Security Policy and Campus Crimes Statistics Act (Clery Act) in the HEA, postsecondary institutions are required to inform both the accuser and accused of the outcome of any institutional disciplinary proceeding brought alleging a sex offense. Current FERPA regulations permit a postsecondary institution to disclose the outcome of a disciplinary proceeding to a victim of an alleged perpetrator of a crime of violence or a non-forcible sex offense, regardless of the outcome, but only on the condition that the institution notify the
notify the recipient that he or she may not redisclose the information without the student-perpetrator’s consent. Some postsecondary institutions have required the victim to execute a non-disclosure agreement before they release the information required under the Clery Act. The Department has determined that the statutory prohibition on redisclosure of information from education records in FERPA does not apply to information that a postsecondary institution is required to release to students under the Clery Act. The final regulations provide that disclosures under the Clery Act are not subject to the prohibition on redisclosure in § 99.33(a) and that postsecondary institutions may not require the victim to execute a non-disclosure or confidentiality agreement in order to receive information that the institution is required to disclose under the Clery Act. No changes from the NPRM.

§ 99.32 Recordkeeping requirements. Current regulations require an educational agency or institution to maintain a record of redisclosures it has authorized under § 99.33(b), including the names of the additional parties to which the receiving party may further disclose the information on behalf of the agency or institution and their legitimate interests under § 99.31 in receiving the information. In response to public comments on this issue, and in order to ease the administrative burdens of recordkeeping, we revised the regulations to require a State or Federal official that rediscloses education records on behalf of an agency or institution to comply with these recordation requirements if the agency or institution does not do so, and to make the record available to an educational agency or institution upon request within a reasonable period of time not exceeding 30 days. An educational agency or institution is required to obtain a copy of the State or Federal official’s record of further disclosures and make it available in response to a parent’s or eligible student’s request to review the student’s record of disclosures. The regulations also allow a State or Federal official to maintain the record by the student’s class, school, district, or other grouping rather than by the name of the student.

§ 99.36 Health and safety emergencies. Current regulations state, in part, that an educational agency or institution may disclose personally identifiable information from education records to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals. The current regulations also state that the health and safety emergencies provisions must be “strictly construed.”

The final regulations remove the language requiring strict construction of this exception and add a provision that says that, in making a determination under § 99.36, an educational agency or institution may take into account the totality of the circumstances pertaining to a threat to the safety or health of the student or other individuals. If the school determines that there is an
there is an articulable and significant threat to the health or safety of a student or other individuals, it may disclose information from education records to appropriate parties whose knowledge of the information is necessary to protect the health and safety of the student or other individuals. In response to public comments, we revised the recordkeeping requirements in § 99.32(a)(5) by requiring an educational agency or institution to record the articulable and significant threat that formed the basis for the disclosure and the parties to whom the information was disclosed. If there is a rational basis for the determination, the Department will not substitute its judgment for that of the educational agency or institution in deciding to release the information. Section 99.36 also provides that “appropriate parties” include “parents of an eligible student.” In response to public comments, the preamble to the final regulations clarifies the circumstances under which an educational agency or institution may release without consent an eligible student’s “treatment records” for purposes other than treatment.

These changes were made as a result of issues that were raised after the Virginia Tech tragedy in April 2007. In the first instance, the Secretary determined that greater flexibility and deference should be afforded to administrators so that they can bring appropriate resources to bear on circumstances that threaten the health or safety of individuals. With regard to the second amendment adding “parents” to those considered an “appropriate party,” this change will clarify to colleges and universities that parents may be notified when there is a health or safety emergency involving their son or daughter, notwithstanding any FERPA provision that might otherwise prevent such a disclosure.

§ 99.37 Directory information. Current regulations permit the disclosure of properly designated directory information without meeting FERPA’s written consent requirement. A school must designate the categories to be disclosed and permit students the opportunity to opt out before making such disclosures.

§ 99.37(b) Former students. Current regulations permit schools to disclose directory information on former students without providing notice as otherwise required or an additional opt-out opportunity. The final regulations require schools to honor a former student’s opt-out request made while in attendance unless it has been specifically rescinded by the former student. This will make clear that schools may not disclose the directory information of a former student if the student opted out of the disclosure while the student was in attendance. No changes from the NPRM.

§ 99.37(c) Student identification and communication in class. Current regulations do not address whether a student who opts out of directory information disclosures may prevent school officials from identifying the student by name or from disclosing the student’s electronic identifier or institutional email address in class. The final regulations provide specifically that an opt-out of directory information disclosures does not prevent a school from...
from identifying a student by name or from disclosing a student’s electronic identifier or institutional email address in class. This change clarifies that a right to opt out of directory information disclosures does not include a right to remain anonymous in class, and may not be used to impede routine classroom communications and interactions, whether class is held in a specified physical location or on-line through electronic communications. No changes from the NPRM.

§ 99.37(d) Use of SSNs. Current regulations do not specifically prohibit the use of SSNs to identify students when disclosing or confirming directory information. The final regulations prohibit the use of an SSN as an identification element when disclosing or confirming directory information unless the student has provided written consent for the disclosure. Some institutions and vendors providing services such as degree verifications on behalf of the institution currently use a student’s SSN as a means of confirming identity. Unless the student has provided prior written consent to confirm the SSN, this implicit confirmation of the SSN is improper under FERPA. No changes from the NPRM.

§ 99.62, § 99.64, § 99.65, § 99.66, § 99.67 Enforcement Provisions. Current regulations contain a number of provisions that address the Department’s authority, through the Family Policy Compliance Office (FPCO), to investigate a school district or postsecondary institution when a parent or eligible student files a complaint. The final regulations enhance and clarify the Department’s enforcement responsibilities as described in Gonzaga University v. Doe, 536 U.S. 273 (2002). In particular, the regulations clarify that FPCO may investigate allegations that FERPA has been violated made by a school official or some other party that is not a parent or eligible student, including information that has been brought to the attention of the Department by media reports. The regulations also clarify that a complaint does not have to allege that an institution has a policy or practice of violating FERPA in order for the Department to initiate an investigation or find the institution in violation. In response to public comments, we removed a provision in the proposed rules that would have required FPCO to find that an educational agency or institution has a policy or practice in violation of FERPA in order to take any enforcement action because it unnecessarily limited the Department’s enforcement authority.

Safeguarding recommendations. The preambles to the NPRM and final regulations contain non-binding recommendations to help agencies and institutions face significant challenges in safeguarding education records from unauthorized access and disclosure. These challenges include inadvertent posting of students’ grades or financial information on publicly available Web servers; theft or loss of laptops and other portable devices that contain education records; computer hacking; and failure to retrieve education records at termination of employment.
employment. Agencies and institutions are encouraged to review the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-100, “Information Security Handbook: A Guide for Managers,” and NIST SP 800-53, “Recommended Security Controls for Federal Information Systems” for guidance and to use any methods or technologies they determine are reasonable to mitigate the risk of unauthorized access and disclosure taking into account the likely harm that would result. The recommendations also include suggested responses to data breaches and other unauthorized disclosures, such as reporting the incident to law enforcement authorities; taking steps to retrieve data and prevent further disclosures; identifying all affected records and students; determining how the incident occurred; determining whether institutional policies and procedures were breached; and conducting a risk assessment. Notification of students is not required but recommended.
North Carolina School Health Program Manual

General Statutes, State Policies, and Administrative Code

Appendix II

Item #22

FERPA

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Health Records Retention and Disposition
Schedule for Local Education Agencies

HEALTH RECORDS FILE. Health-related records for students.

a) DIAGNOSTIC AND SUMMARY REPORTS. Reports from physicians documenting a student’s chronic health condition. (Records may be retained as part of student’s cumulative record or separately. If retained separately records should be merged with student’s cumulative record upon student’s departure from school system but prior to microfilming.)

DISPOSITION INSTRUCTIONS: Retain permanently in student’s cumulative records file.

b) INJURY REPORT FORMS. Injury report forms describing medical attention provided to a student on campus by school officials for injuries deemed serious.

DISPOSITION INSTRUCTIONS: Destroy in office when student reaches 29 years of age and has not received services within the last 10 years, if no litigation, claim, audit, or other official action involving the records has been initiated. If official action has been initiated, destroy in office after completion of action and resolution of issues involved.

c) KINDERGARTEN HEALTH ASSESSMENT FORMS. Initial immunization records and results physical examination necessary for a student to enter kindergarten. (Comply with applicable provisions of G.S. §130A-441 regarding confidentiality of records.)

DISPOSITION INSTRUCTIONS: Retain in cumulative records file until elementary school is completed, then destroy in office, or retain permanently if the form contains the only doctor-signed, clinic-stamped immunization record.

d) MEDICATION AND PROCEDURES LOG. Yearly log documenting medication administration and performance of skilled procedures provided to student by school nurses and/or designated school staff.
DISPOSITION INSTRUCTIONS: Destroy in office when student reaches 29 years of age and has not received services within the last 10 years, if no litigation, claim, audit, or other official action involving the records has been initiated. If official action has been initiated, destroy in office after completion of action and resolution of issues involved.

e) PERMANENT HEALTH RECORDS CARDS FILE. Card providing information on student’s medical history/status while in the public school system. Card includes immunization information, vision/hearing screening results, health status including chronic illness, seizures, allergies, etc., special health considerations, and narrative notes entered by the nurses or other school officials.

DISPOSITION INSTRUCTIONS: Retain permanently in student’s cumulative records file.

f) PHYSICIAN’S AUTHORIZATION FORMS FILE. Authorization forms including physician’s orders to administer prescribed medicine, physician’s orders for medical treatment and/or invasive health care procedures to be performed on the student, and physician’s order for “do not resuscitate.” Parent signs each type of form. (G.S. §115C-307)

DISPOSITION INSTRUCTIONS: Destroy in office when student reaches 29 years of age and has no received services within the last 10 years, if no litigation, claim, audit, or other official action involving the records has been initiated. If official action has been initiated, destroy in office after completion of action and resolution of issues involved.

g) STANDARD ACTION PLANS OR INDIVIDUALIZED ACTION PLANS FILE. Plans for students with life-threatening and/or chronic health conditions that describe procedures to be performed by school staff on the student throughout the year. The plan should be attached to the student’s permanent health record card while in use.

DISPOSITION INSTRUCTIONS: Retain in student’s cumulative file until or obsolete and then destroy. Note on permanent health record card when plan is discontinued.
Clinical Laboratory Improvement Amendments of 1988

School System Compliance

The Clinical Laboratory Improvement Amendments (CLIA) of 1988 require anyone performing even one test, including waived procedures, on “. . . human specimens for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of a human being. . .” to register for a CLIA certificate.

CLIA amendments grew out of a Congressional response to the laboratory Pap smear “crisis” of the 1980s, when some labs were accused of sub-standard quality assurance and inaccurate lab results. As a result, all institutions providing any lab procedures are required to obtain a CLIA certificate to assure compliance with federally-monitored guidelines for safe, accurate laboratory procedures.

School systems providing staff to assist students, based on physician’s order, with any lab procedures must obtain an appropriate CLIA certificate. The school system should identify an individual to oversee CLIA compliance for all appropriate services.

Lab procedures included in the CLIA waiver category are dipstick or tablet reagent urinanalysis, ovulation tests, urine pregnancy tests, erythrocyte sedimentation rate, hemoglobin, fecal occult blood, blood glucose and spun microhematocrit. These procedures are considered to be inherently accurate, risk-free to the patient, or already available over-the-counter. Institutions holding a certificate of waiver are not inspected by the Federal Drug Administration (FDA). School systems are currently providing tests included in the above list.

The following information outlines the requirements of the certification process and the ongoing monitoring required.

- School systems apply for certificate of waiver from North Carolina Division of Facility Services. Request an application for CLIA Certification.
- School systems designate a CLIA Director to oversee compliance at all school buildings.
- School system CLIA Program Manual, including manufacturer’s instructions and who is responsible for conducting the tests, should be available at all building sites.
• A written policy and procedure outlining quality assurance measures for all lab procedures performed in the school system, including equipment maintenance, calibration and log of repairs must be adopted.

Help is available from CLIA Certification:
Division of Health Service Regulation
CLIA Certification
2713 Mail Service Center
Raleigh, NC 27699-2713
(919) 855-4626

Resources for more information:
1. [www.dhhs.state.nc.us/dhsr/ahc/clia/index.html#contact](http://www.dhhs.state.nc.us/dhsr/ahc/clia/index.html#contact)
2. [www.cms.hhs.gov/CLIA/05_CLIA_Brochures.asp](http://www.cms.hhs.gov/CLIA/05_CLIA_Brochures.asp)
   • Brochure titled Certificate of Waiver Laboratory Project
   • Brochure #6
   • This link provides the most current list of waived tests
The final regulations for the reauthorized Individuals with Disabilities Education Act (IDEA) were published in the Federal Register on August 14, 2006, and became effective on October 13, 2006. Since publication of the final regulations, the Office of Special Education and Rehabilitative Services (OSERS) in the U.S. Department of Education has received requests for clarification of some of these regulations. This is one in a series of question and answer documents prepared by OSERS to address some of the most important issues raised by requests for clarification on a variety of high-interest topics. Generally, the questions, and corresponding answers, presented in this Q&A document required interpretation of IDEA and the regulations and the answers are not simply a restatement of the statutory or regulatory requirements. The responses presented in this document generally are informal guidance representing the interpretation of the Department of the applicable statutory or regulatory requirements in the context of the specific facts presented and are not legally binding. The Q&As are not intended to be a replacement for careful study of IDEA and the regulations. The statute, regulations, and other important documents related to IDEA and the regulations are found at [http://idea.ed.gov](http://idea.ed.gov).

The development and implementation of an individualized education program (IEP) that addresses the unique needs of each child with a disability and that assists schools and parents in focusing instruction are at the core of the IDEA. IDEA and the final Part B regulations include significant changes related to the content of IEPs (including content related to secondary transition and State and districtwide assessments), IEPs for children with disabilities who transfer from one public agency to another public agency within the same school year, IEP meetings and participants in those meetings, and changes to IEPs following the annual IEP meeting. The reauthorized IDEA also includes significant changes related to parental consent for initial evaluations and reevaluations.
A. Secondary Transition

**Authority:** The requirements for the content of the IEP related to secondary transition are found in the regulations at 34 CFR §300.320(b).

**Question A-1:** Must an IEP include measurable postsecondary goals based on age appropriate transition assessments for every 16-year-old student with a disability regardless of the student’s skill levels relating to education, employment and training?

**Answer:** Yes. Under 34 CFR §300.320(b), the IEP for each child with a disability, must, beginning not later than the first IEP to be in effect when the child turns 16, or younger if determined appropriate by the IEP Team, and updated annually thereafter, include: (1) appropriate measurable postsecondary goals based upon age appropriate transition assessments related to training, education, employment, and, where appropriate, independent living skills; and (2) the transition services (including courses of study) needed to assist the child in reaching those goals. This requirement applies, whether or not the child’s skill levels related to training, education, and employment are age appropriate. The IEP Team must, however, develop the specific postsecondary goals for the child, in light of the unique needs of the child as determined based on age appropriate transition assessments of the child's skills in these areas.

**Question A-2:** May community access skills be included in the IEP as independent living skills?

**Answer:** It depends. The IEP Team must determine whether it is necessary to include appropriate measurable postsecondary goals related to independent living skills in the IEP for a particular child, and – if so – what transition services are needed to assist the child in reaching those goals. Under 34 CFR §300.43, "transition services" are defined as "a coordinated set of activities for a child with a disability" "to facilitate movement from school to post-school activities," and include among other activities, "independent living, or community participation." Based on the assessment of the student's independent living skills, the IEP Team would need to determine whether transition services in the form of community access skills are necessary for the child to receive a free appropriate public education (FAPE). If so, those skills must be reflected in the transition services in the child's IEP.
**Question A-3:** If an IEP Team chooses to address transition before age 16 (for example, at age 14) are the same standards required?

**Answer:** Yes. The regulations provide, at 34 CFR §300.320(b), that beginning not later than the first IEP to be in effect when the child turns 16, or younger if determined appropriate by the IEP Team, and updated annually, thereafter, the IEP must include-- (1) Appropriate measurable postsecondary goals based upon age appropriate transition assessments related to training, education, employment, and, where appropriate, independent living skills; and (2) The transition services (including courses of study) needed to assist the child in reaching those goals. If the IEP Team for a particular child with a disability determines that it is appropriate to address the requirements of 34 CFR §300.320(b) for a child who is younger than age 16, then the IEP for that child must meet the requirements of 34 CFR §300.320(b).

**Question A-4:** Section 300.320(b)(1) requires that appropriate postsecondary transition goals be measurable. Must we measure goals once a student has graduated or has aged out?

**Answer:** There is no requirement for public agencies to measure postsecondary goals once a child is no longer eligible for FAPE under Part B of the Act. Under 34 CFR §300.101, FAPE must be made available to all children residing in the State in mandatory age ranges. However, the obligation to make FAPE available does not apply to children who have graduated from high school with a regular high school diploma (34 CFR §300.102(a)(3)) or to children who have exceeded the mandatory age range for provision of FAPE under State law (34 CFR §300.102(a)(2)). When a child's eligibility for FAPE pursuant to Part B terminates under these circumstances, in accordance with 34 CFR §300.305(e)(3), the local educational agency (LEA) must provide a "summary of the child's academic achievement and functional performance, which shall include recommendations on how to assist the child in meeting the child's postsecondary goals." However, this provision does not require the LEA to provide services to the child to meet these goals.
B. Transfer of Students with IEPs from One Public Agency to a New Public Agency

**Authority:** The requirements for IEPs for students who transfer from one public agency to another public agency within the same school year are found in the regulations at 34 CFR §300.323(e), (f), and (g).

**Question B-1:** What if a student whose IEP has not been subject to a timely annual review, but who continues to receive services under that IEP, transfers to another public agency in the same State? Is the new public agency required to provide FAPE from the time the student arrives?

**Answer:** If a child with a disability was receiving special education and related services pursuant to an IEP in a previous public agency (even if that public agency failed to meet the annual review requirements at 34 CFR §300.324(b)(1)(i)), and transfers to a new public agency in the same State and enrolls in a new school within the same school year, the new public agency (in consultation with the parents) must, pursuant to 34 CFR §300.323(e) provide FAPE to the child (including services comparable to those described in the child’s IEP from the previous public agency), until the new public agency either - (1) Adopts the child’s IEP from the previous public agency; or (2) Develops, adopts, and implements a new IEP that meets the applicable requirements in 34 CFR §§300.320 through 300.324.

**Question B-2:** What options are available when an out-of-state transfer student cannot produce an IEP, and the parent is the source for identifying “comparable” services?

**Answer:** The regulations require, at 34 CFR §300.323(g), that, to facilitate the transition for a child described in 34 CFR §300.323(e) and (f) - (1) the new public agency in which the child enrolls must take reasonable steps to promptly obtain the child’s records, including the IEP and supporting documents and any other records relating to the provision of special education or related services to the child, from the previous public agency in which the child was enrolled, pursuant to 34 CFR §99.31(a)(2); and (2) The previous public agency in which the child was enrolled must take reasonable steps to promptly respond to the request from the new public agency.

If, after taking reasonable steps to obtain the child’s records from the public agency in which the child was previously enrolled, including the IEP and any other records relating to the
provision of special education or related services to the child, the new public agency is not able to obtain the IEP from the previous public agency or from the parent, the new public agency is not required to provide services to the child pursuant to 34 CFR §300.323(f). This is because the new public agency, in consultation with the parents, would be unable to determine what constitutes comparable services for the child, since that determination must be based on the services contained in the child's IEP from the previous public agency. However, the new public agency must place the child in the regular school program and conduct an evaluation pursuant to 34 CFR §§300.304 through 300.306, if determined to be necessary by the new public agency. If there is a dispute between the parent and the new public agency regarding whether an evaluation is necessary or regarding what special education and related services are needed to provide FAPE to the child, the dispute could be resolved through the mediation procedures in 34 CFR §300.506 or, as appropriate, the due process procedures in 34 CFR §§300.507 through 300.516. Once a due process complaint notice requesting a due process hearing is filed, under 34 CFR §300.518(b), the child would remain in the regular school program during the pendency of the due process proceedings.

**Question B-3:** Is it permissible for a public agency to require that a student with a disability who transfers from another State with a current IEP that is provided to the new public agency remain at home without receiving services until a new IEP is developed by the public agency?

**Answer:** Under 34 CFR §300.323(f), if a child with a disability (who had an IEP that was in effect in a previous public agency in another State) transfers to a public agency in a new State, and enrolls in a new school within the same school year, the new public agency (in consultation with the parents) must provide the child with FAPE (including services comparable to those described in the child’s IEP from the previous public agency), until the new public agency - (1) Conducts an evaluation pursuant to 34 CFR §§300.304 through 300.306 (if determined to be necessary by the new public agency); and (2) Develops, adopts, and implements a new IEP, if appropriate, that meets the applicable requirements in 34 CFR §§300.320 through 300.324.

Thus, the public agency must provide FAPE to the child when the child enrolls in the school in the public agency in the new State, and may not deny services to the child pending the development of a new IEP.
Question B-4: What is the timeline for the receiving public agency to adopt an IEP from a previous public agency or to develop and implement a new IEP?

Answer: Neither the Act nor the regulations establish timelines for the new public agency to adopt the child’s IEP from the previous public agency; or to develop, adopt, and implement a new IEP. However, consistent with 34 CFR §300.323(e) and (f), the new public agency must take these steps within a reasonable period of time to avoid any undue interruption in the provision of required services.

C. IEP Team Membership and IEP Meetings

Authority: The requirements for IEP Team membership are found in the regulations at 34 CFR §300.321.
The requirements for IEP meetings are found in the regulations at 34 CFR §300.323(c)(1), and §300.324(a), (b) and (c).

Question C-1: May the representative of the public agency be excused from an IEP Team meeting?

Answer: Under 34 CFR §300.321(e)(1), the public agency representative is not required to attend an IEP Team meeting in whole or in part, if the parent of the child with a disability and the public agency agree, in writing, that the attendance of the member is not necessary because the meeting will not be dealing with curriculum or related services about which this member is knowledgeable.

As provided at 34 CFR §300.321(e)(2) (see also §300.321(a)(4)), a representative of the public agency may be excused from an IEP meeting, in whole or in part, when the meeting does involve a modification to or discussion of the member's area of the curriculum or related services, if-- (i) The parent, in writing, and the public agency consent to the excusal; and (ii) The member submits, in writing to the parent and the IEP Team, input into the development of the IEP prior to the meeting.

Allowing IEP Team members to be excused from attending an IEP Team meeting is intended to provide additional flexibility to parents in scheduling IEP Team meetings and to avoid delays in holding an IEP Team meeting when an IEP Team member cannot attend due to a scheduling conflict. Although the public agency, not the parent, determines the specific
personnel to fill the roles of the public agency's required participants at the IEP Team meeting, the public agency remains responsible for conducting IEP meetings that are consistent with the IEP requirements of the Act and the regulations. Accordingly, it may not be reasonable for a public agency to agree or consent to the excusal of the public agency representative if that individual is needed to ensure that decisions can be made at the meeting about commitment of agency resources that are necessary to implement the child's IEP that would be developed, reviewed, or revised at the IEP Team meeting.

**Question C-2:** Must the public agency receive consent from a parent to excuse multiple regular education teachers if at least one regular education teacher will be in attendance?

**Answer:** No. As provided in 34 CFR §300.321(a)(2), the public agency must ensure that the IEP Team includes “[n]ot less than one regular education teacher of the child (if the child is, or may be, participating in the regular education environment) ….” Neither the Act nor the regulations require that an IEP Team include more than one regular education teacher. Therefore, if the IEP Team includes not less than one regular education teacher of the child, the excusal provisions of 34 CFR §300.321(e)(2) would not apply to additional regular education teachers.

**Question C-3:** If the regular education teacher were excused from attending the IEP meeting, would an alternate regular education teacher be required to attend?

**Answer:** If the public agency designates a particular regular education teacher as the person who will participate in the IEP Team meeting pursuant to 34 CFR §300.321(a)(2), and that individual is excused from the meeting consistent with the requirements of 34 CFR §300.321(e)(1)-(2), the public agency is not required to include a different regular education teacher in the IEP Team meeting.

**Question C-4:** May a State establish additional regulations to ensure parents’ rights are protected with regard to excusal of IEP Team members?

**Answer:** Yes, but with certain caveats. A State may establish additional requirements to ensure that parents’ rights are protected with regard to excusal of IEP Team members, so
long as those additional requirements are consistent with the requirements of 34 CFR §300.321(e)(1) and (2), and do not diminish the right of parents to agree in writing or consent in writing to such excusal. Further, if a State establishes requirements that exceed those required by Part B of the Act and the Federal regulations, the State would be required by 34 CFR §300.199(a)(2), to identify in writing to the local educational agencies (LEAs) located in the State and to the Secretary that such rule, regulation or policy is a State-imposed requirement, which is not required by Part B of the Act and Federal regulations. However, a State must allow a parent and a public agency to agree in writing or consent in writing to excuse a member of the IEP Team, and this provision cannot be made optional for States. A State may not restrict, or otherwise determine, when an IEP Team member can be excused from attending an IEP Team meeting, or prohibit the excusal of an IEP Team member when the public agency and parent agree or consent to the excusal.

**Question C-5:** May State law or regulations regarding IEP Team membership and IEP Team meeting attendance requirements exceed those of IDEA?

**Answer:** Yes, but with certain caveats. A State may establish laws or regulations for IEP Team membership and IEP Team meeting attendance, but must ensure that in doing so it does not establish provisions that reduce parent rights or are otherwise in conflict with the requirements of Part B of the Act and the Federal regulations. Further, as required by 34 CFR §300.199(a), each State that receives funds under Part B of the Act must--
(1) Ensure that any State rules, regulations, and policies conform to the purposes of this part; (2) Identify in writing to LEAs located in the State and the Secretary any such rule, regulation, or policy as a State-imposed requirement that is not required by Part B of the Act and Federal regulations; and (3) Minimize the number of rules, regulations, and policies to which the LEAs and schools located in the State are subject under Part B of the Act.

**Question C-6:** Must an IEP Team document in writing that they considered all of the requirements of 34 CFR §300.324, regarding the development, review, and revision of IEPs?

**Answer:** Section 300.112 requires that the State ensure that an IEP, or an individualized family service plan (IFSP) that meets the requirements of section 636(d) of the Act, is developed, reviewed, and revised for each child with a disability. Section 300.201 requires public agencies to have in effect policies and procedures established under 34 CFR §§300.101 through 300.163 and §§300.165 through 300.174, which include the requirements related to developing, reviewing, and revising an IEP for each child with a disability in 34 CFR.
North Carolina School Health Program Manual

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Appendix II

Item #25
Q&A IEP

CFR §300.324. While the Act and these regulations generally do not specify what documentation must be maintained consistent with the requirements of 34 CFR §300.324, States and public agencies are required to maintain records to show compliance with the Act and the regulations, in accordance with 34 CFR §76.731 of the Education Department General Administrative Regulations (EDGAR).

Question C-7: How must a public agency document that IEP Team members have been informed of changes to the IEP?

Answer: The regulations provide, at 34 CFR §300.324(a)(4)(i), that, in making changes to a child’s IEP after the annual IEP Team meeting for a school year, the parent of a child with a disability and the public agency may agree not to convene an IEP Team meeting for the purposes of making those changes, and instead may develop a written document to amend or modify the child’s current IEP. The regulations require, at 34 CFR §300.324(a)(4)(ii), that if changes are made to the child’s IEP in accordance with 34 CFR §300.324(a)(4)(i), the public agency must ensure that the child’s IEP Team is informed of those changes. While the Act and the regulations do not specify the manner in which public agencies must document compliance with the requirements of 34 CFR §300.324(a)(4)(ii), they must maintain records to show compliance with the requirements of the Act and regulations, in accordance with 34 CFR §76.731 of EDGAR.

Question C-8: Who must participate when an IEP is amended without convening the IEP Team?

Answer: The regulations provide, at 34 CFR §300.324(a)(4)(i) that, in making changes to a child’s IEP after the annual IEP Team meeting for a school year, the parent of a child with a disability and the public agency may agree not to convene an IEP Team meeting for the purposes of making those changes, and instead may develop a written document to amend or modify the child’s current IEP. The Act and the regulations are silent as to which individuals must participate in making changes to the IEP where there is agreement between the parent and the public agency not to convene a meeting for the purpose of making the changes.
Question C-9: Must a public agency provide a parent with prior written notice when amending an IEP without convening the IEP Team?

Answer: The regulations require, at 34 CFR §300.503(a), that written notice that meets the requirements of 34 CFR §300.503(b) must be given to the parents of a child with a disability a reasonable time before the public agency-- (1) Proposes to initiate or change the identification, evaluation, or educational placement of the child or the provision of FAPE to the child; or (2) Refuses to initiate or change the identification, evaluation, or educational placement of the child or the provision of FAPE to the child. This provision applies, even if the IEP is revised without convening an IEP Team meeting, pursuant to 34 CFR §300.324(a)(4).

D. Consent for Initial Evaluation and Reevaluation

Authority: The requirements for consent for initial evaluations and reevaluations are found in the regulations at 34 CFR §300.300(a), (c), and (d)(4). The requirements for reevaluations are found in the regulations at 34 CFR §300.303.

Question D-1: What may a public agency do if a parent does not respond to the public agency’s request for the parent’s consent to a reevaluation?

Answer: Under 34 CFR §300.300(c)(2), the public agency need not obtain informed parent consent for the reevaluation if the public agency can demonstrate that it made reasonable efforts to obtain consent for the reevaluation, and the child’s parent has failed to respond to the request for such consent. Thus, under this regulation, a public agency may conduct a reevaluation of a child with a disability if the public agency can demonstrate that it made reasonable efforts to obtain parent consent for the reevaluation, and the child’s parent has failed to respond to the request for consent.

Question D-2: The regulations provide, at 34 CFR §300.303(b)(2), that a reevaluation must occur at least once every three years, unless the parent and the public agency agree that a reevaluation is unnecessary. What options are available to a public agency if a parent refuses to consent to a three-year reevaluation under 34 CFR §300.303(b)(2)?

Answer: The regulations provide, at 34 CFR §300.300(c)(1), that subject to 34 CFR §300.300(c)(2), each public agency-- (i) Must obtain informed parental consent, in
accordance with 34 CFR §300.300(a)(1), prior to conducting any reevaluation of a child with a disability. (ii) If the parent refuses to consent to the reevaluation, the public agency may, but is not required to, pursue the reevaluation by using the consent override procedures described in 34 CFR §300.300(a)(3). (iii) The public agency does not violate its obligation under 34 CFR §300.111 and §§300.301 through 300.311 if it declines to pursue the evaluation or reevaluation.

If a parent refuses to consent to a three-year reevaluation under 34 CFR §300.303(b)(2), the public agency has the following options:

1. The public agency and the parent may, as provided at 34 CFR §300.303(b)(2), agree that the reevaluation is unnecessary. If such an agreement is reached, the three-year reevaluation need not be conducted. However, the public agency must continue to provide FAPE to the child.

2. If the public agency and the parent do not agree that the reevaluation is unnecessary, and the parent refuses to consent to the reevaluation, the public agency may, but is not required to, pursue the reevaluation by using the consent override procedures described in 34 CFR §300.300(a)(3) (the procedural safeguards in subpart E of Part B, including the mediation procedures under 34 CFR §300.506 or the due process procedures under 34 CFR §§300.507 through 300.516), if appropriate, except to the extent inconsistent with State law relating to such parental consent.

3. If the public agency chooses not to pursue the reevaluation by using the consent override procedures described in 34 CFR §300.300(a)(3), and the public agency believes based on existing data that the child does not continue to have a disability or does not continue to need special education and related services, the public agency may determine that it will not continue to provide special education and related services to the child. If the public agency determines that it will not continue to provide special education and related services to the child, the public agency must provide the parent with prior written notice of its proposal to discontinue the provision of FAPE to the child consistent with 34 CFR §300.503(a)(2).

**Question D-3:** At an initial IEP meeting, may a parent give consent to provide some or all of the services in the IEP?

**Answer:** If a public agency has provided prior written notice, consistent with 34 CFR §300.503(a)(1), of its proposal to initiate the provision of FAPE, the parent may provide
informed consent to the initial provision of special education and related services, consistent with 34 CFR §300.300(b).

**Question D-4:** May a foster parent provide consent for an initial evaluation even if the biological parent refuses to provide such consent?

**Answer:** If the biological parent of the child refuses consent for an initial evaluation of the child, and the parental rights of the biological parent have not been terminated in accordance with State law or a court has not designated a foster parent to make educational decisions for the child in accordance with State law, a foster parent may not provide consent for an initial evaluation. See 34 CFR §300.30(b)(1).

This document as well as other IDEA related content may be found at: [http://idea.ed.gov/explore/home](http://idea.ed.gov/explore/home)
## Code of Federal Regulations (CFR) – School Nurse, School Health Services

### Individuals with Disabilities Education Improvement Act (IDEA) of 2004

34 CFR Parts 300, 301, 304 (2006)

<table>
<thead>
<tr>
<th>CFR</th>
<th>Subject: Authority</th>
<th>CFR-Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>§300.5</td>
<td>Assistive technology device 20 USC 1401(1)</td>
<td>Not include a medical device that is surgically implanted or replacement of the device</td>
</tr>
<tr>
<td>§300.8(b)</td>
<td>Definition-Child with a disability 20 USC 1401(3), 1401(30)</td>
<td>Child 3 through 9 years experiencing developmental delays (defined by state and measured by appropriate diagnostic instruments and procedures) in one or more development areas—physical, cognitive, communication, social, emotional, adaptive, and needs SE and RS</td>
</tr>
<tr>
<td>§300.8(c)(9)(i)</td>
<td>Other health impaired 20 USC 1401(3), 1401(30)</td>
<td>Adds Tourette Syndrome in list chronic or acute health problems</td>
</tr>
<tr>
<td>§300.18</td>
<td>Highly qualified special education teacher (a-g) 20 USC 1401(10)</td>
<td>Does not include related services providers. The term “highly qualified” applies only to school special education teachers, consistent with definition in the ESEA… See §300.156 Not applicable to private school teachers hired or contracted by LEA by parentally-placed</td>
</tr>
<tr>
<td>§300.21</td>
<td>Indian and Indian tribe 20 USC 1401(12) and (13)</td>
<td>Clarifies no services or funding for State Indian tribe not in recognized list</td>
</tr>
<tr>
<td>§300.30</td>
<td>Definition parent 20 USC 1401(23)</td>
<td>Substitute biological for natural. To be considered a parent, the guardian must be authorized as to act as parent and make educational decisions for the child</td>
</tr>
<tr>
<td>§300.34</td>
<td>Related services 20 USC 1401(26)</td>
<td>(a) General. Related services add interpreting and school nurse services. “Related services also include school health services, school nurse services … in schools…” (b)(1) “Exception. Related services do not include a medical device, surgically implanted, the optimization of device functioning, maintenance of device, or replacement of device.” (b)(2) Rights of the child are not limited to receive related services determined by IEP team and appropriate monitoring and maintaining medical devices needed to maintain health and safety…in transportation to and from or at school… (c)(13) “School health services and school nurse services means health services designed to enable a child with a disability to receive a FAPE as described in the child’s IEP. School nurse services are services provided by a qualified school nurse. School health services are services that may be provided by either a qualified school nurse or other qualified person.”</td>
</tr>
<tr>
<td>§300.35</td>
<td>Scientifically based research 20 USC 1411(c)(2)(C)(xi)</td>
<td>Scientifically based research definition added **</td>
</tr>
<tr>
<td>§300.42</td>
<td>Supplementary aids and services 20 USC 1401(33)</td>
<td>Aids, services, and other supports provided in regular education, other education-related settings, and in extracurricular and nonacademic setting to enable children with disabilities to be educated with nondisabled children</td>
</tr>
<tr>
<td>§300.154</td>
<td>Methods of ensuring services 20 USC 1412(a)(12) and (e)</td>
<td>(d) Children with disabilities who are covered by public insurance. (i) May not require parents to sign up for or enroll in public insurance programs in order for their child to receive FAPE… (iv) Must obtain parent consent consistent §300.622…</td>
</tr>
<tr>
<td>§300.304</td>
<td>Evaluation procedures 20 USC 1414(b)(1)-(3), 1412(a)(6)(B)</td>
<td>(c)(4) The child is assessed in all areas related to the suspected disability, including, if appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities; (same)</td>
</tr>
</tbody>
</table>

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### §300.156 Personnel qualifications

(Removed 300.23) 20 USC 1412(a)(14)  

(a) General. SEA establish and maintain qualifications to ensure personnel necessary to carry out purposes of this part are appropriately and adequately prepared and trained, including personnel have content knowledge and skills to serve children with disabilities  

(b) Related services personnel and paraprofessionals. The qualifications under paragraph (a) must include qualifications for related services personnel and paraprofessionals that --  

(1) Are consistent with any State-approved or State recognized certification, licensing, registration, or other comparable requirements that apply to the professional discipline in which those personnel are providing special education or related services; and  

(2) Ensure related services personnel who deliver services in their discipline or profession—  

(i) Meet requirements of paragraph (b)(1) of this section; and  

(ii) Have not had certification or licensure requirements waived on an emergency, temporary, or provisional basis; and  

(iii) Allow paraprofessionals and assistants who are appropriately trained and supervised, in accordance with State law, regulation, or written policy, in meeting requirements of this part to be used to assist in provision of special education and related services under this part to children with disabilities.  

(d) Policy. a State must adopt a policy that includes a requirement LEAs in the State take measurable steps to recruit, hire, train, and retain highly qualified personnel to provide special education and related services under this part to children with disabilities

### §300.174 Prohibition on mandatory medication.  

20 USC 1412(a)(25)  

(a) "General. SEA must prohibit State and LEA personnel from requiring parents to obtain a prescription for substances identified under schedules I, II, III, IV, or V in section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)) for a child as a condition of attending school, receiving an evaluation under or receiving services under this part  

(b) Rule of construction. Nothing in paragraph (a) shall be construed to create a Federal prohibition against teachers and other school personnel consulting or sharing classroom-based observations with parents or guardians regarding a student's academic and functional performance, or behavior in the classroom or school, or regarding the need for evaluation for special education or related services related to child find

### §300.306 Determination of eligibility.  

20 USC 1414(b)(4) and (5)  

(c) Procedures for determining eligibility and placement. (1)(i) Draw upon information from a variety of sources, including aptitude and achievement tests, parent input, teacher recommendations, physical condition, social or cultural background and adaptive behavior; …(same)
United States Department of Education issued new special education regulation revisions, December 2008

<table>
<thead>
<tr>
<th>§300.300 (b)(4)</th>
<th>Parental consent 20 USC 1414(a)(1)(D) and 1414(c)</th>
<th>Allows parents to unilaterally withdraw children with disabilities from continued special education and related services. Parental revocation of consent for continued special education and related services must be in writing and on revocation of consent a public agency provides the parent with prior written notice</th>
</tr>
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<tbody>
<tr>
<td>§ 300.512 (a)(1)</td>
<td>Hearing rights 20 USC 1415(f)(2), 1415(h)</td>
<td>The exception clause regarding the right to be represented by non-attorneys, revised to apply to any party to a hearing, not just parents</td>
</tr>
<tr>
<td>§300.602 (b)(1)(i)(A)</td>
<td>State use of targets and reporting. 20 USC 1416(b)(2)(C)</td>
<td>The timeline regarding the State’s public reporting on the performance of each LEA located in the State, has been changed from 60 days to 120 days following the State’s submission of the annual performance report to the Secretary</td>
</tr>
</tbody>
</table>

Federal Register /Vol. 73, No. 231 /Monday, December 1, 2008 /Rules and Regulations, pages 73006–73029 [E8–28175]  
accessed May 20, 2009  
Building the Legacy IDEA http://idea.ed.gov/explore/view/p/%2Croot%2Cregs%2C access all laws
General Statutes, State Policies and Administrative Code
Appendix II
Federal Regulations IDEA

(This page intentionally left blank.)
§ 130A-152. Immunization required.
(a) Every child present in this State shall be immunized against diphtheria, tetanus, whooping cough, poliomyelitis, red measles (rubeola) and rubella. In addition, every child present in this State shall be immunized against any other disease upon a determination by the Commission that the immunization is in the interest of the public health. Every parent, guardian, person in loco parentis and person or agency, whether governmental or private, with legal custody of a child shall have the responsibility to ensure that the child has received the required immunization at the age required by the Commission. If a child has not received the required immunizations by the specified age, the responsible person shall obtain the required immunization for the child as soon as possible after the lack of the required immunization is determined.
(b) Repealed by Session Laws 2002-179, s. 10, effective October 1, 2002.
(c) The Commission shall adopt and the Department shall enforce rules concerning the implementation of the immunization program. The rules shall provide for:
   (1) The child's age at administration of each vaccine;
   (2) The number of doses of each vaccine;
   (3) Exemptions from the immunization requirements where medical practice suggests that immunization would not be in the best health interests of a specific category of children;
   (4) The procedures and practices for administering the vaccine; and
   (5) Redistribution of vaccines provided to local health departments.
(c1) The Commission for Public Health shall, pursuant to G.S. 130A-152 and G.S. 130A-433, adopt rules establishing reasonable fees for the administration of vaccines and rules limiting the requirements that can be placed on children, their parents, guardians, or custodians as a condition for receiving vaccines provided by the State. These rules shall become effective January 1, 1994.
(d) Only vaccine preparations which meet the standards of the United States Food and Drug Administration or its successor in licensing vaccines and are approved for use by the Commission may be used.
(e) When the Commission requires immunization against a disease not listed in paragraph (a) of this section, or requires an additional dose of a vaccine, the Commission is authorized to exempt from the new requirement children who are or who have been enrolled in school (K-12) on or before the effective date of the new requirement. (1957, c. 1357, s. 1; 1971, c. 191; 1973, c. 476, s. 128; c. 632, s. 1; 1975, c. 84; 1977, c. 160; 1979, c. 56, s. 1; 1983, c. 891, s. 2; 1985, c. 158; 1993, c. 321, s. 281(a); 2002-179, s. 10; 2007-182, s. 2.)
§ 130A-153. Obtaining immunization; reporting by local health departments; access to immunization information in patient records; immunization of minors.

(a) The required immunization may be obtained from a physician licensed to practice medicine or from a local health department. Local health departments shall administer required and State-supplied immunizations at no cost to patients who are uninsured or underinsured and have family incomes below two hundred percent (200%) of the federal poverty level. A local health department may redistribute these vaccines only in accordance with the rules of the Commission.

(b) Local health departments shall file monthly immunization reports with the Department. The report shall be filed on forms prepared by the Department and shall state, at a minimum, each patient's age and the number of doses of each type of vaccine administered.

(c) Immunization certificates and information concerning immunizations contained in medical or other records shall, upon request, be shared with the Department, local health departments, and the patient's attending physician. In addition, an insurance institution, agent, or insurance support organization, as those terms are defined in G.S. 58-39-15, may share immunization information with the Department. The Commission may, for the purpose of assisting the Department in enforcing this Part, provide by rule that other persons may have access to immunization information, in whole or in part.

(d) A physician or local health department may immunize a minor with the consent of a parent, guardian, or person standing in loco parentis to the minor. A physician or local health department may also immunize a minor who is presented for immunization by an adult who signs a statement that he or she is authorized by a parent, guardian, or person standing in loco parentis to the minor to obtain the immunization for the minor. (1957, c. 1357, s. 1; 1959, c. 177; 1965, c. 652; 1971, c. 191; 1973, c. 476, s. 128; 1979, c. 56, s. 1; 1983, c. 891, s. 2; 1985, c. 743, ss. 1, 2; 1993, c. 134, s. 1; 1999-110, s. 2; 2009-451, s. 10.29A(a).)


(a) A physician or local health department administering a required vaccine shall give a certificate of immunization to the person who presented the child for immunization. The certificate shall state the name of the child, the name of the child's parent, guardian, or person responsible for the child obtaining the required immunization, the address of the child and the parent, guardian or responsible person, the date of birth of the child, the sex of the child, the number of doses of the vaccine given, the date the doses were given, the name and address of the physician or local health department administering the required immunization and other relevant information required by the Commission.

(b) Except as otherwise provided in this subsection, a person who received immunizations in a state other than North Carolina shall present an official certificate or record of immunization to the child care facility, school (K-12), or college or university.
This certificate or record shall state the person’s name, address, date of birth, and sex; the type and number of doses of administered vaccine; the dates of the first MMR and the last DTP and polio; the name and address of the physician or local health department administering the required immunization; and other relevant information required by the Commission. (1957, c. 1357, s. 1; 1959, c. 177; 1965, c. 652; 1971, c. 191; 1979, c. 56, s. 1; 1983, c. 891, s. 2; 1999-110, s. 3.)

§ 130A-155. Submission of certificate to child care facility, preschool and school authorities; record maintenance; reporting.

(a) No child shall attend a school (pre K-12), whether public, private or religious, a child care facility as defined in G.S. 110-86(3), unless a certificate of immunization indicating that the child has received the immunizations required by G.S. 130A-152 is presented to the school or facility. The parent, guardian, or responsible person must present a certificate of immunization on the child's first day of attendance to the principal of the school or operator of the facility, as defined in G.S. 110-86(7). If a certificate of immunization is not presented on the first day, the principal or operator shall present a notice of deficiency to the parent, guardian or responsible person. The parent, guardian or responsible person shall have 30 calendar days from the first day of attendance to obtain the required immunization for the child. If the administration of vaccine in a series of doses given at medically approved intervals requires a period in excess of 30 calendar days, additional days upon certification by a physician may be allowed to obtain the required immunization. Upon termination of 30 calendar days or the extended period, the principal or operator shall not permit the child to attend the school or facility unless the required immunization has been obtained.

(b) The school or child care facility shall maintain on file immunization records for all children attending the school or facility which contain the information required for a certificate of immunization as specified in G.S. 130A-154. These certificates shall be open to inspection by the Department and the local health department during normal business hours. When a child transfers to another school or facility, the school or facility which the child previously attended shall, upon request, send a copy of the child's immunization record at no charge to the school or facility to which the child has transferred.

(c) The school shall file an annual immunization report with the Department by November 1. The child care facility shall file an immunization report annually with the Department. The report shall be filed on forms prepared by the Department and shall state the number of children attending the school or facility, the number of children who had not obtained the required immunization within 30 days of their first attendance, the number of children who received a medical exemption and the number of children who received a religious exemption.

(d) Any adult who attends school (pre K-12), whether public, private or religious, shall obtain the immunizations required in G.S. 130A-152 and shall present to the school a certificate in accordance with this section. The physician or local health department administering a required vaccine to the adult shall give a certificate of immunization to the person. The certificate shall state the person's name, address, date of birth and sex; the
number of doses of the vaccine given; the date the doses were given; the name and addresses of the physician or local health department administering the required immunization; and other relevant information required by the Commission. (1957, c. 1357, s. 1; 1959, c. 177; 1965, c. 652; 1971, c. 191; 1973, c. 632, s. 2; 1979, c. 56, s. 1; 1981, c. 44; 1983, c. 891, s. 2; 1997-506, s. 47; 1999-110, s. 4; 2007-187, s. 2.)

§ 130A-155.1. Submission of certificate to college or universities.
(a) Except as otherwise provided in this section, no person shall attend a college or university, whether public, private, or religious, unless a certificate of immunization or a record of immunization from a high school located in North Carolina indicating that the person has received immunizations required by G.S. 130A-152 is presented to the college or university. The person shall present a certificate or record of immunization on or before the date the person first registers for a quarter or semester during which the student will reside on the campus or first registers for more than four traditional day credit hours to the registrar of the college or university. If a certificate or record of immunization is not in the possession of the college or university on the date of first registration, the college or university shall present a notice of deficiency to the student. The student shall have 30 calendar days from the date of the student's first registration to obtain the required immunization. If immunization requires a series of doses and the period necessary to give the vaccine at standard intervals extends beyond the date of the first registration, the student shall be allowed to attend the college or university upon written certification by a physician that the standard series is in progress. The physician shall state the time period needed to complete the series. Upon termination of this time period, the college or university shall not permit the student to continue in attendance unless the required immunization has been obtained.

(b) The college or university shall maintain on file immunization records for all students attending the school which contain the information required for a certificate of immunization as specified in G.S. 130A-154. These certificates shall be open to inspection by the Department and the local health department during normal business hours. When a student transfers to another college or university, the college or university which the student previously attended shall, upon request, send a copy of the student's immunization record at no charge to the college or university to which the student has transferred.

(c) Within 60 calendar days after the commencement of a new school year, the college or university shall file an immunization report with the Department. The report shall be filed on forms prepared by the Department and shall state the number of students attending the school or facility, the number of students who had not obtained the required immunization within 30 days of their first attendance, the number of students who received a medical exemption and the number of students who received a religious exemption.

(d) Repealed by Session Laws 1999-110, s. 5.

(e) The provisions of this section shall not apply to:
(1) Educational institutions established under Chapter 115D of the General Statutes.
§ 130A-156. Medical exemption.

The Commission for Public Health shall adopt by rule medical contraindications to immunizations required by G.S. 130A-152. If a physician licensed to practice medicine in this State certifies that a required immunization is or may be detrimental to a person's health due to the presence of one of the contraindications adopted by the Commission, the person is not required to receive the specified immunization as long as the contraindication persists. The State Health Director may, upon request by a physician licensed to practice medicine in this State, grant a medical exemption to a required immunization for a contraindication not on the list adopted by the Commission. (1957, c. 1357, s. 1; 1959, c. 177; 1965, c. 652; 1971, c. 191; 1979, c. 56, s. 1; 1983, c. 891, s. 2; 1987, c. 782, s. 18; 1989, c. 122; 1999-110, s. 6; 2007-182, s. 2.)


If the bona fide religious beliefs of an adult or the parent, guardian or person in loco parentis of a child are contrary to the immunization requirements contained in this Chapter, the adult or the child shall be exempt from the requirements. Upon submission of a written statement of the bona fide religious beliefs and opposition to the immunization requirements, the person may attend the college, university, school or facility without presenting a certificate of immunization. (1957, c. 1357, s. 1; 1959, c. 177; 1965, c. 652; 1971, c. 191; 1979, c. 56, s. 1; 1983, c. 891, s. 2; 1985, c. 692, s. 2; 2002-179, s. 17.)
Immunization Law

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School Board Notification to Parents: Meningitis, Influenza, HPV (also known as Garrett’s Law)

§ 115C-375.4. Meningococcal Meningitis and Influenza and Their Vaccines.
Local boards of education shall ensure that schools provide parents and guardians with information about meningococcal meningitis and influenza and their vaccines at the beginning of every school year. This information shall include the causes, symptoms, and how meningococcal meningitis and influenza are spread and the places where parents and guardians may obtain additional information and vaccinations for their children. (2005-22, s. 4(a), (b).)

In 2007 the General Assembly of North Carolina enacted the following to include HPV:

SECTION 1. G.S. 115C-47 is amended by adding a new subdivision to read:
(49) To Ensure that Schools Provide Information Concerning Cervical Cancer, Cervical Dysplasia, Human Papillomavirus, and the Vaccines Available to Prevent These Diseases. – Local boards of education shall ensure that schools provide parents and guardians with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. This information shall be provided at the beginning of the school year to parents of children entering grades five through 12. This information shall include the causes and symptoms of these diseases, how they are transmitted, how they may be prevented by vaccination, including the benefits and possible side effects of vaccination, and places parents and guardians may obtain additional information and vaccinations for their children.
(5/31/07)
North Carolina School Health Program Manual

General Statutes, State Policies, and Administrative Code

Appendix II Item #28

“Garrett’s Law” – Parental Notification About Meningitis, Influenza, HPV Vaccines

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Admission and Assignment of Students

§ 115C-364. Admission requirements.
(a) A child who is presented for enrollment at any time during the first 120 days of a school year is entitled to initial entry into the public schools if:
   (1) The child reaches or reached the age of 5 on or before August 31 of that school year; or
   (2) The child did not reach the age of 5 on or before August 31 of that school year, but has been attending school during that school year in another state in accordance with the laws or rules of that state before the child moved to and became a resident of North Carolina.
(b) A local board may allow a child who is presented for enrollment at any time after the first 120 days of a school year to be eligible for initial entry into the public schools if:
   (1) The child reached the age of 5 on or before August 31 of that school year; or
   (2) The child did not reach the age of 5 on or before August 31 of that school year, but has been attending school during that school year in another state in accordance with the laws or rules of that state before the child moved to and became a resident of North Carolina.
(c) The initial point of entry into the public school system shall be at the kindergarten level. If the principal of a school finds as fact subsequent to initial entry that a child, by reason of maturity can be more appropriately served in the first grade rather than in kindergarten, the principal may act under G.S. 115C-288 to implement this educational decision without regard to chronological age. The principal of any public school may require the parent or guardian of any child presented for admission for the first time to that school to furnish a certified copy of the child's birth certificate, which shall be furnished by the register of deeds of the county having on file the record of the birth of the child, or other satisfactory evidence of date of birth.
(d) A child who has passed the fourth anniversary of the child's birth on or before April 16 may enter kindergarten if the child is presented for enrollment no later than the end of the first month of the school year and if the principal of the school finds, based on information submitted by the child's parent or guardian, that the child is gifted and that the child has the maturity to justify admission to the school. The State Board of Education shall establish guidelines for the principal to use in making this finding. (1955, c. 1372, art. 19, s. 2; 1969, c. 1213, s. 4; 1973, c. 603, s. 3; 1981, c. 423, s. 1; 1983, c. 656, s. 1; 1997-204, s. 1; 1997-269, s. 1; 2007-173, s. 1.)

Comment: This statute took effect for the school year 2009-2010. The age of kindergarten entry was modified 7/4/07 by House Bill 150 in an effort to improve kindergarten readiness and reduce the future dropout rate.
§ 115C-391.1. Permissible use of seclusion and restraint.

(a) It is the policy of the State of North Carolina to:
(1) Promote safety and prevent harm to all students, staff, and visitors in the public schools.
(2) Treat all public school students with dignity and respect in the delivery of discipline, use of physical restraints or seclusion, and use of reasonable force as permitted by law.
(3) Provide school staff with clear guidelines about what constitutes use of reasonable force permissible in North Carolina public schools.
(4) Improve student achievement, attendance, promotion, and graduation rates by employing positive behavioral interventions to address student behavior in a positive and safe manner.
(5) Promote retention of valuable teachers and other school personnel by providing appropriate training in prescribed procedures, which address student behavior in a positive and safe manner.

(b) The following definitions apply in this section:
(1) "Assistive technology device" means any item, piece of equipment, or product system that is used to increase, maintain, or improve the functional capacities of a child with a disability.
(2) "Aversive procedure" means a systematic physical or sensory intervention program for modifying the behavior of a student with a disability which causes or which causes or reasonably may be expected to cause one or more of the following:
a. Significant physical harm, such as tissue damage, physical illness, or death.
b. Serious, foreseeable long-term psychological impairment.
c. Obvious repulsion on the part of observers who cannot reconcile extreme procedures with acceptable, standard practice, for example: electric shock applied to the body; extremely loud auditory stimuli; forcible introduction of foul substances to the mouth, eyes, ears, nose, or skin; placement in a tub of cold water or shower; slapping, pinching, hitting, or pulling hair; blindfolding or other forms of visual blocking; unreasonable withholding of meals; eating one's own vomit; or denial of reasonable access to toileting facilities.
(3) "Behavioral intervention" means the implementation of strategies to address behavior that is dangerous, disruptive, or otherwise impedes the learning of a student or others.
(4) "IEP" means a student's Individualized Education Plan.
(5) "Isolation" means a behavior management technique in which a student is placed alone in an enclosed space from which the student is not prevented from leaving.
(6) "Law enforcement officer" means a sworn law enforcement officer with the power to arrest.
(7) "Mechanical restraint" means the use of any device or material attached or adjacent to a student's body that restricts
freedom of movement or normal access to any portion of the student's body and that the student cannot easily remove.

(8) "Physical restraint" means the use of physical force to restrict the free movement of all or a portion of a student's body.

(9) "School personnel" means:
   a. Employees of a local board of education.
   b. Any person working on school grounds or at a school function under a contract or written agreement with the public school system to provide educational or related services to students.
   c. Any person working on school grounds or at a school function for another agency providing educational or related services to students.

(10) "Seclusion" means the confinement of a student alone in an enclosed space from which the student is:
   a. Physically prevented from leaving by locking hardware or other means.
   b. Not capable of leaving due to physical or intellectual incapacity.

(11) "Time-out" means a behavior management technique in which a student is separated from other students for a limited period of time in a monitored setting.

(c) Physical Restraint:
   (1) Physical restraint of students by school personnel shall be considered a reasonable use of force when used in the following circumstances:
      a. As reasonably needed to obtain possession of a weapon or other dangerous objects on a person or within the control of a person.
      b. As reasonably needed to maintain order or prevent or break up a fight.
      c. As reasonably needed for self-defense.
      d. As reasonably needed to ensure the safety of any student, school employee, volunteer, or other person present, to teach a skill, to calm or comfort a student, or to prevent self-injurious behavior.
      e. As reasonably needed to escort a student safely from one area to another.
      f. If used as provided for in a student's IEP or Section 504 plan or behavior intervention plan.
      g. As reasonably needed to prevent imminent destruction to school or another person's property.

(2) Except as set forth in subdivision (1) of this subsection, physical restraint of students shall not be considered a reasonable use of force, and its use is prohibited.

(3) Physical restraint shall not be considered a reasonable use of force when used solely as a disciplinary consequence.

(4) Nothing in this subsection shall be construed to prevent the use of force by law enforcement officers in the lawful exercise of their law enforcement duties.

(d) Mechanical Restraint:
   (1) Mechanical restraint of students by school personnel is permissible only in the following circumstances:
      a. When properly used as an assistive technology device included in the student's IEP or Section 504 plan or behavior intervention plan or as otherwise prescribed for the student by a medical or related
related service provider.

b. When using seat belts or other safety restraints to secure students during transportation.

c. As reasonably needed to obtain possession of a weapon or other dangerous objects on a person or within the control of a person.

d. As reasonably needed for self-defense.

e. As reasonably needed to ensure the safety of any student, school employee, volunteer, or other person present.

(2) Except as set forth in subdivision (1) of this subsection, mechanical restraint, including the tying, taping, or strapping down of a student, shall not be considered a reasonable use of force, and its use is prohibited.

(3) Nothing in this subsection shall be construed to prevent the use of mechanical restraint devices such as handcuffs by law enforcement officers in the lawful exercise of their law enforcement duties.

(e) Seclusion:

(1) Seclusion of students by school personnel may be used in the following circumstances:

a. As reasonably needed to respond to a person in control of a weapon or other dangerous object.

b. As reasonably needed to maintain order or prevent or break up a fight.

c. As reasonably needed for self-defense.

d. As reasonably needed when a student's behavior poses a threat of imminent physical harm to self or others or imminent substantial destruction of school or another person's property.

e. When used as specified in the student's IEP, Section 504 plan, or behavior intervention plan; and

1. The student is monitored while in seclusion by an adult in close proximity who is able to see and hear the student at all times.

2. The student is released from seclusion upon cessation of the behaviors that led to the seclusion or as otherwise specified in the student's IEP or Section 504 plan.

3. The space in which the student is confined has been approved for such use by the local education agency.

4. The space is appropriately lighted.

5. The space is appropriately ventilated and heated or cooled.

6. The space is free of objects that unreasonably expose the student or others to harm.

(2) Except as set forth in subdivision (1) of this subsection, the use of seclusion is not considered reasonable force, and its use is not permitted.

(3) Seclusion shall not be considered a reasonable use of force when used solely as a disciplinary consequence.

(4) Nothing in this subsection shall be construed to prevent the use of seclusion by law enforcement officers in the lawful exercise of their law enforcement duties.

(f) Isolation. – Isolation is permitted as a behavior management technique provided that:

(1) The space used for isolation is appropriately lighted, ventilated, and heated or cooled.
(2) The duration of the isolation is reasonable in light of the purpose of the isolation.
(3) The student is reasonably monitored while in isolation.
(4) The isolation space is free of objects that unreasonably expose the student or others to harm.
(g) Time-Out. – Nothing in this section is intended to prohibit or regulate the use of time-out as defined in this section.
(h) Aversive Procedures. – The use of aversive procedures as defined in this section is prohibited in public schools.
(i) Nothing in this section modifies the rights of school personnel to use reasonable force as permitted under G.S. 115C-390 or modifies the rules and procedures governing discipline under G.S. 115C-391(a).
(j) Notice, Reporting, and Documentation.
(1) Notice of procedures. – Each local board of education shall provide copies of this section and all local board policies developed to implement this section to school personnel and parents or guardians at the beginning of each school year.
(2) Notice of specified incidents:
   a. School personnel shall promptly notify the principal or principal's designee of:
      1. Any use of aversive procedures.
      2. Any prohibited use of mechanical restraint.
      3. Any use of physical restraint resulting in observable physical injury to a student.
   b. When a principal or principal's designee has personal knowledge or actual notice of any of the events described in this subdivision, the principal or principal's designee shall promptly notify the student's parent or guardian and will provide the name of a school employee the parent or guardian can contact regarding the incident.
   (3) As used in subdivision (2) of this subsection, "promptly notify" means by the end of the workday during which the incident occurred when reasonably possible, but in no event later than the end of following workday.
(4) The parent or guardian of the student shall be provided with a written incident report for any incident reported under this section within a reasonable period of time, but in no event later than 30 days after the incident. The written incident report shall include:
   a. The date, time of day, location, duration, and description of the incident and interventions.
   b. The events or events that led up to the incident.
   c. The nature and extent of any injury to the student.
   d. The name of a school employee the parent or guardian can contact regarding the incident.
(5) No local board of education or employee of a local board of education shall discharge, threaten, or otherwise
retaliating against another employee of the board regarding that employee's compensation, terms, conditions, location, or privileges of employment because the employee makes a report alleging a prohibited use of physical restraint, mechanical restraint, aversive procedure, or seclusion, unless the employee knew or should have known that the report was false.

(k) Nothing in this section shall be construed to create a private cause of action against any local board of education, its agents or employees, or any institutions of teacher education or their agents or employees or to create a criminal offense. (2005-205, s. 2; 2006-264, s. 58.)
§ 115C-375.2 Possession and self-administration of asthma medication by students with asthma or students subject to anaphylactic reactions, or both.

(a) Local boards of education shall adopt a policy authorizing a student with asthma or a student subject to anaphylactic reactions, or both, to possess and self-administer asthma medication on school property during the school day, at school-sponsored activities, or while in transit to or from school or school-sponsored events. As used in this section, "asthma medication" means a medicine prescribed for the treatment of asthma or anaphylactic reactions and includes a prescribed asthma inhaler or epinephrine auto-injector. The policy shall include a requirement that the student's parent or guardian provide to the school:

(1) Written authorization from the student's parent or guardian for the student to possess and self-administer asthma medication.

(2) A written statement from the student's health care practitioner verifying that the student has asthma or an allergy that could result in an anaphylactic reaction, or both, and that the health care practitioner prescribed medication for use on school property during the school day, at school-sponsored activities, or while in transit to or from school or school-sponsored events.

(3) A written statement from the student's health care practitioner who prescribed the asthma medication that the student understands, has been instructed in self-administration of the asthma medication, and has demonstrated the skill level necessary to use the asthma medication and any device that is necessary to administer the asthma medication.

(4) A written treatment plan and written emergency protocol formulated by the health care practitioner who prescribed the medicine for managing the student's asthma or anaphylaxis episodes and for medication use by the student.

(5) A statement provided by the school and signed by the student's parent or guardian acknowledging that the local school administrative unit and its employees and agents are not liable for an injury arising from a student's possession and self-administration of asthma medication.

(6) Other requirements necessary to comply with State and federal laws.

(b) The student must demonstrate to the school nurse, or the nurse's designee, the skill level necessary to use the asthma medication and any device that is necessary to administer the medication.

(c) The student's parent or guardian shall provide to the school backup asthma medication that shall be kept at the student's school in a location to which the student has immediate access in the event of an asthma or anaphylaxis emergency.

(d) Information provided to the school by the student's parent or guardian shall be kept on file at the student's school in a location easily accessible in the event of an
an asthma or anaphylaxis emergency.

(e) If a student uses asthma medication prescribed for the student in a manner other than as prescribed, a school may impose on the student disciplinary action according to the school's disciplinary policy. A school may not impose disciplinary action that limits or restricts the student's immediate access to the asthma medication.

(f) The requirement that permission granted for a student to possess and self-administer asthma medication shall be effective only for the same school and for 365 calendar days and must be renewed annually.

(g) No local board of education, nor its members, employees, designees, agents, or volunteers, shall be liable in civil damages to any party for any act authorized by this section, or for any omission relating to that act, unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing. (2005-22, s. 1; 2006-264, s. 57(b).)
§ 7B-500. Taking a juvenile into temporary custody; civil and criminal immunity. (Including Safe Surrender of Newborns or Infant Homicide Prevention Act)

(a) Temporary custody means the taking of physical custody and providing personal care and supervision until a court order for nonsecure custody can be obtained. A juvenile may be taken into temporary custody without a court order by a law enforcement officer or a department of social services worker if there are reasonable grounds to believe that the juvenile is abused, neglected, or dependent and that the juvenile would be injured or could not be taken into custody if it were first necessary to obtain a court order. If a department of social services worker takes a juvenile into temporary custody under this section, the worker may arrange for the placement, care, supervision, and transportation of the juvenile.

(b) The following individuals shall, without a court order, take into temporary custody an infant under seven days of age that is voluntarily delivered to the individual by the infant's parent who does not express an intent to return for the infant:

1. A health care provider, as defined under G.S. 90-21.11, who is on duty or at a hospital or at a local or district health department or at a nonprofit community health center.
2. A law enforcement officer who is on duty or at a police station or sheriff’s department.
3. A social services worker who is on duty or at a local department of social services.
4. A certified emergency medical service worker who is on duty or at a fire or emergency medical services station.

(c) An individual who takes an infant into temporary custody under subsection (b) of this section shall perform any act necessary to protect the physical health and well-being of the infant and shall immediately notify the department of social services or a local law enforcement agency. Any individual who takes an infant into temporary custody under subsection (b) of this section may inquire as to the parents' identities and as to any relevant medical history, but the parent is not required to provide the information. The individual shall notify the parent that the parent is not required to provide the information.

(d) Any adult may, without a court order, take into temporary custody an infant under seven days of age that is voluntarily delivered to the individual by the infant's parent who does not express
an intent to return for the infant. Any individual who takes an infant into temporary custody under this section shall perform any act necessary to protect the physical health and well-being of the infant and shall immediately notify the department of social services or a local law enforcement agency. An individual who takes an infant into temporary custody under this subsection may inquire as to the parents’ identities and as to any relevant medical history, but the parent is not required to provide the information. The individual shall notify the parent that the parent is not required to provide the information.

(e) An individual described in subsection (b) or (d) of this section is immune from any civil or criminal liability that might otherwise be incurred or imposed as a result of any omission or action taken pursuant to the requirements of subsection (c) or (d) of this section as long as that individual was acting in good faith. The immunity established by this subsection does not extend to gross negligence, wanton conduct, or intentional wrongdoing that would otherwise be actionable. (1979, c. 815, s. 1; 1985, c. 408, s. 1; 1985 (Reg. Sess., 1986), c. 863, s. 1; 1994, Ex. Sess., c. 27, s. 2; 1995, c. 391, s. 1; 1997-443, s. 11A.118(a); 1998-202, s. 6; 1999-456, s. 60; 2001-291, s. 2.)

G.S.115C-47 Section (50): To Ensure That Certain Students Receive Information Annually on Lawfully Abandoning a Newborn Baby. – Not later than August 1, 2008, local boards of education shall adopt policies to ensure that students in grades nine through 12 receive information annually on the manner in which a parent may lawfully abandon a newborn baby with a responsible person, in accordance with G.S. 7B-500. (2007-59, s. 1)
§ 115C-375.5. Education for pregnant and parenting students.

(a) Pregnant and parenting students shall receive the same educational instruction or its equivalent as other students. A local school administrative unit may provide programs to meet the special scheduling and curriculum needs of pregnant and parenting students. However, student participation in these programs shall be voluntary, and the instruction and curriculum must be comparable to that provided other students.

(b) Local boards of education shall adopt a policy to ensure that pregnant and parenting students are not discriminated against or excluded from school or any program, class, or extracurricular activity because they are pregnant or parenting students. The policy shall include, at a minimum, all of the following:

(1) Local school administrative units shall use, as needed, supplemental funds from the At-Risk Student Services allotment to support programs for pregnant and parenting students.

(2) Notwithstanding Part 1 of Article 26 of this Chapter, pregnant and parenting students shall be given excused absences from school for pregnancy and related conditions for the length of time the student's physician finds medically necessary. This includes absences due to the illness or medical appointment during school hours of a child of whom the student is the custodial parent.

(3) Homework and make-up work shall be made available to pregnant and parenting students to ensure that they have the opportunity to keep current with assignments and avoid losing course credit because of their absence from school and, to the extent necessary, a homebound teacher shall be assigned. (2006-69, s. 4(a).)
NORTH CAROLINA STATE BOARD OF EDUCATION
Policy Manual

Policy Identification
Priority: Globally Competitive Students
Category: Basic Education Plan
Policy ID Number: GCS-G-006

Policy Title: 16 NCAC 6D.0402 Policy designating special health care services to be provided under BEP support services

Current Policy Date: 04/06/1995

Other Historical Information:

Statutory Reference: GS 115C-12(9)c; GS 115C-81; GS 115C-307(c)

Administrative Procedures Act (APA) Reference Number and Category: 16 NCAC 6D .0402

.0401 REQUIRED SUPPORT PROGRAMS
Each LEA shall provide its students support services in the following areas:

(1) Pre-school physical and developmental screening;

(2) School counseling services;

(3) School social work services;

(4) School psychological services; and

(5) Health services.

.0402 SPECIAL HEALTH CARE SERVICES

(a) Each LEA shall make available a registered nurse for assessment, care planning, and on-going evaluation of students with special health care service needs in the school setting. Special health care services include procedures that are invasive, carry reasonable risk of harm if not performed correctly, may not have a predictable outcome, or may require additional action based on results of testing or monitoring.
(b) Care planning includes but is not limited to:

(1) identification of appropriate person(s) to perform the procedure;

(2) teaching those persons to perform the procedure; and

(3) identification of a mechanism for registered nurses to provide ongoing supervision to ensure the procedure is performed appropriately and monitoring the student's response to care provided in the school setting.

(c) To assure that these services are provided, LEAs have the flexibility to hire registered nurses, to contract with individual registered nurses, to contract for nursing services through local health departments, home care organizations, hospitals and other providers, or to negotiate coverage for planning and implementing these services with the licensed physician, nurse practitioner, or physician assistant prescribing the health care procedure.

(d) LEAs shall implement this rule in compliance with the provisions of G.S. 115C-307(c).
Appendix II

Item #34
RN – Each LEA

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§ 115C-81. Basic Education Program.

G.S. 115C-81(e1)(4)

(4) Each local school administrative unit shall provide a reproductive health and safety education program commencing in the seventh grade that includes the following instruction:
   a. Teaches that abstinence from sexual activity outside of marriage is the expected standard for all school-age children.
   b. Presents techniques and strategies to deal with peer pressure and offering positive reinforcement.
   c. Presents reasons, skills, and strategies for remaining or becoming abstinent from sexual activity.
   d. Teaches that abstinence from sexual activity is the only certain means of avoiding out-of-wedlock pregnancy, sexually transmitted diseases when transmitted through sexual contact, including HIV/AIDS, and other associated health and emotional problems.
   e. Teaches that a mutually faithful monogamous heterosexual relationship in the context of marriage is the best lifelong means of avoiding sexually transmitted diseases, including HIV/AIDS.
   f. Teaches the positive benefits of abstinence until marriage and the risks of premarital sexual activity.
   g. Provides opportunities that allow for interaction between the parent or legal guardian and the student.
   h. Provides factually accurate biological or pathological information that is related to the human reproductive system.

Materials used in this instruction shall be age appropriate for use with students. Information conveyed during the instruction shall be objective and based upon scientific research that is peer reviewed and accepted by professionals and credentialed experts in the field of sexual health education.

(4a) Each local school administrative unit shall also include as part of the instruction required under subdivision (4) of this subsection the following instruction:
   a. Teaches about sexually transmitted diseases. Instruction shall include how sexually transmitted diseases are and are not transmitted, the effectiveness and safety of all federal Food and Drug Administration (FDA)-approved methods of reducing the risk of contracting sexually
transmitted diseases, and information on local resources for testing and medical care for sexually transmitted diseases. Instruction shall include the rates of infection among pre-teen and teens of each known sexually transmitted disease and the effects of contracting each sexually transmitted disease. In particular, the instruction shall include information about the effects of contracting the Human Papilloma Virus, including sterility and cervical cancer.

b. Teaches about the effectiveness and safety of all FDA-approved contraceptive methods in preventing pregnancy.

c. Teaches awareness of sexual assault, sexual abuse, and risk reduction.

The instruction and materials shall:
1. Focus on healthy relationships.
2. Teach students what constitutes sexual assault and sexual abuse, the causes of those behaviors, and risk reduction.
3. Inform students about resources and reporting procedures if they experience sexual assault or sexual abuse.
4. Examine common misconceptions and stereotypes about sexual assault and sexual abuse.

Materials used in this instruction shall be age appropriate for use with students. Information conveyed during the instruction shall be objective and based upon scientific research that is peer reviewed and accepted by professionals and credentialed experts in the field of sexual health education. Each local board of education shall adopt a policy and provide a mechanism to allow a parent or a guardian to withdraw his or her child from instruction required under this subdivision.

(5) The State Board of Education shall make available to all local school administrative units for review by the parents and legal guardians of students enrolled at that unit any State-developed objectives for instruction, any approved textbooks, the list of reviewed materials, and any other State-developed or approved materials that pertain to or are intended to impart information or promote discussion or understanding in regard to the prevention of sexually transmitted diseases, including HIV/AIDS, to the avoidance of out-of-wedlock pregnancy, or to the reproductive health and safety education curriculum. The review period shall extend for at least 60 days before use.

(6) Repealed by Session Laws 2009-213, s. 7, effective June 30, 2009, and applicable beginning with the 2010-2011 school year.

(7) Each school year, before students may participate in any portion of (i) a program that pertains to or is intended to impart information or promote discussion or understanding in regard to the prevention of sexually transmitted diseases, including HIV/AIDS, or to the avoidance of out-of-wedlock pregnancy, or (ii) a reproductive health and safety education program, whether developed by the State or by the local board of education, the parents and legal guardians of those students shall be given an opportunity to review the
objectives and materials. Local boards of education shall adopt policies to provide opportunities either for parents and legal guardians to consent or for parents and legal guardians to withhold their consent to the students' participation in any or all of these programs.

(8) Students may receive information about where to obtain contraceptives and abortion referral services only in accordance with a local board's policy regarding parental consent. Any instruction concerning the use of contraceptives or prophylactics shall provide accurate statistical information on their effectiveness and failure rates for preventing pregnancy and sexually transmitted diseases, including HIV/AIDS, in actual use among adolescent populations and shall explain clearly the difference between risk reduction and risk elimination through abstinence. The Department of Health and Human Services shall provide the most current available information at the beginning of each school year.

(9) Contraceptives, including condoms and other devices, shall not be made available or distributed on school property.

(10) School health coordinators may be employed to assist in the instruction of any portion of the comprehensive school health education program. Where feasible, a school health coordinator should serve more than one local school administrative unit. Each person initially employed as a State-funded school health coordinator after June 30, 1987, shall have a degree in health education.

(11) Each local school administrative unit shall provide a comprehensive school health education program that meets all the requirements of this subsection and all the objectives established by the State Board. Each local board of education may expand on the subject areas to be included in the program and on the instructional objectives to be met. (2009)
North Carolina School Health Program Manual

General Statutes, State Policies and Administrative Code
Appendix II

Item #35

Reproductive Health and Safety Education

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§ 115C-407.15. Bullying and harassing behavior.

(a) As used in this Article, "bullying or harassing behavior" is any pattern of gestures or written, electronic, or verbal communications, or any physical act or any threatening communication, that takes place on school property, at any school-sponsored function, or on a school bus, and that:

1. Places a student or school employee in actual and reasonable fear of harm to his or her person or damage to his or her property; or

2. Creates or is certain to create a hostile environment by substantially interfering with or impairing a student's educational performance, opportunities, or benefits. For purposes of this section, "hostile environment" means that the victim subjectively views the conduct as bullying or harassing behavior and the conduct is objectively severe or pervasive enough that a reasonable person would agree that it is bullying or harassing behavior.

Bullying or harassing behavior includes, but is not limited to, acts reasonably perceived as being motivated by any actual or perceived differentiating characteristic, such as race, color, religion, ancestry, national origin, gender, socioeconomic status, academic status, gender identity, physical appearance, sexual orientation, or mental, physical, developmental, or sensory disability, or by association with a person who has or is perceived to have one or more of these characteristics.

(b) No student or school employee shall be subjected to bullying or harassing behavior by school employees or students.

(c) No person shall engage in any act of reprisal or retaliation against a victim, witness, or a person with reliable information about an act of bullying or harassing behavior.

(d) A school employee who has witnessed or has reliable information that a student or school employee has been subject to any act of bullying or harassing behavior shall report the incident to the appropriate school official.

(e) A student or volunteer who has witnessed or has reliable information that a student or school employee has been subject to any act of bullying or harassing behavior should report the incident to the appropriate school official. (2009-212, s. 1; 2009-570, s. 39.)

§ 115C-407.16. Policy against bullying or harassing behavior.

(a) Before December 31, 2009, each local school administrative unit shall adopt a policy prohibiting bullying or harassing behavior.

(b) The policy shall contain, at a minimum, the following components:

1. A statement prohibiting bullying or harassing behavior.
(2) A definition of bullying or harassing behavior no less inclusive than that set forth in this Article.

(3) A description of the type of behavior expected for each student and school employee.

(4) Consequences and appropriate remedial action for a person who commits an act of bullying or harassment.

(5) A procedure for reporting an act of bullying or harassment, including a provision that permits a person to report such an act anonymously. This shall not be construed to permit formal disciplinary action solely on the basis of an anonymous report.

(6) A procedure for prompt investigation of reports of serious violations and complaints of any act of bullying or harassment, identifying either the principal or the principal's designee as the person responsible for the investigation.

(7) A statement that prohibits reprisal or retaliation against any person who reports an act of bullying or harassment, and the consequence and appropriate remedial action for a person who engages in reprisal or retaliation.

(8) A statement of how the policy is to be disseminated and publicized, including notice that the policy applies to participation in school-sponsored functions.

(c) Nothing in this Article shall prohibit a local school administrative unit from adopting a policy that includes components beyond the minimum components provided in this section or that is more inclusive than the requirements of this Article.

(d) Notice of the local policy shall appear in any school unit publication that sets forth the comprehensive rules, procedures, and standards of conduct for schools within the school unit and in any student and school employee handbook.

(e) Information regarding the local policy against bullying or harassing behavior shall be incorporated into a school's employee training program.

(f) To the extent funds are appropriated for these purposes, a local school administrative unit shall, by March 1, 2010, provide training on the local policy to school employees and volunteers who have significant contact with students. (2009-212, s. 1; 2009-570, s. 39.)

§ 115C-407.17. Prevention of school violence.

Schools shall develop and implement methods and strategies for promoting school environments that are free of bullying or harassing behavior. (2009-212, s. 1; 2009-570, s. 39.)

§ 115C-407.18. Construction of this Article.

(a) This Article shall not be construed to permit school officials to punish student expression or speech based on an undifferentiated fear or apprehension of disturbance or
out of a desire to avoid the discomfort and unpleasantness that always accompany an unpopular viewpoint.

(b) This Article shall not be interpreted to prevent a victim of bullying or harassing behavior from seeking redress under any other available law, either civil or criminal.

(c) Nothing in this Article shall be construed to require an exhaustion of the administrative complaint process before civil or criminal law remedies may be pursued regarding bullying or harassing behavior.

(d) The provisions of this Article are severable, and if any provision of this Article is held invalid by a court of competent jurisdiction, the invalidity shall not affect other provisions of this Article which can be given effect without the invalid provision.

(e) The provisions of this Article shall be liberally construed to give effect to its purposes.

(f) Nothing in this act shall be construed to create any classification, protected class, suspect category, or preference beyond those existing in present statute or case law. (2009-212, s. 1; 2009-570, s. 39.)
Safford Unified School District v. Redding (2009) was a case decided by the Supreme Court of the United States on June 25, 2009. The Supreme Court decision held that a strip search of a female middle school student violated the Fourth Amendment where the school lacked reasons to suspect either that the drugs involved presented a danger or that they were concealed in her underwear. The court also held, however, that because this was not clearly-established law prior to the court's decision, the officials involved were shielded from liability by qualified immunity.

The text of the Supreme Court decision is below:

Justice Souter, Opinion of the Court

SUPREME COURT OF THE UNITED STATES

SAFFORD UNIFIED SCHOOL DISTRICT #1, ET AL., PETITIONERS v. APRIL REDDING

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JUSTICE SOUTER delivered the opinion of the Court.

The issue here is whether a 13-year-old student’s Fourth Amendment right was violated when she was subjected to a search of her bra and underpants by school officials acting on reasonable suspicion that she had brought forbidden prescription and over-the-counter drugs to school. Because there were no reasons to suspect the drugs presented a danger or were concealed in her underwear, we hold that the search did violate the Constitution, but because there is reason to question the clarity with which the right was
established, the official who ordered the unconstitutional search is entitled to qualified immunity from liability.

The events immediately prior to the search in question began in 13-year-old Savana Redding’s math class at Safford Middle School one October day in 2003. The assistant principal of the school, Kerry Wilson, came into the room and asked Savana to go to his office. There, he showed her a day planner, unzipped and open flat on his desk, in which there were several knives, lighters, a permanent marker, and a cigarette. Wilson asked Savana whether the planner was hers; she said it was, but that a few days before she had lent it to her friend, Marissa Glines. Savana stated that none of the items in the planner belonged to her.

Wilson then showed Savana four white prescription-strength ibuprofen 400-mg pills, and one over-the-counter blue naproxen 200-mg pill, all used for pain and inflammation but banned under school rules without advance permission. He asked Savana if she knew anything about the pills. Savana answered that she did not. Wilson then told Savana that he had received a report that she was giving these pills to fellow students; Savana denied it and agreed to let Wilson search her belongings. Helen Romero, an administrative assistant, came into the office, and together with Wilson they searched Savana’s backpack, finding nothing.

At that point, Wilson instructed Romero to take Savana to the school nurse’s office to search her clothes for pills. Romero and the nurse, Peggy Schwallier, asked Savana to remove her jacket, socks, and shoes, leaving her in stretch pants and a T-shirt (both without pockets), which she was then asked to remove. Finally, Savana was told to pull her bra out and to the side and shake it, and to pull out the elastic on her underpants, thus exposing her breasts and pelvic area to some degree. No pills were found.

Savana’s mother filed suit against Safford Unified School District #1, Wilson, Romero, and Schwallier for conducting a strip search in violation of Savana’s Fourth Amendment rights. The individuals (hereinafter petitioners) moved for summary judgment, raising a defense of qualified immunity. The District Court for the District of Arizona granted the motion on the ground that there was no Fourth Amendment violation, and a panel of the Ninth Circuit affirmed. 504 F. 3d 828 (2007).
A closely divided Circuit sitting en banc, however, reversed. Following the two-step protocol for evaluating claims of qualified immunity, see *Saucier v. Katz*, 533 U. S. 194, 200 (2001), the Ninth Circuit held that the strip search was unjustified under the Fourth Amendment test for searches of children by school officials set out in *New Jersey v. T. L. O.*, 469 U. S. 325 (1985). 531 F. 3d 1071, 1081-1087 (2008). The Circuit then applied the test for qualified immunity, and found that Savana’s right was clearly established at the time of the search: “‘[t]hese notions of personal privacy are “clearly established” in that they inhere in all of us, particularly middle school teenagers, and are inherent in the privacy component of the Fourth Amendment’s proscription against unreasonable searches.’” *Id.*, at 1088-1089 (quoting *Brannum v. Overton Cty. School Bd.*, 516 F. 3d 489, 499 (CA6 2008)). The upshot was reversal of summary judgment as to Wilson, while affirming the judgments in favor of Schwallier, the school nurse, and Romero, the administrative assistant, since they had not acted as independent decisionmakers. 531 F. 3d, at 1089.

We granted certiorari, 555 U. S. ___ (2009), and now affirm in part, reverse in part, and remand.

II

The Fourth Amendment “right of the people to be secure in their persons ... against unreasonable searches and seizures” generally requires a law enforcement officer to have probable cause for conducting a search. “Probable cause exists where ‘the facts and circumstances within [an officer’s] knowledge and of which [he] had reasonably trustworthy information [are] sufficient in themselves to warrant a man of reasonable caution in the belief that’ an offense has been or is being committed,” *Brinegar v. United States*, 338 U. S. 160, 175-176 (1949) (quoting *Carroll v. United States*, 267 U. S. 132, 162 (1925) ), and that evidence bearing on that offense will be found in the place to be searched.

In *T. L. O.*, we recognized that the school setting “requires some modification of the level of suspicion of illicit activity needed to justify a search,” 469 U. S., at 340, and held that for searches by school officials “a careful balancing of governmental and private interests suggests that the public interest is best served by a Fourth Amendment standard of reasonableness that stops short of probable cause,” *id.*, at 341. We have thus applied a standard of reasonable suspicion to determine the legality of a school administrator’s search of a student, *id.*, at 342, 345, and have held that a school
search “will be permissible in its scope when the measures adopted are reasonably related to the objectives of the search and not excessively intrusive in light of the age and sex of the student and the nature of the infraction,” id., at 342.

A number of our cases on probable cause have an implicit bearing on the reliable knowledge element of reasonable suspicion, as we have attempted to flesh out the knowledge component by looking to the degree to which known facts imply prohibited conduct, see, e.g., Adams v. Williams, 407 U. S. 143, 148 (1972); id., at 160, n. 9 (Marshall, J., dissenting), the specificity of the information received, see, e.g., Spinelli v. United States, 393 U. S. 410, 416-417 (1969), and the reliability of its source, see, e.g., Aguilar v. Texas, 378 U. S. 108, 114 (1964). At the end of the day, however, we have realized that these factors cannot rigidly control, Illinois v. Gates, 462 U. S. 213, 230 (1983), and we have come back to saying that the standards are “fluid concepts that take their substantive content from the particular contexts” in which they are being assessed. Ornelas v. United States, 517 U. S. 690, 696 (1996).

Perhaps the best that can be said generally about the required knowledge component of probable cause for a law enforcement officer’s evidence search is that it raise a “fair probability,” Gates, 462 U. S., at 238, or a “substantial chance,” id., at 244, n. 13, of discovering evidence of criminal activity. The lesser standard for school searches could as readily be described as a moderate chance of finding evidence of wrongdoing.

III

A

In this case, the school’s policies strictly prohibit the nonmedical use, possession, or sale of any drug on school grounds, including “‘[a]ny prescription or over-the-counter drug, except those for which permission to use in school has been granted pursuant to Board policy,’ ” App. to Pet. for Cert. 128a.1 A week before Savana was searched, another student, Jordan Romero (no relation of the school’s administrative assistant), told the principal and Assistant Principal Wilson that “certain students were bringing drugs and weapons on campus,” and that he had been sick after taking some pills that “he got from a classmate.” App. 8a. On the morning of October 8, the same boy handed Wilson a white pill that he said Marissa Glines had given him. He told Wilson that students were planning to take the pills at lunch.
Wilson learned from Peggy Schwallier, the school nurse, that the pill was Ibuprofen 400 mg, available only by prescription. Wilson then called Marissa out of class. Outside the classroom, Marissa's teacher handed Wilson the day planner, found within Marissa's reach, containing various contraband items. Wilson escorted Marissa back to his office.

In the presence of Helen Romero, Wilson requested Marissa to turn out her pockets and open her wallet. Marissa produced a blue pill, several white ones, and a razor blade. Wilson asked where the blue pill came from, and Marissa answered, “I guess it slipped in when she gave me the IBU 400s.” Id., at 13a. When Wilson asked whom she meant, Marissa replied, “Savana Redding.” Ibid. Wilson then enquired about the day planner and its contents; Marissa denied knowing anything about them. Wilson did not ask Marissa any followup questions to determine whether there was any likelihood that Savana presently had pills: neither asking when Marissa received the pills from Savana nor where Savana might be hiding them.

Schwallier did not immediately recognize the blue pill, but information provided through a poison control hotline indicated that the pill was a 200-mg dose of an anti-inflammatory drug, generically called naproxen, available over the counter. At Wilson's direction, Marissa was then subjected to a search of her bra and underpants by Romero and Schwallier, as Savana was later on. The search revealed no additional pills.

It was at this juncture that Wilson called Savana into his office and showed her the day planner. Their conversation established that Savana and Marissa were on friendly terms: while she denied knowledge of the contraband, Savana admitted that the day planner was hers and that she had lent it to Marissa. Wilson had other reports of their friendship from staff members, who had identified Savana and Marissa as part of an unusually rowdy group at the school's opening dance in August, during which alcohol and cigarettes were found in the girls' bathroom. Wilson had reason to connect the girls with this contraband, for Wilson knew that Jordan Romero had told the principal that before the dance, he had been at a party at Savana's house where alcohol was served. Marissa's statement that the pills came from Savana was thus sufficiently plausible to warrant suspicion that Savana was involved in pill distribution.

This suspicion of Wilson's was enough to justify a search of Savana's backpack and outer clothing. If a student is reasonably
suspected of giving out contraband pills, she is reasonably suspected of carrying them on her person and in the carryall that has become an item of student uniform in most places today. If Wilson's reasonable suspicion of pill distribution were not understood to support searches of outer clothes and backpack, it would not justify any search worth making. And the look into Savana's bag, in her presence and in the relative privacy of Wilson's office, was not excessively intrusive, any more than Romero's subsequent search of her outer clothing.

B

Here it is that the parties part company, with Savana's claim that extending the search at Wilson's behest to the point of making her pull out her underwear was constitutionally unreasonable. The exact label for this final step in the intrusion is not important, though strip search is a fair way to speak of it. Romero and Schwallier directed Savana to remove her clothes down to her underwear, and then “pull out” her bra and the elastic band on her underpants. Id., at 23a. Although Romero and Schwallier stated that they did not see anything when Savana followed their instructions, App. to Pet. for Cert. 135a, we would not define strip search and its Fourth Amendment consequences in a way that would guarantee litigation about who was looking and how much was seen. The very fact of Savana’s pulling her underwear away from her body in the presence of the two officials who were able to see her necessarily exposed her breasts and pelvic area to some degree, and both subjective and reasonable societal expectations of personal privacy support the treatment of such a search as categorically distinct, requiring distinct elements of justification on the part of school authorities for going beyond a search of outer clothing and belongings.

Savana’s subjective expectation of privacy against such a search is inherent in her account of it as embarrassing, frightening, and humiliating. The reasonableness of her expectation (required by the Fourth Amendment standard) is indicated by the consistent experiences of other young people similarly searched, whose adolescent vulnerability intensifies the patent intrusiveness of the exposure. See Brief for National Association of Social Workers et al. as Amici Curiae 6-14; Hyman & Perone, The Other Side of School Violence: Educator Policies and Practices that may Contribute to Student Misbehavior, 36 J. School Psychology 7, 13 (1998) (strip search can “result in serious emotional damage”). The common reaction of these adolescents simply registers the obviously different meaning of a search exposing the body from the
experience of nakedness or near undress in other school circumstances. Changing for gym is getting ready for play; exposing for a search is responding to an accusation reserved for suspected wrongdoers and fairly understood as so degrading that a number of communities have decided that strip searches in schools are never reasonable and have banned them no matter what the facts maybe, see, e.g., New York City Dept. of Education, Reg. No. A-432, p. 2 (2005), online at http://docs.nycenet.edu/docushare/dsweb/Get/Document-21/A-432.pdf (“Under no circumstances shall a strip-search of a student be conducted”).

The indignity of the search does not, of course, outlaw it, but it does implicate the rule of reasonableness as stated in T. L. O., that “the search as actually conducted [be] reasonably related in scope to the circumstances which justified the interference in the first place.” 469 U. S., at 341 (internal quotation marks omitted). The scope will be permissible, that is, when it is “not excessively intrusive in light of the age and sex of the student and the nature of the infraction.” Id., at 342.

Here, the content of the suspicion failed to match the degree of intrusion. Wilson knew beforehand that the pills were prescription-strength ibuprofen and over-the-counter naproxen, common pain relievers equivalent to two Advil, or one Aleve. He must have been aware of the nature and limited threat of the specific drugs he was searching for, and while just about anything can be taken in quantities that will do real harm, Wilson had no reason to suspect that large amounts of the drugs were being passed around, or that individual students were receiving great numbers of pills.

Nor could Wilson have suspected that Savana was hiding common painkillers in her underwear. Petitioners suggest, as a truth universally acknowledged, that “students … hid[e] contraband in or under their clothing,” Reply Brief for Petitioners 8, and cite a smattering of cases of students with contraband in their underwear, id., at 8-9. But when the categorically extreme intrusiveness of a search down to the body of an adolescent requires some justification in suspected facts, general background possibilities fall short; a reasonable search that extensive calls for suspicion that it will pay off. But nondangerous school contraband does not raise the specter of stashes in intimate places, and there is no evidence in the record of any general practice among Safford Middle School students of hiding that sort of thing in underwear; neither Jordan nor Marissa suggested to Wilson that Savana was doing that, and the preceding search of Marissa that Wilson ordered yielded nothing.
Wilson never even determined when Marissa had received the pills from Savana; if it had been a few days before, that would weigh heavily against any reasonable conclusion that Savana presently had the pills on her person, much less in her underwear.

In sum, what was missing from the suspected facts that pointed to Savana was any indication of danger to the students from the power of the drugs or their quantity, and any reason to suppose that Savana was carrying pills in her underwear. We think that the combination of these deficiencies was fatal to finding the search reasonable.

In so holding, we mean to cast no ill reflection on the assistant principal, for the record raises no doubt that his motive throughout was to eliminate drugs from his school and protect students from what Jordan Romero had gone through. Parents are known to overreact to protect their children from danger, and a school official with responsibility for safety may tend to do the same. The difference is that the Fourth Amendment places limits on the official, even with the high degree of deference that courts must pay to the educator’s professional judgment.

We do mean, though, to make it clear that the T. L. O. concern to limit a school search to reasonable scope requires the support of reasonable suspicion of danger or of resort to underwear for hiding evidence of wrongdoing before a search can reasonably make the quantum leap from outer clothes and backpacks to exposure of intimate parts. The meaning of such a search, and the degradation its subject may reasonably feel, place a search that intrusive in a category of its own demanding its own specific suspicions.

IV

A school official searching a student is “entitled to qualified immunity where clearly established law does not show that the search violated the Fourth Amendment.” Pearson v. Callahan, 555 U. S. __, __ (2009) (slip op., at 18). To be established clearly, however, there is no need that “the very action in question [have] previously been held unlawful.” Wilson v. Layne, 526 U. S. 603, 615 (1999). The unconstitutionality of outrageous conduct obviously will be unconstitutional, this being the reason, as Judge Posner has said, that “[t]he easiest cases don’t even arise.” K. H. v. Morgan, 914 F. 2d 846, 851 (CA7 1990). But even as to action less than an outrage, “officials can still be on notice that their conduct violates

*T. L. O.* directed school officials to limit the intrusiveness of a search, “in light of the age and sex of the student and the nature of the infraction,” 469 U. S., at 342, and as we have just said at some length, the intrusiveness of the strip search here cannot be seen as justifiably related to the circumstances. But we realize that the lower courts have reached divergent conclusions regarding how the *T. L. O.* standard applies to such searches.

A number of judges have read *T. L. O.* as the en banc minority of the Ninth Circuit did here. The Sixth Circuit upheld a strip search of a high school student for a drug, without any suspicion that drugs were hidden next to her body. *Williams v. Ellington*, 936 F. 2d 881, 882-883, 887 (1991). And other courts considering qualified immunity for strip searches have read *T. L. O.* as “a series of abstractions, on the one hand, and a declaration of seeming deference to the judgments of school officials, on the other,” *Jenkins v. Talladega City Bd. of Ed.*, 115 F. 3d 821, 828 (CA11 1997) (en banc), which made it impossible “to establish clearly the contours of a Fourth Amendment right ... [in] the wide variety of possible school settings different from those involved in *T. L. O.*” itself. *Ibid.* See also *Thomas v. Roberts*, 323 F. 3d 950 (CA11 2003) (granting qualified immunity to a teacher and police officer who conducted a group strip search of a fifth grade class when looking for a missing $26).

We think these differences of opinion from our own are substantial enough to require immunity for the school officials in this case. We would not suggest that entitlement to qualified immunity is the guaranteed product of disuniform views of the law in the other federal, or state, courts, and the fact that a single judge, or even a group of judges, disagrees about the contours of a right does not automatically render the law unclear if we have been clear. That said, however, the cases viewing school strip searches differently from the way we see them are numerous enough, with well-reasoned majority and dissenting opinions, to counsel doubt that we were sufficiently clear in the prior statement of law. We conclude that qualified immunity is warranted.

The strip search of Savana Redding was unreasonable and a violation of the Fourth Amendment, but petitioners Wilson,
Romero, and Schwallier are nevertheless protected from liability through qualified immunity. Our conclusions here do not resolve, however, the question of the liability of petitioner Safford Unified School District #1 under Monell v. New York City Dept. of Social Servs., 436 U. S. 658, 694 (1978), a claim the Ninth Circuit did not address. The judgment of the Ninth Circuit is therefore affirmed in part and reversed in part, and this case is remanded for consideration of the Monell claim.

It is so ordered.

Notes

1 When the object of a school search is the enforcement of a school rule, a valid search assumes, of course, the rule’s legitimacy. But the legitimacy of the rule usually goes without saying as it does here. The Court said plainly in New Jersey v. T. L. O., 469 U. S. 325, n. 9 (1985), that standards of conduct for schools are for school administrators to determine without second-guessing by courts lacking the experience to appreciate what may be needed. Except in patently arbitrary instances, Fourth Amendment analysis takes the rule as a given, as it obviously should do in this case. There is no need here either to explain the imperative of keeping drugs out of schools, or to explain the reasons for the school’s rule banning all drugs, no matter how benign, without advance permission. Teachers are not pharmacologists trained to identify pills and powders, and an effective drug ban has to be enforceable fast. The plenary ban makes sense, and there is no basis to claim that the search was unreasonable owing to some defect or shortcoming of the rule it was aimed at enforcing.

2 Poison control centers across the country maintain 24-hour help hotlines to provide “immediate access to poison exposure management instructions and information on potential poisons.” American Association of Poison Control Centers, online at http://www.aapcc.org/dnn/About/tabid/74/Default.aspx (all Internet materials as visited June 19, 2009, and available in Clerk of Court’s case file).

3 There is no question here that justification for the school officials’ search was required in accordance with the T. L. O. standard of reasonable suspicion, for it is common ground that Savana had a reasonable expectation of privacy covering the personal things she
chose to carry in her backpack, cf. 469 U.S., at 339, and that
Wilson's decision to look through it was a "search" within the
meaning of the Fourth Amendment.

‘An Advil tablet, caplet, or gel caplet, contains 200 mg of
ibuprofen. See Physicians’ Desk Reference for Nonprescription
Drugs, Dietary Supplements, and Herbs 674 (28th ed. 2006). An
Aleve caplet contains 200 mg naproxen and 20 mg sodium. See id.,
at 675.
“Strip Search” of Students – U.S. Supreme Court

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SUPREME COURT OF THE UNITED STATES

CEDAR RAPIDS COMMUNITY SCHOOL DISTRICT v. GARRET F., A MINOR, BY HIS MOTHER AND NEXT FRIEND, CHARLENE F. CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT


To help “assure that all children with disabilities have available to them . . . a free appropriate public education which emphasizes special education and related services designed to meet their unique needs,” 20 U. S. C. §1400(c), the Individuals with Disabilities Education Act (IDEA) authorizes federal financial assistance to States that agree to provide such children with special education and “related services,” as defined in §1401(a)(17). Respondent Garret F., a student in petitioner school district (District), is wheelchair-bound and ventilator dependent; he therefore requires, in part, a responsible individual nearby to attend to certain physical needs during the school day. The District declined to accept financial responsibility for the services Garret needs, believing that it was not legally obligated to provide continuous one-on-one nursing care. At an Iowa Department of Education hearing, an Administrative Law Judge concluded that the IDEA required the District to bear financial responsibility for all of the disputed services, finding that most of them are already provided for some other students; that the District did not contend that only a licensed physician could provide the services; and that applicable federal regulations require the District to furnish “school health services,” which are provided by a “qualified school nurse or other qualified person,” but not “medical services,” which are limited to services provided by a physician. The Federal District Court agreed and the Court of Appeals affirmed, concluding that Irving
Independent School Dist. v. Tatro, 468 U. S. 883, provided a two-step analysis of §1401(a)(17)’s “related services” definition that was satisfied here.

First, the requested services were “supportive services” because Garrett cannot attend school unless they are provided; and second, the services were not excluded as “medical services” under Tatro’s brightline test: Services provided by a physician (other than for diagnostic and evaluation purposes) are subject to the medical services exclusion, but services that can be provided by a nurse or qualified layperson are not. Held: The IDEA requires the District to provide Garrett with the nursing services he requires during school hours. The IDEA’s “related services” definition, Tatro, and the overall statutory scheme support the Court of Appeals’ decision. The “related services” definition broadly encompasses those supportive services that “may be required to assist a child with a disability to benefit from special education,” §1401(a)(17), and the District does not challenge the Court of Appeals’ conclusion that the services at issue are “supportive services.” Furthermore, §1401(a)(17)’s general “related services” definition is illuminated by a parenthetical phrase listing examples of services that are included within the statute’s coverage, including “medical services” if they are “for diagnostic and evaluation purposes.” Although the IDEA itself does not define “medical services” more specifically, this Court in Tatro concluded that the Secretary of Education had reasonably determined that “medical services” referred to services that must be performed by a physician, and not to school health services. 468 U. S., at 892–894. The cost-based, multi-factor test proposed by the District is supported by neither the statute’s text nor the regulations upheld in Tatro. Moreover, the District offers no explanation why characteristics such as cost make one service any more “medical” than another. Absent an elaboration of the statutory terms plainly more convincing than that reviewed in Tatro, there is no reason to depart from settled law. Although the District may have legitimate concerns about the financial burden of providing the services Garrett needs, accepting its cost-based standard as the sole test for determining §1401(a)(17)’s scope would require the Court to engage in judicial lawmaking without any guidance from Congress. It would also create tension with the IDEA’s purposes, since Congress intended to open the doors of public education to all qualified children and required participating States to educate disabled children with nondisabled children whenever possible. Board of Ed. of Hendrick Hudson Central School Dist., Westchester Cty. v. Rowley, 458 U. S. 176, 192, 202. Pp. 6–12.

106 F. 3d 822, affirmed.

STEVENS, J., delivered the opinion of the Court, in which REHNQUIST, C. J., and O’CONNOR, SCALIA, SOUTER, GINSBURG, and BREYER, JJ., joined. THOMAS, J., filed a dissenting opinion, in which KENNEDY, J., joined.
U.S. Supreme Court – Duty for Schools to Provide Nursing Services

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(a) Any person, including a volunteer medical or health care provider at a facility of a local health department as defined in G.S. 130A-2 or at a nonprofit community health center or a volunteer member of a rescue squad, who receives no compensation for his services as an emergency medical care provider, who renders first aid or emergency health care treatment to a person who is unconscious, ill or injured,

(1) When the reasonably apparent circumstances require prompt decisions and actions in medical or other health care, and

(2) When the necessity of immediate health care treatment is so reasonably apparent that any delay in the rendering of the treatment would seriously worsen the physical condition or endanger the life of the person,

shall not be liable for damages for injuries alleged to have been sustained by the person or for damages for the death of the person alleged to have occurred by reason of an act or omission in the rendering of the treatment unless it is established that the injuries were or the death was caused by gross negligence, wanton conduct or intentional wrongdoing on the part of the person rendering the treatment. The immunity conferred in this section also applies to any person who uses an automated external defibrillator (AED) and otherwise meets the requirements of this section.

(a1) Recodified as G.S. 90-21.16 by Session Laws 2001-230, s. 1(a), effective October 1, 2001.

(b) Nothing in this section shall be deemed or construed to relieve any person from liability for damages for injury or death caused by an act or omission on the part of such person while rendering health care services in the normal and ordinary course of his business or profession. Services provided by a volunteer health care provider who receives no compensation for his services and who renders first aid or emergency treatment to members of athletic teams are deemed not to be in the normal and ordinary course of the volunteer health care provider's business or profession.

(c) In the event of any conflict between the provisions of this section and those of G.S. 20-166(d), the provisions of G.S. 20-166(d) shall control and continue in full force and effect.

(1975, 2nd Sess., c. 977, s. 4; 1985, c. 611, s. 2; 1989, cc. 498, 655; 1991, c. 655, s. 1; 1993, c. 439, s. 1; 1995, c. 85, s. 1; 2000-5, s. 4; 2001-230, ss. 1(a), 2; 2009-424, s. 1.)
Appendix II

Item #39

“Good Samaritan” Law

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Parents' Guide to the *Family Educational Rights and Privacy Act: Rights Regarding Children’s Education Records*¹

October 2007

The following questions and answers are intended to help you understand your rights as a parent under FERPA. If you have further questions, please contact the U.S. Department of Education's Family Policy Compliance Office using the contact information provided below.

**Q. What is FERPA?**

A. *The Family Educational Rights and Privacy Act (FERPA)* is a federal privacy law that gives parents certain protections with regard to their children's education records, such as report cards, transcripts, disciplinary records, contact and family information, and class schedules. As a parent, you have the right to review your child's education records and to request changes under limited circumstances. To protect your child's privacy, the law generally requires schools to ask for written consent before disclosing your child's personally identifiable information to individuals other than you.

**Q. My child's school won't show me her or his education records. Does the school have to provide me with a copy of the records if I request them?**

A. Schools must honor your request to review your child's education records within 45 days of receiving the request. Some states have laws similar to FERPA that require schools to provide access within a shorter period of time. FERPA requires that schools provide parents with an opportunity to inspect and review education records, but not to receive copies, except in limited circumstances.

Parents whose children receive services under the *Individuals with Disabilities Education Act (IDEA)* may have additional rights and remedies with regard to their children's education records. The school district, local special education director, or state special education director can answer questions about IDEA.

**Q. Who else gets to see my child's education records?**

A. To protect your child's privacy, schools are generally prohibited from disclosing personally identifiable information about your child without your written consent. Exceptions to this rule include:

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disclosures made to school officials with legitimate educational interests;
• disclosures made to another school at which the student intends to enroll;
• disclosures made to state or local education authorities for auditing or evaluating federal- or state-supported education programs, or enforcing federal laws that relate to those programs; and
• disclosures including information the school has designated as "directory information."

Q. What is directory information?

A. FERPA defines "directory information" as information contained in a student's education record that generally would not be considered harmful or an invasion of privacy if disclosed. Directory information could include:
• name, address, telephone listing, electronic mail address, date and place of birth, dates of attendance, and grade level;
• participation in officially recognized activities and sports;
• weight and height of members of athletic teams;
• degrees, honors, and awards received; and
• the most recent school attended.

A school may disclose directory information to anyone, without consent, if it has given parents: general notice of the information it has designated as "directory information;" the right to opt out of these disclosures; and the period of time they have to notify the school of their desire to opt out.

Q. Does FERPA give me a right to see the education records of my son or daughter who is in college?

A. When a student turns 18 years old or enters a postsecondary institution at any age, all rights afforded to you as a parent under FERPA transfer to the student ("eligible student"). However, FERPA provides ways in which a school may—but is not required to-share information from an eligible student's education records with parents, without the student's consent. For example:
• Schools may disclose education records to parents if the student is claimed as a dependent for tax purposes.
Schools may disclose education records to parents if a health or safety emergency involves their son or daughter.

Schools may inform parents if the student, if he or she is under age 21, has violated any law or policy concerning the use or possession of alcohol or a controlled substance.

A school official may generally share with a parent information that is based on that official's personal knowledge or observation of the student.

Contact Information

For further information about FERPA, contact the Department's Family Policy Compliance Office (FPCO).

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Ave. S.W.
Washington, DC 20202-5920
202-260-3887

Additional information and guidance may be found at FPCO's Web site at: http://www.ed.gov/policy/gen/guid/fpc/index.html.
Balancing Student Privacy and School Safety:
A Guide to the Family Educational Rights and Privacy Act
For Elementary and Secondary Schools
October 2007  

School officials are regularly asked to balance the interests of safety and privacy for individual students. While the Family Educational Rights and Privacy Act (FERPA) generally requires schools to ask for written consent before disclosing a student's personally identifiable information to individuals other than his or her parents, it also allows schools to take key steps to maintain school safety. Understanding the law empowers school officials to act decisively and quickly when issues arise.

Health or Safety Emergency

In an emergency, FERPA permits school officials to disclose without consent education records, including personally identifiable information from those records, to protect the health or safety of students or other individuals. At such times, records and information may be released to appropriate parties such as law enforcement officials, public health officials, and trained medical personnel. See 34 CFR § 99.31(a)(10) and § 99.36. This exception is limited to the period of the emergency and generally does not allow for a blanket release of personally identifiable information from a student's education records.

Law Enforcement Unit Records

Many school districts employ security staff to monitor safety and security in and around schools. Some schools employ off-duty police officers as school security officers, while others designate a particular school official to be responsible for referring potential or alleged violations of law to local police authorities. Under FERPA, investigative reports and other records created and maintained by these "law enforcement units" are not considered "education records" subject to FERPA. Accordingly, schools may disclose information from law enforcement unit records to anyone, including outside law enforcement authorities, without parental consent. See 34 CFR § 99.8.

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While a school has flexibility in deciding how to carry out safety functions, it must also indicate to parents in its school policy or information provided to parents which office or school official serves as the school's "law enforcement unit." (The school's notification to parents of their rights under FERPA can include this designation. As an example, the U.S. Department of Education has posted a model notification on the Web at: [http://www.ed.gov/policy/gen/guid/fpco/ferpa/lea-officials.html](http://www.ed.gov/policy/gen/guid/fpco/ferpa/lea-officials.html).)

Law enforcement unit officials who are employed by the school should be designated in its FERPA notification as "school officials" with a "legitimate educational interest." As such, they may be given access to personally identifiable information from students' education records. The school's law enforcement unit officials must protect the privacy of education records it receives and may disclose them only in compliance with FERPA. For that reason, it is advisable that law enforcement unit records be maintained separately from education records.

Security Videos

Schools are increasingly using security cameras as a tool to monitor and improve student safety. Images of students captured on security videotapes that are maintained by the school's law enforcement unit are not considered education records under FERPA. Accordingly, these videotapes may be shared with parents of students whose images are on the video and with outside law enforcement authorities, as appropriate. Schools that do not have a designated law enforcement unit might consider designating an employee to serve as the "law enforcement unit" in order to maintain the security camera and determine the appropriate circumstances in which the school would disclose recorded images.

Personal Knowledge or Observation

FERPA does not prohibit a school official from disclosing information about a student if the information is obtained through the school official's personal knowledge or observation, and not from the student's education records. For example, if a teacher overhears a student making threatening remarks to other students, FERPA does not protect that information, and the teacher may disclose what he or she overheard to appropriate authorities.

Transfer of Education Records

Finally, under FERPA, school officials may disclose any and all education records, including disciplinary records and records that were created as a result of a student receiving special education services under Part B of the Individuals with Disabilities Education Act, to another school or postsecondary institution at which the student seeks or intends to enroll. While parental consent is not required for transferring education records, the school's annual FERPA notification should
indicate that such disclosures are made. In the absence of information about disclosures in the annual FERPA notification, school officials must make a reasonable attempt to notify the parent about the disclosure, unless the parent initiated the disclosure. Additionally, upon request, schools must provide a copy of the information disclosed and an opportunity for a hearing. See 34 CFR § 99.31(a)(2) and § 99.34(a).

Contact Information

While the education agency or institution has the responsibility to make the initial, case-by-case determination of whether a disclosure is necessary to protect the health or safety of students or other individuals, U.S. Department of Education staff members are available to offer assistance in making this determination. For further information about FERPA, contact the Department's Family Policy Compliance Office.

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Ave. S.W.
Washington, DC 20202-5920
202-260-3887

Additional information and guidance may be found at FPCO's Web site at: http://www.ed.gov/policy/gen/guid/fpco/index.html.

Additional resource: National Association of School Nurses (NASN) www.nasn.org. Follow the links from the home page to “Policy and Advocacy” then “Confidentiality” to find more information about the proposed changes to FERPA and get the most current information on the status of these proposals.
Model Notification of Rights for Elementary and Secondary Schools

The Family Educational Rights and Privacy Act (FERPA) affords parents and students over 18 years of age ("eligible students") certain rights with respect to the student's education records. These rights are:

1. The right to inspect and review the student's education records within 45 days of the day the School receives a request for access.

   Parents or eligible students should submit to the School principal [or appropriate school official] a written request that identifies the record(s) they wish to inspect. The School official will make arrangements for access and notify the parent or eligible student of the time and place where the records may be inspected.

2. The right to request the amendment of the student's education records that the parent or eligible student believes are inaccurate, misleading, or otherwise in violation of the student's privacy rights under FERPA.

   Parents or eligible students who wish to ask the School to amend a record should write the School principal [or appropriate school official], clearly identify the part of the record they want changed, and specify why it should be changed. If the School decides not to amend the record as requested by the parent or eligible student, the School will notify the parent or eligible student of the decision and advise them of their right to a hearing regarding the request for amendment. Additional information regarding the hearing procedures will be provided to the parent or eligible student when notified of the right to a hearing.

3. The right to privacy of personally identifiable information in the student's education records, except to the extent that FERPA authorizes disclosure without consent.

   One exception, which permits disclosure without consent, is disclosure to school officials with legitimate educational interests. A school official is a person employed by the School as an administrator, supervisor, instructor, or support staff member (including health or medical staff and law enforcement unit personnel); a person serving on the School Board; a person or company with whom the School has outsourced services or functions it would otherwise use its own employees to perform (such as an attorney, auditor, medical consultant, or therapist); a parent or student serving on an official committee, such as a disciplinary or grievance committee; or a parent, student, or other volunteer assisting another school official in performing his or her tasks.

   A school official has a legitimate educational interest if the official needs to review an education record in order to fulfill his or her professional responsibility.

   [Optional] Upon request, the School discloses education records without consent to officials of another school district in which a student seeks or intends to enroll, or is already enrolled if the disclosure is for purposes of the student's enrollment or transfer. [NOTE: FERPA requires a school district to make a reasonable attempt to notify the parent or student of the records request unless it states in its annual notification that it intends to forward records on request.]

4. The right to file a complaint with the U.S. Department of Education concerning alleged failures by the School to comply with the requirements of FERPA. The name and address of the Office that administers FERPA are:

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202-8520

[NOTE: In addition, a school may want to include its directory information public notice, as required by §99.37 of the regulations, with its annual notification of rights under FERPA.]
## North Carolina School Health Program Manual

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(This page intentionally left blank.)
Kindergarten Health Assessment

Guidelines ¹

Department of Health and Human Services
and
Department of Public Instruction

Legislative Requirements

The Kindergarten Health Assessment legislation (Senate Bill 293), ratified July 1986 by the North Carolina General Assembly and amended May 1987 (Senate Bill 225), June 1993 (House Bill 365), and May 1995 (Senate Bill 506) includes the following requirements:

• Each child entering kindergarten in the public schools must receive a health assessment.

• The health assessment shall be made no more than 12 months prior to the date of school entry.

• The health assessment must include a medical history and physical examination with screening for vision and hearing and, if appropriate, testing for anemia and tuberculosis.

• The health assessment must be conducted by a physician licensed to practice medicine, a physician’s assistant as defined in General Statute 90-18, a certified nurse practitioner, or a public health nurse meeting the State Standards Health Check Services. NOTE: Vision and hearing screening may be conducted by public school personnel who are licensed to perform those screenings. (See Responsibilities of Local School Administrative Units for procedures for reporting information.)

The health assessment results must be submitted to the school principal by the medical provider on form PPS-2K (revised 1/08) developed by The Department of Health and Human Services (DHHS) and the Department of Public Instruction (DPI). After the beginning of the new school year, before or on November 1, the school principal must file a status report with DHHS on the number of children in compliance with the legislation.²

Exemptions

Children in private and religious schools or children of parents whose religious beliefs are contrary to the health assessment requirements are exempt from the legislation. Parents wishing to claim religious exemption must submit a written statement of their beliefs and of their opposition to the health assessment requirements to the local school superintendent or designee.

Purposes

The purposes of the Kindergarten Health Assessment are:

- to alert school personnel to the health-related needs of the children that may affect their school performance;
- to identify the potential need for further evaluation or follow-up of medical problems; and,
- to provide information that will help parents and educators plan appropriate intervention.

Definition of Terms

Health Assessment – Includes a health history, physical examination, vision and hearing screening, and testing for anemia and tuberculosis, if appropriate.

Health History – Includes, but is not limited to: previous and/or current medical problems and handicapping conditions, allergies, childhood illnesses and diseases.

² To obtain a copy of the most current Kindergarten Health Assessment form, contact the Division of Public Health, School Health Unit, or visit the website: www.nchealthyschools.org.
developmental milestones, behavior problems, nutritional assessment, and immunization status.

*Physical Examination* – Includes complete physical examination including dental screening.

*Vision Screening* – Includes screening of visual acuity and stereopsis.

*Hearing Screening* – Includes sweep screening (usually 20dB at 1000, 2000, 4000 frequencies) with pure tone audiometer.

*Developmental Screening* – Includes screening in the areas of cognition, social and emotional functioning, vision, hearing, speech/language, fine and gross motor skills, and physical health. (Developmental screening is not required as a part of the kindergarten health assessment; however, such screening may be conducted either by health professionals or by school personnel in conjunction with the health assessment. Please refer to “Recommended Guidelines for Preschool Screening,” developed by the North Carolina Department of Public Instruction, for an explanation of the components of developmental screening.)

*Health Professionals* – Includes physicians licensed to practice medicine, physician’s assistants as defined in General Statute 90-18, certified nurse practitioners, and public health nurses meeting the standard for state Health Check services.

*Regular Health Provider* – Includes the agency, family doctor or pediatrician examining or treating the child on a regular basis.

*Nursing Support Services* – Includes nursing practices requiring the supervision of a licensed physician or registered nurse.
Responsibilities of Parents/Guardians

1. To secure a health assessment for their child either from the local health department or from a private health provider.

2. To ensure that the completed health assessment form is returned to the school principal or designee. Copies of the forms are available from the local school administrative unit or from the local health department. The completed forms may be returned either by the health provider or by the parent, but it is the parent’s responsibility to see that the school principal receives the results of the required assessment.

3. To pay any costs involved in securing the health assessment. Recommended follow-up medical evaluations and medical interventions are at the discretion of the parent or guardian, who also is responsible for payment of any charges that result.

Responsibilities of Local Health Departments

1. To provide health assessments at no cost to children meeting eligibility criteria and to all other children on a sliding-fee basis to the extent that personnel and resources allow.

2. To report health assessment results of children screened to local school principals or their designees on the Form PPS-2K (revised 1/08) developed by the DHHS and DPI. The form may be returned to the school either by the health provider or by the parent.

3. Forms will be printed by the Division of Women’s and Children’s Health, Department of Health and Human Services and distributed to local health departments and local school systems.
Responsibilities of Private Health Providers

1. To complete all sections of health assessment form (including hearing and vision) on each child presented by the parent or guardian for a kindergarten health assessment required for school entry. Parents or guardians may supply forms received from the local school system, or private health providers may secure forms from the local health department or from the web.

2. To submit the completed health assessment form to the school principal or designee of the school in which the child will be enrolled for kindergarten. The private health provider may return the form by mail or via the parent or guardian.

Responsibilities of Local School Administrative Units

1. To notify parents of children entering kindergarten that a health assessment will be required for school entry.

2. To inform parents of their responsibilities relating to the health assessment and of the types of health providers who may conduct the health assessment. All costs involved are the responsibility of the parent or guardian and not that of the local school administrative unit.

3. To establish a procedure for receiving and routing completed forms to the appropriate school.

4. To maintain files of health assessment results. These files may be maintained by the school nurses. The health assessment form should become a part of the student’s cumulative record file.

5. To make the health assessment results available for review by parents and by school and medical personnel with a legitimate need for the information.
6. To file a status report on the number of children screened and the number not screened. The principal in each school having a kindergarten program will compile the information requested and make it available on or before November 1 of the current school year. The results will be reported to the Department of Health and Human Services on a form developed by DHHS and DPI. ³

7. To provide upon request and at no charge a copy of the health assessment results to the new school officials when a child transfers from one school to another. Children who are transferring into public school kindergarten programs and who have not had the required health assessment must meet the requirement within 30 calendar days from the first day of school attendance.

8. To use the health assessment results in coordinating with the school system’s preschool screening information and follow-up evaluation data to plan appropriate developmental programs for students.

³ To obtain a copy of the Kindergarten Health Assessment Status Report form, contact the NC Division of Public Health School Health Unit.
**Report as of day 30 after the first day of attendance**

### ANNUAL KINDERGARTEN IMMUNIZATION/HEALTH ASSESSMENT STATUS

**SCHOOL SUMMARY REPORT**

County __________________________ School District __________________

Name of School ________________________________________________

- [ ] Public/Charter
- [ ] Private
- [ ] Federal

Address _________________________________

- Street __________________
- City __________________
- ZipCode ________________

Phone _________________________ FAX _____________________

Principal’s Name (PRINT) ________________________________________

Principal’s Signature ___________________________________________

### Immunizations Summary

**A. Total Kindergarten Enrollment**: \((A \text{ should equal } B + C + D + E + F)\) .................................................. (A) ______

**B. Number of students with valid Medical Exemptions (ME)** .......................................................... (B) ______

**C. Number of students with valid Religious Exemptions (RE)** ......................................................... (C) ______

**D. Number of students with complete immunizations**: \((do \text{ not include ME/RE})\) ...................... (D) ______

**E. Number of students with no record on file** .................................................................................. (E) ______

**F. Number of students who do not meet minimum immunization requirements**: \((do \text{ not include ME/RE or students with no record on file})\) ............................................................................. (F) ______

Please list what vaccines the students listed in line F are missing in boxes G-L

<table>
<thead>
<tr>
<th>G. # of students who need a dose(s) of DTaP</th>
<th>H. # of students who need a dose(s) of Polio</th>
<th>I. # of students who need a dose(s) of MMR</th>
<th>J. # of students who need a dose(s) of Hib</th>
<th>K. # of students who need a dose of Hep B</th>
<th>L. # of students who need a dose of Varicella</th>
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<tr>
<td>#</td>
<td>#</td>
<td>#</td>
<td>#</td>
<td>#</td>
<td>#</td>
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</table>

**M. Number of students who did not receive the required immunizations by the first day of attendance and were given 30 days to meet requirements** ......................................................... (M) ______

### Health Assessment Summary

**(not mandatory for private schools)**

**A. Total number of Kindergarten students enrolled for the first time**: .........................................................

**B. Total number of kindergarten assessments on file for first time enrollees**: ...................................................

**C. Total number of repeating kindergarten students with KHA forms on file**: ...................................................

**D. Total number of students who have religious exemptions for assessments**: ...................................................

**E. Total number of students who are not in compliance with this law**: .........................................................

DHHS 2054 (Revised 2/09)
Immunization (Review 2/11)
School Summary Report of Kindergarten Immunization/Health Assessment Status

Purpose: This Summary Report is required by N.C. State Law [G.S. 130A-155(c) and G.S. 130A-440]. It records the immunization status of all kindergarten students enrolled in public/charter and private schools each fall. The Summary Report must be completed annually. It also records the health assessment status of all kindergarten students enrolled in public and charter schools.

Preparation: The Summary Report must be completed by the principal or his/her designee.

Distribution: Each principal or his/her designee must return the original Summary Report to their district school superintendent. A copy of the Summary Report should also be kept at the individual school.

Mail the School Summary Report by November 1st to:
North Carolina Department of Health and Human Services
Division of Public Health
Immunization Branch
1917 Mail Service Center
Raleigh, NC 27699-1917

Disposition: Each school must keep a copy of the Summary Report for at least one year. The N.C. State Immunization Branch, in accordance with the approved records retention schedule, may destroy the Summary Report at their discretion.

Reordering: The user may copy the Summary Report form as needed. You may also call 919-707-5550 for additional copies.

Instructions
Please complete all identifying information at the top of the form. If your school has no kindergarten students, enter 0 on Line A. If your school has closed, please write “CLOSED” across the front of the Summary Report.

The individual Class Worksheets (DHHS 2051) are to be used to gather information for this Summary Report. DO NOT FORWARD THE CLASS WORKSHEETS. Keep the worksheets on file at your school for reference or any future questions about the Summary Report.

Each principal or his/her designee must check the accuracy of all information before submitting the Summary Report to his/her district superintendent.

Line A: Total Kindergarten Enrollment: make sure each class enrollment number is correct.
                      Line A = Line B + Line C + Line D + Line E + Line F.
                      If no students, enter 0 .

Line B: Medical Exemption (ME): Enter the total number of students with a valid ME.
DO NOT attach a copy of each student’s Medical Exemption.

Line C: Religious Exemption (RE): Enter the total number of students with a valid RE.
DO NOT attach a copy of each student’s Religious Exemption.

Line D: Number of students with completed immunizations (met requirements). Report this as of day 30 after the first day of attendance. Do not include students with valid medical or religious exemptions.

Line E: Number of students with no immunization record on file.

Line F: Number of students who did not receive all required immunizations or do not have a valid medical or religious exemption. (This includes students who are past due and those who are in the process of getting the required immunizations.) Report this as of day 30 after the first day of attendance.

Line G-L: Use this table to document the vaccines the students from Line F are missing and not meeting requirements.

Line M: Number of students who did not receive the required immunizations by the first day of attendance and were given 30 days to meet requirements.

DHHS 2054 (Revised 2/09)
Immunization (Review 2/11)
(This page intentionally left blank.)
**School Summary Report of the Immunization Status of Sixth Grade Students**

*Report as of day 30 after the first day of attendance*

<table>
<thead>
<tr>
<th>County</th>
<th>School District</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of School</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check One:  
- [ ] Public  
- [ ] Federal  
- [ ] Private  
- [ ] Other

<table>
<thead>
<tr>
<th>Address</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Principal’s Name: __________________________ Telephone Number: __________________________

<table>
<thead>
<tr>
<th>Administrative Unit Code Number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(may not apply for non-public schools)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School Code Number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(may not apply for non-public schools)</td>
<td></td>
</tr>
</tbody>
</table>

**A. Enter enrollment**…(A should equal B + C + D + E + F)  
Ensure that each reported class enrollment is correct and verify that this enrollment equals lines B + C + D + E + F.

<table>
<thead>
<tr>
<th>(A)</th>
<th></th>
</tr>
</thead>
</table>

**B. Valid Medical Exemptions (ME)**
(See back for definition)

<table>
<thead>
<tr>
<th>(B)</th>
<th></th>
</tr>
</thead>
</table>

**C. Valid Religious Exemptions (RE)**
(See back for definition)

<table>
<thead>
<tr>
<th>(C)</th>
<th></th>
</tr>
</thead>
</table>

**D. Number of children who meet the Tdap requirement**
Document the number of children who meet N.C. Immunization Requirements. (Do not include those with valid medical or religious exemptions). Report this as of day 30 after the first day of attendance.

<table>
<thead>
<tr>
<th>(D)</th>
<th></th>
</tr>
</thead>
</table>

**E. Number of children with no immunization record on file**

<table>
<thead>
<tr>
<th>(E)</th>
<th></th>
</tr>
</thead>
</table>

**F. Number of children who did not receive the required immunization**
This is the number of children needing a dose of Tdap. Report this as of day 30 after the first day of attendance. Do not include those with ME or RE.

<table>
<thead>
<tr>
<th>(F)</th>
<th></th>
</tr>
</thead>
</table>
School Summary Report of the Immunization Status of Sixth Grade Students

PURPOSE: The report is required by state law [G.S. 130A-155(c)] and is used to record the Tdap immunization status of all 6th grade children enrolled in public and private schools each fall. This report must be completed at the beginning of the new school year.

PREPARATION: To be completed by the principal or his/her designee. The immunizations should be reported as of day 30 after the first day of attendance.

DISTRIBUTION: Each principal or his/her designee should return original to the district school superintendent and keep a copy for the school’s files.

Superintendent - By November 1st of each new school year

Mail the School Summary Report to:
North Carolina Department of Health and Human Services
Division of Public Health
Immunization Branch
1917 Mail Service Center
Raleigh, NC 27699-1917

DISPOSITION: This report may be destroyed at the discretion of the Immunization Branch in accordance with the approved records retention schedule. Each school must keep their copy of this document for at least one year.

REORDERING: User may copy form as needed or call (919) 707-5550 to request additional copies.

Minimum Requirements at 6th grade entry for Tdap (tetanus/diphtheria/pertussis vaccine) or Td (tetanus/diphtheria toxoid)

A booster dose of tetanus/diphtheria/pertussis vaccine is required for individuals attending public school who are entering the sixth grade on or after August 1, 2008, if five years or more have passed since the last dose of tetanus/diphtheria toxoid. A booster dose of tetanus/diphtheria/pertussis vaccine is required for individuals not attending public schools who are 12 years of age on or after August 1, 2008, if five or more years have passed since the last dose or tetanus/toxoid. However, pertussis (whooping cough) vaccine is not required for individuals between 7 years of age through the fifth grade for those attending public schools and 7 through 12 years of age for those not attending public schools.

Medical Exemption: G.S.130A-156
A valid Medical Exemption requires a signed statement from a physician licensed to practice medicine in North Carolina. The statement must explain the specific reason why each vaccine is detrimental to the child’s health and the length of time the exemption will apply. Place a copy of the exemption in the child’s permanent file. Do not submit a copy of the Medical Exemption with this form.

Religious Exemption: G.S.130A-157
A child may be exempt when the parent or guardian submits a written statement explaining that it is against their bona fide religious belief to have their child immunized. Place a copy of the exemption in the child’s permanent file. Do no submit a copy of the Religious Exemption with the form.
(This page intentionally left blank.)
Questions and Answers about the Kindergarten Health Assessment

North Carolina General Statute 130A-440 (a)

1. What schools require Kindergarten Health Assessments?
   ANSWER: Every child entering kindergarten in the public schools for the first time in North Carolina shall receive a health assessment. This includes Charter Schools in NC. Unlike immunization requirements, private, parochial and home schools are not included in this statute.

2. If a child enrolls in a NC public school in February, after moving from another state for instance, does he/she still need a health assessment on file?
   ANSWER: Yes. The statute states that health assessments are required upon “the date of entry” into kindergarten. All kindergarten students are required to have the Health Assessment Report on file regardless of when they enter kindergarten.

3. Who is responsible for assuring that students are in compliance with this requirement?
   ANSWER: The school principal. That statute states: “If a health assessment transmittal form is not presented on or before the first day, the principal shall present a notice of deficiency to the parent, guardian, or responsible person.”

4. What happens when parents/guardians do not present the health assessment form to the school?
   ANSWER: Parents/guardians “have 30 calendar days from the first day of attendance to present the required assessment transmittal form” to school. “Upon termination of 30 calendar days, the principal shall not permit the child to attend the school until the required health assessment transmittal form has been presented”. Kindergarten students are to be excluded from school until the Kindergarten Health Assessment Report form is completed and submitted to school.

5. What is the “required Health Assessment transmittal form”?
   ANSWER: It is a form entitled, KINDERGARTEN HEALTH ASSESSMENT REPORT (Form #PPS-2K): that has been approved as the state’s official document by NC Department of Public Instruction and NC Department of Health and Human Services, Division of Public Health. A copy of this form is included in Appendix III of the N.C. School Health Program Manual and is available for download at www.nchealthyschools.org.

6. Is there a certain date that the student’s health assessment or examination must be
Appendix III State-Generated Forms Item #5

Q&A on KHA

completed?
ANSWER: The statute states that the “health assessment shall be made no more than 12 months prior to the start of school.

7. Who may conduct the health assessment and sign the form?
ANSWER: The health assessment must be conducted by a physician licensed to practice medicine, OR a physician’s assistant as defined in General Statute 90-18, OR a certified nurse practitioner, OR a public health nurse meeting the NC standards for Health Check services.

8. Must students who repeat Kindergarten have another health assessment filed at school?
ANSWER: No. The health assessment is only required one time upon initial entry to kindergarten.

9. Must students who enter a school for the first time in first grade have a Kindergarten Health Assessment Report on file at the school?
ANSWER: No. The statute does not require the schools to “make-up” or “catch-up” this assessment requirement after the student completes the kindergarten year.

10. May other pre-Kindergarten classes (such as Head Start,”More at Four” day care centers, pre-K public school programs) including “More at Four” utilize the Kindergarten Health Assessment Report form as their physical examination requirement for entry?
ANSWER: The “Kindergarten Health Assessment Report” (PPS-2K) is the official form adopted for the implementation of this statute. Other programs should create their own health assessment forms. However, the form may be used.

11. When completed Kindergarten Health Assessment Report forms are received at school, where should the forms be filed and how long should they be kept on file?
ANSWER: The intent of this law is to enable schools to readily identify student health conditions that may interfere with learning or impede optimal school participation. This confidential health information should be used by school staff to plan individualized student care and proper classroom placement. School districts need to develop local policies and procedures for utilization of all student health data. School nurses are encouraged to assist schools in this process.

DISPOSITION INSTRUCTIONS: Retain in cumulative records file until elementary school is completed, then destroy in office, or retain permanently if the form contains the only doctor-signed, clinic-stamped immunization record.
12. What if the Kindergarten Health Assessment Report is not fully completed when the parent submits it to school?

**ANSWER:** The school principal may, within LEA policy, refuse to accept an incomplete assessment form. Parents and health care providers should fully complete the assessment form.

13. What if the Kindergarten Health Assessment Report was completed by a physician on a different form than the NC official report form (PPS-2K)? Is it acceptable?

**ANSWER:** The PPS-2K is the only acceptable form for children entering kindergarten in North Carolina. Parents should take the form with them to the physician or clinic to the examination appointment. Even in situations where the child’s physician is not in North Carolina, all efforts should be made to have the student’s health assessment documented on the PPS-2K form. Other forms may not have all of the information that is contained on the NC official form. If another form is presented, the school nurse can be an excellent resource to the principal and parents.

14. Are there any exemptions to this statute? May a student attend kindergarten without this health assessment being on file?

**ANSWER:** Yes. A religious exemption may occur and is acceptable. Parents or guardians must submit a signed statement to the principal which claims a bona fide religious objection to obtaining a health assessment.

15. Are there any reports or accountability procedures that all schools must complete which indicates consistent, state-wide compliance with this law?

**ANSWER:** Yes. After the commencement of the school year, on or before November 1, every principal with kindergarten classes at their schools is required to file a school summary report called the Kindergarten Immunization Assessment Report. This report form is mailed to each school every year from the NC Department of Health and Human Services. It is an assessment for compliance for both the required immunizations and the KHA. This school summary report should be completed by the principal or designee and follow directions on the form concerning how to submit the form to the state Division of Public Health.

16. Who can school personnel, parents, health care providers or others call with questions they may have about kindergarten health assessments?

**ANSWER:** The NC Department of Health and Human Services makes available regional school nurse and child health nurse consultants to assist schools and districts with school-related health concerns or questions. Ask your local school nurse, school
health program manager, or health department about how to contact these state and regional consultants when needed.

\[1\text{Source:}\] This Q and A section has been written by the North Carolina Regional School Nurse Consultants based upon answers to their most frequently asked questions. The text of General Statute 130A-440 is the source for answers to most questions. Text may be found at: http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_130A/GS_130A-440.html
Appendix III

State-Generated Forms

Item #5

Q&A on KHA

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PATIENT AUTHORIZATION

to Permit Use and Disclosure of Health Information (DHHS #4056)

This form implements the requirements for patient authorization to use and disclose health information protected by the federal health privacy law, 45 C.F.R. parts 160, 164. Except as otherwise permitted or required by the privacy law, a health care provider subject to the privacy law may not use or disclose protected health information without an authorization that complies with the requirements of 45 C.F.R. 164.508(c).

If the authorization is obtained to use or disclose information for marketing and the marketing involves direct or indirect payment to the health care provider from a third party, the authorization must state that such remuneration is involved.

[1] Person or class of persons authorized to use or disclose the information

[2] Person or class of persons to whom use or disclosure would be made

[3] Purpose of use or disclosure

[4] Name of covered entity

[5] NOTE: The federal privacy law permits a health care provider, in certain limited circumstances, to condition the provision of health care on obtaining an authorization. For example, a health care provider may condition the provision of health care that is solely for the purpose of creating information for disclosure to a third party on an authorization permitting such disclosure. Where the privacy rule permits the conditioning of services on receipt of an authorization and the health care provider chooses to make treatment conditional on the patient providing an authorization, then the sentence in this form regarding the conditioning of the authorization must be modified to explain what the condition is and the consequences to the patient of a refusal to sign the authorization.

[6] Date or event that relates to the patient or the purpose of the use or disclosure

[7] Explain representative’s authority to act on behalf of the patient

DHHS #4056

School Health Program Manual – January 2010
N.C. Division of Public Health – Children & Youth Branch – School Health Unit
PATIENT AUTHORIZATION
to Permit Use and Disclosure of
Health Information

I am either the patient named above or the patient’s legally authorized representative.
By signing this form, I authorize

[1] Person or class of persons authorized to use or disclose the information
to use or disclose to

[2] Person or class of persons to whom use or disclosure would be made
the following protected health information
(identify the information in a specific and meaningful fashion):

The purpose of the use or disclosure is [3] (describe each purpose of the requested use or disclosure):

I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing. The procedure for how I may revoke the authorization, as well as the exceptions to my right to revoke, are explained in

[4] Name of covered entity
Notice of Privacy Practices, a copy of which has been provided to me.

I understand that I may refuse to sign this authorization. I also understand that

[4] Name of covered entity
cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this Authorization. [5]

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be redisclosed by the person or agency that receives it.

This authorization expires automatically upon

[6] Date or event that relates to the patient or the purpose of the use or disclosure

Signature of patient OR authorized representative Date

Please print name of patient or authorized representative who signed above

[7] Please explain representative’s authority to act on behalf of the patient:
Yo soy el paciente mencionado anteriormente o el representante legal de dicho paciente.

Firmando esta planilla, autorizo a

[1] Persona o clase de personas autorizadas a usar o divulgar la información

A usar o divulgar a

[2] Persona o clase de personas a quien se les suministrará el uso o divulgación

la siguiente información de salud protegida (identifique la información de una forma clara y específica):

El propósito de esta divulgación es [3] (describir cada propósito del solicitado uso o divulgación):

Yo entiendo que, con ciertas excepciones, yo tengo el derecho en cualquier momento de anular esta Autorización. Si quisiera anular esta autorización, lo debo hacer por escrito. El proceso a seguir para anular esta autorización, así como las excepciones a mi derecho de anularlo, están explicadas en el documento “Notificación de Prácticas Privadas” de la entidad

[4] Nombre de la Entidad

Una copia de dicho documento se me ha sido entregado anteriormente.

Yo entiendo que puedo negarme a firmar esta autorización. También entiendo que la Entidad

[4] Nombre de la Entidad

no puede negarse a proveerme tratamiento, pago o inscripción en un plan de salud, o de quitarme el derecho a beneficios porque me niegue a firmar esta Autorización. [5]

Yo entiendo que, una vez que la información ha sido divulgada basada en esta Autorización, es posible que deje de estar protegida por la ley federal de privacidad médica y que pudiera ser divulgada de nuevo por la persona o agencia que la reciba.

Esta autorización vence automáticamente el

[6] Fecha o evento relacionado con el paciente o propósito del uso o divulgación

Firma del Paciente o Representante Autorizado

______________________________  ____________________________
Firma del Paciente o Representante Autorizado  Fecha

Nombre (en letra de imprenta) del Paciente o Representante Autorizado que firmó planilla

[7] Favor explique la autoridad que tiene el Representante para actuar en nombre del Paciente:
# Physical Activity & Nutrition Behaviors

## Monitoring Form

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. NAME</td>
<td>Name of the child or subject</td>
</tr>
<tr>
<td>2. HSIS ID #</td>
<td>Health System Identification System ID number</td>
</tr>
<tr>
<td>3. Date of Birth</td>
<td>Date of birth (Month/Day/Year)</td>
</tr>
<tr>
<td>4. Race</td>
<td>Race of the child or subject (White, Black, Asian, etc.)</td>
</tr>
<tr>
<td>5. Sex</td>
<td>Gender of the child or subject (Male, Female)</td>
</tr>
<tr>
<td>6. County of Residence</td>
<td>County where the child or subject resides</td>
</tr>
<tr>
<td>7. Medicaid Number or N/A</td>
<td>Medicaid number or N/A</td>
</tr>
<tr>
<td>8. Person Completing Form</td>
<td>Name of the person completing the form</td>
</tr>
<tr>
<td>9. Patient's Height</td>
<td>Height of the child or subject (inches)</td>
</tr>
<tr>
<td>10. Patient's Weight</td>
<td>Weight of the child or subject (pounds)</td>
</tr>
</tbody>
</table>

## Physical Activity/Inactivity

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. ACTIVITY LEVEL</td>
<td>Level of activity compared to others of the same age/sex.</td>
</tr>
<tr>
<td>12. EXERCISE DAYS</td>
<td>Number of days exercised in the past 7 days.</td>
</tr>
</tbody>
</table>

## Sweetened Beverages

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. SODA TIMES</td>
<td>Number of times drank on a typical day.</td>
</tr>
<tr>
<td>16. SWEETENED BEVERAGE TIMES</td>
<td>Number of times drank sweetened beverages.</td>
</tr>
<tr>
<td>17. SODA AMOUNT</td>
<td>Amount of soda or sweetened beverage consumed.</td>
</tr>
</tbody>
</table>

## Fast Food Frequency

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. FAST FOOD</td>
<td>Frequency of fast food consumption.</td>
</tr>
</tbody>
</table>

## Fat Snack Intake

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. CHIPS</td>
<td>Frequency of chip consumption.</td>
</tr>
</tbody>
</table>

## Low Fat Dairy Intake

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. MILK AMOUNT</td>
<td>Amount of milk consumed.</td>
</tr>
<tr>
<td>21. MILK TYPE</td>
<td>Type of milk consumed.</td>
</tr>
</tbody>
</table>

## Fruit and Vegetable Intake

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22. VEGETABLES</td>
<td>Frequency of vegetable consumption.</td>
</tr>
<tr>
<td>23. FRUITS</td>
<td>Frequency of fruit consumption.</td>
</tr>
</tbody>
</table>
Instructions for Physical Activity and Nutrition Behaviors Monitoring Form (DHHS 4062)

PURPOSE:
This form may be used by health department clinic staff and/or community- or school-based program staff to document and monitor select physical activity and nutrition behaviors that are key to maintaining a healthy weight. Information collected on this form may be entered on HSIS Screen 67 and local reports generated from HSIS Screen 19. These data will be useful in nutrition and physical activity program planning and evaluation.

PREPARATION:
1-6 Attach in this space the computer generated identification label or emboss the information imprinted on the client’s plastic identification card. If a label or plastic card is not available, record by hand the name, identification number, date of birth, race, ethnicity, and sex.

7 Record respondent’s (child’s) Medicaid number or leave blank.

8 Record the name and title of the person completing the form and the date the form was completed.

9 Record the patient’s height in inches and the date the measurement was taken.

10 Record the patient’s weight in pounds and the date the weight was taken.

11-23 Physical Activity and Nutrition Behavior questions may be asked of older children and adolescents, parents of toddlers and preschoolers, and adults. The form is not designed to be self-administered by clients. In general, the person administering the questionnaire should read each question and assist the respondent with identifying the response that most closely matches his/her behavior. A detailed explanation for information to collect for each item is explained in the North Carolina Physical Activity & Nutrition Behavior -HSIS Data Collection and Reporting Guidance Manual.

DISTRIBUTION:
May be included in the respondent’s (child’s) health or WIC record if completed as part of a clinic assessment.

DISPOSITION:
Dependent on use of the form (community-based surveillance vs clinical screening) the form may be disposed of in accordance with local agency policy or following the Records Disposition Schedule as published by the Division of Archives and History.

ORDER FROM:
Nutrition Services Branch
Women’s and Children’s Health Section
NC DHHS Division of Public Health
1914 Mail Service Center
Raleigh, NC 27699-1914

Copies of this form may be downloaded from the Eat Smart Move More Website: http://www.eatsmartmovemorenc.com/
NC Division of Health Service Regulation
Office of Emergency Medical Services

Do Not Resuscitate (DNR) & Medical Orders for Scope of Treatment (MOST) Forms

Pursuant to N.C. General Statute 90-21.17 (PDF, 17 KB), the department, through the Office of Emergency Medical Services, has adopted an official portable Do Not Resuscitate (DNR) form and Medical Order for Scope of Treatment (MOST) form for use by physicians and other licensed healthcare facilities to assist in providing information relating to a patient's desire for resuscitation or life-prolonging measures. These forms are available only to physicians' offices or other licensed hospital or healthcare facilities. To purchase DNR and MOST forms, use the DNR and MOST order form:

- **DNR & MOST Order Form** (PDF, 54 KB)

For a sample copy of the portable DNR or MOST form:

- **Sample DHHS Do Not Resuscitate (DNR) Form** (PDF, 131 KB)
- **Sample Medical Orders for Scope of Treatment (MOST) Form** (PDF, 1.08 MB)

The online Emergency Medical Services MOST Educational Program was developed by the NC OEMS and the Emergency Medical Services Improvement Performance Center (EMSPIC) to assist EMS agencies and personnel in understanding how the MOST form is to be used. Since patients across the state will begin using this MOST form immediately, all EMS personnel are strongly encouraged to complete the MOST Online Educational Program. This program can be completed in approximately 30 minutes.

Denotes link to site outside of N.C. DHSR.

This page was last modified on April 29, 2008.

Division of Health Service Regulation
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Student’s Permanent Health Record Guidelines

The purpose of the permanent health record is to insure continuity of care for students and to provide basic documentation of the student’s health status. The health record contains pertinent data concerning the student’s health and should be an integral part of the cumulative record which accompanies the student throughout his/her school career.

Information in the student’s permanent health record may include, but is not limited to, the following:

a. the student’s health status at the time of school enrollment or transfer, including immunization record;
b. results of screening evaluations, identified health problems, and notations regarding plan(s) for care or other interventions(s);
c. notation of teacher/nurse conferences;
d. documentation of referrals for health care;
e. documented outcomes including results of services rendered by referral sources; and notation of parent/guardian contacts.

Notations on the record should be made immediately after services are given. All entries must be in ink (except where “in pencil” is noted), with no erasures, and signed by the person providing the service. Corrections are made by lining through the error and writing the correction above.

A student’s “permanent health record” is a collection of legal documents, maintained jointly by school and designated health personnel, and is guaranteed the same safeguards of confidentiality as any other component of the student record as specified by the Family Education Rights and Privacy Act. The permanent health record should be available to school and medical personnel with a legitimate need for information. N.C. DHHS and N.C. DPI have created the PP – S2P, a folder in which documents may be maintained for security and ease of access, and on which some items may be recorded for additional ease of access. A school district may create its own system for collecting and maintaining these documents. A copy of the PP – S2P is in Appendix III for viewing. For information on how to order the most recent version of the PP – S2P (Student Permanent Health Record), go to: www.ncpublicschools.org – Department – Publication Sales – Search by Number – PP (left block) and S2P (right block). Information on cost and ordering is available on the website.
Side 1

Personal Data Section

Personal data includes the student’s name (last name, first name, middle name), birth date (month, day and year, as listed on student’s birth certificate); school ID number; sex; parent or guardian’s name; emergency contact phone #; health alerts

Screening Sections

Vision Screening: Vision screening should be provided by nurses, volunteers or school personnel who have completed an approved training program. Screening for visual acuity should be completed for distance vision, with right, left, and both eyes. When near vision screening is needed, follow the same format. The examiner should record only the most recent failed screenings and screening results. (All other results should be recorded in the student’s individual health record)

Audiometric Hearing Screening: With the exception of speech-language pathologists, all personnel conducting audiometric screening must be under the supervision of a physician or an audiologist. Pure tone screening usually includes sweep screening at 20dB at frequencies of 1000, 2000 and 4000 using a pure tone audiometer. Results are recorded for right and left ears.

Anthropometric Screening: If you choose to perform heights and weights on children and adolescents, follow procedures that yield accurate measurements and use equipment that is well maintained. When measured and plotted correctly, a series of accurate weights and measurements of stature (height) offer important information about a child/adolescent’s growth pattern. Before assuming there is a health or nutrition concern, parental stature and other factors such as the presence of a chronic illness or special health care need must be considered. For information about accurate weighing and measuring procedures and for calculating Body Mass Index (BMI) refer to the North Carolina School Health Program Manual.

Dental Screening: A dentist and other appropriately prepared health professionals (e.g., dental hygienists) may conduct dental screening. Date of screening, results of screening related to dental caries, periodontal disease, malocclusion, and comments pertinent to the management of screening results should be recorded by the examiner.
Other Screening: Other screening data available on the student may be included in this section. Such data might include screenings conducted by physical, occupational or speech therapists.

Side 2

Significant Health History/Conditions

Significant health problems such as allergies, asthma, and/or diabetes should be noted here, along with any individualized health or emergency action plans. Include dates of initiation of plans as well as when plan is discontinued. Location of written plan(s) could be included under Comments.

Kindergarten Health Assessment Report

All students entering public school kindergarten for the first time must have a completed Health Assessment Report (PPS-2K) on file. Check either yes/no. If bona fide religious exemption has been presented, check “no” and indicate “religious exemption.”

Record of Immunizations

The LEA should maintain a provider copy of the immunization record so completing this section is optional. G.S. 130A-152 requires that every child be immunized against diphtheria, tetanus, whooping cough, poliomyelitis, red measles (rubella), mumps, rubella, Hemophilus influenza B and hepatitis B, and varicella (chicken pox). The parent, guardian, or responsible person must present a certificate of immunization within 30 calendar days from the student’s first day of attendance at school. If the administration of vaccine in a series of doses given at medically approved intervals requires a period in excess of 30 calendar days, additional days may be allowed upon certification by a physician to obtain the required immunization. At the end of 30 calendar days, or the extended period, the principal shall not permit the child to attend school until the required immunization has been obtained.

Religious or medical exemptions from this law require that a statement be on file at school in the student’s cumulative record (in lieu of the immunization certificate). The medical exemption must be written by a medical doctor on the approved form. Personnel transferring data from the immunization certificate to the student’s permanent health record should sign the form in the space provided. To determine the required number of doses and age requirement of each vaccine, refer to [www.immunizenc.com](http://www.immunizenc.com)
Inside Narrative Notes

This section provides an opportunity for organization of the student’s health data and increased communication with appropriate school personnel and school health providers. Each entry is dated with a summary statement of findings, actions and outcomes. Documentation may include, but is not limited to, health services directly related to the education of the student, direct care, referrals for care and results of services. Each entry should be signed by the person entering the data.
<table>
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<tr>
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<tr>
<th>Date/maintenance of</th>
<th>Date/method of 1st parent notification (phone/letter/note via student)</th>
<th>Results of professional vision exam (does not need correction, all the time; only for reading/writing work, etc.)</th>
<th>Comment/Signature</th>
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These materials are a joint project of the North Carolina Division of Public Health – School Health Unit and the North Carolina Department of Public Instruction.
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HEALTH HISTORY (MAY USE PENCIL)

☐ Normal growth and development, no known health problems
BP (most recent) Ref?

HEALTH CONDITIONS (IF ANY) & DATE OF ONSET IF KNOWN

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<tr>
<th>EAP on file</th>
<th>IHP on file</th>
<th>Comments</th>
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Allergies:
- Insect
- Food
- Drug
- Other:
- Asthma
- Cardiac
- Diabetes
- Type 1
- Type 2
- Orthopedic
- Seizure
- Sickle Cell
- Other:

Enter "M" for any vaccine for which a valid exemption statement from MD is on file. Enter "R" for any vaccine for which the parents/guardians claim a religious exemption. Place/maintain a valid exemption statement in the student's school record.

Vaccine
#1 #2 #3 #4 #5

DTP, DtaP, DT
6th Grade /age 12. Tdap
Hib
Hepatitis B
MMR
If no MMR:
Measles
Mumps
Rubella
Polio
Varicella
Others: [list below]

Signature: Date:
Title of individual recording / transcribing:
Signature: Date:
Title of individual recording / transcribing:
Signature: Date:
Title of individual recording / transcribing:

KINDERMARTEN HEALTH ASSESSMENT

The Kindergarten Health Assessment report, required for first time entry into public school kindergarten, is on file:
- Yes
- No

SCREENINGS:

VISION SCREENING

Date of most recent vision screening: (pencil)
Known vision problem: 
- Glasses/contact lenses (mark one):
  - Yes
  - No

RESULTS OF FAILED VISION SCREENING:

Screening Date
Date/method of 1st parent notification
(phone/letter/note via student)
Results of professional vision exam
(does not need corrective lenses; needs correction all the time; only for reading/distance work; etc.)
Comment/Signature

HEARING SCREENING

Date of most recent hearing screening: (pencil)
Known hearing problem:

- Preferential seating
- Hearing Aids

RESULTS OF FAILED HEARING SCREENING:

Screening Date
Date/method of 1st parent notification
(phone/letter/note via student)
Results of professional hearing or ENT exam
(does not need correction; sit in front of class; etc.)
Comment/Signature

ANTHROPOMETRIC SCREENING

Date
Ht. Wt. BMI %Comments

DENTAL SCREENING

Date
Results

OTHER SCREENING

Date
Results

These materials are a joint project of the North Carolina Division of Public Health – School Health Unit and the North Carolina Department of Public Instruction.
PPS-2P Student Health Record Form

(This page intentionally left blank.)
MEDICATION ADMINISTRATION FLOW SHEET  (July – December)
(for Medicaid School-Based Services Documentation)

Name of LEA:                      School:                      Grade:
Student name:                    Date of Birth:                 Medicaid #:        ICD-9 Code(s):
Name of Medication:              MD/NP/PA:
Date Begun:                      Date of Change:               Dose:         Route:       Time(s):
If Changed Date of Change:       Dose:         Route:       Time(s):
If Changed Date of Change:       Dose:         Route:       Time(s):
RN Review (Signature, Credentials, Title):  Date:

|        | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|--------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Month  |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| July   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| (time & initials) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Aug.   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
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| Sept.  |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
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| Oct.   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
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| Nov.   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
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| Dec.   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| (time & initials) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Initials Full Name & Title Signature Date

INSTRUCTION/CODES
X= Weekend / Non-Scheduled School Day  A = Absent D/C=Discontinued
D = Early Dismissal (left school before scheduled time)
N = No Medications/supplies available for procedure – Parent Notified
   (document on reverse side)
O = Medication/procedure Omitted (document reason on reverse side)
R = No Show/Student Refusal (document on reverse side)

(Keep with Medication Administration Authorization until complete; then file in student’s folder.)

School Health Program Manual – January 2010
N.C. Division of Public Health – Children & Youth Branch – School Health Unit (form prepared in collaboration with N.C. Division of Medical Assistance for use in Medicaid billing for school nurse services)
**NARRATIVE NOTES & REVIEW OF RESPONSE TO MEDICATION** *(Side 2 of Flow Sheet)*

(To be completed at least weekly by the RN, with UAP if appropriate)

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Date of Birth:</th>
<th>Date:</th>
<th>Time:</th>
<th>Comments: (response to med., side effects, reason for omission, etc.)</th>
<th>RN Signature:</th>
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**Documentation Instructions:**
- One form is needed for each different medication.
- Give medication within 30 minutes of time scheduled.
- Initial immediately in the box to indicate medication was given & time given.
- **Use pen for documentation, no markers or pencils.**
- Do not alter with “white out” or erasures. If you make an unintentional entry, mark through it with a single line & initial, date. Explain on Side 2.
- If student does not take medication, use appropriate code and explain on notes page.
- Sign your full name once, on the front, the first time administered or performed.
- Sign your full name once, on the back, each first time you add comments on the narrative notes page.

**General Instructions for Administering Medications:**
- Wash hands before assisting students.
- Review the 6 R’s to insure safety each time: right student, right medication, right dose, right time, right route, (W)rite- document
- **Keep medications secured at all times.**
- Make two documented contacts with the parent/guardian to pick up expired or discontinued medications before disposing. Document disposal and have a witness.
- Once poured, do not leave medication unattended.
- Immediately report errors to parent, physician and RN. Complete Incident Report.
- Do not repeat medication if a student spits it out unless you are sure he did not retain any. Notify RN for further instructions.
- Do not repeat medication if student vomits. Notify parent.

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School Health Program Manual – January 2010
N.C. Division of Public Health – Children & Youth Branch – School Health Unit (form prepared in collaboration with N.C. Division of Medical Assistance for use in Medicaid billing for school nurse services)
**MEDICATION ADMINISTRATION FLOW SHEET** (January – June)
(for Medicaid School-Based Services Documentation)

<table>
<thead>
<tr>
<th>Name of LEA:</th>
<th>School:</th>
<th>Grade:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student name:</td>
<td>Date of Birth:</td>
<td>Medicaid #:</td>
</tr>
<tr>
<td>Name of Medication:</td>
<td></td>
<td>MD/NP/PA:</td>
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</table>

**Date Begun:**

<table>
<thead>
<tr>
<th>Date of Change:</th>
<th>Dose:</th>
<th>Route:</th>
<th>Time(s):</th>
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**If Changed:**

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<th>Route:</th>
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**RN Review (Signature, Credentials, Title):**

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**INSTRUCTION/CODES**

X = Weekend / Non-Scheduled School Day  A = Absent  D/C=Discontinued  
D = Early Dismissal (left school before scheduled time)  N = No Medications/supplies available for procedure – Parent Notified  
O = Medication/procedure Omitted (document reason on reverse side)  R = No Show/Student Refusal (document on reverse side)

(Keep with Medication Administration Authorization until completed; then file in student’s folder.)

---

**School Health Program Manual – January 2010**

N.C. Division of Public Health – Children & Youth Branch – School Health Unit (form prepared in collaboration with N.C. Division of Medical Assistance for use in Medicaid billing for school nurse services)
Nursing Services Documentation of Medication
For School-based Medicaid reimbursement

Note: A separate sheet is required for each medication to be administered or procedure performed.

Student Name: Medicaid requires the student’s legal name to be on all service documentation.

Date of Birth: Enter the student’s date of birth. This is helpful in identification of the student for Medicaid billing.

District/School: Enter the school that student will be attending during the year. If student transfers, enter the name of the new school.

Medicaid requires documentation of the place where the service was rendered. If provided any place other than the school listed, make a comment on side 2 of the form and state where it occurred. (home, field trip, etc.)

ICD-9 Code: Medicaid requires an ICD-9 diagnosis code for billing to support the medical need for the nursing service.

Medication name: Medicaid requires that documentation include a description of the service to be provided and at what frequency.

MD/NP/PA: Enter the student’s physician or other health care provider prescribing the service. Order must be attached and written on or before first date of medication given.

Date and Time of Service: Medicaid requires that service documentation include the date and time the service is provided.

RN Review/date: The RN transcribing the order signs here and includes the date of the order review.

Initials: The individual administering the medication must initial each time it is done to indicate that the service was provided.

Student’s reaction to medication: Complete NARRATIVE NOTES & REVIEW OF RESPONSE TO MEDICATION at least weekly. The RN completes with input from other caregiver, UAP, if appropriate. After administering the medication, evaluate the student’s response. If the student misses or refuses the dose, has an adverse reaction, or other untoward response, document as event occurs.

Signature/Credentials: The individual performing the service must sign the form and provide appropriate title or credentials the first time the service is rendered. Sign each time an entry is made on the Narrative Notes page.

Codes: The appropriate code must be entered in the day’s box when the service is not performed or the medication not administered. The same code may be used in the reaction box. When indicated, or if (C) is entered, add an explanation on the continuation page, side 2.
PLAN OF CARE (POC) FOR SCHOOL NURSING SERVICES

Student’s Name: _________________________________ School: ________________________________
(Last, first, middle initial)
DOB ______________ Medicaid # _______________ Grade _____ IEP Date ________

Medical Condition or Diagnosis:
___________________________________________________________________________________
___________________________________________________________________________________

Nursing Assessment:
___________________________________________________________________________________
___________________________________________________________________________________

Goals & Objectives:
___________________________________________________________________________________

Treatment/Interventions Ordered by MD, Nurse Practitioner or Physician Assistant (orders must be on file)

<table>
<thead>
<tr>
<th>Date</th>
<th>Time of day</th>
<th>Amount of time</th>
<th>Treatment / Procedure</th>
<th>Comments</th>
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Prescriber: ____________________________ Date of implementation of POC: __________________________

RN: ____________________________ (printed name) ____________________________ (signature) (Date)

Copy to Parent: ____________________________________________ (date)

Physician Signature not required on this form. All medical orders on file.
**Nursing Services Treatments and Procedures Progress Notes**  (make additional pages as necessary)

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<tr>
<th>Date of Service</th>
<th>Goal(s) addressed</th>
<th>Service description</th>
<th>Duration (In minutes)</th>
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<table>
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</tbody>
</table>

(Keep current form with Treatment or Procedure Medical Order, attached. File in student’s folder when complete.)

**School Health Program Manual** – January 2010

N.C. Division of Public Health – Children & Youth Branch – School Health Unit

Prepared in collaboration with N.C. Division of Medical Assistance and Department of Public Instruction for use with Medicaid billing for school nursing services
For use with 2009-2010 reporting forms only
Check with regional school nurse consultant regarding current forms and instructions.

DIRECTIONS AND DEFINITIONS
for completing “Annual LEA School Year Report” 2009-10
(N.C. School Health Nursing Survey and Program Summary)

Introduction: Thank you for completing this survey every school year. These forms are in Word® and in Excel® programs, formats that should make it easy for you to complete. Open each document, and then save it to your computer. You can begin using these documents at any time.

DOCUMENT CHECKLIST:
DUE January 15, 2010:
  Section One (Word document)
  School Nurse Staffing - Form A (Excel spreadsheet)
DUE June 15, 2010:
  Section Two (Word document)
  Screening Worksheet (Excel spreadsheet)
  Any revisions to Section One (Word document)
  Any revisions to School Nurse Staffing - Form A (Excel spreadsheet)

We will provide reminders in December and in March. Contact your regional school nurse consultant if your school year ends after June 15, 2010.

Most of the reporting form is self-explanatory. The definitions that follow are to assist you in collecting and reporting the data accurately. There are some new questions this year, and a few were eliminated. In some questions, the choices are listed in a "drop down" format that asks you to choose one or fill in the blank if “other.” Please call your regional school nurse consultant for assistance or further clarification as needed.

SECTION ONE (Due to your Regional School Nurse Consultant by January 15, 2010; any revisions due by June 15, 2010)
This report is expected from all public school districts (LEAs) in North Carolina. Charter schools are being asked this year to submit the information as well. Private schools are not under any requirement to provide this data, but Division of Public Health would like to collect that data in order to provide a reasonable picture of school health services in ALL North Carolina schools. A public school district (LEA) completing this form should not count data from a charter school in their county; we will collect that information separately. However, it is fine for the LEA to offer this form to a charter or private school in their county and assist in the completion if desired.

School Nursing Staff: In this report, a School Nurse is an RN who serves individual students within the school health program full-time or part-time. Some nurses function as a lead nurse or supervisor in addition to caring for students. These RNs are to be listed in this section also. **DO NOT** include those nurses who do not provide care for individual students but function exclusively as a supervisor/coordinator. They will be listed in another area.
On line A, list the total number of funded school nurse positions (whether or not they are filled).
For use with 2009-2010 reporting forms only
Check with regional school nurse consultant regarding current forms and instructions.

On line B, list how many positions are full-time and on line C, list how many are part-time. The shaded section (D) on full time equivalency (FTE) will be completed by your regional school nurse consultant; leave blank.

**Employer:** Employing agency for the school health program: name the agency responsible for paying the nurses, e.g., who writes the checks? If some nurses are employed by one agency and others by another within the same school health program, list as combination. The answer must be among the choices listed in the drop-down box.

**School Nurse Supervision:** List the name, title, and employing agency of the person who oversees the school health program. (Many lead nurses evaluate and coordinate the school health program but report to the Director of Student Services or EC Director. In that case, the director’s name should be listed as supervisor, and additional lead nurses should be listed below.)

**Influenza Vaccination Clinics:** (New item) The Division of Public Health is supporting the effort to provide influenza vaccination clinics in schools this year. The School Health Unit is interested in obtaining data on how many school districts participated and in how many school children were vaccinated. Please provide this data to the best of your ability; you may need to collaborate with your local health department to obtain this number.

**FORM A (Due to your Regional School Nurse Consultant by January 15, 2010; any revisions due by June 15, 2010)**

Form A is provided to you as an Excel® spreadsheet. It contains multiple columns, and if Excel is unfamiliar to you, there should be someone at your LEA who can help you. If your computer asks you to “enable macros” or “disable macros” when you open the form, click, “disable macros.” The Excel® form allows for continuous additions, so there is no limit to the number of staff members that can be entered onto this form.

**School Nurse Staffing** (Form A): Please include all school nurses in your LEA who are or were employed during the 2009-2010 school year. Include nurses working under CFST or SNFI programs. You will have an opportunity to revise Form A at the end of the school year if there have been any resignations and/or new hires.

**Date hired in present position:** Date this employee began this school nurse position. This date may be different from employment date, for example, if he or she worked in the LEA or health department in either another public health position or another school nurse position (such as a health department nurse who is now transferred into an SNFI school nurse position, or a CFST nurse who is now in an SNFI position), the date needed is when the person began working in this new position, not necessarily the date they began in that agency.

**Date resigned:** Provide if the person began the school year in this position but has resigned. Leave blank if not applicable.
For use with 2009-2010 reporting forms only
Check with regional school nurse consultant regarding current forms and instructions.

**Funding source:** Choose from the Drop Down menu. With this question, Division of Public Health wants to learn about the variety of funding sources used to provide school nurses in this state. (You may need to obtain this information from your finance director). Please name the funding source for each school nurse position; some nurses are paid with local educational funds, some with Exceptional Children’s funds, some through the School Nurse Funding Initiative, some through a health care alliance, etc. Choose “Medicaid only” or “EC only” if the position is funded exclusively from either of those sources.

**Highest degree:** If the Bachelor’s degree is not in nursing, choose BA or BS.

**Certification:** This question asks about national certification in school nursing, not any other specialty. Please provide the month and year that this certification expires. If this is left blank, it will be shown as “Not Certified”.

**Certified by:** ANA (American Nurses Association, same as ANCC - American Nursing Credentialing Center) or NBCSN (National Board for Certification of School Nurses) – From the drop-down box, indicate the specific organization from which nurse is School Nurse certified, if certified.

**Hours working in school(s) per week:** Totals in this column are used to compute the school district’s school nurse to student ratio. Accuracy is important here. For lead nurses who also provide care to students, only put the hours worked in assigned schools or with students.

**Total # Pre K Students Served:** Total number of pre-school students currently enrolled in all schools served by that school nurse.

**SECTION TWO (Due to your Regional School Nurse Consultant by June 15, 2010)**
(If your school year extends beyond June 15, please obtain a later deadline from your regional consultant).

**Student Population:** In this section, please provide the number of students enrolled this year in pre-kindergarten programs operated by your LEA and who are served by school nursing services. Division of Public Health will obtain enrollment of students in grades K-12 from NC DPI.

**End-of-year Staffing:** These questions are extremely important for funding and reporting purposes. They are used to calculate an End of Year Nurse-to-Student ratio by LEA and for the state.

**Form A revision:** Please submit a revised Form A if there were any changes since the January report you provided in Section One. If there was a resignation or retirement, please indicate that under the appropriate column. If there were new hires, please add to the form, following the last entry on your original Form A. If there were no changes to your school staffing since January, you do not need to submit a new Form A.
For use with 2009-2010 reporting forms only
Check with regional school nurse consultant regarding current forms and instructions.

List the number of individual school nurse positions that were vacant for more than six months during the year.

Case Management:
Case management is the process by which the school nurse identifies children who are not achieving their optimal level of health or academic success because they have a chronic illness that is limiting their potential. Please use this description when deciding whether your LEA has a formal case management program:

- A “formal case management program” involves a written individual health care plan for the student being case managed, and follows the nursing process.
- Case management is based on a thorough assessment by the school nurse and involves activities that not only help the child deal with problems but also prevent and reduce their occurrence.
- It not only includes nursing care directed toward the child but also coordination and communication with parents, teachers, and other care providers.
- Case management involves nursing care based on specific interventions and evaluations. Interventions are goal oriented based on specific needs of the student and evaluated based on their impact on the child.
- Case management involves more than occasional contacts with the student, family, teacher, and/or care provider (for example, the nurse is making weekly contacts regarding the student – either seeing the student for follow-up care, or making contact with teacher, parent or provider regarding care).

A student the nurse sees even daily for medication or routine needs, yet is well controlled and not having significant problems in school, is not a student who is case managed.

School Health Policies: Check those district-wide policies that are written, current, and school board adopted/approved.

Identification of student with acute or chronic health care needs/conditions – refers to a policy that states whether and how school staff and/or parents should alert the school nurse of any student that has a health condition that may impact learning or impact the ability of the child to take advantage of the entire school day. May also be called policy on “case finding” or “early identification and referral of health problems.” This policy may include reference to assessment by the nurse and possible initiation of an individual health care plan.

Special Health Care Services - Refers to NC State Board of Education Policy which states that each LEA “shall make available a registered nurse for assessment, care planning, and on-going evaluation of students with special health care service needs in the school setting.”

Health Education Presentations/Programs: Enter the number of health education...
For use with 2009-2010 reporting forms only
Check with regional school nurse consultant regarding current forms and instructions.

presentations/teaching sessions given by a school nurse to a group. Do not enter individual student encounters. Example: A session on HIV may be repeated 12 times to different groups of students. Therefore, the number listed here would be 12. All varieties and topics are to be added together here for a grand total. If two nurses co-teach the class, count that class as one for each time it is co-presented.

Educational Programs: Diabetes: (New Item) These questions are added this school year to assist you with new state reporting requirements regarding care of students with diabetes. This revision in law requires both public schools and charter schools to comply. See Senate Bill 738, 2009 General Assembly, General Statutes 115C, for more information, or contact your Regional School Nurse Consultant for more information. The LEA-level summative responses to these four questions, must also be provided to the State Board of Education, Paula Hudson Collins, Senior Policy Advisor, on or before Aug. 15, 2010. All public school districts and charter schools must comply. Contact information: Paula Hudson Collins, Senior Policy Advisor. Healthy Responsible Students, NC State Board of Education, 6302 Mail Service Center, Raleigh, NC 27699-6302. Fax: 919-807-3198. If the school nurse consultants learn that additional information is needed, we will advise you of that need.

First Responders: First Responder is a recognized title given to LEA staff members formally assigned and trained to respond to health related emergencies at school. This section is addressing how school First Responders are trained and able to respond and care for student injuries/ significant illnesses that occur at school.

AED in Schools (new item): As more schools choose to install Automated External Defibrillators, there is interest in obtaining data concerning their uses and outcomes. Since at this time no other single state agency obtains this data, we are asking school districts to provide this information.

Identified Health Concerns: Indicate total number of health concerns known to the school nurse in each category for elementary, middle and high school.

Health Counseling: This section refers to the school nurse’s role as health counselor working with students on a one-to-one, confidential basis. The numbers of counseling sessions are being requested in this grid. (Example: one student may receive four health-counseling sessions on the same topic. Enter the number “4" beside topic.) In the portion asking for counseling related to illness/injury that occurred outside of school, include those for which you spent time following-up with the parent or guardian. If the student trips on the way to school, for example, and requires only cleaning and a band-aid, do not count this as a counseling session for an injury that occurred outside of school.
This section does not include the nurse’s work in group and classroom education on these topics.

Health Counseling (New item about outcomes): School nurses provide numerous individual health counseling sessions to students, with many often undocumented positive outcomes. The
School Health Unit is asking in this section for your assistance in capturing the numbers of those health-improvement outcomes. In many cases, those positive health changes improve educational outcomes as well. Please contact your regional school nurse consultant if you need advice on how to obtain baseline data and evidence of improved outcomes.

Student Medications: In the grid, when asking for the number of students known to self-carry, enter the number of student’s who actually carry their emergency medications with them during the school day. The number entered is a duplicated count – in other words, these same students would be included in the emergency medication section also. Non-emergency medications, except for transport between home and school, should not be self-carried so should not be listed. In this section, a new item lists how often some emergency medications are given, and whether by licensed or unlicensed personnel. Additional note: The use of Glucagon® and Diastat® in schools is common; the use of Versed® in school is uncommon and not generally recommended.

Injuries occurring at school: An injury that required law enforcement intervention is defined as an injury for which police were called, such as a gun injury. Although some schools have a police officer on grounds, if he or she was notified only as a precaution and no police report or charges were filed, it should not be counted as an injury requiring law enforcement intervention. The Resource Officer may have broken up a minor fight that involved a nosebleed, but that is not, for purposes of this report, an injury that required law enforcement intervention.

Types of Injuries/Incidents: For purposes of this report, an injury or incident is defined as those injuries or incidents occurring while at school which require calling an ambulance/EMT, and/or needing a referral off-campus to a doctor/dentist, and/or losing one half day or more from school time. Enter the number of injuries or incidents, not the number of students. Example: one student may have head injury one day and arm fracture on another day - count as two injuries.

Note: A student who experiences a seizure, but who is managed and remains at school, should not be counted on this chart. Seizure is included if a student has a seizure and still meets one of the three criteria in the definition, for example, is taken to ED in status epilepticus, is taken to the ED because he or she suffered a previously unknown seizure, was seriously injured during the seizure, or other qualifying event.

Identified Health Conditions: Complete this grid as thoroughly as possible. First, list the number of individual students with one or more identified health conditions. Then, fill in the types of health conditions present in those students, with a count of how many have those health conditions in each grade level, including pre-school. Include students who are diagnosed and the condition is currently present. Most of these will have some type of health management plan and will be on current medications or treatment. Include life-threatening allergies but not simple allergies such as mild lactose intolerance, nickel allergy, and similar); do not include glasses, asthma “as an infant” and things of that nature. The listing of chronic conditions includes many conditions found in students across the state. Fit your students into these
For use with 2009-2010 reporting forms only
Check with regional school nurse consultant regarding current forms and instructions.

categories if possible. (For example, many conditions listed as other in previous years could have been counted as Genetic, Orthopedic, or Neuromuscular) If, after consideration of all the categories, the condition still does not fit into a category, include it under “other”.

Health Care Procedures: Number of students who have orders for a specialized care procedure, not the number of times this procedure was done at school. A single student could have multiple orders.

Successes and Goals: Please write any further information about your program or staff that you would like added for your county or LEA in the textbox.

Person Preparing the Report: Insert the name, telephone number, e-mail address and summer contact information of the person completing this report. The regional school nurse consultant may need to contact this person to complete any omissions or to clarify any components of this report.

SCREENING WORKSHEET (Excel worksheet, Due to your regional school nurse consultant June 15, 2010)

Screening, Referrals, and Secured Care: Please complete the attached Excel spreadsheet to indicate the number of students in each grade level who were screened, and those referred and those who secured care (saw a health care provider for the condition.) Please include all screenings that were performed in the schools by any and all personnel, whether by a School Nurse, school health staff, school personnel, or volunteer, at any time during the school year. Please email this spreadsheet to your Regional School Nurse Consultant along with Section Two.

Number screened: Include number of students who were screened in all large group screening projects at school in addition to those screened individually throughout the school year. (If the screening program is set up so that the number of students initially screened is not known and the nurse does only a re-screen on those students who are referred to her, include that number among the screened category.)

Number referred: Number of students referred to an outside medical provider for diagnosis/treatment as a result of the screening.

Number secured care: Of the number of students who were referred, enter number who were seen by a health care provider to rule out or diagnose the suspected health problem found at school through the screening project.

Note: For the purposes of this report, DPH is seeking information only on screenings that may cause a barrier to learning and impact education. If you conduct other screenings to meet local expectations or grant requirements, you are not required to report them here.
**Name of person completing this form:**

**LEA:**

**Charter or Private School Name (if applicable):**

**Instructions:** Please complete and send a copy via email to your regional school nurse consultant. This worksheet will automatically compute the referral completion rate (secured care) for the students in each grade level that your school district screened.

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<th>Vision Screening</th>
<th>Pre-K</th>
<th>K</th>
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<th>12</th>
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<td>b.</td>
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<td>c.</td>
<td>Indicate the number of students who secured vision care.</td>
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</table>

<table>
<thead>
<tr>
<th>4</th>
<th>BMI Screening</th>
<th>Pre-K</th>
<th>K</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Indicate the number of students in each grade who were screened for Ht/Wt/BMI</td>
<td>0</td>
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<tr>
<td>b.</td>
<td>Indicate the number of students who received referral for ≥ 95% or ≤ 5% BMI</td>
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<tr>
<td>c.</td>
<td>Indicate the number of students who secured care for high or low BMI</td>
<td>0</td>
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<tr>
<td>d.</td>
<td>Secured care rate</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
<td>#DIV/0!</td>
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</tbody>
</table>
2009-2010 End of Year Report Section One
School Health Nursing Survey and Program Summary
(Please use this worksheet to gather data about your LEA and complete one summary per school system or LEA. Please complete this form by January 15, 2010.)

County _____ Name of LEA _____ Total # Schools in LEA _____
If applicable:
Name of Private School ______
Name of Charter School ______

School Nursing Staff
For this report, a School Nurse is an RN who serves school children within the school health program full-time or part-time. Please include lead nurses and supervisors who also provide direct services to students, and Child and Family Support Team nurses.

| a. Total number of School Nurse positions (positions, vacant or filled) |
| b. Total number of full-time School Nurse positions |
| c. Total number of part-time School Nurse positions |
| d. To be completed by regional school nurse consultant: |
| Number of funded School Nurse FTEs |

Salaries
This information is used only as aggregate data. It will not be displayed as county-specific data on state reports. County-specific data about salaries will be used with prior permission only. Annual salary range, School Nurses: _____ /year (minimum) to _____ /year (maximum)

Employers
Who is the employing agency of the school nurses? ___________
How many Health Aides does your LEA employ? ______
How many LPNs does your LEA employ? ______

School Nurse Supervision
Supervisor First Name _____
Supervisor Last Name _____
Supervisor Job Title _____
Supervisor's Employer _____________
Is the supervisor of School Nurses a registered nurse? Yes ☐ No ☐
Lead Nurse Name(s) (if applicable) _____________
Does the Lead Nurse provide direct services to students? Yes ☐ Hours/week _____
No ☐

Additional lead nurses (if applicable)
_____ Provides direct services to students? Yes ☐ Hours/week _____ No ☐

_____ Provides direct services to students? Yes ☐ Hours/week _____ No ☐

_____ Provides direct services to students? Yes ☐ Hours/week _____ No ☐

List all other school nurses who do not have assigned schools/provide direct services.
_____ Hours per week in this capacity? __
_____ Hours per week in this capacity? __
_____ Hours per week in this capacity? __
Computer Use by School Nurses
Nurses have computer access at work for daily work (internet, email, etc.)? Yes ☐ No ☐
Do nurses use a computer for nursing documentation? Yes ☐ No ☐
If yes, which, if any, of these programs do they use? none
   Other program: _____

Physician Advisor
Is there a physician advisor for your school health services program? Yes ☐ No ☐
Please indicate the specialty of the physician. No physician advisor
If other specialty, please specify. _____

Kindergarten Health Assessment
Indicate school personnel designated to review Kindergarten Health Assessment forms (KHA)

Medication Administration
Indicate those school personnel designated to administer medications during the regular school day. Please check all that apply.
☐ Secretary
☐ Teacher/teacher assistant/coach
☐ Principal/assistant principal
☐ Health/medication aide
☐ School nurse
☐ Other (specify:       )

Medication administration training
Please check all that apply

<table>
<thead>
<tr>
<th>Training method:</th>
<th>Content covered:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Video</td>
<td>☐ Documentation</td>
</tr>
<tr>
<td>☐ Small group lecture</td>
<td>☐ Confidentiality policy</td>
</tr>
<tr>
<td>☐ One-on-one demonstration</td>
<td>☐ School-specific forms</td>
</tr>
<tr>
<td>☐ Self learning module</td>
<td>☐ The Six Rights</td>
</tr>
<tr>
<td>☐ Powerpoint presentation</td>
<td>☐ RN Duty to obtain order</td>
</tr>
<tr>
<td>☐ Pre and post quiz</td>
<td>☐ RN Delegation guidelines</td>
</tr>
</tbody>
</table>

How frequently is routine training provided? Medication-specific training should be conducted as needed.
☐ Annually, at or near beginning of school year, to staff that routinely give medication
☐ More frequently than annually
☐ At orientation of a new staff member

School nurses frequently audit medication administration documentation to assure delivery of services. How often do routine documentation audits occur? Never

Vaccination
Did your LEA host school-located seasonal influenza clinics this year? Yes ☐ No ☐
How many individual students were immunized for seasonal flu? (Do not count parents or staff).
Did your LEA host a school-located H1N1 vaccination clinic this year? Yes ☐ No ☐
How many individual students were immunized for H1N1? (Do not count parents or staff).
2009-2010 End Of Year Report, Section 2
School Health Nursing Survey And Program Summary
(Please use this worksheet to gather data about your LEA and complete one summary per school system or LEA. Please complete this form by June 15, 2010.)

County _____ Name of LEA _____ Total # of Schools in LEA _____

If applicable:
Name of Private School _____
Name of Charter School_____  

Student Population
Total number of pre-kindergarten students served by school nurses: _____

End of Year Staffing
Please update Form A with any changes that have occurred since Form A was completed in January and return to your Regional School Nurse Consultant with Section Two.

Number of School Nurse positions that were vacant for more than six months during the 2009-2010 school year. _____

Case Management
Does your LEA have a Formalized Student Case Management Program with identified case management criteria? Yes ☐ No ☐

If yes, which of these core components of student case management are included in your program? Please check all that apply.
☐ Assessment
☐ Health care management
☐ Community resources and support
☐ Psychosocial intervention
☐ Documentation and evaluation

Does your Case Management Program have identified student outcomes that are documented and measured (evaluated)? Yes ☐ No ☐

If yes, how many students were case managed this school year, not including students case managed through the Child and Family Support Team (CFST) program? _____
(The nurses case managing through CFST program will report this figure to the CFST program.)

Does your LEA have school nurses funded under Child and Family Support Team (CFST) Initiative? Yes ☐ No ☐

If you have a formal case management program, we'd like to hear more about it. Please provide additional information on the last page, Successes and Goals.
School Health Policies
The following school health policies have been approved by the local Board of Education. Please check all that apply.

- Medication administration
- Prevention and control of communicable disease
- Provision of emergency care
- Screening, referral and follow-up
- Maintenance of student health records
- Identification of students with acute or chronic health care needs/conditions
- Non-school bus transportation for students with health care needs
- Special health care services (State Board of Education Policy HSP – G-006-.0402, see School Health Program Manual)
- Response to Do Not Resuscitate (DNR) order
- Reporting student injuries

Health Education Presentations/Programs
Number of times presentations were given by the school nurse for groups of students, parents, and/or school staff. Please include presentations given more than once. _____

Other than asthma, medication and first aid, what other health education topics were covered in group presentations given by the school nurse? Please check all that apply.

- Alcohol and drug abuse
- Tobacco
- Allergies (other than medication training)
- Blood Borne Pathogens (BBP - OSHA)
- Cancer prevention (sun safety, other cancer prevention if not included in other categories)
- Diabetes Management
- Reproductive health (includes sex education, HIV/STD’s, puberty education, etc.)
- Violence prevention (includes safe dating)
- Dental health
- Health careers
- Infection prevention & control, other than STD, including hand washing, flu prevention, immunizations, MRSA prevention
- Pest prevention & control (pediculosis, mosquitoes, ticks)
- Nutrition (including bone health, weight control, eating disorders)
- Physical activity (including cardiac health)
- Personal hygiene (if not covered under reproductive health)
- Injury prevention (seatbelt safety, safe bicycling, helmet use, school bus safety, pedestrian safety)

Educational Programs
Asthma
Does your school have an asthma education program for staff? Yes ☐ No ☐
Does your school have an asthma education program for students? Yes ☐ No ☐
If yes, what curriculum is used? None

Number of students in asthma education program taught by school nurse: _____
Number of students using peak flow meters per asthma plan: _____
Number of students using pulse oximeters per asthma plan: _____

Diabetes
Does your LEA offer annual generalized diabetes training to school staff, system-wide? Yes ☐ No ☐

How many students with diabetes were enrolled in your LEA this past school year? Yes ☐ No ☐
Did your LEA have at least 2 staff persons who were intensively trained on diabetes care, in each school where students with diabetes are or were enrolled this school year? Yes ☐ No ☐
How many students with diabetes, upon notification and/or parental request, had an IHP completed by a school nurse in the past school year?

First Aid
School nurses provide:
First aid classes Yes ☐ No ☐
Certified CPR classes Yes ☐ No ☐

First responders
Are available daily on each school campus? Yes ☐ No ☐
Are available daily in each school building? Yes ☐ No ☐
What agency trains first responders? none
Other agency: _____

Use of Automated External Defibrillators (AEDs) in schools
Does your LEA have one or more AEDs in any of your school buildings? Yes ☐ No ☐
How many times was one of those AEDs used this year? Student ☐ Staff ☐ Visitor ☐
What was the outcome of that usage? (If the AED was used multiple times, select all that apply.) Survival ☐ Death (immediately or within 24 hours) ☐ Unknown ☐

Home Visits
Number of home visits made by the School Nurses: _____
Reasons for home visits (please indicate all that apply):
Assessment ☐ Chronic illness ☐ Parent/family education ☐
Absenteeism ☐ IHP development ☐ Other ☐

Identified Health Concerns Known to School Nurse
Please indicate the number of students in grade categories with the following identified health concerns:

<table>
<thead>
<tr>
<th>Identified Health Concern</th>
<th>Elementary</th>
<th>Middle</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
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<tr>
<td>Pregnant receiving homebound care</td>
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<tr>
<td>Dropped out of school due to pregnancy</td>
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<tr>
<td>Suicide attempt</td>
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<tr>
<td>Death from suicide</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Suicide occurred at school</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Death from homicide</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Homicide occurred at school</td>
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<tr>
<td>Other student deaths (from injury, illness,</td>
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</tbody>
</table>
etc.) regardless of location of death
How many student deaths from other causes occurred on school grounds?

**Health Counseling**
Please indicate the number of **one-on-one** health counseling sessions provided by the School Nurses on the following topics in each grade category. Do not include group presentations.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Pre-K</th>
<th>Elementary</th>
<th>Middle</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD/ADHD</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Child Abuse/Neglect</td>
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<tr>
<td>Depression/Suicide / Other</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Grief/Loss</td>
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<tr>
<td>Hygiene</td>
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</tr>
<tr>
<td>Mental Health Issues</td>
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<td></td>
</tr>
<tr>
<td>Pregnancy</td>
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<tr>
<td>Puberty; Reproductive Health</td>
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<tr>
<td>Seizure Disorders</td>
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<tr>
<td>Severe Allergies</td>
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<tr>
<td>Sickle Cell</td>
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<tr>
<td>Substance Abuse</td>
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<tr>
<td>Tobacco Use</td>
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<tr>
<td>Violence/Bullying</td>
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<tr>
<td>Injury/Illness that began/occurred outside of school.</td>
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</tbody>
</table>

If one or more school nurses provided individual health counseling on any of these four health concerns, please provide answers on up to two of these health concerns.

**Asthma Counseling Outcomes**

Following individual health counseling of students with asthma:
(select 2 or more outcomes to measure) Number of Students Reporting

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Number of Students Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Verbalized increased knowledge of pathophysiology of illness</td>
<td></td>
</tr>
<tr>
<td>2. Demonstrated correct use of asthma inhaler and/or spacer</td>
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<tr>
<td>3. Listed 2 or more of his/her asthma triggers</td>
<td></td>
</tr>
<tr>
<td>4. Remained within acceptable peak flow/pulse oximeter parameters according to care plan</td>
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</tr>
<tr>
<td>5. Increased participation in PE and/or after school physical activity</td>
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</tr>
</tbody>
</table>

**Diabetes Counseling Outcomes**

Following individual health counseling of students with diabetes: (select 2 or more outcomes to measure) Number of Students Reporting

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Number of Students Reporting</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>
1. Verbalized increased knowledge of pathophysiology of illness
2. Maintained normal blood sugar 90% or more of times checked
3. Improved ability to correctly count carbohydrates
4. Improved skill in testing own blood sugar
5. Calculated and correctly drew own dose of insulin 100% of time

<table>
<thead>
<tr>
<th>Severe Allergies Counseling Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Following individual health counseling of students with severe allergies: (select 2 or more outcomes to measure)</td>
</tr>
<tr>
<td>1. Verbalized increased knowledge of pathophysiology of illness</td>
</tr>
<tr>
<td>2. Improved skill in delivering own epinephrine</td>
</tr>
<tr>
<td>3. Reduced episodes of severe allergic reactions requiring use of epi-pen</td>
</tr>
<tr>
<td>4. Verbalized skill in recognizing hidden sources of allergen</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Weight Management Counseling Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Following individual health counseling of students with weight management conditions: (select 2 or more outcomes to measure)</td>
</tr>
<tr>
<td>1. Verbalized increased knowledge of pathophysiology of illness / condition</td>
</tr>
<tr>
<td>2. Kept a daily food diary for at least 30 days</td>
</tr>
<tr>
<td>3. Increased participation in PE, sports or after school physical activity</td>
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<tr>
<td>4. Improved ability to correctly count calories, or equivalent (e.g., points, carbs, fats)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student Medications</th>
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</thead>
<tbody>
<tr>
<td>Number of students on <strong>long term medications</strong> (more than 3 weeks)</td>
</tr>
<tr>
<td>Number of students on <strong>short term medications</strong> (less than 3 weeks)</td>
</tr>
<tr>
<td>Number of students on PRN (non-emergency) medications</td>
</tr>
<tr>
<td>Number of students on emergency medications</td>
</tr>
<tr>
<td>Out of number with emergency medications, # of students known to self carry</td>
</tr>
<tr>
<td>Epinephrine auto injectors</td>
</tr>
<tr>
<td>Diabetes medication</td>
</tr>
<tr>
<td>Asthma inhalers</td>
</tr>
</tbody>
</table>

How often were the following medications administered at school by these personnel:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Number of times administered by LPN</th>
<th>Number of times administered by RN</th>
<th>Number of times administered by other school personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucagon</td>
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<tr>
<td>Diastat</td>
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<tr>
<td>Versed</td>
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</table>
Were any new medications given this school year (medications that had never been given in your LEA)? Yes __ No ___ If yes, please list. ____________________________________________________________________________________________

Injuries Occurring at School

<table>
<thead>
<tr>
<th>Number of injuries</th>
<th>Number</th>
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<tbody>
<tr>
<td>Injuries occurring at school that resulted in permanent disability:</td>
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<tr>
<td>Type of disability:</td>
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<tr>
<td>Injuries occurring at school that resulted in death</td>
<td></td>
</tr>
<tr>
<td>Cause of death:</td>
<td></td>
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<tr>
<td>Injuries occurring at school that required law enforcement intervention</td>
<td></td>
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</tbody>
</table>

Types of Injuries/Incidents
Please indicate the numbers of injuries or incidents, not numbers of students, requiring EMS response or immediate care by a physician or dentist, and/or loss of ½ or more days of school.

<table>
<thead>
<tr>
<th>Type of Injury or Incident</th>
<th>Bus</th>
<th>Hall</th>
<th>Classroom</th>
<th>Playground</th>
<th>Phys Ed</th>
<th>Shop</th>
<th>Restroom</th>
<th>Lunchroom</th>
<th>Other location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal/Internal Injuries</td>
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<tr>
<td>Anaphylaxis</td>
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<tr>
<td>Back Injuries</td>
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<td>Dental Injury</td>
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<td>Drug Overdose</td>
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<tr>
<td>Eye Injuries</td>
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<td>Fracture</td>
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<tr>
<td>Head Injuries</td>
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<tr>
<td>Heat Related Emergency</td>
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<tr>
<td>Laceration</td>
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<tr>
<td>Neck Injuries</td>
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<tr>
<td>Psychiatric Emergency</td>
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<tr>
<td>Respiratory Emergency</td>
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<tr>
<td>Seizure</td>
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<tr>
<td>Sprain or Strain</td>
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<tr>
<td>Other</td>
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</tbody>
</table>
Identified Health Conditions
Total number of **individual students** with one or more chronic health conditions. _________

Please indicate the number of students in each grade category with the following identified health conditions. An individual student may have dual/multiple diagnoses, so the total number of diagnoses may be larger than the total number of students with chronic health conditions.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-K</th>
<th>Elementary</th>
<th>Middle</th>
<th>High</th>
<th>Number of Related IHPs per notification from parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD/ADHD</td>
<td></td>
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<td></td>
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<tr>
<td>Addison's Disease</td>
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<tr>
<td>Allergies (Severe)</td>
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<tr>
<td>Anorexia/Bulimia</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Autistic Disorders (ASD) including Asperger’s Syndrome, PDD</td>
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<tr>
<td>Blood Disorders including Chronic Anemia, Thalassemia</td>
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<tr>
<td>Cancer, including Leukemia</td>
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<tr>
<td>Cardiac Condition</td>
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<tr>
<td>Cerebral Palsy</td>
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<tr>
<td>Chromosomal Conditions: including Down's Syndrome, Fragile X, Trisomy 18</td>
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<tr>
<td>Chronic Encopresis</td>
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<tr>
<td>Chronic infectious diseases: including Toxoplasmosis, Cytomegalovirus, Hepatitis B, Hepatitis C, HIV, Syphilis, Tuberculosis</td>
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<tr>
<td>Cystic Fibrosis</td>
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<tr>
<td>Diabetes Type I</td>
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<tr>
<td>Diabetes Type II</td>
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<tr>
<td>Emotional/Behavior and/or Psychiatric Disorder other than ADD/HD</td>
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<tr>
<td>Condition</td>
<td>Pre-K</td>
<td>Elementary</td>
<td>Middle</td>
<td>High</td>
<td>Number of Related IHPs per notification from parent</td>
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<tr>
<td>Fetal Alcohol Syndrome</td>
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<tr>
<td>Gastrointestinal Disorders (Crohn’s, etc.)</td>
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<tr>
<td>Hearing Loss</td>
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<tr>
<td>Hemophilia/Bleeding Disorder</td>
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<tr>
<td>Hydrocephalus</td>
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<tr>
<td>Hypertension</td>
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<tr>
<td>Hypo/Hyperthyroidism</td>
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<tr>
<td>Metabolic Conditions: Hypo/Hyperthyroidism, Others</td>
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<tr>
<td>Migraine Headaches</td>
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<tr>
<td>Multiple Sclerosis</td>
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<tr>
<td>Muscular Dystrophy</td>
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<tr>
<td>Obesity (&gt; 95th% BMI)</td>
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<tr>
<td>Orthopedic Disability (Permanent)</td>
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<tr>
<td>Other Neuromuscular or Neurological Condition</td>
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<tr>
<td>Renal Condition</td>
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<tr>
<td>Rheumatological Conditions</td>
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<tr>
<td>Seizure Disorder/Epilepsy</td>
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<tr>
<td>Sickle Cell Anemia</td>
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<tr>
<td>Sickle Cell Trait</td>
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<tr>
<td>Spina Bifida</td>
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<tr>
<td>Substance Abuse</td>
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<tr>
<td>Traumatic Brain Injury</td>
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<tr>
<td>Visually Impaired</td>
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</tbody>
</table>

List other identified health conditions:

**Health Care Procedures**

Please indicate the number of students in each grade category who have orders for the following health care procedures at school.

<table>
<thead>
<tr>
<th>Type of Procedure</th>
<th>Pre-K</th>
<th>Elementary</th>
<th>Middle</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Glucose Monitoring</td>
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<tr>
<td>Clean Intermittent Catheterization</td>
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<tr>
<td>Central Venous Line Monitoring</td>
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<tr>
<td>Diastat (Rectal Valium)</td>
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<tr>
<td>Epinephrine Auto Injector</td>
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<tr>
<td>Type of Procedure</td>
<td>Pre-K</td>
<td>Elementary</td>
<td>Middle</td>
<td>High</td>
<td>Total</td>
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<tr>
<td>Insulin Injection</td>
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<tr>
<td>Insulin Pump</td>
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<tr>
<td>Glucagon Injection</td>
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<tr>
<td>Nebulizer Treatment</td>
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<tr>
<td>Pulse Oximeter</td>
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<tr>
<td>Respirator Care</td>
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<tr>
<td>Shunt Care</td>
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<tr>
<td>Tracheal Suctioning (include Tracheostomy Care)</td>
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<tr>
<td>Stoma Care (other than tracheal)</td>
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<tr>
<td>Tube Feeding</td>
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<tr>
<td>Vagal Nerve Stimulator</td>
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<tr>
<td>Other (Total)</td>
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</tbody>
</table>

List other health care procedures:

Screening, Referrals and Secured Care
Please complete the attached Excel spreadsheet to indicate the number of PreK-12 students screened, referred and those who secured care by the School Nurses, school health staff, school personnel, or volunteers in each category at any time during the school year. Please email this spreadsheet to your Regional School Nurse Consultant along with this report.

School Health Advisory Council
Is at least one school nurse a regular member of your local School Health Advisory Council (SHAC)? Yes □ No □
Is there a physician on your local School Health Advisory Council (SHAC)? Yes □ No □
How many times did your SHAC meet during 2009-2010? _____

Successes and Goals
Please describe the successes and accomplishments of your School Health Program for the 2009-2010 school-year. Include successes of your SHAC and other partners.

Please describe any specific goals or objectives for your School Health Program for next year (2010-2011).

Person preparing the report (only one per school system, please)
First Name: _____
Last Name: _____
Job Title: _____
Phone number, school-year: _____
Phone number, summer: _____
Email address (if more than one, list the one you would check during summer): ____

Thank you!
# Health Related School Forms

<table>
<thead>
<tr>
<th>Type</th>
<th>Maintenance</th>
<th>Archiving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma Action Plan</td>
<td>Cumulative Folder – attach to permanent health card while active. Original in individual health record</td>
<td>May destroy if superseded. If D/C note on permanent health card.</td>
</tr>
<tr>
<td>Court Subpoena</td>
<td>Central office.</td>
<td>Retain permanently with subpoenaed records.</td>
</tr>
<tr>
<td>Daily Procedure Logs</td>
<td>File when complete in individual health record.</td>
<td>Retain until age 29.</td>
</tr>
<tr>
<td>Diet Order</td>
<td>File in individual health record.</td>
<td>Retain until age 29.</td>
</tr>
<tr>
<td>Emergency Action Plan (EAP)</td>
<td>Cumulative Folder – attach to permanent health card while active. Original in individual health record</td>
<td>May destroy if superseded. If D/C note on permanent health card.</td>
</tr>
<tr>
<td>Emergency Information Form</td>
<td>Accessible file for office staff.</td>
<td>May destroy when superseded.</td>
</tr>
<tr>
<td>Health Assessment forms for Exceptional Children</td>
<td>Retain current assessment in EC file.</td>
<td>May destroy when superseded.</td>
</tr>
<tr>
<td>Health History Form</td>
<td>Retain in individual health record.</td>
<td>Retain permanently.</td>
</tr>
<tr>
<td>Health Related 504 Accommodation Plans</td>
<td>Retain in cumulative folder.</td>
<td>May destroy if superseded or retain according to local 504 policy.</td>
</tr>
<tr>
<td>Immunization Records</td>
<td>Retain permanently attached to permanent health card.</td>
<td>Retain permanently.</td>
</tr>
<tr>
<td>Individual Education Plan (IEP)</td>
<td>Retain in EC folder.</td>
<td>Retain according to EC policy.</td>
</tr>
<tr>
<td>Individual Health Care Plan (IHP)</td>
<td>Cumulative Folder – attach to permanent health card (unless of sensitive nature) Original in individual health record</td>
<td>May destroy if superseded. If D/C note on permanent health card.</td>
</tr>
<tr>
<td>Injury Incident Reports</td>
<td>File per LEA policy. Do not reference in individual health</td>
<td>Retain until age 29.</td>
</tr>
</tbody>
</table>

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1 This table compiled by Regional School Nurse Consultants based on available information current in January 2010.
### Maintenance of Forms

<table>
<thead>
<tr>
<th>Type</th>
<th>Maintenance</th>
<th>Archiving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kindergarten Health Assessment</td>
<td>Retain in cumulative folder.</td>
<td>Retain until completion of elementary school.</td>
</tr>
<tr>
<td>Medication Administration Logs</td>
<td>File in individual health record, or batch together per LEA policy.</td>
<td>Retain until age 29.</td>
</tr>
<tr>
<td>Medication Administration Variance Forms</td>
<td>File per LEA policy. Do not reference in individual health record.</td>
<td>Retain until age 29.</td>
</tr>
<tr>
<td>Medication Authorization Forms</td>
<td>Retain current form in medication administration notebook.</td>
<td>Retain until age 29.</td>
</tr>
<tr>
<td>Outside Medical Records</td>
<td>Retain in individual health record.</td>
<td>Retain until age 29.</td>
</tr>
<tr>
<td>Psychological Evaluations</td>
<td>Retain in EC folder or according to LEA policy.</td>
<td>Retain until age 29.</td>
</tr>
<tr>
<td>Referral Forms</td>
<td>Retain in applicable record.</td>
<td>Retain until age 29.</td>
</tr>
<tr>
<td>Staff Training</td>
<td>Maintain current year in location specified in LEA policy.</td>
<td>Retain according to LEA policy.</td>
</tr>
<tr>
<td>Screening Results</td>
<td>Record on permanent health card.</td>
<td>Permanent health card is retained permanently.</td>
</tr>
<tr>
<td>Specialized Care Authorization Forms (parent)</td>
<td>Retain in applicable file.</td>
<td>Retain until age 29.</td>
</tr>
<tr>
<td>Treatment Order (health care provider)</td>
<td>Retain in individual health record.</td>
<td>Retain until age 29.</td>
</tr>
</tbody>
</table>
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