2013-2014

STUDENT FORMS

Important: Forms needing your signature are included

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Charlotte-Mecklenburg Schools

Every Child. Every Day. For a Better Tomorrow.

P.O. Box 30035 • Charlotte, NC 28230 • www.cms.k12.nc.us

Charlotte-Mecklenburg Schools

2013 – 2014
Student Forms

This packet includes important forms previously found in the Parent-Student Handbook. Please read the full packet, fill out and return the applicable forms to your child's school. The complete 2013-2014 Parent-Student Handbook can be found on the CMS website: www.cms.k12.nc.us.

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Vision

CMS provides all students the best education available anywhere, preparing every child to lead a rich and productive life.

Mission

The mission of Charlotte-Mecklenburg Schools is to maximize academic achievement by every student in every school.

Charlotte-Mecklenburg Schools

CMS STUDENT TEXTBOOK ACCOUNTABILITY STANDARDS

Agreement for Students Enrolled in CMS

Charlotte-Mecklenburg Schools teachers and administrators are committed to providing students with textbooks during the first 10 days of school and promise to work together to promote a sound and positive teaching and learning experience for each student. This contract is an agreement to work in partnership to ensure the successful attainment of our mutual goal.

As a **student**, I pledge to

- ❑ use textbooks appropriately
- ❑ avoid damaging and losing textbooks
- ❑ pay for textbooks that I damage or lose

Student's Signature: _____ Date: _____

As a parent/guardian of _____, I pledge to

- ❑ encourage appropriate use of textbooks and monitor the textbooks my child brings home from school
- ❑ support the school staff in their efforts to provide my child with the textbooks needed for learning
- ❑ monitor the textbooks my child brings home from school
- ❑ encourage my child to be responsible for the proper use of the textbooks
- ❑ return textbooks at the end of the year, or if my child moves to another school within or outside the district
- ❑ pay for textbooks that are damaged or lost

Parent/Guardian Signature: _____ Date: _____

As a **teacher,** I pledge to

- ❑ explain my expectations and instructional goals to students and parents during orientation and throughout the year
- ❑ assign textbooks to students being careful to evaluate the book before issuing it to the student
- ❑ provide a challenging, caring, learning environment, using the textbook as a teaching tool to support the *North Carolina Standard Course of Study*
- ❑ maintain accurate records on textbooks
- ❑ collect and issue a receipt for lost and/or damaged textbooks

Homeroom Teacher's Signature: _____ Date: _____

The principal, as the instructional leader of the school, is committed to providing your child with the textbooks needed to support the *North Carolina Standard Course of Study*. Parental involvement is essential as we work to give your child the best educational experiences possible.

FOR SCHOOL USE ONLY

Issued Textbooks for the _____ - _____ School Year

Subject	Course #	Title	Book #	Condition	Cost	Teacher #
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

Please complete form and return to your student's school.

Charlotte-Mecklenburg Schools

STUDENT LOCKER ASSIGNMENT (GRADES 6-12)

Lockers are the property of the district. They should only contain supplies needed for school and are subject to authorized searches at any time, including sniff inspections done by specially trained dogs, as permitted by CMS Board Policy JIHD.

Signature of student: _____

Signature of parent/guardian: _____

School: _____ No. of locker assigned: _____

Date assigned: _____ Date: _____

Assigned by: _____ Locker combination: _____

Charlotte-Mecklenburg Schools

PARTICIPATION IN PHYSICAL EDUCATION (GRADES K-12)

All students shall participate in physical education. No student shall be permitted to waive or substitute other classes for the physical education requirement except as follows: Suitably adapted physical education shall be included as part of the Individualized Education Program for students with a chronic health problem, other disabling conditions, or other special needs that preclude following the Physical Education portion of the Essential Standards: http://www.ncpublicschools.org/acre/standards/new-standards/. (IDEA: http://www2.ed.gov/policy/speced/leg/idea/idea.pdf).

Name of student: _____

Teacher: _____ Grade: _____

School: _____

Please Check One:

- ❑ My child is able to fully participate in physical education.
- ❑ I would like the physical education teacher to be aware of the following health concerns (e.g., diabetes, allergic reactions, asthma, heart conditions) that may require modifications or a specially designed physical education program:

_____

_____

Signature of parent/guardian: _____ Date: _____

Please complete form and return to your student's school.

Charlotte-Mecklenburg Schools

PHOTO AND VIDEO RELEASE FORM

I grant Charlotte-Mecklenburg Schools the unlimited right to use and/or reproduce photographs*, likenesses or the voice of my child in any legal manner and for the internal or external promotional and informational activities of Charlotte-Mecklenburg Schools. I also agree to allow my child to be interviewed and/or photographed* by representatives of the external news media and CMS Communications in relation to any and all coverage of Charlotte-Mecklenburg Schools in which he/she is involved. I also agree to allow my child's work and/or photograph* to be published on the Charlotte-Mecklenburg Schools website/Intranet Web pages and in CMS publications. I further understand that by signing this release, I waive any and all present or future compensation rights to the use of the above stated material(s) including, print, electronic and online media..

School name: _____

Student's name:_____ Homeroom teacher:_____

Parent/guardian signature: _____ Date: _____

Parent/guardian name (Print):_____

Parent/guardian address: _____

** "Photograph" in this Release Form is intended to only refer to photos and videos of your child alone. Group photographs and videos (two or more children), with no additional identifying information, are considered Directory Information. Please review the FERPA information sheet in the Parent-Student Handbook.*

This information to be completed by school officials only.

Your Name: _____ Date: _____

Type of Material

- ❑ Photograph
- ❑ Slide
- ❑ Videotape
- ❑ Other (please specify) _____

Use of Material

(Please provide additional information such as name of news outlet, brochure, purpose of presentation, etc.)

- ❑ News outlet_____
- ❑ CMS website/Intranet site(s)_____
- ❑ Brochure _____
- ❑ PowerPoint presentation _____

Please complete form and return to your student's school.

Charlotte-Mecklenburg Schools

MUSICAL INSTRUMENT DISCLAIMER FORM

Instrument Storage Areas

Individual schools may provide storage areas where instruments may be kept overnight, **if necessary**.

These storage areas are not individual lockers, but shelving areas. Since students have access to these areas before and after class, the Charlotte-Mecklenburg Board of Education assumes no responsibility for any loss or damage to any instrument stored at these locations.

School-Owned Instruments - Instrument Changes

Students who will be using school-owned instruments such as a tuba, barisax, tenor sax, oboe, bass, clarinet, French horn, cello or string bass must complete a Charlotte-Mecklenburg Schools Liability Form before an instrument can be used by the student. This form can be obtained from the instrumental music teacher.

All changes of instruments are at the discretion of the music director.

Instrument Repair

If a student's instrument (student-owned) needs repair, it should be taken to an instrument repair shop in a timely manner. Please provide a written note with the name of the repair shop, the date the instrument was taken in and when it is expected to be returned so that your child's grade will not be affected.

Name of school: _____
(Please print)

Student name: _____
(Please print)

Signature of parent/guardian: _____ Date: _____

Please complete form and return to your student's school.

Charlotte-Mecklenburg Schools

MEDICATION AUTHORIZATION FOR CMS STUDENTS

School name: _____ Telephone: _____ Fax: _____

To the parent or guardian of: _____ Birth date: _____

In order to help protect your child's health, your consent and written authorization from a licensed healthcare provider are required when it is necessary for your child to receive either prescription or non-prescription medicines in the Charlotte-Mecklenburg Schools. No medications will be given to your child at school until this authorization has been received. A separate form is required for each medicine. New authorization forms are required every year at the beginning of school, whenever the dose or directions change, or when a new medicine is prescribed. It is your responsibility to provide all medicines to be given at school. Each medicine must be in an appropriately labeled original container from the pharmacy or healthcare provider's office. Most pharmacies will provide an extra container for school use upon request. A completed authorization is also required for the administration of non-prescription medicines at school.

PARENT OR GUARDIAN'S PERMISSION: I give permission for my child to receive the medicine described below during school hours. I understand that it is my responsibility to purchase and supply this medicine. On behalf of my child, I absolve the Charlotte-Mecklenburg Board of Education and their agents and employees from any and all liability whatsoever that may result from my child taking this medicine at school.

Signature of parent or guardian: _____ Date: _____

Contact numbers: _____

(pager or mobile, work, home telephone #s)

FOR LICENSED HEALTHCARE PROVIDER USE ONLY: (Please write legibly using lay terms.)

Medication prescribed: _____ Strength/dose: _____

Specific Directions:
[include exact amount to give, at what time and/or how often, relationship to meals, specific indications, e.g. if prn (as needed)]

Purpose of medication: _____

Relationship to meals, if applicable: _____

How often and at what time (hour): _____

Specify side effects or adverse reactions: _____

Other instructions (including emergency situations): _____

Please check all appropriate items. If either of the first two items is checked, please complete the form on page 6.

- ❑ Please allow this student to self-administer this medication while at school during school hours. **(must complete the form on page 6)**
- ❑ This student should carry the medication with him/her at all times during the school day, while at school-sponsored events, or while in transit to or from school or school-sponsored activities. **(must complete the form on page 6)**
- ❑ This medication is to be used for emergencies only.

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the principal and/or school nurse and parents/guardians if there are any problems.

Signature of healthcare provider: _____ Provider's last name (Print): _____

Practice name or address: _____

Telephone: _____ Fax: _____ Date: _____

FOR SCHOOL USE ONLY:

Signature of healthcare provider: _____ Provider's last name (Print): _____

Please complete form and return to your student's school.

Charlotte-Mecklenburg Schools

AUTHORIZATION FOR SELF-MEDICATION BY CMS STUDENTS

Student's name: _____ Birth date: _____

Medication: _____ For: _____

Eligibility: In accordance with CMS Policy JLCD, Administering Medications to Students, and its accompanying regulation, JLCD-R, only students who meet the following descriptions may possess and self-administer medications: (1) Students with special medical needs such as asthma and/or severe allergies or who are subject to anaphylactic reactions and may require emergency medications (i.e., asthma inhaler or epinephrine auto-injector ["Epi-pen"]); and (2) Students who require frequent administrations of non-prescription medications or prescription medications that are not controlled substances.

Healthcare provider: The student named above has (1) asthma or an allergy that could result in an anaphylactic reaction and may require emergency medications; or (2) a condition that requires frequent administration of a prescription or non-prescription medication. The medication is not a controlled substance. This student is capable of, has been instructed on the procedures for, and has demonstrated the skill to self-administer this medication as directed on page 5. Please allow him/her to self-administer the medication during school hours and as otherwise indicated on page 5.

❑ This student will not require adult supervision while taking this medication.

Physician signature: _____ Date: _____

Parent/guardian: I give consent to the Charlotte-Mecklenburg Schools to allow my child to self-administer this medicine at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. If the medication that is prescribed for my child is for the treatment of asthma or anaphylactic reactions, I agree to provide a supplementary supply of the medication that will be kept by the school in a location where my child has immediate access. I absolve the Charlotte-Mecklenburg Board of Education, its agents and employees from any and all liability whatsoever that may result from my child possessing or taking this medicine at school. I further consent for the information about my child included on pages 5 and 6 to be shared with appropriate school staff as necessary for the safety of my child.

Parent/guardian signature: _____ Date: _____

Student: I am capable of taking this medicine as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to discipline under the *Code of Student Conduct* if I abuse the privilege of being allowed to self-medicate while at school or school-sponsored activities. Unless the medication is prescribed for the treatment of asthma or anaphylactic reactions, I understand that I will lose the privilege of self-administering my medication if I do not follow these rules.

Student signature: _____ Date: _____

School nurse: I have reviewed this request and acknowledge that this student has demonstrated the skill level to self-administer this medication. I have informed this student that he/she must tell an appropriate staff member whenever he/she has used the medication at school.

Nurse signature: _____ Date: _____

Please complete form and return to your student's school.

Charlotte-Mecklenburg Schools

ASTHMA ACTION PLAN/ MEDICATION AUTHORIZATION FORM

Student Name: _____ Student ID#: _____

School/Year: _____20_____ to 20_____ Grade: _____ Teacher: _____

Parent/Guardian:_____ Contact Number: _____

Physician's Name:_____ Physician's Phone/Fax: _____

IMPORTANT INSTRUCTIONS

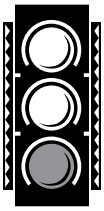
1. **NO SMOKING in your home or car, even if your child is not with you.**
2. Always use a spacer with inhalers (MDIs).
3. Shake inhaler before every spray (puff).
4. Remove, control and stay away from known triggers in your child's environment.
5. Clean plastic part of inhaler weekly using package directions.
6. Prime inhaler after opening and before use if not used in more than two weeks. Proair-three puffs, all others four puffs.

CHILD'S TRIGGERS ARE: *(circle or check all that apply to your child)*

❑ Respiratory infections or flu	❑ Mold	❑ Pollen	❑ Dust, dust mites
❑ Weather/temperature changes	❑ Indoor pets	❑ Exercise	❑ Strong odors or sprays
❑ Indoor/outdoor pollution	❑ Household cleaners	❑ Strong emotion	❑ Cockroaches
❑ Smoke	Other allergies _____		

GREEN ZONE - ALL CLEAR

ASTHMA IS WELL CONTROLLED



You should have:

No wheezing
No coughing
No chest tightness
No waking up at night because of asthma
No problems with play because of asthma

Peak flow number from _____to _____

USE CONTROLLER MEDICINES

No Controller medicine needed at this time.

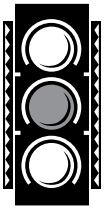
Medicine	Method	How much	How often
_____	_____	_____	_____**times per day**
_____	_____	_____	_____**times per day**
_____	_____	_____	_____
_____	_____	_____	_____

15 minutes before exercise use _____ puffs (inhaled) _____

**Rinse child's mouth after using inhaled steroids (daily/controller medicines).*

YELLOW ZONE - CAUTION! - TAKE ACTION

ASTHMA GETTING WORSE



You may have:

Wheezing
Coughing
Chest Tightness
First signs of a cold
Coughing at night

Peak flow number from _____to _____

USE CONTROLLER MEDICINES

Continue to use green zone daily medicines and add:

Medicine	Method	How much	How often
Albuterol/Xopenex	inhaled	____ puffs **OR** ____ vial	Every____hours prn

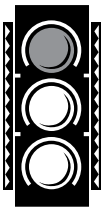
_____May repeat after 20 minutes x 1 (Indicate with check)

Also take:

_____ _____ _____ _____

If yellow-zone symptoms continue for 24 hours or child needs extra rescue medicine more than twice per week, call your child's doctor.

RED ZONE - STOP! GET HELP NOW!



You may have:

Quick relief medicine that is not helping
Wheezing that is worse
Faster breathing
Blue lips or nail beds
Trouble walking or talking
Chest and neck pulled in with each breath

Or peak flow less than _____

TAKE QUICK RELIEF MEDICINE

THIS IS AN EMERGENCY!

Continue to use green zone medicines and do the following:
Use_____ puffs **OR** 1 vial Albuterol/Xopenex inhaled every 20 minutes for a total of _____ doses.

CALL DOCTOR NOW! If you cannot reach doctor, call **911** or go directly to the emergency room. **Do not wait!**

Physician Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

School Health Nurse Signature: _____ Date: _____

(SCHOOL NURSE USE ONLY) Student carries inhaler: **Y / N** Inhaler in the Health Room: **Y / N** Inhaler in classroom: **Y / N**

Please complete form and return to your student's school.

Charlotte-Mecklenburg Schools

DIET ORDER FORM

Annual Medical Statement for Students with Special Nutritional Needs for School Meals

This form gives Child Nutrition Services the information required for meal modifications at school.

Steps to Complete Diet Order Form

1. Parent/Guardian, complete Section #1 and #2. Sign and date form (required for processing).
2. Medical Authority, complete Section #3. Print name, sign and date form (required for processing).
3. Medical Authority Office Staff, complete Section #4. Stamp form with medical office stamp (required for processing).
4. Mail or Fax completed Form to CMS Child Nutrition Services.
5. Child Nutrition Services will forward processed form to the student's school cafeteria and incomplete form will be returned to parent/guardian.

PARENT GUARDIAN

- **CMS Cafeterias do not serve peanuts or products containing peanuts; therefore, a diet order form only specifying a peanut allergy is not needed.**
- **Monthly menu with carbohydrate content in grams and major food allergens is posted at http://www.cms.k12.nc.us/cmsdepartments/cns. A completed Diet Order Form is not required if above information is sufficient for parent/guardian to manage a student's diet at school.**
- **This form must be completed at the start of each school year and each time student's diagnosis or change of treatment is indicated during the school year. Annual completion of this form by the student's medical authority ensures that current nutritional needs are being met at school.**

1 STUDENT INFORMATION

Student ID Number

School Year 20____- 20____

Last, First, MI

Date of Birth | School Attended | Grade

Which meals provided by the School Cafeteria will the student eat?

☐ Breakfast ☐ Lunch ☐ Before School Program ☐ After School Program

Does the student have an identified disability (IEP or 504 Plan)?

☐ Yes ☐ No

2 PARENT / GUARDIAN INFORMATION

First, Last | Day Time Phone Number

Mailing Address, City, State, Zip

E-mail Address

Parent / Guardian Signature (required for processing) | Date

X

By signing above I give Child Nutrition Services permission to speak with the Licensed Medical Doctor (MD) or recognized Medical Authority signing the Diet Order Form to discuss the student's dietary needs described in Section #3.

3 MEDICAL AUTHORITY To be completed by Licensed Medical Doctor (MD) or recognized Medical Authority treating the student

Check the appropriate box:

☐ **Diet Order Form for school year 20____ - 20_____**

☐ **Revision to Diet Order Form submitted during current school year.**

Student Diagnosis

Describe major life activities affected

FOOD ALLERGIES: Students with life threatening food allergies must have an emergency action plan in place at school.

Check the appropriate box(es): ☐ Ingestion ☐ Contact ☐ Inhalation

FOOD THAT SHOULD BE AVOIDED: Check all that apply

Milk ☐ All Milk Proteins - Casein, Whey, etc.
☐ Fluid Milk - Substitute with ☐ Lactose-free milk ☐ Juice
Fresh milk products: ☐ Cheese ☐ Yogurt ☐ Ice Cream

Egg ☐ All Egg Proteins - Albumin (white) and Yolk
☐ Whole Egg - hard boiled or scrambled

Soy ☐ All Soy Protein

Wheat ☐ All Wheat

Fish ☐ All Fish

Corn ☐ All maze/corn
☐ Whole Corn - fresh kernel or whole grain corn

Other (Specify if it is a cooked ingredient or when consumed fresh or raw)

_____

_____

TEXTURE MODIFICATION: Mark consistency requirement for food

☐ **Pureed** ☐ **Ground** ☐ **Chopped** ☐ _____

Medical Authority Name | Medical Authority Signature (Required) | Date

4 MEDICAL OFFICE STAMP & SEND DIET ORDER

1. Stamp below with medical office stamp (required for processing)

2. Mail or Fax form to:

Charlotte Mecklenburg Schools
Child Nutrition Services

PO Box 668847
Charlotte, NC 28266

Phone (980) 343-6041
Fax (980) 343-6045

Provide office phone and fax numbers if not in the stamp.

Phone Number | Fax Number

CHILD NUTRITION SERVICES NOTES

Created by Child Nutrition Services on 4/30/2013

Charlotte-Mecklenburg Schools

PARENT REVOCATION OF STUDENT INTERNET ACCESS

Parents who do not want their child to be able to access the CMS Network or use the Internet while at school must complete this form and return it to their child's school.

I do not want my child, _____, to be allowed to use a Charlotte-Mecklenburg Schools' computer to access the CMS Network or the Internet. By my signature below, I also acknowledge that without access to the Internet and the CMS Network, my child will not be able to do all or some of the following activities that use the CMS Network or the Internet while at school:

- ✘ Use any computer on the CMS Network (this is because networked computers automatically access the Internet and the CMS Network and require students to accept the Student Internet Use Agreement before they can use the computer for any purposes)
- ✘ Access the school media center catalog of books
- ✘ Use online learning tools such as Accelerated Reader
- ✘ Do online research
- ✘ Work with another student who is using a networked computer

Student's full name (printed):

Last:_____ First:_____ Middle:_____

Date of birth: _____ Student ID#:_____ Grade: _____

School: _____ Homeroom or Homebase teacher:_____

Address: _____ Home telephone: _____

Parent's name (Printed): _____

Address (if different from student's):_____

Phone numbers: Home:_____ Work: _____

Parent/guardian signature: _____ Date: _____

Please complete form and return to your student's school.

Charlotte-Mecklenburg Schools

U.S. DEPARTMENT OF EDUCATION
OFFICE OF INDIAN EDUCATION

Title VII Student Eligibility Certification

Parents: Please return this completed form to your child's school. In order to apply for a formula grant under the Indian Education Program, your child's school must determine the number of Indian children enrolled. Any child who meets the following definition may be counted for this purpose. You are not required to complete or submit this form to the school. However, if you choose not to submit a form, the school cannot count your child for funding under the program. **This form will become part of your child's school record and will not need to be completed every year.** This form will be maintained at the school and information on the form will not be released without your written approval.

Definition: Indian means any individual who is (1) a member (as defined by the Indian tribe or band) of an Indian tribe or band, including those Indian tribe or bands terminated since 1940, and those recognized by the State in which the tribe or band reside; or (2) a descendent in the first or second degree (parent or grandparent) as described in (1); or (3) considered by the Secretary of the Interior to be an Indian for any purpose; or (4) an Eskimo or Aleut or other Alaska Native; or (5) a member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

NAME OF CHILD _____ Date of Birth _____
(As shown on school enrollment records)

School Name _____ Grade _____

NAME OF TRIBE, BAND OR GROUP _____

Tribe, Band or Group is: (check one)

- ❑ Federally Recognized, Including Alaska Native
- ❑ State Recognized
- ❑ Terminated
- ❑ Organized Indian Group Meeting #5 of the Definition Above

Name of individual with tribal membership: _____

Individual named is (check one): _____ Child _____ Child's Parent _____ Child's Grandparent

Proof of membership, as defined by tribe, band, or group is:

A. Membership or enrollment number (if readily available) _____ OR

Other (explain)_____

Name and address of organization maintaining membership data for the tribe, band or group:

_____

I verify that the information provided above is accurate:

PARENT'S SIGNATURE_____ **DATE** _____

Mailing Address _____ Telephone_____

Charlotte-Mecklenburg Schools

2013 – 2014
Notices

The following pages have been removed from this handbook:

- Notification Of Rights Under FERPA
- Directory Information
- Model Notification Of Rights Under The Protection Of Pupil Rights Amendment (PPRA)
- Housing Emergencies
- Title IX
- § 115C-391.1. Permissible Use Of Seclusion And Restraint
- Federal Law Parental Rights Regarding Section 504 Of The Rehabilitation Act of 1973
- Exceptional Children
- Americans With Disabilities Act
- Elementary and Secondary Education Act
- Annual EPA Mandatory Asbestos Awareness Letter
- Student Discipline

You may access these pages in the Parent-Student Handbook.

The complete 2013-2014 Parent-Student Handbook
can be found on the CMS website:
www.cms.k12.nc.us.