## North Carolina School Health Program Manual

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Appendix Index
The purpose of this manual is to assist school nurses, school administrators, 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 students outcomes. A coordinated school 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.

North Carolina Division of Public Health/School Health Unit
http://www.ncdhhs.gov/dph/wch/aboutus/childrenyouth.htm

School Health Nurse Consultants
http://www.ncdhhs.gov/dph/wch/aboutus/schoolnurses.htm

Questions or comments may be directed to the office of the State School Health Nurse Consultant, 919-707-5667.
Section A
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, local education agencies, and local hospitals, 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 inspections done during the school term 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.

The dissolution of that committee 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 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 ongoing evaluation of students with special health care services in the school setting. This policy may be found in Section B, Chapter 4 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 statewide organizational downsizing and restructuring, the Department of Environment, Health and Natural Resources underwent a change 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
North Carolina School Health Program Manual

Section A  History of School Health In North Carolina

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;
- 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 under the School Nurse Funding Initiative.
positions; additional funding in July 2009 and in July 2011 brought the total of school nurse positions funded by the SNFI allocation to 235.75 by the start of the 2011-2012 school year.

The SNFI funds authorization act stated that DHHS/DPH “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 42 by end of 2012-2013. Since initiation, the program has helped reduce the average school nurse to students ratio from 1:1,897 to 1:1,177.

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 its success led to additional funding for three years, to implement similar work in an additional number of counties throughout the state. The research and funding for the project concluded at the end of the 2010-2011 school year, and elements of the N.C. School Nurse Case Management Project have become parts of standard practice in North Carolina school nursing activities.

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. Less than two years later, January 1, 2010, all public restaurants and bars were also smoke-free by state law.

A major rewrite of the law that laid out how schools would approach sexual health education was passed in 2009 and took effect during the 2010-2011 school year. In addition to continuing to teach students abstinence from sexual activity outside of marriage, the Healthy Youth Act required that lessons starting in 7th grade would also include information about sexually transmitted infections, safety and effectiveness of FDA-approved contraceptive methods, and
awareness of sexual assault and sexual abuse, with approaches to reducing such risks. The law also removed the requirement that school districts must hold a public hearing before engaging in comprehensive sexual health education, but parents could preview the curriculum and materials and could choose to withdraw a child from the instruction.

The death and/or serious disability of some student athletes following head injuries resulted in passage of the Gfeller-Waller Concussion Act in 2011. Named after two high school students who suffered post-concussion head injuries that resulted in death, the law governs eligibility to return to practice or games following concussions.

In 2013 the North Carolina Department of Public Instruction (NCDPI), Healthy Schools Section was awarded funding from the Centers for Disease Control and Prevention (CDC) related to HIV/STD prevention in schools and communities. The funding was provided to support efforts to conduct school-based surveillance on youth risk behaviors and school health policies and practices; implement school-based programs and practices designed to reduce HIV infection and other STDs among adolescents; and reduce disparities in HIV infection and other STDs among specific adolescent populations.

Additionally, the North Carolina Division of Public Health (NCDPH), Chronic Disease and Injury Section was simultaneously awarded funding from the CDC to support statewide implementation of cross-cutting approaches related to nutrition, physical activity and the management of chronic diseases, specifically asthma and diabetes in the school setting. Collaboration between these two projects is a funding requirement.
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Section B
Child Abuse and Neglect

Children are reported as abused, neglected or dependent in North Carolina each year. One of the primary sources of these reports is educational personnel. Public awareness and understanding about the responsibility to report is vital for the protection of at-risk children. Educators are in a key position to identify and respond to child abuse and neglect. They have a legal mandate to report suspected concerns to county child welfare agencies; 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. (http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/BySection/Chapter_7B/GS_7B-301.html)
- 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. (http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_7B/GS_7B-309.html) However, personal concerns of educators regarding the repercussions of making a report can be significantly diminished by a clear policy and a supportive environment.
- According to the statute, reports may be made in person, by telephone, or in writing to the county child welfare agency. 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.

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1 The remainder of this chapter was prepared jointly by the Child Welfare Policy Unit, North Carolina Division of Social Services, and the Division of Public Health, June 2013.
• All information that may be helpful to the assessing social worker should be reported. Include as much of the following information as possible:
  o Name, address, age or birth date of the child;
  o Name, address, and telephone number of the child's parent, guardian or caretaker;
  o Parent's place of employment, address and hours of work (if known);
  o Present whereabouts of the child;
  o Names and ages of siblings;
  o 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;
  o Reporter's name, address and telephone number, and
  o 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. Please see the DSS 1402 (CPS Intake Form) to see a sample of what the Intake Report looks like. ([http://info.dhhs.state.nc.us/olm/forms/dss/dss-1402.pdf](http://info.dhhs.state.nc.us/olm/forms/dss/dss-1402.pdf))

• The law requires the reporting of a suspicion of child abuse or neglect. The responsibility for assessment and findings lies with the county child welfare agency. 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 or has not received proper care by the parent or caregiver. The child most likely will have to recount the incident a number of times during the assessment.

• 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.
  o Believe the child and take him or her seriously.
  o Use words the child understands and allow the child to describe the situation in his or her own language.
  o 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.
  o Respond evenly and confidently without disclosing feelings of shock, repugnance, anger or fear.
  o 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 county child welfare agency will begin an assessment to ascertain the facts in cases of abuse within 24 hours and in cases of neglect within 72 hours. The county child welfare agency 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. Child welfare workers continue to monitor the safety of the children throughout the life of the
case and are always assessing whether the risk level necessitates a removal of the children.

• The person making the report will receive written notice of the action being taken by the county child welfare agency.
• (http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_7B/GS_7B-302.html). 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 District Attorney within five working days of the receipt of the letter.
• Err on the side of the child. Caseworkers in county child welfare agencies encourage individuals to call and discuss situations about which they are concerned.

An Overview of Child Protective Services

In North Carolina, each county child welfare agency has the legal responsibility and authority to assess reports of suspected child abuse, neglect, or dependency (http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_7B/GS_7B-302.html). 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 county child welfare agency. 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. If you do not give your name, you will not receive a letter letting you know whether the case was accepted or not, or a letter letting you know the findings of the assessment at the end.

After you have made a child protective services report, the county child welfare agency 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 county child welfare agency 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. County child welfare agencies cannot provide child protective services to unborn children, children who have been legally emancipated (by marriage or court order), or to those who have reached their 18th birthday.
- The allegations, if found to be true, must meet the legal definitions of abuse, neglect or dependency as set forth in G.S. § 7B-101.

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- 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 harms a child in violation of a criminal statute, social services is required to report this to the district attorney and appropriate law enforcement agency.

Some Common Situations That CPS Usually Does Not Assess

The following situations are often reported to county departments of social services but usually do not result in a CPS assessment unless there are other factors to indicate serious risk of harm to the child.

**Head Lice:**
County child welfare agencies sometimes get calls from schools regarding children with untreated head lice. Unless there are other indicators of neglect, this is considered to be a health issue that can be dealt with by education of the parent or caretaker or referral to the public health department.

**ADHD Medication:**
Children with hyperactivity or attention-deficit disorder may have prescriptions for medications that help the child control his or her behavior. Frequently, dosage is altered under supervision of an attending physician, and an observer may not be aware of this. Additionally, parents may decide that they do not want the child to take this type of drug because of the side effects. This is not considered to be a child protective service issue unless there is evidence that the child is being harmed by not taking the medication. The parent’s refusal to give the child the prescribed medication is not, in and of itself, neglect.

**Failure to Get Immunizations:**
Children are required to be properly immunized before they start school. Some parents do not know the importance of getting these shots at the time they are due and think they can wait and get them all at once. For some families, immunizations are considered to be against their religious or cultural beliefs. Every effort should be made to educate parents about the importance of keeping their child’s immunizations up to date and to help parents to obtain them for their child. If a parent’s failure to allow the child to get his or her immunizations results in the child getting sick, this could possibly be investigated as neglect. Otherwise, (CPS) usually does not get involved.

Some Common Situations That CPS Usually Does Assess:

**Reports of Abuse**
In North Carolina, there are four types of abuse investigated by the Child Protective Services unit of the county child welfare agency. **Physical abuse** involves intentional serious injury of a child, or intentionally putting the child at risk of serious injury. **Sexual abuse** involves committing,
permitting or encouraging criminal sexual acts 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. These 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 county child welfare agency. Some indicators of neglect are:

- abandonment of a child by the parent, guardian, custodian or caretaker.
Students at Risk

Child Abuse and Neglect

• unattended medical problems, including illness and physical conditions that can be treated or cured with appropriate therapy.
• consistent lack of age or cognitive developmentally appropriate supervision or inappropriate supervision by the parent, guardian, custodian or caretaker.
• ongoing drug or alcohol abuse by a parent or caregiver which hinders the ability to provide supervision and care.
• consistent hunger resulting in malnourishment.
• clothing inappropriate to extreme weather conditions, or poor hygiene resulting in increased risk of sickness.
• 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 child welfare agency 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 the 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 child welfare agency 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 and may occur as a result of over-discipline or from punishment which is improper or 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

- afraid to go home
- aggressiveness, or withdrawl
- apprehensive when other children cry
- behavioral extremes:
- frightened of parents
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- reports injury by parents
- wary of adults contacts

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
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- 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 child welfare agency. (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 Child Protection Services staff who are assessing alleged cases of child abuse and neglect.

It is the responsibility of Child Protection 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.”
(/http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_7B/GS_7B-309.html)

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

Name of Student__________________________________Date of Birth_____________

School________________________________________School Phone_____________

Name of Parent or Guardian_________________________________________________

Address________________________________________Home Phone_____________

Employer________________________________________Work Phone_____________

Incident Requiring Report

___________________________________________________________________________

___________________________________________________________________________

Reported by__________________________________________Phone________

Date of Report___________________________________________________

Result of CPS Assessment:

□ Substantiated      □ Unsubstantiated      □ Under Investigation

Case Worker__________________________________________Phone________

Date___________________________

NOTES:___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
Students With Special Needs
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. While some funding comes with IDEA there is no funding attached to Section 504 laws. In North Carolina a process has been established whereby an LEA can bill for nursing services that are included in a student’s IEP when that student has Medicaid. More information can be found at http://ec.ncpublicschools.gov/finance-grants/medicaid-in-education.

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 the most current Policies Governing Services for Children with Disabilities 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 the NASN position statement Section 504 and Individuals with Disabilities Education Improvement Act - The Role of the School Nurse (2013)².

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¹ NC Department of Public Instruction, Exceptional Children Division. Retrieved from http://ec.ncpublicschools.gov/policies
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 definitions apply.

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.

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.

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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.

In 2004, IDEA was re-authorized with amendments and re-named Individuals with Disabilities Education Improvement Act of 2004 (IDEIA). The amendments were incorporated into North Carolina’s amended Policies Governing Services for Children with Disabilities in 2007 and further amended in June 2010. Any school nurse working with students with disabilities is referred to the state policies document on the N.C. Department of Public Instruction’s website.

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 (2013)*, the terms used in the definition of children with special needs are further defined as follows:

1. **Autism Spectrum Disorder** means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects the child’s educational performance. This impairment may include: Autistic Disorder, Pervasive Developmental Disorder-Not Otherwise Specified (Atypical Autism), Asperger’s Disorder, Rett’s Disorder, Childhood Disintegrative Disorder or all Pervasive Developmental Disorders.
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. **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 make educational progress that cannot be explained by intellectual, sensory, or health factors.
   - Inability to build or maintain satisfactory interpersonal 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. The term “hard of hearing” may be used in this capacity.

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 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 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 –
   - 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** means 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 (pragmatic), the content of language (semantic), and the form 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 and/or psychosocial impairment, or both, that adversely affects a child’s educational performance. Traumatic brain injury may result from a series of events (e.g., multiple concussions). Traumatic brain injury also can occur with or without a loss of consciousness at the time of injury. Traumatic brain injury may result 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, 2013 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://ec.ncpublicschools.gov/

**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)\(^4\)

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, based on peer-reviewed research to the extent practicable, to be provided to the child, or on behalf of the child, and a statement of the program modification or supports for school personnel that will be provided to enable the child—
   - To advance appropriately toward attaining the annual goals;
   - To be involved in and make progress in the general education curriculum to advance appropriately toward attaining the annual goals, and to participate in extracurricular and other nonacademic activities; and
   - To be educated and participate with other children with disabilities and nondisabled children in the activities.
5. An explanation of the extent, if any, to which the child will not participate with nondisabled children in regular class.
6. A statement of any individual appropriate accommodation that are necessary to measure the academic achievement and functional performance of the child on State and districtwide assessments consistent with IDEA.
7. The projected date for the beginning of the services/modifications.
8. The IEP must include a statement of initial transition components including the child’s needs, preference and interests, and course(s) of study (such as advanced placement classes or a vocational education program).
9. Transfer of rights at age of majority. Beginning not later than one year before the child reaches the age if majority, which under State law is 18, the IEP must include a statement that the child and their parent have been informed of the rights under Part B of the IDEA, that will transfer to the child upon reaching age 18.

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\(^4\) Reference: 34 CFR 300.347
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: [http://ec.ncpublicschools.gov/](http://ec.ncpublicschools.gov/)
## 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 notice to the parent or guardian with respect to identification, evaluation and/or placement.</td>
<td>Requires written notice. Does not require written notice, but a district would be wise to do so.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires written notice. Requires notice only before a “significant change” in placement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Requires written notice. Requires notice only before a change in placement.</td>
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<td></td>
<td></td>
<td>Requires re-evaluations to be conducted at least every three years.</td>
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<tr>
<td></td>
<td></td>
<td>Requires an update and/or review before any change in placement.</td>
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<tr>
<td></td>
<td></td>
<td>Information from a variety of sources. Information from a variety of sources.</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 Sect. 504 and provide grievance procedure.</td>
</tr>
</tbody>
</table>

5 This chart reflects guidelines from references in N.C. Department of Public Instruction, U.S. Department of Education, and U.S. Office of Civil Rights. Reviewed by James F. McKethan, LLC, Fayetteville, NC 2010
## Students at Risk: Students with Special Needs

<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</td>
<td>Requires that the parent have</td>
</tr>
<tr>
<td></td>
<td>districts to provide</td>
<td>an opportunity to participate</td>
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<td></td>
<td>impartial hearings for</td>
<td>and be represented by</td>
</tr>
<tr>
<td></td>
<td>parents or guardians who</td>
<td>counsel. Other details are left</td>
</tr>
<tr>
<td></td>
<td>disagree with the</td>
<td>to the discretion of the local</td>
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<tr>
<td></td>
<td>identification, evaluation</td>
<td>school district. These should</td>
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<tr>
<td></td>
<td>or placement of a student</td>
<td>be covered in school district</td>
</tr>
<tr>
<td></td>
<td>with disabilities.</td>
<td>policy.</td>
</tr>
<tr>
<td>Independent ed. eval</td>
<td>Not required</td>
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<tr>
<td>“Stay put”</td>
<td>Not required</td>
<td></td>
</tr>
<tr>
<td>Attorney fees</td>
<td>Attorney fees</td>
<td></td>
</tr>
<tr>
<td>Exhaustion</td>
<td>Requires the parent or guardian to pursue</td>
<td>Not required</td>
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<td></td>
<td>administrative hearing</td>
<td></td>
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<td></td>
<td>before seeking redress</td>
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<td></td>
<td>in the courts.</td>
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<tr>
<td>Enforcement</td>
<td>Enforced by Exceptional</td>
<td>Enforced by the Office of</td>
</tr>
<tr>
<td></td>
<td>Children’s Division,</td>
<td>Civil Rights, U.S. DOE</td>
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<tr>
<td></td>
<td>Public Schools of North</td>
<td>Carolina.</td>
</tr>
<tr>
<td>Discipline</td>
<td>If action is contemplated</td>
<td>Section 504 will follow</td>
</tr>
<tr>
<td></td>
<td>to remove child with</td>
<td>IDEA with the exception of</td>
</tr>
<tr>
<td></td>
<td>disability due to school</td>
<td>“no manifestation” in which</td>
</tr>
<tr>
<td></td>
<td>code violation, a review</td>
<td>case services do not have to</td>
</tr>
<tr>
<td></td>
<td>to determine whether the</td>
<td>be provided.</td>
</tr>
<tr>
<td></td>
<td>the behavior was a</td>
<td>Manifestation not required for</td>
</tr>
<tr>
<td></td>
<td>manifestation of the child’s</td>
<td>alcohol and drug violations.</td>
</tr>
<tr>
<td></td>
<td>disability will be done.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If Yes – May be placed in other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>situation WITH services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If No – Relevant disciplinary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>procedures applicable as with</td>
<td></td>
</tr>
<tr>
<td></td>
<td>children without disabilities, WITH</td>
<td></td>
</tr>
</tbody>
</table>
Side by Side: IDEA and 504

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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

<table>
<thead>
<tr>
<th>IDEA</th>
<th>SECTION 504</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation</td>
<td>Evaluation</td>
</tr>
<tr>
<td>Eligibility – adversely affects</td>
<td>Eligibility – substantial limitation</td>
</tr>
<tr>
<td>Annual review</td>
<td>No annual review</td>
</tr>
<tr>
<td>Re-evaluations</td>
<td>Re-evaluation</td>
</tr>
<tr>
<td>LRE</td>
<td>Educational setting (LRE)</td>
</tr>
<tr>
<td>Consent for placement</td>
<td>Consent for placement(^1)</td>
</tr>
<tr>
<td>Special education</td>
<td>Special education</td>
</tr>
<tr>
<td>Culture, economic &amp; environment</td>
<td>Culture, economic &amp; environment</td>
</tr>
<tr>
<td>Discipline – manifestation</td>
<td>Discipline-manifestation</td>
</tr>
</tbody>
</table>

\(^1\) Consent implied, OCR On-line Q & A, #43.
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. An allowance of 10 school days has not been found to be excessive in other U.S. Office of Civil Rights (OCR) complaints related to this topic. In a decision in 1999, OCR 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 to allow 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)

The school nurse serves 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;
Students At Risk

Students Assisted by Medical Technology

- 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 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

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: ________________________________ Date

6. ________________________________________________________________________________

Physician’s Signature Date

Address Phone

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.

____________________________________________________________________________________

To: (name of school) ___________________________ Child’s Name Birth Date

(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.

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 should 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.

1 [www.ncbon.com](http://www.ncbon.com), Nurse Practice Act, August 2009 (Article 9 of Chapter 90 of the N.C. General Statutes, Article 9A, Nursing Practice Act).
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. May assist 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**

*Sample*

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 caregiver’s agency supervisor: ____________________________________

Date & Signature of “private-duty” one-to-one caregiver: ____________________________

Date & Signature of classroom teacher: _____________________________________________

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2 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 Nadine Schwab and Mary Gelfman, Legal Issues in School Health Services (2001).
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: __________________________________________________

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: _________________________________
The Homeless Student

Federal legislation provides protection for a student whose family is homeless. A homeless student is defined as one that lacks a “fixed, regular, and adequate nighttime residence.” It includes children and youth who are doubling up temporarily with family or friends; living in a shelter, motel, vehicle, camp ground or temporary trailer; living "on the street" or living in another type of temporary or inadequate housing.

The federal McKinney-Vento Homeless Assistance Act, passed in 1987 and reauthorized several times over the years, was the first significant federal legislative response to homelessness. Guidance developed in July 2004 was specifically designed to address the problems that homeless children and youth face in enrolling, attending and succeeding in school.

All school districts must appoint a local homeless education liaison.

The North Carolina Homeless Education Program (NCHEP, http://center.serve.org/hepnc/) provides technical assistance to North Carolina’s local homeless education liaisons, and provides informational and awareness materials to parents and families, educators, school nurses, and other interested parties. The program is located at The SERVE Center at the University of North Carolina at Greensboro. SERVE Center was contracted by N.C. Department of Public Instruction in 2009 to administer the NCHEP. The SERVE Center also houses the National Center for Homeless Education, which is the U.S. Department of Education’s technical assistance center in the area of homeless education.

The provisions of the McKinney-Vento Act assure that eligible students have the right to:

- Go to school no matter where they live or how long they have lived there;
- Continue attending their same school (the school they attended before they became homeless) or to be enrolled in the local school where they are living (their choice);
- Enroll in the new local school immediately, even if missing records normally required for enrollment, and
- Receive transportation to and from the school of origin at no cost to the parent or student.

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1 This chapter reflects guidelines provided in the N.C. Homeless Education Program. Available at: http://www.serve.org/Homeless-Education.aspx (North Carolina specific) and http://center.serve.org/nche/mv.php (national guidelines)

Guidelines for compliance with immunization and Kindergarten Health Assessment requirements

Students who meet the definition of homeless under the McKinney-Vento Act must be allowed to enroll in the new local school immediately, even if missing records normally required for enrollment. School nurses, in their natural and legal support for immunizations, may inadvertently violate portions of McKinney-Vento by declaring the students out of compliance and therefore excluded from school due to lack of immunizations or required physical examinations.

Former U.S. Surgeon General Dr. Joycelyn Elders, in February 2007, wrote a memo that declared that excluding homeless students from school due to insufficient or missing health records, violated McKinney-Vento. Schools must allow enrollment for the homeless student while contacting and waiting for the former school to send records. In the memo, she wrote that school nurses and school staff should “work with parents to obtain immunization and other medical records and to arrange necessary immunizations or screenings. In the meantime, the student is to be attending school.”

Section C
A coordinated school health program promotes the maximum physical, social, emotional, and educational growth of children through health-related support services and health education. 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.

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 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.

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.

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1 NASN 2008, and, *School Nursing: A Comprehensive Text*, chapter 4
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 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, environmental health specialists, 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/


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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.
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.
Health counseling, a helping relationship designed to assist students and parents in meeting health care needs, consists of:

- individualized recommendations for health maintenance;
- information and support in coping with illness and disability;
- information on consumer options for making health care choices; and
- crisis intervention for situations involving substance abuse, child abuse, depression, suicide threats or attempts, and other indications of acute stress.

Health counseling should be provided to students identified through the health appraisal process or by referral from the principal, teacher, other school staff, parent, or self.

Health counseling implies a one-to-one communication between a health professional and a student, parent or staff member. It generally centers on a child with a specific health problem. The distinction is made between health counseling and health education, in which groups of children receive general health information according to a planned curriculum to assist them in decision making.
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.

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
   - students with known medical problems.

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. Handling of student health care and medication needs during an event requiring school evacuation or ‘lock down’ requires planning and practice. 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, and staff training to recognize serious emergencies, such as the training required as part of the Gfeller-Waller Concussion Act (see Appendix II for a copy of the Act);
- 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 for North Carolina law.) School employees shall have immunity from civil liability for 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 exclusion of students who pose a communicable disease threat to others at school
- HIV/AIDS
- 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)

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/Electronic 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, both on paper and in electronic format, should be a part of every school district’s written policies and procedures and be in compliance with FERPA and, where relevant, HIPAA.

10. Do Not Attempt to Resuscitate (DNAR) Response

Do Not Attempt to Resuscitate is a directive for specifying that CPR not be used in the event of cardiac or respiratory arrest. DNAR 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 DNAR orders for their children appear to be increasing. Whether to accept or deny a request for DNAR in the schools is up to local policy. Convene a multidisciplinary task force to determine school policy so the widest 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 DNAR orders
- The school’s obligation in loco parentis
- The school’s responsibility/authority to honor DNAR 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.

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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) and assure that each school building follows 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.

12. Local School Wellness Policy

Local wellness policies are an important tool for parents, LEAs, and schools to promote student wellness, prevent or reduce childhood obesity, and provide assurance that school meal nutrition guidelines meet the minimum federal school meal standards. As of school year 2006-2007, all school districts were required to establish a local school wellness policy. Enacted in 2004 as part of the U.S. Department of Agriculture Food and Nutrition Service (including school meals), the law was modified in 2010 as the Healthy, Hunger-Free Kids Act of 2010. The modification encourages LEAs to review their policies during 2011-2012 school year and begin implementing the new requirements. The new requirements expand the scope of wellness policies, bring additional stakeholders to its development, implementation and review, and require public updates on the content and implementation of the wellness policies. For further information, see Public Law 111-296, Section 204, [http://www.fns.usda.gov/tn/Healthy/wellnesspolicy.html](http://www.fns.usda.gov/tn/Healthy/wellnesspolicy.html)


All boards of education must implement integrated pest management programs as of Oct. 1, 2011. See Chapter 8 in this section for more information on this law.

14. Special health care services (State Board of Education Policy GCS – G – 006)

N.C. State Board of Education requires that each LEA 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. This rule complies with the provisions of G.S. 115C-307(c). An LEA policy regarding GCS-G-006 could include description of an annual Memorandum of Understanding with the local health department for collaboration; may include a contract with a local hospital for consultation regarding specialized procedures, may include a job description of the school nurse which addresses state board description of care planning; and may include guidelines on development of procedures to carry out the requirement.
15. School Violence Prevention Act (GS 115C-407.6)

As of December 31, 2009, each local school administrative unit must adopt a policy prohibiting bullying or harassing behavior. The policy must contain at least eight components that essentially adopt a zero-tolerance policy on bullying or harassing behavior.

16. Healthy Youth Act (Reproductive Health and Safety Education)

Effective with the beginning of school year 2010-2011, this act requires each LEA to provide reproductive health and safety education beginning in 7th grade that includes information on STDs, sexual abuse/assault, and the effectiveness and safety of FDA-approved methods of STD and pregnancy prevention. A local school policy related to this law may include information regarding that parents may choose to “opt-out” their students during this portion of their education, and may also include a policy regarding referrals to off-campus providers of additional information and services regarding reproductive health and safety. The policy may also reinforce state law, G.S. 115C-81 (e1)(9), that prohibits distribution of or availability of any contraceptive devices, products or medications on school property, including at school – based (though not school-linked) health centers.

17. Jessica Lunsford Act

In 2008 the N.C. General Assembly enacted Session Law 2008-0117, known as the Jessica Lunsford Act. Named after the Florida girl who was abducted, sexually battered and killed by a previously-convicted sex offender, the law became effective Dec. 1, 2008. The law requires each local board of education to adopt a policy on whether and under what circumstances an applicant for a school personnel position shall be required to be checked for a criminal history before the applicant is offered an unconditional job. The law also requires that the principal of each school register with the N.C. Sex Offender and Public Protection Registry to receive e-mail notification when a registered sex offender moves within a one-mile radius of the school. (The law also requires the same of directors of child care centers and preschools.)

Among its many other requirements, the law requires schools to check sex offender registries before allowing school contractual personnel to have direct interaction with students. This provision does not apply to individuals who are carrying out duties that are customarily performed by school personnel, such as nurses, custodians, bus drivers, substitute teachers. Existing law, G.S. 115C-332, already requires that criminal background checks be done of these individuals.
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.

Organization of Participants/Functions

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).
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
- Participate in health education activities that promote wellness and positive health behaviors
- Establish a school health advisory council
- Participate in development of school health policy
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.
Health Office Suite

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
Coordinated School Health Program

Health Office Suite

• 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
- 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:


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Guidelines for Developing and Implementing a School Health Program Plan

As a means for developing a coordinated health services plan, a contract or memorandum 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 (NC GS115C-407)

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
  - Diabetes Care as required by NC GS115C-375.3
  - Health screenings, referral and follow-up
  - Identification of students with acute or chronic health care needs / conditions
  - DNAR 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. Guidelines are provided annually to assist the local agencies in the planning process. 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 Health Nurse Consultant through the Regional School Health Nurse Consultant each year, by September 1. Dual copies will be maintained by the Regional Consultant and in the office of the Division of Public Health, Child Health agreement files.

Questions regarding the Memorandum of Agreement should be directed to the Regional School Health 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:
  - Hiring, termination, and supervision of school health personnel
  - Maintenance, storage, destruction, and archiving of Health Records (FERPA, 1974; NC DCR, 1999)
  - Provision of supplies and facilities for school health program personnel
  - Professional development of school health program personnel
  - Quality assurance policies and procedures
  - 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

**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
  - School nurse case management for students with complex health needs
  - 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
- Diabetes Care as required by 115C-375.3
- Health screenings, referral and follow-up activities
- Case management activities
- DNAR Response

III. PROCESS FOR DEVELOPING RECOMMENDED AND LOCALLY APPROVED WRITTEN POLICIES AND RELATED PROCEDURES

IV. 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 the start of each school year. If there are no changes, a signature page signed and dated annually 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 Health Nurse and Child Health Consultants

Regional School Health Nurse and Child Health Consultants
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 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. Program evaluation requires asking questions of the stakeholders as well as a careful analysis of the information received. Many tools have now been developed to assist in evaluation of school health services. Use of these tools can reduce the perceived challenges and provide structure and consistency to the evaluation process.

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 effectiveness and future direction. 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 are illustrated in the diagram and discussed on the following pages.

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.
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 2012 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 policies or staff wellness, students have opportunities to become participants in their own learning as well as within their own school community.

All providers of 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,
Coordinated School Health Program

Health Education

- 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.

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.”

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.”

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” 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)

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

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1 http://www.cdc.gov/HealthyYouth/CSHP/#5
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?

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.

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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.¹

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

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.

¹ 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)
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, bed bugs) 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](http://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.

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.
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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 position statement on Coordinated School Health 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 School Meals on which a physician would prescribe the nutritional needs for a student’s school meals, if needing modification. (See the link for form and other resources at the end of this section.) Among the conditions that may require special diets are: high blood pressure,

1 Centers for Disease Control and Prevention, http://www.cdc.gov/HealthyYouth/CSHP/
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.

Resources: [http://childnutrition.ncpublicschools.gov/information-resources/special-diet-food-allergies](http://childnutrition.ncpublicschools.gov/information-resources/special-diet-food-allergies)
Section D
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 was revised in 2011 and produced with the National Association of School Nurses (NASN) in “School Nursing: Scope and Standards of Practice,” 2nd Edition.1 The books 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 situation;
- analyzes the assessment data to determine the diagnosis or issues;
- identifies expected outcomes for a plan individualized to the client or situation;
- develops a plan that prescribes strategies and alternatives to attain expected outcomes;
- implements the identified plan, and
- evaluates progress towards achievement of outcomes.1

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;

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School Nursing Practice Standards

- 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 Students²

<table>
<thead>
<tr>
<th>Ratio</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 nurse to 750 students</td>
<td>regular education student population</td>
</tr>
<tr>
<td>1 nurse to 250 students</td>
<td>student population with children with special health care needs</td>
</tr>
<tr>
<td>1 nurse to 125 students</td>
<td>severely and/or multi-handicapped student population</td>
</tr>
</tbody>
</table>

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 health services areas that are the focus of activities for SNFI nurses. As the number of “initiative nurses” has increased in North Carolina, those health service areas have become the basic standard of service expectation for North Carolina school health programs. The health service areas were additionally revised in June 2011 by HB 200 (Session Law 2011-145) and school nurses funded by SNFI were to perform all of the following with respect to school health programs:

(1) Serve as the coordinator of the health services program and provide nursing care;
(2) Provide health education to students, staff and parents;
(3) Identify health and safety concerns in the school environment and promote a nurturing school environment;
(4) Support healthy food services programs;
(5) Promote healthy physical education, sports policies, and practices;
(6) Provide health counseling, assess mental health needs, provide interventions, and refer students to appropriate school staff or community agencies;
(7) Promote community involvement in assuring a healthy school and serve as liason to a health advisory committee;

² American Nurses Association (2005), National Association of School Nurses (2011), the American School Health Association (1998), American Academy of Pediatrics (2009), Healthy People 2020 (CDC)
(8) Provide health education and counseling and promote healthy activities and a healthy environment for school staff, and
(9) Be available to assist the county health department during a public health emergency.

The General Assembly in 2011 also prohibited school nurses funded by SNFI from assisting in any instructional or administrative duties associated with a school’s curriculum.
Roles and Responsibilities of the School Nurse

As the role of the school nurse has evolved, so have the position statements defining that role. In 2010, 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. (National Association of School Nurses [NASN], 2010).

In 2011, the National Association of School Nurses refined the practice of professional school nursing in a position statement describing the role of the school nurse, including:

1. School nurses facilitate normal development and positive student response to interventions.
2. School nurses provide leadership in promoting health and safety, including a healthy environment
3. School nurses provide quality health care and intervene with actual and potential health problems.
4. School nurses use clinical judgment in providing case management services.
5. School nurses actively collaborate with others to build student and family capacity for adaptation, self-management, self advocacy and learning.

A student’s health is directly related to his/her ability to learn. As such, the role of the school nurse is not limited to the five areas described above. The school nurse is the leader in the school community to oversee health policies and programs so she/he may take on additional roles as needed to meet the needs of the school community. Each school nurse and/or system should complete a needs assessment of the school (student, staff and community population) in order to set priorities among those described roles. Additional discussion on the needs assessment process is included at the end of this section. 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. To assist in the process, the following chart may be used for nurses to set priorities.

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1 National Association of School Nurses. (2011, April). Role of the School Nurse. (Position Statement) Silver Spring, MD: National Association of School Nurses
## Setting School Nurse Priorities

### (#1) Highest Priority and Life Threatening
1. ABC emergencies
2. Identification of students with life threatening chronic conditions
3. EAPs for life threatening issues
4. MD orders for life threatening issues
5. Staff training for life threatening issues
6. Suicide assessment
7. Orientation of school nurses and new staff who will be providing delegated nursing care to students

### (#2) High Priority and Not Life Threatening
1. MD orders
2. Medication training
3. Medication audits
4. Supervision of delegation
5. IHP/EAP development for non-life threatening
6. Staff training for IHPs/EAPs
7. Communicable disease control for seasonal and outbreaks
8. Nursing assessment of students referred for issues, not acute care (outcome of assessment determines priority of subsequent care)
9. Documentation
10. Ongoing nursing management of student with chronic problems to facilitate access to education

### (#3) Lower Priority and Not Life Threatening
1. Review, revision, development of policy
2. Oversight/coordination of mass screenings
3. Follow-up for screenings - secured care
4. Regular faculty/principal meetings
5. General staff training - immunization, CPR, OSHA, diabetes,
6. Reports
7. Self Inservice
8. IEP, 504, SAT meetings
9. Staff assessment for self referred issues
10. F/U Immunizations/Imm Review
11. F/U KHAs/Review
12. General record maintenance
13. General call response (parent, agencies, etc)
14. Developing student resources - (knowledge of resources in the community/staying abreast of changes)
15. Understanding the school system

### (#4) Time permitting, when higher priorities have been addressed
1. Kindergarten orientation for parents
2. Daily, routine acute care of students
3. Health related newsletters/bulletin boards
4. Classroom health instruction as guest adjunct to classroom teacher
5. Performing (as opposed to coordinating) routine mass screenings
6. Lice response

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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2 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. As mentioned earlier, the National Association of School Nursing, together with the American Nurses Association, have developed professional standards for school nursing practice.

There are 17 standards outlined in the School Nursing Scope and Standards of Practice, second edition (ANA & NASN, 2011). Each standard is followed by a list of competencies supporting the standard. This book describes the scope of professional practice for school nurses and gives additional guidance for school nursing practice and roles.

School health programs and school nursing roles should be based on these sources. To assist programs in our state, the Professional Standards and Practice Committee of the School Nurse Association of North Carolina (SNANC) has developed both a School Nurse Job Description and a QI tool, based on these standards. 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 QI tool is designed to help assess the overall quality of a School Health Program. The American Academy of Pediatrics has also issued a policy statement regarding school nursing roles. You can locate additional information at http://pediatrics.aappublications.org/content/108/5/1231.full.html

Either tool may be individualized and made specific for the program. Both can be found at www.snanc.org

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 position requirements that pertain to all employees, but does not allow for an evaluation of professional nursing practice-related 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 performance examples include hiring and firing activities, salary adjusting, compliance with district policies and procedures, use of leave time, punctuality, etc. All staff benefit from regular evaluation to foster professional growth and program development. To this end, school nurses also benefit from the opportunity for professional development that is provided by practice review and evaluation. Ensuring student health and safety as well as continual improvement in individual school nurse practice is the ultimate goal of evaluation. Such review should be formalized and occur at regular intervals. Those nurses who are supervised by a registered nurse can have an evaluation of their nursing practice incorporated into the overall performance evaluation. School nurses without a registered nurse supervisor, can still obtain nursing practice review through other means. Nurses who work with a peer group may utilize a peer review process. This would be consistent with the Board of Nursing requirement that the supervision and evaluation of a registered nurse’s practice only be completed by another registered nurse.

In the summer of 2013, the NC State Board of Education approved a School Nurse Evaluation Process. It includes a rubric based on requirements of the NC Board of Nursing, Scope of Practice and Professional School Nursing Standards, as well as the competencies. The evaluation process is written in its entirety as a User’s Guide that may be found at the following NC Department of Education wiki [space](http://ncees.ncdpi.wikispaces.net/Support+Staff). It reinforces evaluation by another registered nurse within the school system or through peer review. This tool was written for school nurses employed by LEAs in North Carolina and requires appropriate training. However, other agencies employing school nurses may adapt it for their use.

Use of the standards for school nurses will provide the focus for schools and districts as they support, monitor and evaluate their school nurses, and it will guide school nurses as they move forward in the 21st Century, so they can maintain the skills and knowledge needed.

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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 can be found at Standardized Nursing Languages. 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 (also see revised edition 2010). A companion reference by Carpenito-Moyet, Handbook of Nursing Diagnosis, 2012, 14th ed., is useful for relating a nursing diagnosis to a functional health pattern. The reference is updated every four years.

1. 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?
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); heart sounds; pulses
Range of motion, gait, posture
Respiratory pattern: depth/rhythm
Lung sounds

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 ______ Wt. ______
- 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

Objective:

Subjective:

Vision:

Eyes:

Far Near
R | L

Muscle

Correction Y N

Balance

pass fail NA

Binocularity

pass fail NA

Color Vision

pass fail NA

Stereopsis

pass fail NA

1000 2000 4000

R L

Nose:

1000 2000 4000

R L

Neurologic

Trauma

H/A

Self-Perception/Self-Concept Pattern

Objective: (attach drawings, etc.)

Subjective: Child/Family

Role-Relationship Pattern

Objective: Observation:

Subjective: Child/family/peers/teacher

Class/playground/lunchroom/bus/home

Coping-Stress-Tolerance

Pattern Subjective:

Stressors/examples

Otoscopic Inspection of ear:

School Performance:

School Performance:

Neurodevelopmental (attach instruments)

Laterality: self examiner

Eye L R Ear L R Hand L R

Motor persistence

Self-Perception/Self-Concept Pattern

Objective:

Subjective: Child/Family
### Subjective:

- Relationships with peers
- Siblings
- Family
- Endocrine conditions
- Puberty

### Objective:

**Sexuality-Reproductive Pattern**

Subjective: Observation as appropriate

- Observation as appropriate

**Value-Belief Pattern**

Subjective: Observation as appropriate

- Cultural Variations
- Religious practices
- Dietary Restrictions

**Home Visit: (or parent interview)**

Subjective Data: Observation as appropriate

- Home Description

<table>
<thead>
<tr>
<th>SMR / Tanner staging</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

### Assessment Summary:

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

**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 (2012), 14th ED.PHILADELPHIA: J.B. LIPPINCOTT)

Case Management Plans:
IEP: _____yes _____no _____ referral
504: _____yes ___ no ___ referral
IHP: _____yes _____no _____needed
EAP: __yes _____ no _____ needed
Medication Forms:  yes ____no _____needed
Treatment Forms:  yes ____no _____needed
Other Referrals:
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. 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 1995 the North Carolina State Board of Education established a Special Health Care Services policy, 16 NCAC 6D.0402, which states:

Each LEA shall make available a registered nurse for assessment care planning, and ongoing 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)

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 process required by the North Carolina Board of Nursing and the recognized standard in professional nursing. School personnel often must provide healthcare activities but 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 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, 2011). 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, Ch. 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 template 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.

<table>
<thead>
<tr>
<th>See</th>
<th>See</th>
<th>Hear</th>
</tr>
</thead>
<tbody>
<tr>
<td>rest</td>
<td>eat</td>
<td>verbalize</td>
</tr>
<tr>
<td>walk</td>
<td>observe</td>
<td>communicate</td>
</tr>
<tr>
<td>move</td>
<td>expectorate</td>
<td>state</td>
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<tr>
<td>assess</td>
<td>position</td>
<td>describe</td>
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<tr>
<td>monitor</td>
<td>demonstrate</td>
<td>teach</td>
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<tr>
<td>turn</td>
<td>wash</td>
<td>instruct</td>
</tr>
<tr>
<td>ambulate</td>
<td>exercise</td>
<td>report</td>
</tr>
<tr>
<td>assist</td>
<td>stand</td>
<td>consult</td>
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<tr>
<td>perform</td>
<td>sit</td>
<td>discuss</td>
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<tr>
<td>offer</td>
<td>avoid</td>
<td>explain</td>
</tr>
<tr>
<td>inspect</td>
<td>write</td>
<td>identify</td>
</tr>
<tr>
<td>apply</td>
<td>measure</td>
<td>respond</td>
</tr>
<tr>
<td>practice</td>
<td>record</td>
<td>list</td>
</tr>
<tr>
<td>cough</td>
<td>change</td>
<td>relate</td>
</tr>
<tr>
<td>deep breathe</td>
<td>irrigate</td>
<td>listen</td>
</tr>
<tr>
<td>drink</td>
<td>suction</td>
<td>refer</td>
</tr>
</tbody>
</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>
</tr>
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<tbody>
<tr>
<td>know</td>
<td>permit</td>
<td>be</td>
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<tr>
<td>employ</td>
<td>keep</td>
<td>get</td>
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<tr>
<td>understand</td>
<td>use</td>
<td>ensure</td>
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<tr>
<td>indicate</td>
<td>allow</td>
<td>prepare</td>
</tr>
<tr>
<td>enable</td>
<td>engages</td>
<td>introduce</td>
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<tr>
<td>provide</td>
<td>learn</td>
<td>put</td>
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<tr>
<td>facilitate</td>
<td>limit</td>
<td>do</td>
</tr>
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</table>
Individual Health Care Plan Form (sample)

Name __________________________________________ School __________________
School Year ____________________________ Grade/Teacher ______________

Description of health problem:

Symptoms:

Student Specifics:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
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</tbody>
</table>

I have read and agree to the contents of this plan. Please notify necessary school staff with this form.

Parent Signature __________________________________________ Date __________________
(If Required)
Phone __________________________

School Nurse __________________________________________

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:
Health Care Plan

Latex Allergy
(Sample)

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

Parent Signature __________________________________________ Date __________
(If Required)

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:  12-14-13
Name:  Mrs. Smith, homeroom teacher Date:  12-14-13
Name:  Mrs. Johnson, school secretary / First Responder Date:  12-14-13
(This page intentionally left blank)
Sample Nursing Care Plan Form

IEP: Yes ☐ No ☐

Name: ___________________________ DOB: _______ Gender: _____ Date Initiated: ______________

Relevant Diagnosis(es):______________________________________________________________

Health Care Provider:_____________________________ Allergies:____________________________

Medical History:________________________________________________________________________

Diet:_______________ Mobility:_______________ Equipment:_______________________________

Medication/Treatment:____________________________________________________________________

Print Name:_____________________________ Signature:_______________________________

School Nurse

Principal Contacts:____________________________________________________________________

School Health Program Manual – 2014
NC Division of Public Health – Children & Youth Branch – School Health Unit
# Sample Nursing Care Plan Form

<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 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 health 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, a variety of other health-related forms exist. The storage and management of all health records and forms should be addressed in the LEA policies and procedures.

Documentation in Student’s Permanent Health Record

The NC Student’s Permanent Health Record is stored within the cumulative education record (Guidelines available in Appendix). It holds health related information that will further a student’s academic achievement and /or maintain a safe and orderly teaching environment. It also contains such information as: student health status, immunization information, emergency health information, notations that an EAP or IHP exists, and results of screenings 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 education 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 such as: medication authorization and administration forms, injury report forms, IHPs and EAPs, health care procedure documentation, emergency information cards, and immunization records. Storage and maintenance of these health forms should be addressed in the LEA procedures.

Data collection is another type of health information generated by schools. Such data may be used for reports to supervisors and 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
individually 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 (NASN) 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 documentation system. These would provide a place to record the 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/consent 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 credential) must be in a signature box on one side of each page.
2. Documentation must be legible, factual, concise, and complete.
3. Be aware of the risks of using abbreviations. Use only authorized abbreviations, such as an LEA, 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. (Additional information follows on next page.)
4. Document promptly and in ink.
5. Note date and time of care on all documentation.
6. Correctly identify late entries.
7. Correct inaccuracies by crossing through the error with a single line, writing “Mistaken Entry” above error, and initial the correction. Do not erase or alter previously 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 readable as the paper record would be.
8. Clearly identify exact quotes if included. Document non-adherence to medications or treatments as well as missed procedures.
Use of Abbreviations, Acronyms & Symbols

The use of abbreviations in charting is a useful timesaver, but the practice can lead to confusion and serious mistakes. Any abbreviations 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 any “short cuts” in charting that are not on that list, should be avoided.

The Joint Commission, also known as the Joint Commission on Accreditation of Healthcare Organizations, recommends that certain abbreviations never be used in charting. This list is available at: http://www.jointcommission.org/assets/1/18/Do_Not_Use_List.pdf

The Joint Commission website also states: Any reasonable approach to standardizing abbreviations, acronyms, and symbols is acceptable.

Examples include:

- Standardized abbreviations developed by the individual organization.
- Use of a published reference source. However, if multiple abbreviations, symbols or acronyms are used for the same term, the organization identifies what will be used to eliminate any ambiguity.
- A decision that individuals who work in the organization may use any abbreviation, acronym, or symbol that is not on the list of unacceptable abbreviations. However, if multiple abbreviations, symbols, or acronyms exist for the same term, the organization identifies what will be used to eliminate ambiguity.

Standardized Nursing Languages (NASN)

It is the position of the National Association of School Nurses (NASN, 2012) that standardized nursing languages (SNL) are essential communication tools for registered professional school nurses (hereinafter, school nurses) to assist in planning, delivery, and evaluation of quality nursing care. SNL help identify, clarify and document the nature and full scope of quality school nursing practice (i.e., nursing diagnoses, interventions and outcomes). There are four main reasons that SNL are essential in school nursing documentation. SNL provide a common language, contribute to quality of care, enable continuity of care, and support research (Deney, 2010). SNL enable communication about the contribution of professional school nursing practice to the health and academic success of students.

NASN supports the use of SNL in school nursing practice, electronic health records (EHR), and school nursing education programs. NASN further supports the continued research and development of SNL to advance evidence-based, quality school nursing practice.
Confidentiality of Health Information in Schools

The National Association of School Nurses (NASN) and the National Association of State School Nurse Consultants (NASSNC) 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.

Traditionally, most school children have been healthy and have needed school health services primarily for basic screening procedures or communicable disease control. However, in today’s culture broader a much broader focus on health is needed. There is an increasing prevalence of psychosocial issues such as behavioral disturbances, child abuse, stress, and substance abuse that must be included as part of school health. Similarly, passage of such federal laws as PL 94-142 and PL 99-457 have 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, a nursing assessment of existing health problems needs to be completed and planning executed and communicated to appropriate personnel.

It is essential to treat all health information confidentially. Specific school staff may have a ‘need to know’ regarding a student’s existing health condition. This knowledge will allow staff 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 what school personnel might need this information. Sharing of confidential information for any other purpose would be inappropriate and unethical. A breach of confidentiality can 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 policy:

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.
FERPA and Confidentiality

Managing school health records is a challenging responsibility for school nurses. These responsibilities, shared by school district administrators, should follow system-wide policies and procedures for documentation that include the generation and maintenance; protection through secured storage and access; and disclosure and destruction of students’ school health records. School systems generally have a student records policy and procedure. School nurses should ensure that the policy and procedures address health records, whether integrated within the existing policy or added as an additional “health records” section.

Family Educational Rights and Privacy Act (FERPA) allows for health information to be shared with other individuals within a school system who have been determined to have a legitimate educational interest. 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 for links to 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 any 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 can be stored within the cumulative education record
  - Individual Health/Nursing Record is to be 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 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 confidentiality 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 earlier (This includes third party medical records from outside sources and sensitive 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 of this chapter.

- As the primary health care provider, the school nurse may determine on a case by case basis, how much and under what circumstances, school staff would have access to the individual health information. Limit disclosure to the 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 that school health records (both the Student Permanent Health Record and the Individual Health/Nursing Record) move with the student to other schools within the district and when transferring to another district or state.

- Avoid circulating lists/making logs with multiple student names or diagnosis, for general distribution, 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 current 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 and are often operated by independent agencies. According to FERPA regulations, such centers are considered “outside agencies” and consent is required to disclose student records to them. The center’s health records are subject to the HIPAA rules and regulations.

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. System wide procedures for releasing health information should address:

- Obtaining written parental consent before releasing Individual Health/Nursing Records or the Student’s Permanent Health Record outside a school system except as allowable by FERPA.

- The consent to disclose information 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 memorandum of agreement that addresses confidentiality issues with other agencies that provide services to students. (These agency employees working in the school are still bound by FERPA)

- If transmitting information 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 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/herself 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 be 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.
References:


Additional Resources:


Public Schools of North Carolina

State Board of Education • Phillip J. Kirk, Jr. Chairman
Department of Public Instruction • Michael E. Ward, State Superintendent
301 N. Wilmington Street, Raleigh, North Carolina 27601-2825
http://www.dpi.state.nc.us

North Carolina Department of Public Instruction

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.

1 Undated Position Statement during administration of N.C. Superintendent of Public Instruction Michael E. Ward, 1996 to 2004
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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 2013 NCBON Position Statement defines delegation as "transferring to a competent individual the authority to perform a selected nursing activity in a selected situation. The nurse 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 patient [student] care activities through the delegation process.” Supervision is “the provision of guidance or direction, evaluation, and follow-up for accomplishment of an assigned or delegated nursing activity or set of activities.”

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:

- 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;

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

- Federal mandates ensuring students with health-related disabilities access to appropriate educational programs and related services in the least restrictive environment; and

- 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 members 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 to note the distinction between parents as caretakers in the home, and employees of the school who function as care providers within their work place. 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 to consider when 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 for 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 plan of care when notification, reassessment and intervention by the RN 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, agency procedures and need for supervision of care.

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 Health 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. (2013). Position Statement for RN and LPN Practice, Delegation and Assignment of Nursing Activities
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 by the 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 clients.</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>
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</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

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<thead>
<tr>
<th>Nursing Service Administrator (NSA)</th>
<th>Staff Nurse</th>
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<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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</table>

Right Person

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<tr>
<th>Nursing Service Administrator (NSA)</th>
<th>Staff Nurse</th>
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<tr>
<td>• Establish organizational standards consistent with applicable law and rules which identify educational and 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 boards 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>
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</table>

Right Direction/Communication

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<tr>
<th>Nursing Service Administrator (NSA)</th>
<th>Staff Nurse</th>
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<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>
</tbody>
</table>
| • Situation specific communication includes:  
  o Specific data to be collected and method and timelines for reporting.  
  o Specific activities to be performed and any client specific instruction and limitation, and  
  o The expected results or potential complications and time limits for communicating such information. |
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.

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<thead>
<tr>
<th><strong>Nursing Service Administrator (NSA)</strong></th>
<th><strong>Staff Nurse</strong></th>
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<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>
</tbody>
</table>
| • Identify the licensed nurses responsible to provide supervision by position, title, and role delineation. | • Provide directions and clear expectations of how the activity is to be performed:  
  o Monitor performance;  
  o Obtain and provide feedback;  
  o Intervene if necessary, and  
  o Ensure proper documentation. |
| • Evaluate outcomes of client community and use information to develop quality assurance and to contribute to risk management plans. | • Evaluate the entire delegation process:  
  o Evaluate the client, and  
  o Evaluate the performance of the activity. |
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, found 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 cannot 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

Step 1 of 4: Assessment and Implementation

Is the task within the scope of practice for a licensed nurse (RN/LPN)?

Yes → Is the activity allowed by the Nursing Practice Act, Board Rules, Statements, or by any other law, rule or policy?

Yes → Is RN assessment of client’s nursing care needs complete?

Yes → Is the RN/LPN competent to make delegation decisions? Nurse is accountable for the decision to delegate, to implement the steps of the delegation process, and to assure that the delegated task is appropriate based on individualized needs of each client which includes stability, absence of risk of complications, and predictability of change in condition. The delegating nurse must be competent to perform the activity. See (A) and (B) pg. 2

Yes → Is the task consistent with the rules for delegation to UAP? Must meet all the following criteria:

- 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.

No → Stop! Do not delegate to UAP.

Yes → Is the UAP properly trained and validated as competent by an RN to accept the delegation?

Yes → Does the capability of UAP match the care needs of the client? See (A) and (B) pg. 2

Yes → Are there written agency policies, procedures, and/or protocols in place for this task?

Yes → Is appropriate supervision available? See (C) (D) (E) pg. 3

Yes → Proceed with delegation.

No → Stop! Do not delegate until evidence of education and validation of competency available, and then reconsider delegation; otherwise do not delegate.

No → Stop! Do not delegate until the nurse has evaluated capability of UAP matches the care needs of the client.

No → Stop! Do not proceed without evaluation of need for policy, procedures and/or protocol or determination that it is in the best interest of the client to proceed with delegation in urgent or emergency situations.

No → Stop! Do not delegate to UAP.

Stop! Do not delegate to UAP.
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

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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.

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.
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. Confirm the identity of 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 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 at www.snanc.org.)

3. What health policies and procedures exist? Read them. A list of relevant policies and procedures can be found on each year’s Annual School Health Services Report Section 2 surveys.

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 principal(s) and office staff. Establish how health issues are dealt with in each school, especially related to immunization review, Kindergarten Health Assessment review, emergency response, diabetes care training, first aid provision and first responders, responsibility for infection control and OSHA Blood Born Pathogen training, and medication administration procedures.

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 database of students with chronic health problems available? How up to date is it? Compile or update a database 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.

8. Obtain information needed to plan a schedule, taking into consideration the number of assigned schools, number and type of students, number of grades in each school, and when multi-disciplinary staffing meetings are scheduled. Create 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 it is subject to change, as unexpected issues arise.

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 current Memorandum of Agreement), 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 highest priority and begin to work with administrators to develop appropriate ones.
Section E
Guidelines for Prevention and Control of Communicable Diseases

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 evidence based 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 care and treatment can help inhibit the spread of contagious illness in school and minimize excessive absence.
- 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.

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1 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. Refer to the “home page” of websites for the most current information.
Parents, students, and teachers should understand their responsibilities in communicable disease control. Measures to effectively control communicable disease include:

- Immunizations.
- Environmental sanitation controls.
- Prophylaxis and treatment.
- 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.)

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 evidence based 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 evidence based procedures and techniques to prevent transmission of infectious disease. (See “Guidelines for Handling Body Fluids” at the end of this chapter.)

• Students and staff should receive instruction regarding cleanliness and hygiene measures including proper hand washing techniques. They are to be provided equipment and facilities to support such measures.

• 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 most current guidance available from the CDC and State Epidemiology Section.

• 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 facilitating communication among the student’s family, personal physician and community health agencies and school staff.

• 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.

• Recommendations for response to outbreaks of vaccine preventable diseases can be found at [http://www.immunize.nc.gov/providers/vpdreporting.htm](http://www.immunize.nc.gov/providers/vpdreporting.htm)
• According to G.S. 130A-153 and 10A NCAC 41A.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.
Prevention and Control of State-Reportable Communicable Diseases
(sample policy)

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 Chapter Two for further information.)

A list of students who have not been vaccinated for religious or medical reasons or who have illnesses that cause immunosuppression will be maintained in the school health office so that appropriate action can be taken to protect these individuals when serious communicable disease outbreaks do occur.

References:


North Carolina Department of Health and Human Services, Division of Public Health, Epidemiology Section (2013).

Prevention and Control of Non-Reportable Communicable Diseases

(sample policy)

The school administration makes every effort to reduce the prevalence of disease-causing organisms 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 illnesses 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. The school nurse can be a resource for information, but a child’s physician is the best source of medical advice. 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 cases where an illness has become chronic and personally disabling, modifications may be needed at school and students may be eligible for services under Section 504 of the Rehabilitation Act. (See Section B for further information).

The following are some common communicable diseases for which school health staff provides recommendations:

Conjunctivitis (Pink Eye): This is an inflammation of the covering of the white part of the eye and inside of the eyelids and may be caused by allergens, viruses and/or bacteria. 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.

Diarrhea: Diarrhea is not a disease but a symptom of a disease or condition. If a student is unable to participate in classroom activities or has accompanying signs of illness such as fever then the parent should be notified. 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: This is a common contagious skin infection among children. A child is considered contagious until treated with antibiotics for at least 24 hours or the crusting lesions are no longer present. If the child is at school when the lesions are discovered direct contact with other children should be minimized to the extent possible 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 until seen by a physician for evaluation and treatment. 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:** *M*ethicillin-resistant *staphylococcus aureus* (MRSA) is another form of skin infection. A diagnosis is made by performing a wound culture. Having or harboring MRSA bacteria (carrier) is *not* a reason for exclusion from school. All suspected cases should be referred to their health provider and lesions should be kept covered while at school. Consider excluding athletes from sports participation until evaluated by a health care provider.

**Pediculosis:** A common condition (not a disease) that is often seen in school aged children is pediculosis (head lice). Additional information is provided starting in this chapter regarding prevention and control of pediculosis.

**Scabies:** This is another common skin ailment where small insects called mites burrow under the skin resulting in an itchy rash. Student is usually isolated from direct contact with other students until he and his family are treated with prescription medication. A treatment is usually completed overnight and repeated in a week though the itching may continue for several weeks.

**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 more serious bacterial 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):** This is a viral illness that causes a blister-like rash and fever. Suspected cases of chickenpox should be referred for health provider evaluation to ensure accurate diagnosis. Students should be excluded from school until all blisters have formed scabs.

References:


N.C. Immunization Requirements

Every child present in the state of North Carolina must, by state law, be immunized against state required vaccine-preventable diseases at appropriate ages.

As conditions change and new vaccines emerge, states, including North Carolina, find it necessary to update or change their school entry requirements. The Centers for Disease Prevention and Control (CDC) Advisory Committee on Immunization Practices (ACIP) makes regular recommendations for vaccinations. Visit the website: [http://www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html) for periodic updates. General Statutes direct North Carolina-specific minimum entry requirements. For specific immunization requirements, refer to the following website: [http://www.immunize.nc.gov/](http://www.immunize.nc.gov/).

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.

If the required immunizations have not been completed within the time allowed, regardless of whether or not a student has an appointment, the student must be excluded from school. Students, who have begun an immunization series but have not completed the series due to the required minimum interval between doses, are considered “in process” and may attend school. 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.

At the end of the 30 calendar days, or the extended period, the principal shall not permit the student to attend school unless he/she is immunized and presents the required documentation. Refer to [http://www.immunize.nc.gov/](http://www.immunize.nc.gov/) 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 statement must be completed 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 submitted on one of the two forms approved by the state Division of Public Health. Copies of required forms are available at [http://www.immunize.nc.gov/](http://www.immunize.nc.gov/).
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 each student’s certificate of immunization. The school shall file a kindergarten and sixth grade immunization summary report with the Division of Public Health no later than November 1st of each year.

The North Carolina Immunization Branch has consultants available to answer questions about its services and programs. That contact information is located at http://www.immunize.nc.gov/contacts.htm.
Immunizations: Frequently Asked Questions

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 transmittal form 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 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 parent will have 30 calendar days to provide a certificate of immunization to the school after which time the student will be excluded from school due to non-compliance with immunization law

2. 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, medical exemption or religious exemption statements are provided or proof that a medical exemption request has been sent to the State Health Director by the student’s physician who is licensed to practice medicine in North Carolina.

What does the law allow when a student needs more than 30 calendar days to receive required immunizations?

If time is needed beyond the 30-calendar-day period due to vaccine dose and/or dose interval requirements only, 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 excluded 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 or a medical or religious exemption statement is provided or under review by the State Health Director.

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. name and address of the physician or clinic. (The record produced by NCIR does not need additional signatures/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 [10A NCAC 41A.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 submit a written statement to be put on file in the student's permanent record. Objections based upon a “scientific” belief or non-religious personal belief or philosophy are **not acceptable**.

(3) The written statement must be maintained in the student's record and should contain at a minimum the:

1. Student’s name and date of birth;
2. Parent(s), guardian or person in loco parentis statement of their detailing the bona fide religious objection; and
3. Parent(s), guardian or person in loco parentis signature and date signed.

What records 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 North Carolina Immunization Registry (NCIR) satisfies the requirements for a Certificate of Immunization.** The immunization record from Power School or other school data report is **not** sufficient to serve as the Certificate of Immunization unless it contains the required elements of a 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 or who are immunocompromised should be kept in the school health office for reference in the event of an outbreak of a vaccine-preventable disease.

If a child has had 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:** Those with laboratory tests showing immunity or a history of chicken pox documented by a health care provider, parent, guardian, or person in loco parentis shall not be required to receive the vaccine. Such documentation must be on or attached to the lifetime immunization card or Certificate of Immunization.
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 4th day prior to the minimum age requirements for immunization, the individual dose shall not be required to be repeated.

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?

No, under FERPA, the school may not release an immunization record to another agency or person, except to another school, without authorized parental consent. Parental consent may be obtained through written release.
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 has documented that such practices did little to reduce the incidence and spread 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.

Position Statement: National Association of School Nurses (revised January 2011)

SUMMARY

It is the position of the National Association of School Nurses that the management of pediculosis (infestation by head lice) should not disrupt the educational process. No disease is associated with head lice, and in-school transmission is considered to be rare. When transmission occurs, it is generally found among younger-age children with increased head-to-head contact (Frankowski & Bocchini, 2010).

Children found with live head lice should remain in class, but be discouraged from close direct head contact with others. The school nurse should contact the parents to discuss treating the child at the conclusion of the school day (Frankowski & Bocchini, 2010). Students with nits only should not be excluded from school (American School Health Association, 2005, Frankowski & Bocchini, 2010, Pollack, Kiszewski & Spielman, 2000) although further monitoring for signs of re-infestation is appropriate. It may be appropriate to screen other children who have had close head-to-head contact with a student with an active infestation, such as household family members, but classroom-wide or school-wide screening is not merited (Andresen & McCarthy, 2009). In cases that involve head lice, as in all school health issues, it is vital that the school nurse prevent stigmatizing and maintain the student’s privacy as well as the family’s right to confidentiality (Gordon, 2007).

The school nurse, as a student advocate and nursing expert should be included in school district-community planning, implementation, and evaluation of vector control programs for the school setting. School nurses are also in a pivotal position to dispel myths and stigmas regarding pediculosis by providing education on the life cycle of the louse, methods of transmission, treatment options and care of the environment to the student’s family, school and community at large.

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2 National Association of School Nurses, Position Statement, Pediculosis Management in the School Setting, January 2011
HISTORY

Head lice (pediculosis capitus) are small parasitic insects that live on the scalp and neck hairs of their human hosts. The presence of lice is most often detected through the presence of adult lice or nits (eggs) attached to the hair shaft of the host, most often at the nape of the neck and behind the ears. Complications of infestations are rare and involve secondary bacterial skin infection (Lebwohl, Clark & Levitt, 2007). Pruritis (itching) is the most common symptom of a lice infestation, along with the following additional symptoms:

- a tickling feeling or a sensation of something moving in the hair;
- irritability and sleeplessness; and
- sores on the head caused by scratching. Sores caused by scratching can sometimes become infected with bacteria normally found on a person’s skin (CDC, 2010).

DESCRIPTION OF ISSUE

Some people consider pediculosis to be a public health issue that is brought into the school setting. Families and school staff expend innumerable hours and resources attempting to eradicate lice infestations, both live lice and their nits. The Centers for Disease Control and Prevention (CDC) (2010) reports an estimated 6 million to 12 million infestations occur each year in the United States among children 3 to 11 years of age. It is thought that head lice infestations are often misdiagnosed when medical and lay individuals identify the presence of lice based on the presence of eggs (Pollack, Kiszewski & Spielman, 2000). In addition, millions of dollars are spent annually on pediculicides, lice combs, physician visits, and parental time away from work. In an effort to find an easy, effective, and safe treatment, a variety of alternative therapies (e.g., occlusive agents such as oil-based and grease-based products, electric combs, herbal shampoos and enzyme solutions,) have been attempted by parents. There is little scientific evidence regarding the effectiveness of these alternative treatments, and all have an associated cost (Frankowski & Bocchini, 2010). Treatment recommendations for pediculosis should be based on evidence based literature from public health, medical and nursing content experts rather than anecdotal reports or commercial advertisements.

Parents, school staff, and the community often become unduly anxious when a case of head lice occurs within a classroom, and this anxiety is multiplied if more than one case is identified. A negative social stigma frequently accompanies the identification of pediculosis as well as the frustration involved with the cost, time and effort needed for treatment and environmental control (Gordon, 2007). It is important, as a part of a comprehensive educational program, that the school nurse emphasizes that head lice are not associated with poor hygiene (Lebwohl, Clark & Levitt, 2007).
In 2007, international guidelines established for effective control of head lice infestations reinforced that policies that required a student to be free of nits to attend school, known as “no nit” policies, were based on misinformation rather than objective science and were therefore unjust and should be discontinued (Mumcuoglu et. al., 2007). The CDC (2010) cites the following reasons to discontinue “no nit” policies in school:

- Many nits are more than 1/4 inch from the scalp. Such nits are usually not viable and unlikely to hatch to become crawling lice, or may in fact be empty shells, also known as casings.
- Nits are cemented to hair shafts and unlikely to be transferred successfully to other people.
- The burden of unnecessary absenteeism to the students, families and communities far outweighs the risks associated with head lice.
- Misdiagnosis of nits is very common during nit checks conducted by nonmedical personnel.

RATIONALE

The school nurse is the key health professional to provide education and anticipatory guidance to the school community regarding best practice guidance in the management of pediculosis. The school nurse’s goals are to facilitate an accurate assessment of the problem, contain infestation, provide appropriate health information for treatment and prevention, prevent overexposure to potentially hazardous chemicals, and minimize school absence.

There is discussion in the scientific community 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 & Bocchini, 2010). New categories of pediculicides have recently been developed, including benzyl alcohol (CDC, 2010).

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 (Frankowski & Bocchini, 2010). Research data does not support immediate exclusion upon the identification of the presence of live lice or nits as an effective means of controlling pediculosis transmission. By the time a child with an active head lice infestation has been identified, he or she may have had the infestation for one month or more and, therefore, poses little additional risk of transmission to others (Frankowski & Bocchini, 2010). The school nurse is in a position to take the lead in eliminating school exclusion policies and, instead, incorporate evidence-based practices that reduce the stigma associated with head lice, and work to increase classroom time with an emphasis on keeping students in school (Gordon, 2007).
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 or as directed by the child’s health care provider.

3 Recommendations of N.C. Division of Public Health, Children & Youth Branch, School Health Unit
• 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 has 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 and is not recommended for North Carolina public schools.

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 and are not efficient use of school staff time.

- 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 by parents, for aesthetic reasons and to minimize confusion about reinfection 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. For the remainder of the school day, the child with head lice should avoid any activity that involves head-to-head contact with other children or the sharing of any headgear.

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 weeks. Articles that can not be laundered or dry-cleaned may be sealed in air-tight plastic bags for at least two weeks 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.
• 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

National Association of School Nurses (2011) Position Statement: Pediculosis Management in the School Community
Universal Precautions: Guidelines for Handling Body Fluids

(Note: Guidelines included here apply to all body fluids regardless of the health condition of the injured person. 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, and 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 bloodstream 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 requires 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.publichealth.nc.gov) or the website of the U.S. Centers for Disease Control and Prevention (www.cdc.gov).
Guidelines for Medication Administration

The needs of children who require medication during school hours to maintain and support their health and well-being during the educational day 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, has led to an increased number of children whose health problems require medication to be given while at school.
- Students with chronic illness 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. (G.S.115C-375.1).
- All medications administered at school must have a written request/permission signed by the parent or legal guardian (G.S.115C – 375.1).
- 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 within certain parameters.
- All medications should be administered according to the six “rights”.

School Health Program Manual – 2014
NC Division of Public Health – Children & Youth Branch – School Health Unit
Preparation of School Personnel to Administer Medications

Written local policies and procedures should be in place and reviewed periodically for needed revision. A variety of personnel are capable of assisting students with their medications. 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 and disaster situations.

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 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 when an error is made.

**To avoid 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 30 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:**

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 those necessary in order to maintain the child at school.

2. Provide a written request for school personnel to administer the medication. This should be in the form of a request/permission form (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.

3. Parents may choose to administer the medication at school themselves.

4. Complete an authorization form, signed by a health care provider licensed to prescribe medications, which includes the following:
   - 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.

5. Provide each medication in a separate pharmacy-labeled container that includes the child’s name, name of the medication, the exact dose to be given, the number of doses in the original container, the time the medication is to be given, how it is to be administered, and the expiration date of the medication.

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

6. Over-the-counter medications administered at school should be provided in their original packaging labeled with the student name.

7. Provide the school with new, labeled containers when dosage or medication changes are prescribed.

8. Retrieve all unused medications from school when medications are discontinued, and/or at end of school year (according to local written policy).

9. Maintain communication with the school staff regarding any changes in the medical treatment and child’s needs at school.
10. Deliver the medication to the school. In the event that transmittal of the medication to the school presents an undue hardship for the parent or guardian, arrangements should be made with the principal for another way to secure the medication. These might include authorizing the bus driver to transport the medication, or requesting other designated school personnel to arrange for pickup.

11. If school 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) 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. North Carolina agencies charged with safe disposal of medications refer to the recommendations written by the U.S. Food and Drug Administration. The N.C. Department of Insurance, Safe Kids Program, urges communities to establish Operation Medicine Drop programs. See:

   http://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm for assistance in setting up an Operation Medicine Drop program in your community, and for downloadable materials, contact N.C. Department of Insurance at 888-347-3737 or go to:

Recommendations on Role of the School Nurse in Medication Administration

In many 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-medically 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 made by the principal and school nurse, taking into account the needs of students, the nurse to student ratio, and other relevant information. Consistency in medication administration reduces the potential for error and it is best to select a staff member who will be available on a day to day basis.

The school nurse also:

- Serves on school system committee for the development and annual evaluation of written school policy and procedures for medication administration.
- Coordinates, monitors and audits the administration of medication in each school according to adopted policy.
- Reviews the documentation of medication in the school. Periodically audits the completed forms and procedures for quality, accuracy, safety, and compliance with written guidelines. Recommends changes to principals and school staff.
- Serves as consultant to principals, school staff, and parents regarding medications. In the school setting the registered nurse is often the sole source of medically-accurate information regarding pharmaceuticals. The Board of Nursing has issued guidelines regarding the Registered Nurse who makes 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 their recommendations. The ability to monitor is not available to most school nurses outside of boarding or residential schools.
- 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 regular medication never taken by a student should not be given at school. The North Carolina Board of Nursing maintains that the RN may refuse to delegate, or may postpone administration of, a medication based on nursing judgment and pending clarification with the medical provider.
- Serves as liaison with parents, physicians and the appropriate individuals regarding status and effectiveness of student’s medication treatment plan.
- Provides training for school staff who are assigned the responsibility for administering and safely securing medications at school.
• Assures access to emergency medication for all students and assistance for students needing help.
• Makes available to staff a current medication reference source 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, will be self-administered 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 both:

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. The student’s parent or guardian, to include:

a. Written authorization for school personnel allowing the student to carry and self-administer the medication. The authorization should include a signed statement 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, as required by law.

b. Parent/guardian signature; telephone number and date. (May use Medication Authorization Form included in this Section E).

c. 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, in the event the student does not have the required medication.

The request is reviewed by the school nurse, who provides the student with health counseling to include:

- Review of health condition, medications, triggers, precautions.
- Assessment of student’s knowledge and developmental ability to be independent with medication.
- Role play of procedure to be used when necessary and how to obtain help when needed.
Student Agreement for Self-Carried Medication
(Sample)

Student: _____________________________________________________ Grade: ______

School: ________________________________________________________

Parent: ___________________________ Phone Number/s: ___________________________

Health Care Provider: ___________________________ Phone Number: ___________________

Medication: ___________________________ Dose and Time: ___________________________

Medication is permitted in accordance with state laws and district policy. Both student’s health care provider and parent/guardian must complete Medication 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: ___________________________
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, labeled with your child’s name, 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-carry medication. Students must demonstrate the necessary knowledge and developmental maturity to safely assume responsibility for and management of self-carry medications.

School personnel will not administer any medication to 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 ____________________________

NC Division of Public Health – Children & Youth Branch – School Health Unit
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 to 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 ____________________________
  b. Telephone ____________________________
     Take child immediately to the emergency room at ____________________________

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

Asthma/allergic reaction ___MDI (*Metered Dose inhaler) ___MDI with spacer *
Diabetes ___ insulin ___ glucose ___Epinephrine

*Parent/guardian must provide an extra inhaler/epinephrine injector/source of glucose to be kept at school in case of emergency and that will be replaced when it expires.
A written statement, treatment plan and written emergency protocol developed by the student’s health care provider must accompany this authorization form in accordance with requirements stated in G.S. 115C –375.2 The student also must have a self-medication agreement on file.

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) and replace the medication when it expires.

Parent or Guardian’s Signature: _____________________________________________

Telephone Number ______________________ Date: ______________________

(School Use Only)

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

Approved by __________________________________________________________

Principal’s Signature ______________________ Date ______________________

Reviewed by __________________________________________________________

School Nurse’s Signature ______________________ Date ______________________
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.

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 and updated as needed for the child, that written permission is given by them to institute emergency measures and that all medications are replaced when they have expired.
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:
   a. 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.
   b. 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.
   c. Provide these medications doses, any emergency medications, and any special directions for the field trip “med/first aid provider.”
   d. 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”.
d. 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: ___________________________________________
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 ICD codes may not be needed.
(This page intentionally left blank)
## 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>
<th>Signature</th>
</tr>
</thead>
<tbody>
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</table>

1 This inventory log may be used as a temporary record before transferring the information to the student’s individual medication
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 medication must initial each time it is done to indicate that the service was provided.

**SIDE TWO OR PAGE TWO. Narrative Notes and Review of Response to Medication [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]

<table>
<thead>
<tr>
<th>Name of LEA:</th>
<th>School:</th>
<th>Grade:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Student name:</th>
<th>Date of Birth:</th>
<th>*Medicaid #:</th>
<th>*ICD-9 Code(s):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Medication:</th>
<th>MD/NP/PA:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date Begun:</th>
<th>Dose of medication (in mg):</th>
<th>Route:</th>
<th>Time(s):</th>
</tr>
</thead>
</table>

If Changed Date of Change:

<table>
<thead>
<tr>
<th>Dose:</th>
<th>Route:</th>
<th>Time(s):</th>
</tr>
</thead>
</table>

If Changed Date of Change:

<table>
<thead>
<tr>
<th>Dose:</th>
<th>Route:</th>
<th>Time(s):</th>
</tr>
</thead>
</table>

**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 |
|-------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Jan.  |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| (time & initials) |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Feb.  |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| (time & initials) |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| March |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| (time & initials) |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| April |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| (time & initials) |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| May   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| (time & initials) |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| June  |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| (time & initials) |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

**Initials**

<table>
<thead>
<tr>
<th>Full Name &amp; Title</th>
<th>Signature</th>
</tr>
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<tbody>
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</tbody>
</table>

**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>
</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>
</tr>
<tr>
<td>Date Begun:</td>
<td>Dose of medication (in mg):</td>
<td>Route:</td>
</tr>
<tr>
<td>If Changed</td>
<td>Date of Change:</td>
<td>Dose:</td>
</tr>
<tr>
<td>If Changed</td>
<td>Date of Change:</td>
<td>Dose:</td>
</tr>
</tbody>
</table>

**RN Review (Signature, Credentials, Title):**

**INSTRUCTION/CODES**

X = Weekend / Non-Scheduled School Day
A = Absent
D/C = Discontinued
D = Early Dismissal (left school before scheduled time)
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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.)

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School Health Program Manual – 2014
NC Division of Public Health – Children & Youth Branch – School Health Unit
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)

STUDENT NAME: ________________________________ Date of Birth ________________________________

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.

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 given and time given.
- Use pen for documentation, no markers or pencils.

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 out unless you are sure he did not retain any. Notify RN for further instructions.
Do not repeat medication if student vomits. Notify parent.

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.

Date: ______ Time: ______ Comments: (response to med., side effects, reason for omission, etc.) RN Signature: ________________
## Medication Audit Record

<table>
<thead>
<tr>
<th>Student Initials</th>
<th>Date of Audit</th>
<th>School Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorization for Medication signed by both parent and health care provider</td>
<td></td>
<td></td>
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<tr>
<td>Right Medication/Right Dosage/Right Time/Right Route</td>
<td></td>
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<tr>
<td>Medication label and authorization form in agreement</td>
<td></td>
<td></td>
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<tr>
<td>Properly labeled container for each medication</td>
<td></td>
<td></td>
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<tr>
<td>Medication not expired</td>
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<tr>
<td>Correct name, dosage, and time transcribed correctly on medication log</td>
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<tr>
<td>Documentation</td>
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<tr>
<td>Individual medication log for each medication</td>
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<td></td>
</tr>
<tr>
<td>Signature lines and initials completed by each person administering medications</td>
<td></td>
<td></td>
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<tr>
<td>All boxes filled with initials or appropriate code</td>
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<tr>
<td>Date and amount of medication brought to school</td>
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<tr>
<td>Medication changes documented correctly (nurse notified)</td>
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<tr>
<td>Errors corrected properly (nurse notified)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All documentation completed in black ink</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication stored and secured properly</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Person(s) Administering Medication(s):</em></td>
<td></td>
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<tr>
<td>*only those trained should administer medications</td>
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</tr>
</tbody>
</table>

**Medication Audit Codes:**

- ✓ = No errors noted
- ✗ = Errors noted
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

- Injuries account for a significant portion of health problems cared for by school health personnel.
- 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 disabilities 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.

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 and accessibility. 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.
• A current 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.

Current 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 advisor, such as private physician, health department medical director, or physician member of the School Health Advisory Council.
North Carolina School Health Program Manual

Section E
School Health Services

Chapter 3
Health Problems – Guidelines

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Preventing 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 variety 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 and resources 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 Doyle, J. (2011). *Disaster preparedness - Guidelines for school nurses*. Silver Spring, MD: National Association of School Nurses.
- 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.
• Review FEMA guidelines

  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?
  ✓ Does the plan account for the special needs of students with disabilities?
  ✓ 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.
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 be updated as needed 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

Hospital/Emergency Room Preference

Known Serious Health Condition or Disability

List any medications taken daily or medications needed in a medical emergency

List any adaptive equipment or essential medical supplies

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

The 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 physician advisor.1

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 prompting. 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, and 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.

Review 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, non-traditional, or alternative treatment.

1 Local school district physician advisor may be a private physician, Health Department Medical Director, or member of the School Health Advisory Council.
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).
Guide for Teacher’s Referral to School Nurse

The following conditions should be referred to the school nurse:

EYES:

a. Sty 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. Excessive 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. Skin lesions or rashes
c. Habitual scratching of scalp or skin
d. Nits on the hair
e. State of uncleanliness
f. Excessive redness of face

GROWTH:

a. Failure to gain weight regularly over a 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. Overly studious, docile, withdrawing
d. Overly excitable, uncontrollable emotions
e. Stuttering or other forms of speech difficulty
f. Poor accomplishment in comparison with ability
g. Lying
h. Lack of appreciation of property rights
i. Abnormal sexual behavior
j. Antagonistic, negative, quarrelsome
k. Excessive use of toilet
l. Enuresis (accidental wetting)
Section E  Chapter 3
School Health Services  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. Obvious cavities 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
e. Poor coordination

HEART:

a. Excessive breathlessness
b. Easily tires
c. Bluish lips or fingernails
d. Excessively pale

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 area at front of throat
ANY CHRONIC ILLNESS, CONDITION OR DISABILITY:
(known or suspected diagnosis)

a. Diabetes  
b. Seizure disorder  
c. Rheumatic fever or congenital heart defect  
d. Cystic fibrosis  
e. Orthopedic condition  
f. Severe hearing loss  
g. Uncorrected visual loss or handicap  
h. Other special conditions  
i. Sickle cell anemia

OTHER:

a. Students who lack medical care due to financial situation or religious views.  
b. Known or suspected social, family, financial situations affecting the health of the student  
c. Prolonged absenteeism  
d. Homebound students  
e. Suspected or known pregnancies  
f. Signs of physical abuse  
g. Children receiving medications for prolonged time and/or for chronic conditions.  
h. 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.......?**

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td><strong>Allergies</strong></td>
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<td></td>
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<tr>
<td>If yes, what is your child allergic to?</td>
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<td></td>
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<tr>
<td>Is medication needed at school/home?</td>
<td></td>
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<tr>
<td><strong>Asthma</strong></td>
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<tr>
<td>If yes, when was the last episode?</td>
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<td></td>
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<tr>
<td>Is medication needed at school?</td>
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<tr>
<td><strong>Diabetes</strong></td>
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<tr>
<td>Does your child use insulin?</td>
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<tr>
<td><strong>Seizures</strong></td>
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<tr>
<td>If yes, when was the last seizure?</td>
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<tr>
<td>Is your child on medication for seizures?</td>
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<td></td>
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<tr>
<td>Is medication needed at school?</td>
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<td></td>
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<tr>
<td><strong>Vision Problems</strong></td>
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<tr>
<td>Does your child wear glasses or contacts?</td>
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<tr>
<td>Has your child ever failed a vision screening?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td><strong>Hearing Problems</strong></td>
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<tr>
<td>Does your child have a known hearing loss?</td>
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<tr>
<td>Does your child wear a hearing aid?</td>
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<td></td>
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<tr>
<td><strong>Heart Problems</strong></td>
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<tr>
<td>If yes, name of problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is exercise limited?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is child on medication for this problem?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
Orthopedic Problems

Yes  No

If yes, name of problem ________________________________________________

Other health problems

Yes  No

If yes, please describe ________________________________________________

Was your child hospitalized or did your child have major changes in health within the past year?

Yes  No

Does your child need any adaptive equipment or communication assistance or other accommodations?

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 and share 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.

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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 cannot 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.**
- **Do not use first aid measures beyond your skill.**
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 or per local policy:

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.
STUDENT INJURY REPORT FORM

Student Information
Name____________________________________________ Date of Incident_____________________
Date of Birth_______________________________________ Time of Incident_____________________
Grade____________________________________________ □ Male □ Female

Parent/Guardian Information
Name(s)_____________________________________________________________________________________
Address_____________________________________________________________________________________

Phone # Work______________________________________ Home_____________________________________

School Information
School___________________________________________ Phone #____________________________________
Principal__________________________________________

Location of Incident (check appropriate box):
□ Athletic Field  □ Playground
□ Cafeteria  □ No Equipment Involved
□ Classroom  □ Equipment Involved (describe)_____________________
□ Gymnasium  □ Hallway
□ Bus  □ Parking Lot
□ Stairway  □ Vocation/Shop Lab
□ 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
□ Carpet  □ Gravel  □ Mat(s)  □ Tile  □ Other (specify)________
□ Concrete  □ Ice/Snow  □ Synthetic Surface

North Carolina Department of Health and Human Services
STUDENT INJURY REPORT FORM
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
- Collision with Person
- Hit with Thrown Object
- Weapon
- Compression/Pinch
- Tripped/Slipped

Specify_________________________

Other__________________________________

Type of Injury (check all that apply):

<table>
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<tr>
<th></th>
<th>Head</th>
<th>Eye</th>
<th>Ear</th>
<th>Nose</th>
<th>Mouth/Lips</th>
<th>Teeth/Teeth</th>
<th>Jaw</th>
<th>Chin</th>
<th>Neck/Throat</th>
<th>Collarbone</th>
<th>Shoulder</th>
<th>Upper Arm</th>
<th>Elbow</th>
<th>Forearm</th>
<th>Wrist</th>
<th>Hand</th>
<th>Finger</th>
<th>Fingernail</th>
<th>Finger/Toes</th>
<th>Back</th>
<th>Abdomen</th>
<th>Groin</th>
<th>Genitals</th>
<th>Pelvis/Hip</th>
<th>Leg</th>
<th>Knee</th>
<th>Ankle</th>
<th>Foot</th>
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Description of the Incident:

____________________________________________________________________________________
____________________________________________________________________________________
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____________________________________________________________________________________

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 (EGS), 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 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.
ALLERGIC REACTION

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?

NO

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.

YES

Check student’s airway.
Look, listen and feel for breathing.
If student stops breathing, start CPR.

Does student have an emergency care plan available?

NO

Refer to student’s plan.
Administer doctor-and parent/guardian-approved medication as indicated.

Follow school policies for students with severe allergic reactions. Continue CPR if needed.
ASTHMA – WHEEZING – DIFFICULTY BREATHING

Students with a history of breathing difficulties including asthma/wheeze 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.

A student with asthma/wheeze 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?

YES

CALL EMS 9-1-1

NO

Refer to student’s emergency care plan.

Does the student have doctor – and parent/guardian – approved medication?

YES

Has an inhaler already been used?
If yes, when and how often?

NO

Remain calm. Encourage the student to sit quietly, breathe slowly and deeply in through the nose and our through the mouth.

Are symptoms not improving or getting worse?

YES

CALL EMS 9-1-1

NO

Administer medication as directed.

Contact responsible school authority & parent/legal guardian.
BEHAVIORAL EMERGENCIES

Students with a history of behavioral problems, emotional problems or other special needs should be known to appropriate school staff. An emergency care plan should be developed.

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: Check student’s immunization record for tetanus. See “Tetanus Immunization”.
   - No: Hold under running water for 2-3 minutes.
5. Bites from the following animals can carry rabies and may need medical attention:
   - Dog
   - Opossum
   - Raccoon
   - Coyote
   - Bat
   - Skunk
   - Fox
   - Cat
6. Is bite from an animal or human?
   - Human:
     - If skin is broken, contact responsible school authority & parent/legal guardian. URGE IMMEDIATE MEDICAL CARE.
   - Animal:
     - 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.
8. Is bite large or gaping? Is bleeding uncontrollable?
   - Yes: CALL EMS 9-1-1.
   - No: Contact responsible school authority & parent/legal guardian.
9. Report bite to proper authorities, usually the local health department, so the animal can be caught and watched for rabies.
BLEEDING

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.

CALL EMS 9-1-1.

YES

• 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.

IF WOUND IS GAPPING, STUDENT MAY NEED STITCHES. CONTACT RESPONSIBLE SCHOOL AUTHORITY & PARENT OR LEGAL GUARDIAN. URGE MEDICAL CARE.

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.

Contact responsible school authority & parent or legal guardian.
BLISTERS
(FROM FRICTION)

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?

YES

NO

Rest injured part.

Contact responsible school authority & parent or legal guardian.

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”
BURNS

Always make sure the situation is safe for you before helping the student.

ELECTRICAL

What type of burn is it?

Is the student unconscious or unresponsive?

YES

See “Electric Shock”

NO

Flush the burn with large amounts of cool running water or cover it with a clean, cool, wet cloth. Do NOT use ice.

HEAT

• Is burn large or deep?
• Is burn on face or eye?
• Is student having difficulty breathing?
• Is student unconscious?
• Are there other injuries?

CALL POISON CONTROL

1-800-222-1222 while flushing burn and follow instructions.

• Wear gloves and if possible, goggles.
• Remove student’s clothing and jewelry if exposed to chemical.
• Rinse chemicals off skin, eyes IMMEDIATELY with large amounts of water.
• See “EYES” (p.57) if necessary.
• Rinse for 20-30 minutes.

CHEMICAL

Contact responsible school authority & parent or legal guardian.

Cover/wrap burned part loosely with a clean dressing.

Check student’s immunization record for tetanus. See “Tetanus Immunization”

Call EMS 9-1-1
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 1 1/2 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-lift 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.
CARDBIOPULMONARY RESUSCITATION (CPR)
FOR CHILDREN 1 TO 8 YEARS OF AGE

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 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. 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.
   Lift fingers to avoid pressure on ribs. Use equal compression and relaxation times. Limit interruptions in chest compressions.
9. Give 2 normal breaths, each lasting 1 second. Each breath should make the chest rise.
10. REPEAT CYCLES OF 30 COMPRESSIONS TO 2 BREATHS AT A RATE OF 100 COMPRESSIONS PER MINUTE OR 30 COMPRESSIONS IN ABOUT 20 SECONDS UNTIL THE CHILD STARTS BREATHING ON OWN OR HELP ARRIVES.
11. Call EMS after 2 minutes (5 cycles of 30 compressions to 2 rescue breaths) if not already called.

*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 BREATH EFFECTIVELY ON OWN OR HELP ARRIVES.

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CARDIOPULMONARY RESUSCITATION (CPR)
FOR CHILDREN OVER 8 YEARS OF AGE & ADULTS

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 lasti 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 DOES NOT RISE WITH RESCUE BREATH (AIR DOES NOT GO IN):

7. Re-lift head back. Try to give 2 breaths again.

IF CHEST RISES WITH RESCUE BREATH, FOLLOW LEFT COLUMN.

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.

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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 than 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.

CUTS (SMALL), SCRATCHES & SCRAPES
(INCLUDING ROPE & FLOOR BURNS)

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 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.

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.

Refer to student’s emergency care plan.

Is the student:
- Unconscious or losing consciousness?
- Having a seizure?
- Unable to speak?
- Having rapid, deep breathing?

Does student have a blood sugar monitor available?

NO

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.

LOW

- 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?

or

Is blood sugar “HIGH” according to emergency care plan?

HIGH

Contact responsible school authority & parent/legal guardian.

CALL EMS 9-1-1.
If the student is unconscious, see “Unconsciousness”.

YES

NO
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.

- **NO**
  - Do you suspect a live insect is in the ear?
    - **YES OR NOT SURE**
      - Do *NOT* attempt to remove.
      - Contact responsible school authority & parent or legal guardian.
      - **URGE MEDICAL CARE.**
    - 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.
**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.**

**YES**

- **Is 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”

  **Contact responsible school authority & parent/legal guardian.**

**NO**

- **Treat any burns. See “Burns”**

  **Contact responsible school authority & parent or legal guardian.**

  **URGE MEDICAL CARE.**
EYE PROBLEMS

EYE INJURY:

Keep student lying flat and quiet.

With any eye problem, ask the student if he/she wears contact lenses. Have student remove contacts before giving any first aid to eye.

YES

- Is injury severe?
- Is there a change in vision?
- Has object penetrated eye?

NO

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

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”

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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.

---

Keep student in flat position.
- Elevate feet.
- Loosen clothing around neck and waist.

---

- 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?

---

YES

If student feels better, and there is no danger of neck injury, he/she may be moved to a quiet, private area.

---

NO

Contact responsible school authority & parent/legal guardian.
FEVER & NOT FEELING WELL

1. Take student’s temperature. Note oral temperature over 100.0 F as fever.
2. Have the student lie down in a room that affords privacy.
3. Give no medication, unless previously authorized.
4. Contact responsible school authority and parent or legal guardian.
**FRACTURES, DISLOCATIONS, SPRAINS OR STRAINS**

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.

**Treat all injured parts as if they could be fractured.**

**YES**
- 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.**

- Leave student in a position of comfort.
- Gently cover broken skin with a clean bandage.
- **Do NOT move injured part.**

Contact responsible school authority & parent/legal guardian.

**NO**

- 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?

If discomfort is gone after period of rest, allow student to return to class.

**YES**

Contact responsible school authority & parent or legal guardian.

**NO**

**URGE MEDICAL CARE.**
FROSTBITE

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.

**CALL EMS 9-1-1.** Keep student warm and part covered.

**Contact responsible authority & parent or legal guardian.**

**Encourage medical care.**

**Does extremity/part:**
  - Look discolored – grayish, white or waxy?
  - Feel firm/hard (frozen)?
  - Have a loss of sensation?

**YES**

**KEEP STUDENT WARM AND PART COVERED.**

**NO**

**KEEP STUDENT AND PART WARM.**
HEADACHE

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?

See “Head Injuries”

NO

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.

If headache persists, contact parent/legal guardian.

NO

CONTACT PARENT/Legal guardian.

URGE MEDICAL CARE.
**HEAD INJURIES**

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”

- Have student rest, lying flat.
- Keep student quiet and warm.

**Is student vomiting?**

- 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.**

**Are any of the following symptoms present:**
- 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?

**CALL EMS 9-1-1.**

- 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.

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.
HEAT STROKE – HEAT EXHAUSTION

Heat emergencies are caused by spending too much time in the heat. Heat emergencies can be life-threatening situations.

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.

Is student unconscious or losing consciousness?

Yes
- 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”.

No
- Does student have hot, dry, red skin?
- Is student vomiting?
- Is student confused?

No
- 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.

Yes
- 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.

Hypothermia can occur after a student has been outside in the cold or in cold water. Symptoms may include:
- Confusion.
- Weakness.
- Blurry vision.
- Slurred speech.
- Shivering.
- Sleepiness.
- White or grayish skin color.
- Impaired judgment.

- 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?

NO

YES

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

NO

Are cramps mild or severe? MILD

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.

See “Pregnancy”

For mild cramps, recommend regular activities.
MOUTH & JAW INJURIES

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?  
YES → See "Head Injuries"

NO → See "Teeth".

YES → Have teeth been injured?

NO → Has jaw been injured?  
YES → Do NOT try to move jaw.  
       Gently support jaw with hand.

NO → If tongue, lips or cheeks are bleeding, apply direct pressure with sterile gauze or clean cloth.

Contact responsible school authority & parent/legal guardian.  
URGE IMMEDIATE MEDICAL CARE.

• Is cut large or deep?  
• Is there bleeding that cannot be stopped?  
YES → See "Bleeding"

NO → Place a cold compress over the area to minimize swelling.

Contact responsible school authority & parent/legal guardian.  
Encourage medical care.
NECK & BACK PAIN

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?  NO

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.

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.

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/legal guardian.

- Keep student quiet and warm.
- Hold the head still by gently placing one of your hands on each side of the head.
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.

BROKEN NOSE

• Care for nose as in "Nosebleed" above.
• Contact responsible school authority & parent/legal guardian.
• URGE MEDICAL CARE.
OBJECT IN NOSE

Is object:
- Large?
- Puncturing nose?
- Deeply imbedded?

YES OR NOT SURE

Do NOT attempt to remove. See “Puncture Wounds” if object has punctured nose.

NO

Have student hold the clear nostril closed while gently blowing 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.

**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”

**CALL EMS 9-1-1.**

Contact responsible school authority & parent or legal guardian.

**CALL POISON CONTROL**

1-800-222-1222

Follow their directions.

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.
Pregnancy 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:

1. Severe Stomach Pain
   - Call EMS 9-1-1. Contact responsible school authority & parent or legal guardian.

2. Seizure
   - This may be a serious complication of pregnancy.

3. Vaginal Bleeding
   - Contact responsible school authority & parent or legal guardian.
   - Urge immediate medical care.

4. Amniotic Fluid Leakage
   - This is NOT normal and may indicate the beginning of labor.
   - Contact responsible school authority & parent/legal guardian.

5. Morning Sickness
   - Treat as vomiting. See "Vomiting"
**PUNCTURE WOUNDS**

- Wear disposable gloves when exposed to blood or other body fluids.
- Has eye been wounded?
  - YES: See “Eyes – Eye Injury”
  - NO: Do NOT touch eye.
- Is object still stuck in wound?
  - YES: Do NOT try to probe or squeeze.
  - NO: 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.
- Do NOT remove object.
  - Wrap bulky dressing around object to support it.
  - Try to calm student.
- Is object large?
  - YES: Call EMS 9-1-1.
  - NO: Is wound deep?
    - YES: See “Bleeding” if wound is deep or bleeding freely.
    - NO: Is wound bleeding freely or squirting blood?
      - YES: See “Bleeding” if wound is deep or bleeding freely.
      - NO: Check student’s immunization record for tetanus. See “Tetanus Immunization.”
- Contact responsible school authority & parent or legal guardian.
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.

See “Allergic Reaction” and “Communicable Disease” for more information.

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.
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.).

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:
- 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.
SHOCK

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.
- Blueness 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.
**SPLINTERS OR IMBEDDED PENCIL TIP**

1. Wear disposable gloves when exposed to blood or other body fluids.
2. Check student's immunization record for tetanus. See "Tetanus Immunization".
3. Gently wash area with clean water and soap.
4. Is splinter or pencil tip:
   - Protruding above the surface of the skin?
   - Small?
   - Shallow?

   *NO*  
   • Leave in place.  
   • Do *NOT* probe under skin.

   *YES*  
   • Remove with tweezers unless this causes student pain.  
   • Do *NOT* probe under skin.

   Contact responsible school authority & parent or legal guardian. Encourage medical care.

5. Were you successful in removing the entire splinter/pencil tip?

   *NO*  
   Wash again. Apply clean dressing.

   *YES*
**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.
STINGS

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?

NO

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.

See “Allergic Reaction”

YES

Refer to student’s emergency care plan.

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”.

“School Health Program Manual” – 2014
N.C. Division of Public Health – Children & Youth Branch – School Health Unit

E3-68
**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.

**KNOCKED-OUT OR BROKEN PERMANENT TOOTH**

- Find tooth.
- Do **NOT** handle tooth by the root.
- Do not replant primary (baby) teeth back in socket. (No. 1 in list.)
- 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.
**UNCONSCIOUSNESS**

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?

- **YES**
  - See “Fainting”
  - 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.

- **NO**
  - Is student breathing?
    - **YES**
      - Begin CPR. See “CPR”
    - **NO**
      - CALL EMS 9-1-1.

CALL EMS 9-1-1.

- 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.

Contact responsible school authority & parent/legal guardian.
VOMITING

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?

YES

NO

Contact responsible school authority & parent/legal guardian.
URGE MEDICAL CARE.

Contact responsible school authority & parent/legal guardian.
Procedures and Referral Basis for Health Screening Programs

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 information in an easy-to-use format, suitable for the health professional and the lay person alike.

Screening is an intervention to discover a health problem early. If a potential disability 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 disabling condition. Additionally, people at low risk are spared the trouble and expense of undergoing those more involved procedures.
Before a school health professional embarks 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:

- Condition is treatable or controllable.
- Early treatment improves academic outcome.
- Screening and follow up time is adequate.
- Firm diagnosis is possible.
- Condition is relatively prevalent.
- Condition is serious.
- Condition is one which may interfere with learning.

Criteria for selecting which screening procedures are to be used include:

- Acceptability to both professionals and to the public.
- Simplicity, requiring no complicated or hard-to-move equipment.
- Reliability (repeatability of results).
- Validity (frequency with which the screening test result is confirmed by the diagnosis).
- Appropriateness for the population being screened.
- Cost.

In addition to deciding on conditions to screen and 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:

- The condition may be a barrier to learning.
- Medical knowledge should be adequate to deal effectively with a problem which may be identified.
- Health care providers should be available to deal with any problems discovered and other facilities such as laboratories, hospitals, etc. should be accessible.
- 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:

- Use simple administrative procedures. Complicated ones may discourage students. Time-consuming ones may not be practical in the school setting.
- 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.
- Eliminate unnecessary referrals. For example: All failed vision screenings done by volunteers should be rescreened by the school nurse before a referral is made.
- Communicate fully with student, parents, and physician.
- Provide both a setting and staff that promote the comfort and self-esteem of the student.
- Avoid duplication of services.
- Provide supportive services when possible, (e.g., translators, transportation).
- Protect confidentiality.
- Know what resources are available in your community.
- 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 opportunity to promote health awareness and invite personal commitment to health. The target audience participates in various health screenings, 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:

• For students, obtain parental permission.
• Obtain authorization from school administrators to hold fair.
• Decide location and date.
• Identify personnel and target audience.
• Explore community agency interest and commitment for personnel and/or exhibits.
• Identify types of screenings to be offered and equipment needed.
• Establish training schedule.
• Determine how follow-up of abnormal findings will occur.
Anthropometric Measurements

Height and weight measurements of children are part of the total physical assessment completed on any child at well child health exams by the health care provider. Increasingly, mass screenings for height/weight and BMI (Body Mass Index) are being conducted at school in order to:

- Collect data as part of a school-wide needs assessment to establish objectives and priorities.
- 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;
- 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 or conditions that may affect normal growth patterns or those suspected of having eating disorders or weight management issues.

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 and appropriateness for students being measured. 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.

• For students referred, school nurses should assess nutrition and physical activity in conjunction with height and weight measurement, and provide basic health counseling as necessary and appropriate.

• Students with newly-identified or untreated nutritional deficits should be referred to their physician or other local community resource. 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. When students transfer, their chart should be included as part of their school health record.

• Local public health, health providers, and/or school district nutritionists are a valuable resource for the school nurse needing assistance in the management of students with nutritional needs.

Resources


• CDC Training Modules on Growth Charts and BMI: [http://www.cdc.gov/nccdphp/dnpa/growthcharts/training/modules/module1/text/page1a.htm](http://www.cdc.gov/nccdphp/dnpa/growthcharts/training/modules/module1/text/page1a.htm)

• 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.

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://childnutrition.ncpublicschools.gov/who-we-are/maps

http://childnutrition.ncpublicschools.gov
Medical Statement for Students with Special Nutritional Needs for School Meals- Revised 6-2011: Find this under Forms/Template/Worksheets on the previous link. Choose MYplate.gov: www.choosemyplate.gov
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 disabilities or 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 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) who are referred by their parent or teacher for hearing concerns.

The number of children screened should take into consideration the extent of personnel available for both screening and follow-up activities and should be conducted under supervision of an audiologist or physician as defined in General Statutes.
Student Preparation

For mass screenings, prepare students for the 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. 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. 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.

Procedure

- Equipment used must be calibrated per manufacturer’s instruction.
- Nurse must be trained (and supervised) by the audiologist or physician specific to the equipment used.

Suggestions for 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:
  - 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.
  - It is helpful to allow the child to watch other children or his/her teacher being tested before he/she is tested.
  - Make it a fun game. Maintain a kind and patient demeanor. Praise the child promptly for correct responses.
Suggestions for Screening the Young/Hard-to Test Child (continued)

- Try to do the test as quickly and as crisply as possible. Young children tire and bore easily.
- 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.

Referral Sources
If the local school system has an audiologist, the student should first be referred to this professional for further evaluation. 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 / Contact Information

Please return this form to the school nurse listed above.
Findings: School Hearing Screening Test

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<thead>
<tr>
<th>Frequency</th>
<th>Left Ear</th>
<th>Right Ear</th>
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<tbody>
<tr>
<td>1000</td>
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<td></td>
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<tr>
<td>2000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4000</td>
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</tbody>
</table>

I. Results of 1st School Screening

Date: 
Calibration: ANSI

II. Results of 2nd School Screening

Date: 
Calibration: ANSI

Report of Hearing Examination:

Diagnosis or explanation: ____________________________________________

III. Results of Hearing Examination

Date: _____________________________
Hearing Test: _______________________
Calibration: ANSI

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Left Ear</th>
<th>Right Ear</th>
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</thead>
<tbody>
<tr>
<td>1000</td>
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<td>8000</td>
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</tbody>
</table>

Pure Tone Average DB loss (1000-2000-4000)

Plan of treatment: ____________________________________________

Recommendation for school: ____________________________________

Signature of Examiner: _____________________________ Phone #: _____________
North Carolina School Health Program Manual

Section E  Chapter 4
School Health Services  Audiometric Hearing Screening

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

21 NCAC 64 .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 audiometric 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

School Health Program Manual – 2014
NC Division of Public Health – Children & Youth Branch – School Health Unit
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; Amended Eff. October 1, 2009.
Dental Screening

Purpose

Dental health screening programs are multifaceted and serve to:

- Increase awareness and importance of good oral health;
- School nurses may assist students, teachers and parents with familiarization of available services.

The partnership between nurses and dental professionals offers great benefits for children. Dental hygienists or other oral health professionals may conduct mass dental screenings in schools with permission of LEA administration. School health programs may help facilitating dental screenings and assist with referral and follow-up for students.

Available Resources for Oral Health

The mission of the North Carolina Oral Health Section is preventing oral disease and promoting access to dental care based on prevention and education. Their web site provides resources for teachers, other health professionals, and consumers: 
http://www.ncdhhs.gov/dph/oralhealth/education/index.htm
Vision Screening

Regulations

Every student entering kindergarten in public schools should obtain a vision screening as a required element of the mandated North Carolina Kindergarten Health Assessment. This is to be completed by the primary care physician.

Recommendations for Vision Screenings

School screenings are a means of identifying vision difficulties. Screenings should be considered for students who: are new to the school system, are being evaluated for special education program, failed academically the previous year, demonstrate possible vision problems, or are referred by teachers or parents.

In addition, mass vision screenings may be done in selected grades. 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, as well as other items described for a screening program.

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 to be the single most important test of visual ability with proven reliability in detecting the above conditions.

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.

When screening for potential placement in EC programs, vision screening must include both near and distance acuity

Additional information and resources can be found at Prevent Blindness NC, www.preventblindness.org/nc or 1-800-543-7839.

Additional Types of Vision Screening

Additional 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 additional screenings do not need to be done routinely for all students or as part of a mass screening program. The various types of vision screening tools will provide information on how to score and record test results.

The most current information about vision screening, 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 by calling 1-800-543-7839.
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 on 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.)
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 ___________
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 Annual School Health Services 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.

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 services expected to be delivered through the SNFI program. The SNFI Work Plan Report documents fulfillment of the work plan.

Contact your regional school health nurse consultant for a copy of the current Annual School Health Services Report form, the current SNFI Work Plan, or the SNFI Work Plan Report form.
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.

<table>
<thead>
<tr>
<th>Assessment of School Health Program</th>
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<tbody>
<tr>
<td>Criteria</td>
</tr>
<tr>
<td>Number of students</td>
</tr>
<tr>
<td>Number of schools</td>
</tr>
<tr>
<td>Nurse ratio per school</td>
</tr>
<tr>
<td>Employing agency: LEA, HD, Hospital</td>
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<tr>
<td>Nurse location (where SN can be reached)</td>
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<tr>
<td>Is there an MOA with HD?</td>
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<tr>
<td>Is your workspace adequate? (include all schools)</td>
</tr>
<tr>
<td>▪ equipment</td>
</tr>
<tr>
<td>▪ telephone for confidential conversations</td>
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<tr>
<td>▪ a place to isolate those with communicable diseases</td>
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<tr>
<td>Do you have a written job description?</td>
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<tr>
<td>Does your job description reflect what you do?</td>
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<tr>
<td>Did you have an opportunity to participate in writing or updating your job description?</td>
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<tr>
<td>Do you receive an annual, formal evaluation?</td>
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<tr>
<td>Who is responsible for providing leadership for school health services?</td>
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<td>Criteria</td>
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<tr>
<td>How do you determine in-service needs of health staff and school personnel?</td>
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<tr>
<td>What is your procedure for compiling health services data?</td>
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<tr>
<td>What is the process for providing information and health updates to appropriate school administrators and/or health department and local school board?</td>
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<tr>
<td>Is there medical consultation available to the school system? Is there a written agreement?</td>
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<tr>
<td>Who serves on your SHAC? Do members represent the larger community? Do they look at current policies?</td>
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<tr>
<td>Who is responsible for health curriculum?</td>
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<tr>
<td>Do you have a health education coordinator?</td>
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<tr>
<td>What student health record(s) are you using?</td>
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<tr>
<td>Where are health records kept?</td>
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<tr>
<td>Who has access to health records?</td>
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<tr>
<td>Are confidentiality rules, including rights of access to individual health records, observed as required by law?</td>
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<tr>
<td>Are policies for the following procedures followed?</td>
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</table>
## Reports of School Health Programs

### Criteria

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<tr>
<th>Criteria</th>
<th>4</th>
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<th>Comments</th>
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<tr>
<td>Medication</td>
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<td>Injuries-reporting</td>
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<td>Abuse/neglect</td>
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<td>Prevention and control of</td>
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<td>Immunizations</td>
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<td>Infection Control</td>
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<td>Provision for emergency care: (first aid, fire, and)</td>
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### What mass screenings are provided:

- vision
- hearing
- blood pressure
- dental
- other

### Student health appraisals and physical assessment according to policy for: *Kindergarten Health Assessments* for new students:

- Students with known health problems
- Students involved in athletic competition
- Students involved in Special Olympics
- Students referred by parents and/or school personnel

### Is there a School Health Services Procedure Manual?  

### Is this manual available to school personnel?
### Reports of School Health Programs

<table>
<thead>
<tr>
<th>Criteria</th>
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<tr>
<td>• What is your involvement with the Exceptional Children’s Program?</td>
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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? Staff development?</td>
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Does the School Health Services Program undergo periodic evaluation and revision?

What are your training or in-service needs?

Recommended steps to be taken:
Appendices
<table>
<thead>
<tr>
<th>Appendix Item #1</th>
<th>CLIA – Laboratory Regulations</th>
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<tbody>
<tr>
<td>Appendix Item #2</td>
<td>Credentialing of Individuals to Administer Life Saving Treatment in Anaphylaxis</td>
</tr>
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<td>Appendix Item #3</td>
<td>Duty for Schools to Provide Nursing Services, Supreme Court of US, Cedar Rapids Community School District v. Garrett</td>
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<td>Appendix Item #4</td>
<td>FERPA Legislation</td>
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<tr>
<td>Appendix Item #5</td>
<td>Kindergarten Health Assessment (KHA): Guidelines</td>
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<tr>
<td>Appendix Item #5</td>
<td>Kindergarten Health Assessment (KHA): Frequently Asked Questions (FAQ)</td>
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<td>Appendix Item #6</td>
<td>Maintenance of Forms: Guidance</td>
</tr>
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<td>Appendix Item #7</td>
<td>Relevant Legislative References</td>
</tr>
<tr>
<td>Appendix Item #8</td>
<td>Record Maintenance and Confidentiality</td>
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<tr>
<td>Appendix Item #9</td>
<td>RN – Each LEA Shall Make Available</td>
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<tr>
<td>Appendix Item #10</td>
<td>Organizations and Applications: Health Promotion, Health Support</td>
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<tr>
<td>Appendix Item #11</td>
<td>School Nurse Certification and Salary</td>
</tr>
<tr>
<td>Appendix Item #12</td>
<td>Self-Administration and Possession of Asthma and Anaphylaxis Medications</td>
</tr>
<tr>
<td>Appendix Item #13</td>
<td>Students with Diabetes</td>
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<tr>
<td>Appendix Item #14</td>
<td>Student’s Permanent Health Record: Guidelines</td>
</tr>
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</table>
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 urinalysis, 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/ahec/clia/index.html#contact](http://www.dhhs.state.nc.us/dhsr/ahec/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
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 anaphylactic reaction.

Forms available at http://www.ncdhhs.gov/dhsr/EMS/formapps.h
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(Bench Opinion) OCTOBER TERM, 1998

Syllabus
NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader.

SUPREME COURT OF THE UNITED STATES
Syllabus
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.
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 date 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

Or you may visit: http://www.ed.gov/policy/gen/guid/fpc/index.html
Kindergarten Health Assessment

Guidelines

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 1/11) 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


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: http://www.ncdhhs.gov/dph/wch/families/kindergartenhealth.htm
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, 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,)
Kindergarten Health Assessment

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, or arrange for, 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 1/11) 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 may be downloaded and printed from http://www.ncdhhs.gov/dph/wch/families/kindergartenhealth.htm
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, concurrent with the annual immunization compliance report, in an on-line format.³

³ To obtain a copy of the Kindergarten Health Assessment Status Report form, contact the NC Division of Public Health School Health Unit.
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.
Questions and Answers about the Kindergarten Health Assessment

This Q and A section has been written by the North Carolina Regional School Health 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.

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. The 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, revised 1/2011): 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 available for download at [http://www.ncdhhs.gov/dph/wch/doc/aboutus/KHA_1-11.pdf](http://www.ncdhhs.gov/dph/wch/doc/aboutus/KHA_1-11.pdf)
6. **Is there a certain date that the student’s health assessment or examination must be 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 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 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.

14. 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.

15. 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.

16. 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.

17. What if the Kindergarten Health Assessment Report is not fully completed when the parent submits it to school?
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19. 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.

20. 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.

21. 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.
## 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 perm. health card while active. Original in individual health record</td>
<td>May destroy if superseded. If D/C note on perm. 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 perm. health card while active. Original in individual health record</td>
<td>May destroy if superseded. If D/C note on perm. 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 perm. 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 perm. health card (unless of sensitive nature) Original in individual health record</td>
<td>May destroy if superseded. If D/C note on perm. health card.</td>
</tr>
<tr>
<td>Injury Incident Reports</td>
<td>File per LEA policy. Do not reference in individual health record.</td>
<td>Retain until age 29.</td>
</tr>
<tr>
<td>Kindergarten Health Assessment</td>
<td>Retain in cumulative folder.</td>
<td>Retain until completion of elementary school. Retain perm. if only immun. rec.</td>
</tr>
</tbody>
</table>
## Maintenance of Forms: Guidance

<table>
<thead>
<tr>
<th>Type</th>
<th>Maintenance</th>
<th>Archiving</th>
</tr>
</thead>
<tbody>
<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>
Child Protective Services: NC G.S. 7B Juvenile Code; Sub Chapter 1 Abuse, Neglect, and Dependency

Credentialing of Individuals to Administer Life Saving Treatment in Anaphylaxis: 
10A NCAC 13P .0509

Employee Health Certificate: NC G.S. 115C-323

Environmental Health Regulations for Public, Private and Religious Schools: 
NC G.S. 130A-236, NC G.S. 115C-47, and NC Administrative Code 15A NCAC 18A .2400-.2417

“Good Samaritan” Law, Including AED: NC G.S. 90-21.14

Healthy Active Children / Coordinated School Health: State Board of Education Policy number GCS-S-000

Medical Care to Students by School Personnel: NC G.S. 115C-375.1 Article 25A

Medical Treatment of Minors: NC G.S. 90-21.1 Article 1A Treatment of Minors


Pregnant and Parenting Students: NC G.S. 115C-375.5

Reproductive Health and Safety Education: NC G.S. 115C-81(e1)

Safe Surrender of Newborns: NC G.S. 7B-500 Responsibility of Schools to Inform Students: 115C-47 Section (52)

School Violence Prevention Act including Bullying: NC G.S. 115C-407.15

Tobacco Free Schools: NC G.S. 115C-407
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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.

(4) The superintendent or the superintendent’s designee determines that the maintenance of the record is no longer needed to adequately serve the child.

(c) Notwithstanding subdivision (b)(1) of this section, a superintendent or the superintendent’s designee may expunge from a student’s official record any notice of suspension or expulsion provided all other criteria under subsection (b) are met.

(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.

(c) 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 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 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)
.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:
   a. identification of appropriate person(s) to perform the procedure;
   b. teaching those persons to perform the procedure; and
   c. 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)
American Nurses Association  
800-274-4262  
www.nursingworld.com

American National Red Cross  
800-257-7575  
www.redcross.org

Annual School Health Services Reporting Forms  

CLIA – Laboratory Regulations  
www.cms.hhs.gov/CLIA/05_CLIA_Brochures.asp

Communicable Disease  
http://epi.publichealth.nc.gov/cd/sbc.html

Division of Medical Assistance – School Nursing Services Reimbursement Forms  
http://ec.ncpublicschools.gov/finance-grants/medicaid-in-education/resources

DNAR – Medical Orders for scope of Treatment (MOST Form)  
http://www.ncdhhs.gov/dhsr/ems/dnrmost.html

FERPA Legislation  

Food Allergy and Anaphylaxis Network  
800-929-4040  
www.foodallergy.org

KIDBASE – Helping Emergency Personnel Care for a Child with Special Health Care Needs  
http://www.ncdhhs.gov/dhsr/EMS/injrchld.htm

Kindergarten Health Assessment (KHA) – Form  
http://www.ncdhhs.gov/dph/wch/families/kindergartenhealth.htm

IDEA – Federal Register Q&A  
http://idea.ed.gov/explore/home
Medical Exemption – Physician’s Request for Medical Exemption
http://www.immunize.nc.gov/providers/forproviders.htm

Medline Plus

National Association of School Nurses
1-866-627-6767
www.nasn.org

North Carolina Board of Nursing, Nursing Practice Act and Regulations
919-782-3211
www.ncbon.com

North Carolina Healthy Schools
www.nchealthyschools.org

North Carolina Immunization Branch Division of Public Health
http://www.immunize.nc.gov

North Carolina Lions Foundation
828-478-2135
www.nclf.org

North Carolina Nurses Association
800-626-2153
www.ncnurses.org

North Carolina Public Health Association
919-828-6201
www.nepha.com

OSHA Regulations – Federal Department of Labor:
http://www.oah.state.nc.us/rules/
www.osha.gov/Regulations
www.nciabor.com

Patient Authorization Form, Use and Disclosure of Health Information – Instructions; DHHS
#4056 Form in English and Spanish
http://publichealth.nc.gov/lhd/
Physical Activity & Nutrition Behaviors Monitoring Form  
http://www.eatsmartmovemorenc.com/BehaviorsForm/BehaviorsForm.html

Prevent Blindness North Carolina  
919-755-5044  
www.nc.preventblindness.org

School Nurse Association of North Carolina  
www.snanc.org

School Summary Report, Annual Kindergarten Immunization and Health Assessment Status  
http://www.immunize.nc.gov/schools/annualimmunizationreports.htm

School Summary Report, Annual Immunization Status of Sixth Grade Students  
http://www.immunize.nc.gov/schools/annualimmunizationreports.htm

Special Education:  http://ec.ncpublicschools.gov/

Student’s Permanent Health Record, Form Order (PPS2P)  
http://www.ncpublicschools.org/publications/ordering/

“Apps” is an abbreviation for application.  Apps refers to internet applications that run on smartphones and other mobile devices.  They help connect users to internet services and make it easier to use the internet on portable devices.  School Nurses can use a variety of apps to connect to medically related internet sites to stay up to date with current information.  Some sites that have useful apps include: Centers for Disease Control, OSHA, American Red Cross & FEMA.
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CERTIFICATION OF SCHOOL NURSES

115C-315 Hiring of school personnel.

(a) Janitors and Maids. - In the city administrative units, janitors and maids shall be appointed by the board of education of such local school administrative unit upon the recommendation of the superintendent.

(b) Election by Local Boards. - School personnel shall be elected by the local board of education upon the recommendation of the superintendent, in accordance with the provisions of G.S. 115C-276(j).

It is the policy of the State of North Carolina to encourage and provide for the most efficient and cost-effective method of meeting the needs of local school administrative units for noncertified support personnel. To this end, the State Board of Education shall recommend to the General Assembly by November 1, 1984, a system using factors and formulas to determine the total number of noncertified support personnel allotted to local school administrative units. The recommended system for allotting noncertified support personnel shall include the proposed State's funding obligation for these positions and shall be developed in consultation with school-based support personnel or their representatives.

(c) Prerequisites for Employment. - All professional personnel employed in the public schools of the State or in schools receiving public funds shall be required either to hold or be qualified to hold a certificate in compliance with the provision of the law or in accordance with the regulations of the State Board of Education: Provided, that nothing herein shall prevent the employment of temporary personnel under such rules as the State Board of Education may prescribe.

(d) Certification for Professional Positions. - The State Board of Education shall have entire control of certifying all applicants for professional positions in all public elementary and high schools of North Carolina; and it shall prescribe the rules and regulations for the renewal and extension of all certificates and shall determine and fix the salary for each grade and type of certificate which it authorizes: Provided, that the State Board of Education shall require each applicant for an initial certificate or graduate certificate to demonstrate his or her academic and professional preparation by achieving a prescribed minimum score at least equivalent to that required by the Board on November 30, 1972, on a standard examination appropriate and adequate for that purpose: Provided, further, that in the event the Board shall specify the National Teachers Examination for this purpose, the required minimum score shall not be lower than that which the Board required on November 30, 1972.

(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.

(e) Repealed by Session Laws 1989, c. 385, s. 3.
(f) Employing Persons Not Holding nor Qualified to Hold Certificate. - It shall be unlawful for any board of education to employ or keep in service any professional person who neither holds nor is qualified to hold a certificate in compliance with the provisions of the law or in accordance with the regulations of the State Board of Education. (1955, c. 1372, art. 5, s. 4; art. 18, ss. 1-4; 1965, c. 584, s. 20.1; 1973, c. 236; 1975, c. 437, s. 7; c. 686, s. 1; c. 731, ss. 1, 2; 1981, c. 423, s. 1; 1983 (Reg. Sess., 1984), c. 1103, s. 9; 1985 (Reg. Sess., 1986), c. 975, s. 16; 1989, c. 385, s. 3; 2002-126, s. 7.41(a.).)

(d1) 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 STATE BOARD OF EDUCATION
Policy Manual

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.

School nurse salary information is found in Section D
§ 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 asthma or anaphylaxis emergency.
Item #12
Self-Administration of Medication

(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).)
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.
North Carolina School Health Program Manual

Appendix  

<table>
<thead>
<tr>
<th>Item #13</th>
<th>Students with Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>c.</td>
<td>Procedures for regular review of an individual care plan.</td>
</tr>
<tr>
<td>d.</td>
<td>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.</td>
</tr>
<tr>
<td>e.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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
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.)
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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.nepublicschools.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.
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

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.
SCREENINGS: The results and details of health related screenings should be recorded in the student’s individual health record. Here it is important to record only those findings and final results that may impact the student’s educational progress and provide information that teachers and other educators need to know to assist the student.

### VISION SCREENING

Date of most recent vision screening: (pencil)

<table>
<thead>
<tr>
<th>Known vision problem:</th>
<th>Glasses/contact lenses (mark one):</th>
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<tbody>
<tr>
<td></td>
<td>Yes. No.</td>
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</table>

Classroom Accommodations (if any):

Other comments:

Results of failed vision screening:

<table>
<thead>
<tr>
<th>Screening Date</th>
<th>Date/method of 1st parent notification (phone/letter/note via student)</th>
<th>Results of professional vision exam (does not need corrective lenses; needs correction all the time; only for reading/distance work, etc.)</th>
<th>Comment/Signature</th>
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</table>

### HEARING SCREENING

Date of most recent hearing screening: (pencil)

<table>
<thead>
<tr>
<th>Known hearing problems:</th>
<th>Preferential seating</th>
<th>Hearing Aids Under MD Care:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Yes. No.</td>
<td>Yes. No.</td>
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</table>

Results of failed hearing screening:

<table>
<thead>
<tr>
<th>Screening Date</th>
<th>Date/method of 1st parent notification (phone/letter/note via student)</th>
<th>Results of professional hearing or ENT exam (does not need correction; sit in front of class; etc.)</th>
<th>Comment/Signature</th>
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</table>

### ANTHROPOMETRIC SCREENING

<table>
<thead>
<tr>
<th>Date</th>
<th>Ht.</th>
<th>Wt.</th>
<th>BMI %</th>
<th>Comments</th>
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### DENTAL SCREENING

<table>
<thead>
<tr>
<th>Date</th>
<th>Results</th>
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### OTHER SCREENING

<table>
<thead>
<tr>
<th>Date</th>
<th>Ht. Wt. BMI % Comments</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.
<table>
<thead>
<tr>
<th>Date</th>
<th>Notes</th>
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</table>
### Health History (May Use Pencil)

- Normal growth and development, no known health problems
- BP (most recent)

### Student's Permanent Health Record

- Full Name
- ID # (if needed)
- Sex: ☐ M ☐ F
- Birth date: _____/_____/_____
- Parent/Guardian Name: _____________________________________
- Emergency contact phone: ______________________

#### Screenings

**Vision Screening**
- Date of most recent vision screening: (pencil)
- Known vision problem: ☐ Glasses/contact lenses (mark one):
  - ☐ Yes
  - ☐ No
- Classroom Accommodations (if any):
- Other comments:

**Results of failed vision screening:**

<table>
<thead>
<tr>
<th>Screening</th>
<th>Date</th>
<th>Method of notification</th>
<th>Results of professional vision exam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(phone/letter/note via student)</td>
<td>(does not need corrective lenses; needs correction all the time; only for reading/distance work; etc.)</td>
</tr>
</tbody>
</table>

**Hearing Screening**
- Date of most recent hearing screening: (pencil)
- Known hearing problems:
  - ☐ Preferential seating
  - ☐ Hearing Aids
  - Under MD Care: ☐ Yes ☐ No
- Results of failed hearing screening:

**Anthropometric Screening**

<table>
<thead>
<tr>
<th>Date</th>
<th>Height</th>
<th>Weight</th>
<th>BMI</th>
<th>Comments</th>
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</table>

**Dental Screening**

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<tr>
<th>Date</th>
<th>Results</th>
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</table>

**Other Screenings**

<table>
<thead>
<tr>
<th>Date</th>
<th>Results</th>
</tr>
</thead>
</table>

### Health History

- May use pencil

#### Record of Immunizations – Enter Date of Each Dose – MO/DAY/YEAR

This section is optional. This transcription does not serve as an official record of immunization. A copy of the student’s official immunization certificate or record(s) shall be maintained within the student’s health record. Follow the current NC recommended schedule for immunizations.

Unprotected against (name of VPDs):

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
<th>#5</th>
</tr>
</thead>
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</tbody>
</table>

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.

### Kindergarten Health Assessment

The Kindergarten Health Assessment report, required for first time entry into public school kindergarten, is on file: ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
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<tr>
<th>Title of individual recording / transcribing:</th>
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