The Office of Healthful Living looks forward to working with you to keep Cumberland County School’s students happy and healthy!

Shirley Johnson
Healthful Living Coordinator
910-678-2406

Cumberland County Schools

Protocol for Administration of Medication
**General Information**

Cumberland County Schools embraces the diverse health needs of our student population and has created this protocol to educate parents and staff with best practices for medication administration. School nurses are present in schools one day each week and respond on call for emergency situations. The school district retains the right to reject a request for administration of medication. The only responsibility of liability that can be assumed by the school system or its personnel is to comply with the instructions forwarded by parent/guardian and physician. The Office of Healthful Living in collaboration with Cumberland County Department of Public Health provides a variety of parent support services, workshops, and connections to community resources.

**Parent Responsibilities**

- The parent/guardian will complete the Confidential School Health Form and return immediately to the school. (*see form 1A and B*)
- The parent/guardian will complete current Emergency Contact Information and update often.
- The parent/guardian will bring medication to school, check-in and sign out medication with medication clerk.
- The parent/guardian will provide medication refills as needed.
- The parent/guardian will replace expired medication.
- The parent/guardian will pick-up medication by the last day of school. (All medications not picked up within two weeks from last day of school, will be properly disposed of)
- Parent/guardian of the student must assume responsibility for informing the primary medication clerk of any changes in the medication.

**Staff Responsibilities**

- The principal will designate a minimum of three (3) individuals at each school who will be responsible for administering medications. (One primary full time personnel and at least two back up for administration of medication)
- Primary Medication Clerk or principal’s designee will organize and maintain a Confidential School Health Form notebook.

**Prevent Blindness North Carolina**

Prevent Blindness North Carolina has several programs that provide free eye exams and eyeglasses to qualifying low-income and uninsured students.

Contact your school social worker for questions and applications.

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**Prevent Blindness North Carolina**

Vision Resources for Youth January 1-December 31, 2010

**FSP Sight for Students Program**

Sight for Students is a charitable program funded by Vision Service Plan, the nation’s oldest and largest managed vision care plan. The program provides free vision exams and glassess to low-income uninsured children who have a Social Security number. Sight for Students operates nationally through a network of community partners, including Prevent Blindness North Carolina, who identify children in need and FSP network doctors who provide the eye care services.

**PBCSR Honor Docs Program**

PBCSR Honor Docs Program is a volunteer program of ophthalmologists and ophthalmologists across the state of North Carolina. This program covers vision exams and in some cases, glasses for uninsured children who have had vision screening and need a comprehensive eye exam. Services are available on a first come, first serve basis until all donated services have been used in the local area. Optometrist services are not included in all areas.

**Healthy Eyes Eyeglasses Program**

The Healthy Eyes Eyeglasses Program is a charity program funded by the Luxottica Group Foundation in partnership with Prevent Blindness America. This program is an extension of the OneSight program which provides free eyeglasses to qualifying families. Healthy Eyes Eyeglasses recipients may choose from a special selection of frames at Asian Optical, Target Optical, LensCrafters, or select Persil Vision stores.

<table>
<thead>
<tr>
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<th>200% of federal poverty level – FSP &amp; Healthy Eyes</th>
<th>200% of federal poverty level – Honor Docs</th>
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<td>8 persons</td>
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</tr>
</tbody>
</table>

For further information to [www.preventblindness.org](http://www.preventblindness.org) under the Financial Resources tab or call 919-755-5644 or 800-543-7815.
Friendly Neighborhood Dental Van

The Friendly Neighborhood Dental Van (FNDV) is a mobile dental service that is being offered to elementary students throughout Cumberland County. The goal of FNDV is to provide comprehensive dental services to those children who do not normally receive routine and on-going dental care.

Frequently Asked Questions

Who pays for the treatment?
- If the child is covered by Medicaid or North Carolina Health Choice, that information is collected and FNDV processes the necessary paperwork.
- If the child has private insurance, that is also accepted. There is also the option to pay in cash.
- In cash payment instances, the parent/guardian should contact FNDV in advance to discuss cost of treatment.

What if the child already has a local dentist?
- If the child already has a dentist and they are routinely visiting them, we encourage the parent/guardian to stay with that dentist for their child’s care. FNDV is primarily designed for children that do NOT have a dentist that is seen on a regular basis.

Who gives permission for the child to be seen?
- The parent/guardian of the child must complete and sign a form giving permission for treatment to occur. Without a signed, completed form, a child cannot be seen by FNDV.

Letters and applications will be sent home prior to the Dental Van’s visit to the school. For scheduled dates, you may contact your school or the Office of Healthful Living at 678-2406.

- This notebook will be alphabetized and organized by grade level.
- The completed notebook is due to the school nurse by the 30th calendar day from the start of school.
- School nurse will review for accuracy and areas of concern and provide an overview of major chronic illnesses to school staff and all resource teachers.
- School nurse will provide follow up as needed and devise emergency action plans.
- Confidential School Health form must be maintained according to local protocol for:
  - 24 years for Elementary School
  - 16 years for Middle School
  - 14 years for High School
- Upon receipt of medication, medication clerk will notify the other medication clerks, and teacher(s) if applicable, of any change to the order.

Staff Training Requirements

These courses are designed to familiarize staff with policies and procedures for managing student health care at school.

- Diabetes Training
  - Staff must attend annually
- Asthma Training
  - Certification is valid for two years
- Medication Training
  - Certification is valid for two years

Administration of Medication

Long Term Medications

- The parent/guardian must bring the medication in the original pharmacy labeled container to the school.
- Long-term medications are prescribed for fifteen (15) days or longer.
- Prior to acceptance of medication, parents must have a completed Physicians School Medication form and a signed Release of Liability. (see form 2)

Administration of Medication Cont.

- The physicians directions on the Physicians School Medication Form must match the pharmacy labeled container.
Short Term Medications

- Parent/guardian must bring the prescribed medication in the original pharmacy labeled container to the school.
- Parent/guardian is also required to complete a Short Term Medication form (see form 3) to include:
  - Right dose
  - Right time
  - Right route (by mouth, injection, etc.)
  - Right student
  - Right medication
  - Right “written” document

- All medications must be counted/measured with the medication clerk prior to acceptance.
- Parent/guardian must also sign the Release of Liability Form.
- Short-term medications may not exceed 14 days.

Over the Counter Medications

- The use or administration of over-the-counter (OTC) medications (non-prescription medications) i.e. sunscreen, insect repellant, medicated lip balm, etc. are not permitted at school, unless accompanied by a physician’s school medication form.
- Students with major/chronic illnesses or conditions (Sickle Cell Anemia, Arthritis, Migraines, Dysmenorrhea, etc.) that necessitate PRN (as needed) medicines will be dealt with individually.
- Over the counter medications must have a prescription labeled container and have a completed Physician’s School Medication Form/Release of Liability Form signed by the parent/guardian.

Administering and Documenting Medication

- The only responsibility or liability that can be assumed by the school system or its personnel is to comply with instructions forwarded by the student’s parents and physician.
- Students with life threatening conditions are permitted to self-medicate upon receipt of required documentation and approval from school nurse and principal.
- A back-up medication must be provided by the parent/guardian for all students.

Healthful Living Resources

Information for Uninsured Children

The state of North Carolina offers two health insurance programs for children:

Health Check (Medicaid for Children)
NC Health Choice (Federal name: CHIP)

Both programs offer free or low cost health insurance for children and teens. The same application is used to determine eligibility for both programs. Children may qualify for one of the programs based on family income level and age. Children may cross over from Health Check to NC Health Choice as they age. Families may have children in different programs. As a family’s income changes, their children may go back and forth between programs. The only way to know what program the children will qualify for is to apply.

Benefits include:
- Well-child Checkups
- Sick Visits
- Medicines
- Immunizations
- Vision & Hearing Care
- Dental Care
- Lab Tests
- Counseling
- Medical Equipment and Supplies
- Hospital Care
- Therapies
- Surgery

*Additional benefits may be available for children with Special Health Care Needs. Call 1-800-737-3028 for more information.

How can a family obtain an application for Health Check (Medicaid)/ NC Health Choice?

- Go online to www.NCHealthyStart.org
- Visit the “FOR THE PUBLIC” section and click on the “Child Health Insurance” link
- The application can be self-completed and mailed in or delivered to the local department of social services with the documentation requested

For help with questions and completing the application, families may contact Erica Milligan with Carolina Collaborative Community Care at 910-485-1250 ext. 258.
12. Immunization Requirements

**IMMUNIZATION REQUIREMENTS**

**2011-2012**

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**Asthma**

**Nebulizer Administration**

- Nebulizer Action Plan must include:
  - Frequency of the Nebulizer treatment/medication, and dose.
  - Procedures to follow if the students condition does not change or improve following nebulizer treatment.
  - Nebulizer machine and prescribed medication for nebulizer administration will be provided by parent/guardian.
  - Replacement tubing and mouth pieces for nebulizer treatment are the responsibility of the parent/guardian. School staff will clean mouthpiece w/hot water and allow to air dry after administration.
  - The parent/guardian will provide training regarding the administration of nebulizer treatment to designated staff and school nurse.
  - Parent will have 14 calendar days to provide the school with an Asthma Action Plan. (see form 4)

**Regulations for Emergency Self-Medication**

- The parent/guardian and physician must sign the Emergency Self Medication Authorization Form. (see form 5)
- The student’s physician must prescribe the emergency medication and state in writing that the student has sufficient knowledge and maturity to safely and correctly self-manage their medical condition.
- The parent/guardian must state in writing that the student has sufficient maturity to use the emergency medication correctly and release the school and its personnel from any responsibility regarding the emergency medication.

**The student shall comply with the following:**

- The student will demonstrate the skill level necessary to use his/her emergency medication to the School Nurse.
- The student shall keep the emergency medication in his/her possession at all times and shall not leave it in a place accessible to other students.
- The student shall not offer, nor allow use or possession of his/her emergency who self-medicate.
Students who share medications will lose self-administration privileges.

The student shall act in a responsible and discreet manner concerning his/her emergency medication.

If the student is having significant difficulty with his/her emergency medication, i.e. requiring repeated use of inhaled medication; he/she shall not continue to use the emergency medication in place of getting appropriate care.

The principal is the final judge of the student’s compliance with these guidelines in the school.

The parent must provide back up medication to the school. (see form 6)

Back up medication is required by House Bill 496

Allergens and Your Child

Food/Substance Allergies

The most important step to preventing life threatening allergic reactions is to avoid student contact with food/substances to which they are allergic. This can be achieved by following this protocol:

- In the absence of a physician’s written dietary order, the parent must complete a Temporary Special Nutritional Needs form with the assistance from the school nurse or primary medication clerk and submit to the cafeteria manager. (see form 7A-C)
- Parents of a student with food allergies will provide a dietary order to cafeteria staff, principal and school nurse with 14 calendar days.
- Parents of students with food/substance allergies are requested to supply classroom teacher appropriate snacks.
- Students and staff are to use effective hand washing techniques prior to and immediately following food consumption.

Insect/Substance Allergens

Epinephrine (Adrenalin) may be administered by injection in case of extreme medical emergency, i.e., serious life-threatening allergic reaction (anaphylaxis). Shock-like reactions can occur within minutes of exposure to the allergen. Immediate action is necessary if the student has severe allergy symptoms such as: swelling of eyes, lips, face or throat, raised rash (hives), difficulty breathing, loss of consciousness, etc.
REGISTRATION REQUIREMENTS

Age Requirements
In order to be enrolled in a public kindergarten program in the state of North Carolina, a child must be 5 years old ON or BEFORE August 31 of the year in which he/she is presented for enrollment.

Verification of Address
Each parent must complete a verification of address form at the beginning of the school year or upon enrollment during the year. This form must be on file for each student. If a student has a change of address or phone number during the school year, the teacher and office should be notified. Please be sure to include emergency contacts so that we are always able to contact you if needed. All students must attend the school in the attendance area in which they live. Exceptions include special assignment and School of Choice applications as approved by the Cumberland County Student Assignment Office.

Birth Certificates and Immunizations
In accordance with state law, parents enrolling kindergarten students MUST present a birth certificate, shot record, and proof of residence to school personnel. Within 30 days of the first day of school, all students entering school for the first time shall have completed or have started the course of immunizations for each of the following:

- 5 doses of Diphtheria, Tetanus, and Pertussis. A booster dose must be given on or after the fourth birthday. Children receiving #4 DTP on or after the fourth birthday are not required to have #5.
- 4 doses of Polio vaccine. Children receiving #3 Polio on or after the fourth birthday are not required to have #4.
- 2 doses of MMR (Measles, Mumps, Rubella) LIVE VACCINE. The first dose must be given on or after the first birthday, and the second dose must be given BEFORE enrolling in school (K-1) for the first time. There should be at least a 28-day interval between doses.
- 3 doses of Hepatitis B vaccine are required for children born on or after July 1, 1994. The third dose shall not be given prior to 24 weeks of age if born on or after 11/17/01. If third Hepatitis B vaccine was administered before the child was 24 weeks of age, a repeat dose will be required.
- 1 dose of Varicella. Given on or after 12 months of age (if born on or after 4/1/01). Varicella is not required if the student has a documented history of Chickenpox. Two Varicella are recommended but not required.
- 1-4 doses of Haemophilus Influenza (HIB). If the first HIB is given on or after 15 months of age, series is completed. If third dose is given on or after 12 months of age, a fourth dose is not needed. NOTE: No HIB is given after 5 years of age.

Four-day rule applies to any specified dates for required vaccines.

The following guidelines will be followed when parent/guardian present with emergency medication:
- Physician’s School Medication form completed and prescription label on emergency medication must match.
- Staff training regarding the administration of emergency medication will be provided by the school nurse.
- An emergency care plan will be completed by the school nurse.
- It is the responsibility of the student’s parent/guardian to replace used and/or expired medication.
- In the absence of the emergency medication the school nurse will create an emergency care plan that instructs the school staff to call 911 in the event of severe allergic reaction.

Care Plans
In absence of a care plan and/or rescue medication, school staff will:
- Call parent/guardian
- In case of life threatening event, call 911

Poison Control and the Administration of Activated Charcoal

1. When directed by the Poison Control Center, the recommended dose of Activated Charcoal in children is 1 gram of charcoal per kilogram (1 kilogram equals 2.2 pounds of body weight). Poison Control will provide instructions on the dosage of Activated Charcoal to be administered according to student’s weight. Be prepared to provide the following: name of substance ingested, medication history, approximate height/weight, and approximate amount of poison consumed. Poison Control Center will determine emergency care to be given.
Poison Control and the Administration of Activated Charcoal Cont.

2. School staff will call 911 as directed by Poison Control.
3. School staff will notify parent/guardian or other necessary parties.
4. The only liability or responsibility assumed by the school system or its personnel in the administration of Activated Charcoal is to administer the medication in accordance with accepted first-aid procedures.

CAROLINA POISON CENTER
1-800-848-6946 (Charlotte, NC) or
1-800-222-1222 (Charlotte, NC)

Missed Doses

- Staff may not administer doses not ordered on the Physician’s School Medication form.
- A parent’s request to administer medication not on the Physician’s School Medication form will not be honored (to include phone requests).
- Medication may be administered 30 minutes before or 30 minutes after the scheduled dose.
- Incident report must be completed and submitted to:
  - Safety Coordinator
  - Healthful Living Coordinator
  - School Nurse
  - Principal
- Parents and school nurse (and physician if necessary) must be notified of missed doses immediately.

Student Non-Compliance

When a student refuses to cooperate with staff who is administering medication the following procedures shall be implemented:

- **First Incident:** The primary medication clerk or principal designee shall make a telephone call to parent/guardian explaining the concern.
- **Second Incident:** A parent conference shall be held at the school with the following people: principal, medication clerk, school nurse and parent.
- **Third Incident:** The principal will inform the parent that the student has remained non-compliant with medication administration regulations and that school staff will no longer administer the prescribed medication.
9. Medication Check-In/Check-Out 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>
</tr>
</thead>
</table>

Administration of Medication in Prime Time

- It is the responsibility of the parent/guardian to inform Prime Time staff of their child’s physician’s order to take medication during Prime Time. The parent/guardian must provide medication to Prime Time staff for administration prior to enrolling in the program. Students enrolled who are diagnosed during the course of the year will have 14 calendar days to present with emergency medications. In the absence of emergency medication(s) the school nurse will devise an emergency care plan that consists of calling 911.
- Prime Time Staff must secure emergency medications and supporting documentation for all children with documented life threatening conditions. (i.e. asthma, diabetes, seizures and food/insect allergies). All medications must be locked, secured and mobile for transport in emergency situations.
- It is the responsibility of Prime Time Staff to secure afternoon medications from the parent or primary administrator of medication prior to the closing of the main office. **Prime Time Staff are also required to verify the most recent administration of medication to include PRN (as needed).**
- Prime Time Staff will adhere to all regulations and guidelines of the Cumberland County Schools Protocol for Administration of Medication.

Best Practices for Accepting Forms

- Prior to accepting forms, verify that each form includes the six R’s.
- Verify parent and physician signature.
- Ensure that the physician’s medication form matches the pharmacy label on the medication container.
- Dosage must be specific (e.g. cannot state take 1 to 2 pills).
- Order must specify a time to be administered (ex. A.M. or P.M. and before lunch/at lunch is not acceptable).
Best Practices for Accepting Forms Cont.

- Do not accept medication if the prescribed time does not occur within school hours.
- Short-term Medications—Ensure that parents have written six R’s and signed the release of liability.
- Check the date of forms and expiration date of medication prior to accepting.
- Medication forms are valid for one (1) year from the date of the physician’s signature.
- Upon expiration it is the parent/guardian responsibility to provide a current Physician’s School Medication Form.
- Medication administration staff will document the date the Physician’s School Medication form expires at the top of the Individual Medication Log. (see form 8)
- All medication logs and Physician’s School Medication forms must be maintained according to local protocol for a period of 24 years for elementary schools, 16 years for middle schools, and 14 years for high school.
- During the school day, medications need to be stored in a secure area where children don’t have access and in the school vault or other locked area after school hours.
- In case of a bomb threat, fire drill, etc. medication and supplies must be transported to the student assembly area.

Medication Logs

- Each school shall maintain a medication log. This log provides information necessary for medical protection of the students and protection of the person giving the medication.
- A new medication log must be established for each medication and whenever a student’s medication has changed i.e. dose, route, time, etc.
7C. Temporary Dietary Medical Statement page 3

Approved Codes for Medication Log

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<table>
<thead>
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<td>DC</td>
<td>Medication Discontinued</td>
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<td>ED</td>
<td>Early Dismissal</td>
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<tr>
<td>FT</td>
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<td>I</td>
<td>Initial dose administered</td>
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<tr>
<td>NM</td>
<td>No medication at school</td>
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<tr>
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<td>Omitted/Attempted</td>
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<td>R</td>
<td>Refused</td>
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<tr>
<td>SD</td>
<td>School Delay</td>
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</table>

Log must include:
⇒ Student’s name
⇒ medication (Ex: Ritalin, Albuterol Metered dose inhaler, etc.)
⇒ Dosage/Route (Ex. 10 mg./1 tablet po (by mouth), 1 puff before PE, etc.)
⇒ Time to administer or interval in cases of as needed medications
⇒ Initials of person(s) administering medication and time of administration
⇒ Medication administration staff must complete all information on the top portion of the medication log

Questions/Answers:

Who can complete the Temporary Special Nutritional Needs Form?
The school nurse and the student’s parent/guardian may complete the form. The school nurse is not available and dietary modifications are requested, the parent/guardian and the primary medication desk may complete the form.

When should this form be filled out?
The form should be completed if the student has an immediate need for dietary modification. The form is used for temporary purposes only. A Medical Statement for Student with Special Nutritional Needs must be completed and signed by a doctor within 14 calendar days.

Once a medication has been discontinued, indicate with a “DC” and draw a single horizontal line through the remaining blocks of the student’s entry on the medication log and remove the student’s medication from the other current medications. When a parent/guardian picks up the medication, staff will document it on the Medication Check-Out Log. (see form 9)
Administration of Medication on Field Trips

It is the responsibility of the parent to coordinate the administration of the medication through the school office. If there are students who are in need of medication while on field trips, weekend or overnight school-related activities, the principal shall designate an individual to administer the medication. This individual must review the “Protocol for Administration of Medications”. When medicine is transported for a field trip, the medicine should be placed in individual containers (Ziploc bag or envelope) by the school nurse or their designee, and identified by the following information:

- Student’s name
- Name, dosage, and route of medication
- Time to be administered
- Copy of School Physicians Medication form

Upon return to the school, the individual who administered the medication must record information on the medication log and sign the bottom of the medication log. (see form 10)

Children with Disabilities

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination against any person with a disability by any federally funded agency or organization. It requires states to provide programs for eligible students with disabilities that are equal to those for students without disabilities. For more information, contact the District 504 Coordinator at (910) 678-2433.

Healthful Living Forms

Included are samples of Healthful Living Forms. These forms are available at all schools and are provided online at www.healthfulliving.ccs.k12.nc.us/servicesandforms.htm for your convenience.

Directions for completing the Temporary Special Nutritional Needs Form

- When a parent/guardian informs the school or school nurse of a student with allergies (or other medical condition which requires diet modifications), and the student will be receiving breakfast, lunch or meals through Child Nutrition Services, the parent and/or school nurse should complete a temporary special nutritional needs form and submit it to the cafeteria manager. The form is for temporary use (14 calendar days) and should only be used when a medical authority has not completed a Medical Statement for Student’s with Special Nutritional Needs for School Meals.

- If a school nurse is not available, the primary medication clinician may complete the Temporary Special Nutritional Needs Form. A copy of the form should be given to the cafeteria manager.

- Once the cafeteria manager receives the form, the cafeteria manager will make a note on the student’s account for example: “student is allergic to nuts on the account should state ‘no peanuts’” and the form should be filled in the HACCP notebook, located in the cafeteria manager’s office. The cafeteria manager may provide additional information to the student, parent, nurse, teacher and/or primary medication clinician to help ensure that the student is making the appropriate food selections.

- The school nurse or parent/guardian is required to complete a Medical Statement for Student’s with Special Nutritional Needs for School Meals (signed by a medical authority) and submit it to the cafeteria within 14 calendar days after receiving the temporary special nutritional needs form. A copy of the Medical Statement for Student’s with Special Nutritional Needs for School Meals can be found on the Child Nutrition Services website http://www.scsnus.k12.nc.us/program_laws and online in the manual.

- If a parent contacts the cafeteria manager regarding their student’s allergy, the cafeteria manager should provide the parent/guardian with the Medical Statement for Student’s with Special Nutritional Needs for School Meals. If the parent/guardian requests that reasonable accommodations be made immediately to the student’s meal for example if a student has an allergy or if exposure to the food substance results in an anaphylactic reaction and an EpiPen is needed, the cafeteria manager should refer the parent to the primary medication clinician or school nurse to complete the Temporary Special Nutritional Needs Form.

Please note the following:

In Cases of Food Allergy

Generally, children with food allergies or intolerances do not have a disability as defined under either Section 504 or Part B of IDEA, and the school food service may, but is not required to, make food modifications for them.

However, when in the licensed physician’s assessment, food allergies may result in severe, life-threatening (anaphylactic) reactions, the child’s condition would meet the definition of “disability” and the accommodations prescribed by the licensed physician must be made.

Other Special Dietary Needs

The school food service may make food substitutions, at their discretion, for individual children who do not have a disability, but who are medically certified due to having a special diet or dietary need.
7A. Temporary Dietary Medical Statement page 1

Temporary Special Nutritional Needs Form

The Temporary Special Nutritional Needs Form may be completed by a parent/guardian and the school nurse to inform the cafeteria manager or dietitian/clinical dietitian of a student with special nutritional needs due to a medical condition (e.g., allergies). This form is for temporary purposes only. A Medical Statement for Students with Special Nutritional Needs for School Meals must be completed by a medical authority (Physician, Physician Assistant or Nurse Practitioner) and submitted to the cafeteria manager of the school or Child Nutrition Service within 14 calendar days of the initial request.

Student's Name: ___________________________ Grade: ___________________________
Name of Parent/Guardian (please print): __________________________________________
School: ___________________________ Teacher’s Name: ___________________________

This section must be completed by a parent/guardian.

State the medical or dietary need that restricts the student’s diet:

List the food items to be restricted:

List the food items to be substituted:

I understand that the only liability that Child Nutrition Services or the school can assume is to comply with the terms of the information provided. I understand that Child Nutrition Services or the school cannot assume any liability for monitoring.

I verify that the student has a diagnosed medical condition that requires a diet modification. I understand that this form is for temporary purposes only and that a Medical Statement for Students with Special Nutritional Needs for School Meals must be completed by a medical authority and submitted to the cafeteria manager within 14 calendar days.

Signature of Parent/Guardian: ___________________________ Date: ___________________________
Phone number: ___________________________ Physician: ___________________________

This section should be completed by the school nurse (if the school nurse is unavailable, this section can be completed by the primary medication clerk).

Course of Action:

Was the parent provided a copy of the Medical Statement for Students with Special Nutritional Needs for School Meals? Yes ______ No ______

Was the parent/guardian made aware that the Medical Statement for Students with Special Nutritional Needs for School Meals must be completed and submitted within 14 calendar days? Yes ______ No ______

Special Notes/Instructions: ___________________________

Name of School Nurse/Primary Medication Clerk: (please print): ___________________________ Date: ___________________________
Signature: ___________________________ Phone: ___________________________
Title: ___________________________

1A. Confidential School Health Form page 1

CONFIDENTIAL SCHOOL HEALTH FORM

(PLEASE UPDATE AS CONDITIONS CHANGE)

STUDENT'S NAME: ___________________________ GRADE: ___________________________
HOME room TEACHER: ___________________________ SCHOOL: ___________________________

PARENT/GUARDIAN NAME (1): ___________________________ Home Phone: ___________________________
Cell Phone: ___________________________ Work Phone: ___________________________ Other Phone: ___________________________

PARENT/GUARDIAN NAME (2): ___________________________ Home Phone: ___________________________
Cell Phone: ___________________________ Work Phone: ___________________________ Other Phone: ___________________________

STUDENT’S HOME ADDRESS: ___________________________

Dear Parent,

In order to meet your child's needs, please provide the following health information. Place a check in the appropriate block below.

MY CHILD HAS

☐ ADD/ADHD

☐ Autoimmune Disease

☐ Allergies

☐ Anorexia

☐ Asthma

☐ Autoimmune Disorders (e.g., Addison’s Disease, Lupus, Chronic Kidney Disease)

☐ Blood Disorders (e.g., Hemophilia, Sickle Cell Disease)

☐ Cancer, including Leukemia

☐ Cardiac Condition

☐ Cerebral Palsy

☐ Chronic Asthma

☐ Chromosomal Condition

☐ Down’s Syndrome, Fragile X, Turner’s Syndrome

☐ Diabetes Type I

☐ Diabetes Type II

☐ Dwarfism

☐ Emotional or Behavioral Problems

☐ Epilepsy

☐ Hemophilia

☐ Hepatitis B, Hepatitis C, HIV/AIDS

☐ Sickle Cell Anemia

☐ Tourette’s Syndrome

☐ Cystic Fibrosis

☐ Spina Bifida

☐ Diabetic Ketoacidosis

☐ Substance Abuse

☐ Spina Bifida

☐ Tuberous Sclerosis

☐ Traumatic Brain Injury

☐ Other Neurological or Neurodevelopmental Condition

☐ Other Health Condition(s):

Short description of your child's health problem and how the condition may affect your child's school work:

______________________________________

______________________________________
ALLERGIES:

a. Has your child required medical attention requiring an injection following a bee sting, injection of food or medication, or exposure to latex (i.e., gloved)?
   - Yes
   - No

b. Was your child prescribed any allergy shots?
   - Yes
   - No

c. Does your child require emergency medication at school?
   - Yes
   - No

CURRENT MEDICATIONS: Please list all medications your child is currently taking:

- Home: ____________________________
- During School Hours: ________________

If your child needs medication during school hours:

a. Pick up "Physician's School Medication Form" at the school office. This form is to be completed by both the student's physician and the parent.

b. Only prescription medications may be administered at school. All medications must be in a pharmacy-labeled prescription bottle that makes the "Physician's School Medication Form".

c. Parent must transport medications to the school office and sign them in with the medication desk. Do not send medications with your child.

d. Medications that need to be kept with the child must have an Emergency Self-Medication Authorization Form completed by the pharmacist. The student's parent or guardian shall provide the school with an action plan in the event of an asthma or anaphylaxis emergency.

In case of emergency, parent must be called first. If the school is unable to reach the parent, emergency contact person #1 should be called:

Emergency Contact Person #1: ____________________________
Name ____________________________ Phone Number ____________________________

Emergency Contact Person #2: ____________________________
Name ____________________________ Phone Number ____________________________

If unable to reach the parent or an emergency contact person in case of accident or serious illness, I authorize the sharing of information pertinent to my child's current condition between school nurse, administrator, and physician. I authorize the school to call the physician below or make whatever arrangements deemed necessary.

Physician ____________________________ Phone No. ____________________________

This letter is to be signed by the parent/guardian and returned to the school.

Parent/Guardian Signature ____________________________ Date ____________________________

6. Back-Up Medication Form

Cumberland County Schools
P.O. Box 2587
Fayetteville, North Carolina 28302
910-678-1300

To: Parent/Guardian of ____________________________

In 2006, North Carolina passed House Bill 696 to ensure the safety of all North Carolina students. The bill requires that the student's parent or guardian provide 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.

In a recent review of your child's emergency medication, the following items marked are missing or not in compliance with local and state guidelines:

____ An Emergency Self-Authorization Form that must be completed by the student's healthcare provider, parent, and submitted to the medication desk prior to medication being accepted.

____ Properly labeled emergency backup medication that must be brought by the parent to the school. All medications must be signed in with the medication desk.

____ Emergency medication is missing pharmacy label with the:
- Student's name
- Medication
- Dose
- Time to be administered
- Route
- Emergency medication is expired or will expire on ________.

Items marked missing or non-compliant must be submitted within 14 calendar days of this notification.

Thank you,
5. Emergency Self-Medication Authorization Form

EMERGENCY SELF-MEDICATION AUTHORIZATION FORM

SCHOOL

STUDENT

GRADE

MEDICATION

DOSE

ROUTE

TIME INTERVAL

Under which conditions should medications be administered:

I certify that the student has a medical condition that could result in an emergency situation or spell, and that I, the
health care practitioners, prescribed medications for use on school premises during the school day, at school-sponsored
activities, or while in attendance at school or school-sponsored events.

I agree to follow the school’s emergency medication policy and to inform the student’s assigned principal, by telephone,
if possible, immediately in the event of the administration of a medication that results in an emergency situation or spell.

Physician’s Signature

Home Number

Date

I authorize the administration of the medication listed below to my child:

Name of Student

Date

Physician’s Signature

School Nurse’s Signature

Date

FOR SCHOOL USE ONLY

These forms will expire on (1) year from date of physician’s signature.

For School Use Only

Date Emergency Self-Medication Form Expires

Date Physician School Medication Form Expires

Please remind form within (1) year from date of physician’s signature.
3. Short Term Medication / Release of Liability Form

SHORT-TERM MEDICATION FORM

Name of School: ___________________________  Grade: ___  Age: ___

Name of Student: ___________________________  Medication: ___________________________

Date: _____________________________________

Time to be administered: _____________________

Route and directions for administering medication: ___________________________________________

________________________

Prescribing doctor’s name/phone number

________________________

Emergency Contact Phone Number

RELEASE OF LIABILITY FORM

I, ___________________________ the parent/for legal guardian of

Name of Child: ___________________________  Name of School: ___________________________

realizing the importance of administering medication to my child as prescribed by the child's
physician, do hereby agree to absolve designated school personnel of any liability from any
potential ill effects as a result of their injecting or giving my child medication prescribed by the
child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize
its ramifications and thoroughly understand the meaning of these statements. I consent for the
medical provider to disclose health or medical information regarding medication prescribed.

I further understand that I may revoke this consent at any time. Except to the extent action has been
taken in reliance on it. This consent is valid until I rescind it in writing for the term of one year.

Parent or Guardian’s Signature: ___________________________  Phone Number: ___________________________  Date: ___________________________

________________________

Principal’s Signature: ___________________________  Phone Number: ___________________________  Date: ___________________________

FOR SCHOOL USE ONLY

Date of Short-term Medication Form Expiry: ___________________________  /  ___________________________

Please be reminded:

- Administration of short-term medications may not exceed 14 days.

4. Asthma Action Plan

My Asthma Action Plan

[Diagram showing Peak Flow: Above, Between, Below]

- Severe Persistent
- Moderate Persistent
- Mild Persistent
- Mild Intermittent
- Strong Smells
- Grass, trees, weeds
- Weather changes
- Other:

Severity:

Triggers:

School: ___________________________

Target Peak Flow: ___________________________

[Additional fields for doctor's name/phone number, current date, etc.]

[Additional text not legible]