HANDBOOK
FOR
SCHOOL NURSES

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INTRODUCTION

The Case for School Nurses

A student's health status is directly related to his or her ability to learn. Children with unmet health needs have a difficult time engaging in the educational process. The school nurse supports student success by providing health care through assessment, intervention, and follow-up for all children within the school setting. The school nurse addresses the physical, mental, emotional, and social health needs of students and supports their achievement in the learning process. The school nurse not only provides for the safety and care of students and staff but also addresses the need for integrating health solutions into the education setting.

The number of children that have a chronic condition has increased dramatically over the past four decades. Chronic conditions such as asthma, anaphylaxis, type 1 diabetes, epilepsy, obesity and mental health concerns may impact the student's ability to attend school and be ready to learn. The number of students with special health care needs also has increased dramatically over the past decade. Students are coming to school with increasingly complex medical problems, technically intricate medical equipment and complicated treatments.

This School Nurse's Handbook has been prepared to serve as a resource for school nurses and to guide their day-to-day activities in schools and ultimately promote student health and achievement.
Hopefully, you will find this handbook to be a useful tool and source of reference as you implement a program that will meet the needs of *all* students served by the Richmond County School System.

NASN: Chronic Health Conditions Managed by School Nurses
nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/17/Chronic-HealthConditions-Managed-by-School-Nurses-Revised-January-2012 Complex Child Magazine complexchild.com/about.html

RICHMOND COUNTY SCHOOL SYSTEM (RCSS)

MISSION STATEMENT

The mission of the Richmond County School System is building a world-class school system through education, collaboration, and innovation.

VISION STATEMENT

The Richmond County School System will create a world-class, globally competitive school system where all students will graduate and are college/ career ready.

BELIEFS

We believe that:

- Every person has a right to a quality education.
- Education is the shared responsibility of the individual, home, school and community.
- Every person can learn.
- Respect and acceptance are essential for learning and personal development.
- A safe, healthy and orderly environment is essential to learning.
- Communication is the key to understanding among people.
- Excellence cannot be compromised.

MOTTO

LEARNING TODAY….LEADING TOMORROW

RCSS SCHOOL HEALTH NURSE PROGRAM
JGC

The Richmond County Board of Education, in order to implement the requirements of Official Code of Georgia § 20-2-771.2, and to refine its current program adopts a school health nurse program for the system as follows:

- The program will be staffed by licensed health professionals and others whose duties will be set forth in job descriptions to be prepared by the Superintendent and approved by the Board.

- The Superintendent shall be responsible for developing and amending other regulations which may be necessary, in combination with the job descriptions, to implement and refine this program. These regulations shall comply with any and all rules implemented by the State Board of Education, the Department of Human Resources or any state agency with jurisdiction or authority over any aspect of services to be provided or which may be provided to students under the above referenced code section.

- Subject to approval by the Board, services to students under this policy may be provided through contracts or agreements with the Health Department or with private health facilities or agencies.

- In developing and amending job descriptions and regulations under this policy, the Superintendent and staff may consult with health professionals knowledgeable in children's health issues to assist in establishing the standards and procedures for the program.

All employees performing services under this policy shall be subject to the restrictions set forth in Official Code of Georgia § 20-2-773, specifically, none of the following health services shall be provided to public school students pursuant to this policy: (1) Distribution of contraceptives; (2) Performance of abortions; (3) Referrals for abortion; or (4) Dispensing of abortifacients.

Richmond County Schools Date Adopted: 9/11/2008

State Reference	Description
O.C.G.A 20-02-0186	Allocation of funds to pay beginning salaries of 12 mo. employees; funds for failing schools
O.C.G.A 20-02-0191	Supplies for school health nurse programs
O.C.G.A 20-02-0770	Rules for nutritional screening and eye, ear, and dental exams of students
O.C.G.A 20-02-0771	Immunization of students
O.C.G.A 20-02-0771.2	School health nurse programs
O.C.G.A 20-02-0772	Screening of students for scoliosis
O.C.G.A 20-02-0773	Restrictions on student health services; utilization of state funds
O.C.G.A 20-02-0774	Self administration of asthma medication
O.C.G.A 20-02-0775	Automated external defibrillator
O.C.G.A 20-02-0776	Auto-injectable epinephrine defined; requirements for student retention of medication; liability of school system
O.C.G.A 20-02-0776.1	Administration of auto-injectionable epinephrine by school personnel
O.C.G.A 20-02-0776.2	Stock supply of auto-injectable epinephrine; requirements; limited liability
O.C.G.A 20-02-0777	Annual Fitness Assessments; reporting and compliance
O.C.G.A 20-02-0778	Required information to parents of students regarding meningococcal meningitis
O.C.G.A 20-02-0779	Care of students with diabetes

O.C.G.A 20-2-149.1	Instruction in cardiopulmonary resuscitation and use of automated external defibrillator requirements
Rule 160-1-3-.03	Infectious Diseases
Rule 160-4-8-.01	Student Support Services
Rule 160-4-8-.18	Diabetes Medical Management Plans

Federal Reference	**Description**
20 USC 7906	Prohited uses of funds

These references are not intended to be part of the policy itself, nor do they indicate the basis or authority for the board to enact this policy. Instead, they are provided as additional resources for those interested in the subject matter of the policy.

The Role of the School Nurse, Licensure and Job Description

ROLE OF SCHOOL NURSE

The registered professional school nurse is the leader in the school community that oversees school health policies and programs, according to National Association of School Nurses (NASN). The school nurse serves in a pivotal role providing expertise and oversight for the provision of school health services and the promotion of health education. Using clinical knowledge and judgment, the school nurse provides health care to students and staff, performs health screenings and coordinates referrals. The nurse also serves as a liaison between school personnel, family, community and healthcare providers to advocate for health care and a healthy school environment.

A Certified Professional School Nurse (*RN* or *LPN*) is one who is currently licensed by the Georgia Board of Nursing and certified in CPR and First Aid instruction.

The daily responsibilities of the school nurse in Richmond County Public Schools include the following:

- Manages the school health services under the direction of the Superintendent and Principal, and in compliance with school district and state policies.
- Functions in accordance with the Standards of Professional School Nursing Practice, the Nurse Practice Act, and Federal and State statutes that impact school nursing practice.
- Provides information to the school board and school administrators as they develop school health policies and procedures.
- Provides health-related training to school personnel.
- Provides preventive health services to students including health education, screening, consultation, and referrals.
- Provides nursing assessments and nursing diagnoses and develops plans of care for students needing health and nursing interventions.
- Implements interventions within the plan of care directly, through delegation, or through the provision of oversight and coordination to other responsible staff based on consideration of health, safety, and welfare of the student.
- Coordinates in-school health care with the student's primary care physician, and other providers/staff as necessary and appropriate.

EDUCATIONAL AND COMPETENCY REQUIREMENTS FOR SCHOOL NURSES IN GEORGIA

The National Association of School Nurses (NASN) supports that the school nurse is a registered professional nurse who has a commitment to lifelong learning. Educational preparation for the school nurse should be at a minimum at the associate degree level, and the school nurse should continue to pursue professional development and continuing nursing education.

In 2013, the Georgia state legislature amended its state nurse licensing requirements to include continuing education credits as a condition of licensure renewal. These rules apply to any nursing license expiring on or after January 31, 2016;

- Effective January 31, 2016, registered nurses will be required to complete (30) hours of continuing education and to submit documentation of continuing competency as a condition of licensure renewal.

- Effective March 31, 2017, licensed practical nurses will be required to complete (20) hours of continuing education and to submit documentation of continuing competency as a condition of licensure renewal.

The Georgia Board of Nursing suggests that all nurses set up a free account with CE Broker and to submit their documentation through that site. For more information, visit sos.ga.gov/index.php/licensing/plb/45

The following documents provide a list of options, from which you may select to fulfill your continuing competency/education requirements, as well as a list of acceptable providers for continuing education.

School Nurses must use Options One through Three below:

Georgia Board of Nursing

Continuing Competency/Education Plan Options for Registered Nurses

In 2013, Georgia law was amended to require licensees to complete continuing competency/education requirements as a condition of licensure renewal. These requirements become effective as part of the 2016 renewal cycle (any license expiring
on or after January 31, 2016). Licensees may select one of the following options to fulfill the continuing competency/education requirements. If audited, the licensee will be required to submit documentation of completion of one the following five options. Licensees who submit a renewal application, are selected for renewal audit and do not complete the audit requirements will be considered to have submitted an incomplete renewal and the license will not be renewed.

Please Select From One Of The Following Five Options

The selected option must be completed during the biennial renewal period

Option 1

- Completion of thirty (30) continuing education hours by a Board approved provider [O.C.G.A. §43-26-9(b.1)(1)].
- Please submit certificates of completion documenting thirty (30) continuing education hours completed during the biennial renewal period.
- Please visit the Board's website at sos.ga.gov/plb/nursing for a list of acceptable providers.

Option 2

- Maintenance of certification or recertification by a national certifying body recognized by the Board in Rule 410-12-12 [O.C.G.A.
  §43-26-9(b.1)(2)].
- Please submit evidence of recertification completed during the biennial renewal period.
- Please visit the Board's website at sos.ga.gov/plb/nursing, click on "Laws, Rules and Policies" and view Rule 410-12-.12 for a complete list of Board approved certifying bodies.

Option 3

- Completion of an accredited academic program of study in nursing or a related field as recognized by the Board [O.C.G.A. §43-
  26-9(b.1)(3)].
- Program of study must be a minimum of two credit hours. Acceptable areas of study include respiratory therapy, informatics, health care administration, and business administration.
- Please submit transcripts showing completion of course(s) during the biennial renewal period. Please include course description(s).

Option 4

- Verification of competency by a health care facility or entity licensed under O.C.G.A. §31-7 or by a physician's office that is part of a health system and at least five hundred (500) hours practiced as evidenced by employer certification on a form approved by the Board [O.C.G.A. §43-26-9(b.1)(4)].
- Please have your employer complete and submit the verification of competence/active practice form.

Option 5

- Completion of a Board approved reentry program or graduation from a nursing education program [O.C.G.A. §43-26-9(b.1)(5)].
- Please submit documentation of completion of a Board approved reentry program or graduation from an approved nursing education program within the biennial renewal period.

Georgia Board of Nursing

Continuing Competency/Education Plan Options for Licensed Practical Nurses

In 2013, Georgia law was amended to require licensees to complete continuing competency/education requirements as a condition of licensure renewal. These requirements become effective as part of the 2017 renewal cycle (any license expiring on or after March 31, 2017). Licensees may select one of the following options to fulfill the continuing competency/education requirements. If audited, the licensee will be required to submit documentation of completion of one the following options.

Licensees who submit a renewal application, are selected for renewal audit and do not complete the audit requirements will be considered to have submitted an incomplete renewal and the license will not be renewed.

Please Select From One Of The Following Options

The selected option must be completed during the biennial renewal period

Option 1

- Completion of twenty (20) continuing education hours by a Board approved provider [O.C.G.A. §43- 26-39(b.1)(1)].
- Please submit certificates of completion documenting twenty (20) continuing education hours completed during the biennial renewal period.
- Please visit the Board's website at sos.ga.gov/plb/nursing for a list of acceptable providers.

Option 2

- Completion of an accredited academic program of study in registered professional nursing, as recognized by the board. [O.C.G.A. §43-26- 39(b.1)(2)].
- Please submit documentation of graduation from a Board approved nursing education program within the biennial renewal period.
- Please visit the Board's website at sos.ga.gov/plb/nursing, click on "Education and Exam" for a complete list of Board approved nursing education programs in Georgia.

Please note, documentation of completion of continuing competency requirements should only be submitted if you are audited during the license renewal process

Georgia Board of Nursing
Acceptable Providers for Continuing Education for Registered Nurses or Licensed Practical Nurses

Acceptable continuing education may be taken in a conventional classroom setting, through online courses, professional journals, correspondence or independent study.

1. Any provider, recognized by a national credentialing body, offering certification in the licensed nurse's specialty area of practice.

Examples of National Nurse Credentialing/Certification bodies include but are not limited to:

- American Nurses Credentialing Center Commission on Certification (ANCC)
- Oncology Nursing Certification Corporation (ONCC)
- Board of Certification for Emergency Nursing (BCEN)

2. Any provider, recognized by a national credentialing body, recognized by the Georgia Board of Nursing in Rule 410-12-.12, offering certification to advanced practice nurses.

Examples of National Nurse Credentialing/Certification bodies include but are not limited to:

- American Nurses Credentialing Center Commission on Certification
- American Midwifery Certification Board
- National Board on Certification and Recertification of Nurse Anesthetists

3. Georgia Nurses Association ("GNA"), including offerings given by the GNA Continuing Education Provider/Approver Unit. Information regarding the Georgia Nurses Association can be found at: www.georgianurses.org

4. Area Health Education Centers (AHEC) in Georgia or any state AHEC that is a member of the National AHEC Organization. Information on Georgia AHEC can be found at: www.gru.edu/ahec

5. American Nurses Association (ANA), or ANY ANA affiliated state nurses association provider/approver unit

- ANA – www.nursingworld.org
- GNA – www.georgianurses.org

6. National League for Nursing (NLN)

- www.nln.org

7. National Council of State Boards of Nursing (NCSBN)

- www.ncsbn.org

8. Employer sponsored continuing education programs having a minimum of one course objective.

Unless the program is accredited through one of the other bodies mentioned on this document, employer sponsored continuing education may only be used for up to 50% of total contact hours.

9. Any provider of professional continuing education for health care professionals.
   Examples include offerings related to specialty areas of nursing practice such as research, case management, health policy, forensics, mental health, or complementary alternative therapies offered by bodies including but not limited to:
   - Commission for Case Manager Certification (CCMC)
   - Healthcare Quality Certification Board (HQCB)
   - American Legal Nurse Consultant Certification Board (ALNCCB)

10. Professional Journals (i.e. *The American Journal of Nursing*, *Nursing 2013*, *Nursing Management* and *The Nurse Practitioner*) offering continuing education approved by appropriate bodies including but not limited to:

   - American Nurses Credentialing Center (ANCC) www.nursingworld.org/ancc
   - American Association of Critical Care Nurses (AACN) www.aacn.org

11. Any provider recognized by another state board of nursing within the United States.

Activities NOT accepted as Continuing Education

Offerings designed for lay

persons Offerings less than 30

minutes in duration On-the-job

orientation

On-the-job training related to new policies, procedures or equipment

Other educational activities not sufficiently professional in character to reasonably qualify as continuing education.

Definition of Continuing Education Units and Contact Hours

The Georgia Board of Nursing accepts either contact hours or CEUs (in any combination) to fulfill the continuing education requirements of O.C.G.A. §43-26-9(b.1)(1)

- One Contact Hour is equal to 60 minutes of instruction.
- 0.1 CEU is equal to 60 minutes of Instruction.
- 1 CEU is equal to ten hours of instruction.

May 2015

NURSING PROGRAM IN RICHMOND COUNTY

GOAL:
To provide a health program which contributes significantly to the attainment of the full health and educational potential of each student.

OBJECTIVES:
School health services are designed to:

- Appraise the health status of pupils and school personnel.
- Counsel pupils and school personnel.
- Help prevent communicable diseases.
- Provide emergency care for injury or sudden illness.
- Protect and promote the health of school personnel.
- **Administer reasonable first aid (never prescribe. diagnose nor give medication without written permission from the parent or guardian).**

QUALIFICATIONS:
A public school nurse must hold a current license issued by the Georgia State Board. He/She may be a registered nurse or a licensed practical nurse.

RICHMOND COUNTY SCHOOL SYSTEM

(RCSS) JOB DESCRIPTION

OFFICIAL TITLE: School Nurse

SUPERVISOR: School Principal

SALARY RANGE: In accordance with RCBOE Salary Schedules

TERMS OF EMPLOYMENT: Work Year - 10 Months

SUMMARY DESCRIPTION:

Serves as nurse for schools.

PERFORMANCE RESPONSIBILITIES: (Asterisk for essential job duties.)

1. Maintains clinic records (*)
2. Obtains, updates and files certificates of immunization on each student, and dental, hearing, and vision certificates on students who enter a Georgia School for the first time (*)
3. Obtains current and up to date health cards (which include emergency address) on each student
4. Initiates referrals to parents and school personnel
5. Notifies teachers of any medical problems a student might have
6. Obtains, files, and delivers to principal accident reports on students and employees
7. Assists the school administrators and teachers in gaining insight into student health problems
8. Assesses the school environment for its safety and serves on safety and other committees
9. Reports contagious diseases to principal, director of student services and to the Richmond County Health Department
10. Maintains adequate clinic supplies-first aid supplies and stock medications
11. Serves students by monitoring and/or giving medication brought from home with proper paperwork in place and determining who is to go home and notifies parent (*)
12. Conducts internal audits on certificates of immunization and dental, visual, and hearing certificates
13. Screens and evaluates findings for scoliosis, blood pressure, head lice, and scabies and maintains records and reports these findings to the appropriate personnel or department (principal, student services department, Richmond County Health Department)
14. Conducts vision, hearing, and scoliosis screenings
15. Identifies children with potential health problems
16. Provides crisis intervention for student illness, injury, and emotional disturbances (*)
17. Follows procedures outlined by a physician or monitors the performance of the procedures described by a physician in handling problems to include abdominal pain, bites, bleeding, blisters, burns, colds, convulsive seizures, cuts, exhaustion, poison, rash, shock, sore throat, splinters, sprains, and toothache
18. Assists in the control of communicable diseases with the school environment
19. Covers schools for emergency situations when needed
20. Initiates referrals to community health resources and serves as a liaison between home, school, and community

21. Performs catheterization, tracheotomy suction and care, vision screenings on referrals and communicates with hearing impaired students where applicable according to physician orders
22. Maintains and updates medical skills through CPR certification, Multi-Media First Aid, Disaster, Sickle Cell, Child Abuse, Scoliosis Workshop, Epilepsy Workshop, and Drug Abuse
23. Conducts ongoing health counseling with students, parents, school personnel, and interprets the health status of students to school personnel and parents
24. Assists the doctor in conducting physical examinations for special education students desiring to participate in special Olympics when requested
25. Serves as a resource person to school administrators or classroom teachers in health education instruction
26. Acts as a resource person in promoting health careers
27. Serves as a resource person or works cooperatively with curriculum department in teaching family life education courses to special education students, general health habits to elementary students, and care to older students
28. Evaluates nursing program on an annual basis
29. Assists director of student services in writing revising and/or updating procedure manual
30. Teaches CPR and First Aid courses to school personnel
31. Conducts nursing education and skills workshop on an annual basis
32. Conducts awareness programs for students, staff members, and parents (ex: Drug Abuse, Asthma 101)
33. Conducts in-services on how to address medical related incidents among students supervised by the school staff
34. The employee shall carry out such other and further duties, whether specifically listed above or not, as are assigned or required by such employee's supervisor, other appropriate school personnel, law board policy administrative regulation, department handbook, as are reasonably necessary to the efficient operation of the school system and its mission.

KNOWLEDGE, ABILITIES, AND SKILLS:

Thorough knowledge of nursing procedures, student growth,
and development, first aid and CPR. Ability to effectively communicate orally and in writing.

EDUCATION, TRAINING, AND EXPERIENCE:

Hold a current license issued by the Georgia State Board as a Registered Nurse or Licensed Practical Nurse, certification in CPR and first aid instruction.

CERTIFICATE AND LICENSE REQUIREMENTS:

Holder of a current license issued by the Georgia State Board, Registered Nurse or Licensed Practical Nurse, Certification in CPR and First Aid instruction within one year of employment.

PHYSICAL DEMANDS:

Light work, exerting up to 10-20 pounds of force occasionally.

SPECIAL REQUIREMENTS:

Must wear a medical uniform or lab coat.

EVALUATION:

Performance of this job will be evaluated in accordance with provisions of the School Board policy on evaluation of personnel.

Date Established:
Date(s) Revised: 2/09

This description may be changed at any time. This job description in no way states or implies that these are the only duties to be performed by the employee. The employee will be required to follow any other instructions and to perform any other related duties as assigned by the Board. Richmond County Schools reserves the right to update, revise or change this job description and related duties at any time.

*** Essential job duties - the basic job duties that an employee must be able to perform, with or without reasonable accommodation.**

I acknowledge that I have read the essential duties required in this job description and can perform these duties with or without reasonable accommodations.

_____

Employee

_____

Date

Board of Education

Richmond County *Augusta, Georgia*

SCHOOL NURSE APPRAISAL RECORD

Name: _____ **School :** _____

Social Security No: _____ **Number of years in Present Assignment:**_____

Number of Years in School System: _____ **Appraisal is for the period** _____ **to**_____

Instructions

The Richmond County School Nurse is to be appraised by the principal on a three point scale. The scale is as follows:

1	2	3
Needs Improvement	Satisfactory	Outstanding

COMPETENCY I:

The Richmond County Nurse provides a competent and effective program in accordance with existing guidelines.

Indicators

	The Richmond County School Nurse	1	2	3
1.	Displays the knowledge and skills necessary for adequately performing the duties of a Richmond County School Nurse.	☐	☐	☐
2.	Maintains adequate records and prepares reports in a neat and accurate manner.	☐	☐	☐
3.	Is punctual in reporting to work.	☐	☐	☐
4.	Is regular in attendance.	☐	☐	☐
5.	Is available to counsel students, staff, and parents in regard to health problems.	☐	☐	☐
6.	Maintains an attractive, neat, and clean clinic.	☐	☐	☐
7.	Exhibits an awareness of interpersonal skills necessary in working with students, staff, and parents.	☐	☐	☐
8.	Displays a cooperative attitude toward students, staff and parents.	☐	☐	☐
9.	Provides adequate emergency care.	☐	☐	☐
10.	Works well under pressure.	☐	☐	☐
11.	Provides adequate first aide care.	☐	☐	☐
12.	Makes prompt and adequate referrals.	☐	☐	☐
13.	Helps to protect and promote good health within the school setting.	☐	☐	☐
14.	Maintains a neat, clean, professional appearance at all times.	☐	☐	☐
15.	Understands and follows established regulations, policies, procedures and practices of the Richmond County Board of Education.	☐	☐	☐
16.	Executes any instructions or directions from the principal.	☐	☐	☐

General Comments from School Nurse:

General comments from Principal:

Specific areas where improvement is needed:

Signature of Principal

Date

Signature of School Nurse

Date

Personnel Appraisal # 15

National Association of School Nurses
CODE OF ETHICS

Preamble

Acknowledging the diversity of the laws and conditions under which school nurses practice, the National Association of School Nurses (NASN) believes in a commonality of moral and ethical conduct. As such, NASN adopts the American Nurses Association's (ANA) *Code of Ethics for Nurses with Interpretive Statements* (2015), which establishes an ethical foundation for all nurses. Furthermore, this foundation is supported by the *School Nursing: Scope and Standards of Practice, 2nd Edition (*ANA & NASN, 2011*)* and ethical guidelines provided by state boards of nursing. School nursing practice, built upon these ethical foundations, is grounded in the NASN core values of child well-being, diversity, excellence, innovation, integrity, leadership, and scholarship (NASN, 2015). It is the responsibility of both the individual nurse and nursing organizations to function within these ethical provisions. For the purpose of this document the term student also refers to families and school communities.

Organizational Ethics

NASN, a 501(c)(3) non-profit organization established to support student health through the advancement of school nursing practice, has ethical responsibilities to its members and the communities those members serve (NASN, 2015). These organizational responsibilities include:

- Promotion of ethical work environments that support student and community health;
- Development of "…a research agenda that will lead to a culture of ethical practice in diverse settings that is evidence-based and measurable in terms of outcomes…" (Johns Hopkins School of Nursing & Johns Hopkins Berman Institute of Bioethics, 2014, p. 5);
- Development of relationships with organizations whose principles and actions are in harmony with NASN's mission and values and the termination of relationships with organizations whose known actions violate NASN's business and ethical principles; and
- Support of the role of the school nurse through advocacy, integrity, and participation in public policy development and social justice.

School Nurse Ethics

School nurses straddle two statutory and regulatory frameworks, health and education. Because school nurses practice nursing in an educationally focused system, they face unique legal, policy, funding and supervisory issues that may also have ethical dimensions. These issues may include:

- Unsafe school nurse to student ratios,

- Accountability for care delegated to Unlicensed Assistive Personnel (UAP),
- School administrator request to amend documentation,
- School administrator assignment of nursing tasks to UAP without the input of the school nurse, and
- Parent/guardian request for medical treatment for his/her student, which is inconsistent with school nurse scope of practice (Brent, 2013).

As such, school nurses must have not only the skills to communicate within both the healthcare and education arenas, but also the requisite knowledge and skills to interpret applicable laws, regulations and professional standards, as well as apply ethical theories and principles (ANA & NASN, 2011).

Child Well-being

- School nurses support and promote student abilities to achieve the highest quality of life as understood by each individual and family.
- School nurses integrate "caring, kindness, and respect into nursing practice" (ANA & NASN, 2011, p. 51).
- School nurses serve a unique role in transition planning to address student health needs within the school environment.
- School nurses maintain protection of, and confidentiality with, student health records according to the Health Insurance Portability and Accountability Act (HIPAA), Family Education Rights Protection Act (FERPA), other applicable federal laws, state laws and regulations, and professional standards of practice to safeguard privacy.
- School nurses utilize interventions designed to mitigate the effects of adverse childhood experiences and other social determinants of health.
- School nurses refer students to other health professionals and community health agencies as needed to promote health and well-being.

Diversity

- School nurses deliver care in a manner that promotes and preserves student autonomy, dignity and rights so that all are treated equally regardless of race, gender, socio-economic status, culture, age, sexual orientation, gender identity, disability or religion.
- School nurses deliver care in an inclusive, collaborative manner that embraces diversity in the school community.
- School nurses actively promote student health, safety, and self worth.
- School nurses intervene to eliminate discrimination and bullying.

Excellence

- School nurses must have knowledge relevant to meet the needs of the student and maintain the highest level of competency by enhancing professional knowledge and skills and by collaborating with peers, other health professionals and community agencies.
- School nurses incorporate information from supervisory clinical evaluation to improve their nursing practice.

- School nurses evaluate their own nursing practice in relation to professional standards of practice and applicable laws, regulations and policies.

Innovation

- School nurses utilize available research in developing health programs, individual plans of care, and interventions.
- School nurse workplace environments impact the quality of health care; therefore, school nurses collaborate to improve these environments.
- School nurses are aware of social determinants of health in the school community, provide health care to all students, support school staff, and partner with families and other community members to reduce health disparities.

Integrity

- School nurses maintain confidentiality within the legal, regulatory and ethical parameters of health and education.
- School nurses understand, follow and inform others about student health record protection according to HIPAA, FERPA, other applicable federal laws, and state laws and regulations.
- School nurses take "appropriate action regarding instances of illegal, unethical, or inappropriate behavior that can endanger or jeopardize the best interest of the healthcare consumer or situation" (ANA & NASN, 2011, p. 50).

Leadership

- School nurses are student advocates.
- School nurses support student rights in navigating the educational environment.
- Delegation or assignment of nursing tasks, including accountability for delegated tasks, may be the responsibility of the school nurse. School nurse assignments and delegations must be consistent with state nurse practice guidelines and established best practice.
- School nurses work within educational institutions to define and implement professional standards of practice and school health policy development.

Scholarship

- School nurses are life long learners in pursuit of knowledge, training and experiences that enhance the quality of their nursing practice.
- School nurses participate in and promote research activities as a means of advancing student health and school health services.
- School nurses conduct research as appropriate to the nurse's education, position and practice environment.
- School nurses adhere to the ethics that govern research, specifically:
    - Rights to privacy and confidentiality;
    - Voluntary and informed consent; and

- Awareness of and participation in the mechanisms available to ensure the rights of human subjects, particularly vulnerable populations (e.g. minors, disabled).

Conclusion:

In the course of day-to-day practice and based upon the applicable state nurse practice act and professional scope and standards of practice, school nurses may find themselves in situations that present ethical dilemmas. School nurses and school nurse organizations have a responsibility to practice in accordance with the NASN core values, *NASN Code of Ethics* and professional standards of practice. School nurse decision-making is guided by these principles that promote improved student health, academic success and excellence in school
health services. NASN believes the practice of school nursing demands a vigilant focus on ethics.

References

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American Nurses Association & National Association of School Nurses. (2011). *School nursing: Scope and standards of practice* (2nd ed.). Silver Spring, MD: Nursebooks.org.

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Source: https://www.nasn.org/nasn-resources/professional-topics/codeofethics

National School Nurses Code of Ethics

Client Care

The school nurse is an advocate for students, families and members of the school community. To that end, school nurses facilitate positive 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. Each individual's inherent right to be treated with dignity and confidentiality is respected. All clients are treated equally regardless of race, gender, socio-economic status, culture, age, sexual orientation, disability or religion.

- School nurses deliver care in a manner that promotes and preserves student, family and community client autonomy, dignity and rights.
- School nurses support and promote individuals' and families' ability to achieve the highest quality of life as understood by each individual and family.
- School nurses deliver care in an inclusive, collaborative manner that embraces diversity in the school community.
- School nurses maintain client confidentiality within the legal, regulatory and ethical parameters of health and education.
- School nurses advocate on behalf of clients' needs.

Professional Competency

The school nurse maintains the highest level of competency by enhancing professional knowledge and skills, and by collaborating with peers, other health professionals and community agencies while adhering to the standards of school nursing practice.

- The profession of nursing is obligated to provide competent nursing care. The school nurse must be aware of the need for continued professional learning and must assume personal responsibility for currency of knowledge and skills.
- School nurses must evaluate their own nursing practice in relation to professional practice standards and relevant statutes, regulations and policies.
- School nurses must have knowledge relevant to meet the needs of clients within the school setting. Since individual expertise varies, nurses consult with peers and other health professionals with expertise and recognized competencies in various fields of practice. When in the client's best interest, the school nurse refers clients to other health professionals and community health agencies.
- Nurses are accountable for judgments made and actions taken in the course of nursing practice. The scope and standards of school nursing practice reflect a practice rounded in ethical commitment. The school nurse is responsible for establishing and maintaining a practice based on these standards.

Professional Responsibilities

The school nurse participates in the profession's efforts to advance the scope and standards of practice, expand the body of knowledge through nursing research and improve school nursing practice work environments.

- The school nurse is obligated to demonstrate adherence to the profession's standards by monitoring these standards in daily practice, participating in the profession's efforts to improve school health services and promoting student health and academic success.
- The school nurse utilizes available research in developing the health programs and individual plans of care and interventions.

- The school nurse participates in and promotes research activities as a means of advancing school health services and the health of students. This is done as appropriate to the nurse's education, position and practice environment and in adherence to the ethics that govern research, specifically:
  - o Right to privacy and confidentiality,
  - o Voluntary and informed consent and
  - o Awareness of and participation in the mechanisms available to ensure the rights subjects, particularly vulnerable populations (minors, disabled, etc.)
- The school nurse recognizes that practice environments impact the quality of client care and is cognizant of the need to work with others to improve these environments.

School Staffing

Daily access to a professional school nurse (hereinafter referred to as a school nurse) can significantly improve students' health, safety, and abilities to learn, according to NASN. To meet the health and safety needs of students, families and school communities, school nurse workloads should be determined at least annually, using student and community specific health data.

School nurse-to-student ratios were first recommended in the 1970s, when laws were enacted to protect the rights for all students to attend public school, including those with significant health needs. Those laws included The Rehabilitation Act of 1973, Section 504 (2000) and Public Law 94-142, the Education for all Handicapped Children Act (1975), reauthorized in 2004 as the Individuals with Disabilities Education Improvement Act [IDEIA], (2004). Although evidence to support ratios was limited, some states and NASN recommended one school nurse to 750 students in the healthy student population; 1:225 for student populations requiring daily professional nursing services; 1:125 for student populations with complex healthcare needs; and 1:1 for individual students requiring daily, continuous professional nursing services (American Nurses Association [ANA]/NASN, 2011). While a ratio of one school nurse to 750 students has been widely recommended and was acknowledged in Healthy People 2020 (U.S. Department of Health and Human Services [USDHHS], 2014a) and by the American Academy of Pediatrics [AAP] (2008), a one-size-fits-all workload determination is inadequate to fill the increasingly complex health needs of students and school communities (AAP, 2008; ANA/NASN, 2011).

Appropriate school nurse staffing is related to better student attendance and academic success, according to multiple studies.

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SCHOOL NURSING BASICS

Overview of Services

This information is provided to assist with areas of concern which confront school health personnel in the daily operation of the school health clinic. If a question or situation arises that is not addressed by general guidelines or local policies or procedures, remember the school principal always has the ultimate responsibility for the health and well-being of the student during school hours and school-sponsored activities. Nurses and other school health personnel should work within the guidelines established by school board policy and local school procedures and in partnership with the principal.

Duties/Responsibilities of School Nurse

This list may be used and modified for your staffing model as needed:

- Maintain confidentiality by respecting the privacy of students in the clinic, during telephone conversations and when handling their health records.
- Provide appropriate health services and demonstrate care and concern for students.
- Notify principal and parents of any need for further care. Contact parents regarding student health issues whenever necessary.
- Coordinate communicable disease control in the school. Report concerns to the principal and the public health department as necessary. Assist with immunization surveillance as requested.
- Maintain a current list of students with ongoing health concerns and develop Individual Health Plans and emergency plans as needed for each. Keep the principal apprised of any situations that develop with these students.
- Communicate pertinent student health information in a timely and confidential manner to appropriate persons (principal/ designee and/or other necessary school staff), with parent permission.
- Maintain documentation of clinic records accurately and completely.
- Develop effective working relationships with school personnel and parents/guardians.
- Administer student medications in accordance with school system guidelines, the Georgia Nurse Practice Act (including rules and regulations of the Georgia Board of Nursing) and professional nursing judgment.
- Provide special healthcare procedures and treatments to students, as prescribed.
- Coordinate mandated school screenings and ensure necessary follow-up care.
- Maintain an orderly health clinic. Maintain and restock supplies, per school policy.
- Maintain current certification in basic first aid and CPR. Maintain up-to-date knowledge of school health procedures through district training and continuing education.
- Promote a healthy and safe environment within the school.
- Provide employee wellness education and services to school staff.
- Provide or assist with classroom health education as requested.
- Participate on school committees as appropriate, providing health input on individual students or for the general student population (i.e. Crisis Team, SST/IEP, etc.).
- Complete monthly report of school health activities, per local policy. Assist with an annual school health report to the local school board as requested.

School Clinic Procedures

School Nurses and Clinic Personnel Should:

- Accept students into the clinic as they walk in or with referral slip from teacher.
- Record name of child and time on daily log or using computerized system.
- Ensuring confidentiality, listen to child's complaint and take a focused health history.
- Check the clinic health information card for that student to ensure you know the health history, allergies, etc.
- Assess the child, taking vital signs as needed, and give care according to clinical judgment, local guidelines and policies and the Georgia School Health Resource Manual.
- Contact parent and/or consult with school nurse supervisor or administration, as necessary. A direct or dedicated telephone line in the clinic will facilitate this.
- Release child from clinic per local school policies and procedures:
  - to return to the classroom, or
  - to the parent/guardian or other person designated by the parent.
- Students coming in for daily medications should be kept in an orderly line, so that clinic personnel may concentrate on one at a time, document each child appropriately and avoid potential for medication errors.
- Complete daily log with requested information including tallies for monthly report.
- Record any pertinent information/observations in the child's health card/record.
- Clinic personnel should plan a regular lunch break per local policy, perhaps after the bulk of the daily medications. A consistent schedule will help teachers know when to avoid sending students with non-urgent problems.
- If the school nurse is responsible for more than one building or multiple schools, a cell phone/ walkie talkie can be provided, so the nurse can be reached in an emergency.
- Standard precautions and infectious control procedures should be used in all situations that have the potential to present a hazard involving infectious materials.
- Students who require an Individual Healthcare Plan should be provided such a plan, based upon the individual needs of the student and based upon the decisions of a group of appropriate District personnel.
- Sick or injured individuals should be cared for per current first aid guidelines
- The school Emergency Medical Plan should include actions to be taken in medical emergencies and should be activated in the event of a medical emergency.

School Nurses and Clinic Personnel Should Not:

- Perform any invasive procedures such as probing in the eyes, ears, nose, skin or throat.
- Make a medical diagnosis, prescribe treatment or medication.
- Apply any unauthorized topical creams, ointments or sprays.
- Transport students.
- Administer or assist students with prescription or non-prescription medications, without a signed medication authorization form.

Setting up the Health Clinic

- An organized workspace will be critical to your success. You may not have control of how much space, furniture and equipment you have to work with, but you can still organize your space with some attention to the functions of your job. Some nurses have set up their offices with multiple work stations, each with the supplies and resources needed for that task readily available (i.e. First Aid, Medication Administration, Phone, Paperwork and Referrals).

- Keep your student clinic cards or files in order alphabetically and possibly by grade. These should be easily accessible, keeping confidentiality in mind. You can use color-coded flags or dots to mark the cards of students with ongoing health concerns. Students who have specific instructions, treatments and emergency plans should have a separate duplicate file that can be transported with the portable emergency kit if needed.

- Medication Authorization forms may be filed together in a notebook with tabs for Daily, PRN and Aerosols (updated weekly as needed). Medications must be kept locked either in a mounted cabinet or a file cabinet. Limited access to that key is suggested. Some nurses keep the medications and authorization forms for one student in a file folder with sides stapled. These folders are labeled and alphabetized, and the drawers are separated by Daily, PRN and Aerosols. You may want to keep aerosols together in a container that can be put into the portable emergency kit for an evacuation. Of course, some medications require storage in a refrigerator. See Chapter 3 (Medication Administration) for more details.

- Resources to have posted in the clinic include: Communicable Disease chart, list of staff currently certified in CPR/ first aid or First Responder/AED, emergency numbers (including poison control), CPR poster and handwashing reminders. Also keep posted by the phone the school's phone number, fax number and address; valuable time can be lost if you have to search for these during an emergency.

- A computer can be used to access student emergency contact information from the school database, to access the Internet for quick research and to maintain student health records with an adequate software program.

- Have a substitute clinic personnel folder (easily found) with important information and/or instructions; including some Clinic Do's and Don'ts.

- Use a bulletin board in your health clinic or in the hall near your office for health education. Refer to Chapter 9, Health Education: The School Nurse Role, for ideas and use your imagination!

- Clinic supplies and equipment can be obtained from school districts, partners in education, principal's funds, and "clinic showers" sponsored by PTA and individual classes. The PTA may also be able to help you with a secondhand clothing "closet," so that you can provide clean clothes for students who have accidents of various kinds during the day. Let people know what you need. It will take a while for you to make your clinic just like you want it, but keep working at it.

- You may want to keep a phone logbook for easy reference. Many nurses have found that keeping a spiral notebook for notes written during the day can be invaluable when many things are happening at once.

- Have an Emergency Go (Evacuation) Bag or Emergency To-Go Cart supplied and ready. Check expirations dates routinely.

Recommended School Clinic Supplies List

The following supplies and equipment are recommended for each school clinic. Questions should be directed to the Nurse Supervisor.

Permanent Equipment

Bed (2) (w/adjustable headrest)
Toilet facility
Chairs (4)
Biohazard (sharps) container
Clock with second hand Desk
with chair Thermometer
Thermometer covers if needed
Bookcase or shelf
Flashlight
Bandage scissors
Computer
Bulletin board
Tweezers
Locked medication cabinets
Goose neck lamp (for head checks)
File cabinet with lock
Weight scale and stadiometer (measures height)
Telephone
Small refrigerator
Sink with hot and cold water
Soap dispensers
Privacy screen
Vision testing equipment
Covered trash can
Pure tone audiometer
Rolling chair (less expensive than a wheelchair)
Sphygmomanometer with cuffs
Disposable mouth barrier for CPR
(suggest one per CPR provider in the school)
Microwave

Injury Care Supplies

Non-latex, hypoallergenic tape (assorted sizes)
Tongue depressors
Band-aids, assorted sizes
Emesis basins
Pint-sandwich size baggies for ice, frozen sponge
Elastic bandages
Non-sterile gauze (2x2 and 4x4)
Dental wax and floss
Sterile gauze (2x2 and 4x4)
non-stick gauze 4x4 squares (such as telfa)
Rolled non-sterile gauze
Normal saline eyewash
Cold packs (small and medium)
Eye pads/dressing/shield
Arm splints, slings
Cotton-tipped applicators
Portable first aid kit for field trips
Cotton balls
Disposable diapers (may be used for compression)

General Supplies

Alcohol prep pads
Fingernail clippers, ring cutter
Blanket
Facial tissues
School-approved disinfectant
Paper towels with dispenser
Cleaning supplies, plastic bags
Table paper for bed (disposable)
Bed pillow, plastic cover
3 oz. paper cups
Glucose gel ("Cakemate" icing can be used)
Medicine cups
Non-latex gloves (disposable)
General office supplies Sanitary
pads
Hand lotion, Vaseline for chapped lips
Liquid soap, in dispenser
Cooler for ice (if no freezer)
Pediculosis sticks (optional)
Magnifying glass
Donated /thrift store clothing for younger students
Heating pad (UL approved) (prek-2nd grade sizes) for changes due to "accidents,"
including socks and underwear
Quart sized baggies
Marker
Peppermints
Ginger ale Tea
bags Bottled
water

Do not use peroxide as a wound cleanser as it has been proven to be damaging to tissues. Simply use soap and water or normal saline to clean. If bleach is used as a disinfectant and is approved for use in your district, it should be diluted 1:10 with water and made up daily.

Questions for Parents of a New Student

These questions can be completed in an interview with the parent/legal guardian at the time of registration of the new student or by telephone, ideally within the first week of the child's attendance. Take this time to briefly explain the school health program in your school, your role as the school nurse and how you may be contacted.

- Will your child need to take any medications in school? If so, discuss and give copies of policies and needed forms for regular and prn meds.
- Does your child have a current care plan or an Individualized Health Care Plan; such as a Seizure Action Care Plan, Allergy Care Plan, Asthma Care Plan, Diabetic Care Plan, or Sickle Cell Care Plan?
- Does your child have asthma? Initiate discussion about Asthma Action Plan.
- Does your child have any allergies to foods, animals, insects, medications, latex or other substances?
- Does your child have diabetes? Initiate discussion about Diabetes Management Plan.
- Does your child have any activity restrictions for PE or recess?
- Is there anything that causes your child to miss school frequently?
- Does your child have any vision or hearing problems? Corrected?
- Are there any other health problems that I, as the school nurse, need to know about (i.e. seizures, diabetes or other chronic health conditions which may affect your child during the school day or affect his ability to learn successfully)? The school nurse can advocate for your child in the school setting if health problems affect or can be affected by the learning environment.
- Have you completed the emergency contact cards with all of the information I may need to reach you if necessary?
- Does your child have a healthcare provider for regular checkups and illnesses? If not, do you need referral information (PeachCare, Medicaid, local practitioners)?
- Is your child current on immunizations? Offer information here, about needed 6th grade immunizations and tetanus/diphtheria boosters.
- Is there anything else about your child's health that you would like to share with me?
- Do I have your permission to share this information with your child's teacher, the principal or other school staff as needed? Discuss why this may be important and have parent sign permission for release of medical information.
- After this interview, find a time to introduce yourself to the child and show him where the clinic or health room is

Communicating with Families

Communication with families is an important component of school health services. Because of societal changes and work situations, parents may be difficult to contact. In some cases, the nurse will be communicating with grandparents, guardians, foster parents or social workers. Nurses will need to reach families to request further information, as well as to report screening results and health issues that come up during the school day.

Sending a letter or form home with information about clinic visits will assist with keeping the lines of communication open (See Clinic Visit Report to Parent at the end of this chapter). The nurse should document and maintain a record of communication with parents. Helping parents understand, during registration and interviews with families new to the school, that the nurse is there to be an advocate for the child can help the nurse obtain good contact information and pave the way for good communications.

Collaborating with All School Employees

School nurses have a responsibility for monitoring and maintaining a healthy school environment in which students can learn. In order to accomplish this goal, collaboration with other school employees is a key ingredient of success.

- The principal is the leader of the school team. The principal should be made aware of any obstacles or problems that occur in the school health clinic, such as the following:
  - if a child is seriously ill or injured
  - if emergency services need to be called
  - if there is a concern with communication with a parent/guardian
  - if there is a pattern of illness, infection, injury or infestation
  - if there is suspected child abuse or neglect
  - if there is a concern about the safety or health of the school environment
  - any time there is a situation with which the school nurse or clinic worker needs assistance.
- The school administrative staff can provide information on the students and families, class scheduling, building concerns, problems that may be occurring in other schools and community resources.
- Teachers can be your best observers. They will most likely be the first ones to notice students' physical symptoms, patterns of illness, health complaints and psychological changes. Special education teachers and paraprofessionals also have a wealth of knowledge and experience in dealing with students with special needs.
- The school social worker, guidance counselor, Student Support Team leader and other allied health professionals (speech therapist, etc.) can be your best allies in gathering information about children and families and available resources. District level personnel such as audiologists and school psychologists are also important contacts.
- The cafeteria staff can be helpful with snacks you may need for children, ice and observation of a child's eating patterns. The district level Nutrition Director can also provide assistance with students with special nutrition needs.
- The custodial staff can help you with infection control issues, clean-up of spills and building safety issues.
- The media center staff can help you with researching a health issue and finding resources for health education.
- Interpreters are becoming more and more important as our population becomes more diversified.
- The technical support staff at your school or district can help you with computer software needs and problems.
- Many times you may be asked to help with a staff member's health concern as well. You may be able to provide first aid, assist with referrals, help with health education curriculum and ideas for bulletin boards, etc.

School Health Records

CONFIDENTIALITY

FERPA AND HIPAA

The Family Educational Rights and Privacy Act (FERPA) is a federal Law that protects the privacy of student education records. The Law applies to all schools that receive funds under an applicable program of the U.S. Department of Education. FERPA gives parents certain rights with respect to their children's education records. To view a complete copy of the Law click on the link below.

- Family Rights & Privacy Act (FERPA)
  www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html

Further Reading nasn.org/ToolsResources/DocumentationinSchoolHealth/HIPAAandFERPA

School Nurse Role in Electronic School Health Records

In 2011, 74% of school nurses reported using Electronic Health Records (NASN, 2011). Therefore, it is important for school districts to have policies and procedures in place regarding the types, maintenance, protection, access, retention, destruction, and confidentiality of student health records. Information technology professionals with school districts may require expert assistance in addressing the requirements for health documentation standards; thus school nurses should participate in the selection of documentation systems as well as the development of appropriate policies and procedures.

For Further Reading
nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/641/Electronic- School-Health-Records-School-Nurse-Role-in-Adopted-January-2014

Documentation

Parents/guardians should complete a health form for every child at the beginning of the school year or upon registration, which includes:

- All emergency contact information (including cell phones and pagers)
- Pertinent health history
- Primary care provider/insurance information
- All medications taken
- Allergies
- Persons to whom child may be released
- Signed permission to release medical information or contact the primary care provider (PCP).

Ideally, this form (or a copy or computer version) should be available in the school health clinic, filed under student name alphabetically and by grade. It should be updated annually, especially for emergency contact and health history information. Some schools put space on the back of the form to record specific student health information as it occurs, such as clinic visits,
immunizations given and screening reports. Some schools have incorporated this information onto a health folder, which can then be filed and used to hold other pertinent health information for this child.

The child's complete school health record includes all of the following. Those marked with * are required for ALL students, the rest are required inclusions as needed:

- Immunization Certificate (form 3231) and supporting documents including GRITS (Georgia Registry of Immunization Transactions and Services) records*
- Vision, Hearing, Dental and Nutrition Screening (form 3300)*
- Medication authorization forms
- Correspondence from physicians and parents
- Treatment authorization forms
- Results from school screenings, referral letters sent
- Clinic visit reports, nurse's notes
- Student accident forms
- Any other documentation related to the child's health in school.

Some schools may choose to keep all information in one record in the office, but keeping health information filed separately in the health clinic is better for logistics and confidentiality. Wherever this information is kept, it must be locked and accessible only to authorized persons to maintain confidentiality. Orders for medications and treatments should be written and signed per local district policy. Acceptance of verbal or faxed orders should be addressed in school policy. Ideally, two people should always listen to a telephone verbal order from a healthcare provider and both should sign the order. Verbal orders, if taken, should always be followed by an order in writing within a specified time period, usually 48-72 hours. Personal health information that is faxed should come in and be sent out with a cover sheet, clearly marking the information as confidential.

Standards of documentation for the school health record are similar to any other nursing documentation. All written materials should be accurate, objective, concise, complete, timely and well-organized. Entries should be legible, in ink, with each entry timed and dated. Subjective student data should be recorded in the student's own words. Assessment data should include significant findings, both positive and negative. Nursing actions should be documented completely; personal judgments and opinions should be omitted. An accepted method of error correction is one single line drawn through the entry, and the nurse's signature written above it. Avoid late entries; however, if necessary, make the entry with the correct date and time and mark as "late entry."

Source: https://www.choa.org/~/media/files/Childrens/medical-professionals/nursing-resources/ch-1-school-health-services-and-school-nursing-practice.pdf?la=en

SCHOOL NURSING ACTIVITIES CALENDAR

ROUTINE MONTHLY ACTIVITIES

- Address emergencies
- Make routine visits to assigned schools
- Initiate referrals to parents and school personnel
- Notify principal and teachers of any medical problems a student might have
- Report **contagious diseases** and child abuse/neglect to principal, director of Guidance and to the Richmond County Health Department. Report child abuse (neglect/physical/sexual) to Department of Family and Children Services, and to the Department of Public Safety
- Ascertain that adequate supplies are on hand
- Conduct hearing and vision screenings as requested to facilitate testing.
- Submit copies of monthly report to School Nurse Supervisor

Framework	AUGUST/SEPTEMBER	COMPLETED/ NOTES
Standards of Practice	• Identify and review new practice guidelines, policies and documents. Identify any changes needed	
Care Coordination	• Set up health room • **Collect school health cards from *all* students** • **Develop Medical Alert List** • **Submit an updated Medical Alert List to Nurse Supervisor** • Work with students/parents/guardians to update or develop individual health care plans (IHPs) and emergency care plans (IEPs) • Train school staff as appropriate regarding health and emergency care plans • Obtain necessary provider information and forms for medications and health procedures to be administered in schools • **Train other school staff as appropriate regarding medications and procedures to be administered in schools** • **Begin review of immunization records** • **Check AED and submit report** • **Complete and submit Monthly Report of Services to Nurse Supervisor**	
Leadership	• **Meet with principals and staff.** • Confirm forms, IHPs/IEPs, and training methods are current, evidence-based • Identify student-based and personal growth goals for the school year • **Identify required and self-imposed reporting deadlines for the year.** Plan and prepare weekly, monthly and yearly schedules. • Send a message to teachers and parents/guardians introducing yourself and sharing about your role keep students and schools health	
Quality Improvement	• Set up documentation system for the year; include Step Up! data points	
Community/ Public Health	• Case-find and prioritize students with special health care needs/chronic conditions. Plan accordingly to work with those students, their parents/guardians, and appropriate staff as needed • Provide training to school staff and others regarding universal precautions, cardiopulmonary resuscitation, first aid, and other potential health emergencies according to needs in your school (i.e. seizures, food allergies, stock emergency medication and other training) • Work with parents/guardians, school staff, and community health care providers to identify and follow up with students needing required immunizations	

	SEPTEMBER	COMPLETED/ NOTES
Standards of Practice	• Review evidence-based guidelines regarding screenings/referrals	
Care Coordination	• Continue to complete student IHPs/IEPs and training • **Conduct Scoliosis Screenings for students in grades 6 & 8** • **Begin Vision and Hearing Screenings for Grade 3** • **Begin Vision Screenings for Grades 5 & 7** • **Check AED and submit report** • **Complete and submit Monthly Report of Services to Nurse Supervisor**	
Leadership	• Continue to advocate for student needs • Develop a plan for accomplishing yearly personal/professional goals	
Quality Improvement	• Review monthly data for trends and make adjustments as needed	
Community/ Public Health	• Work with administrators regarding required and recommended screening activities, and the process of obtaining appropriate parental consents.	
	OCTOBER	COMPLETED/ NOTES
Standards of Practice	• Review an evidence-based practice that pertains to your students' needs	
Care Coordination	• Continue ongoing supervision of implementation of health care and procedure plans • **Continue Scoliosis Screenings for students in grades 6 & 8** • **Continue Vision and Hearing Screenings for Grade 3** • **Continue Vision Screenings for Grades 5 & 7** • **Check AED and submit report** • **Complete and submit Monthly Report of Services to Nurse Supervisor**	
Leadership	• Continue to advocate for students' needs • Include short message in PTA/school newsletter and make yourself available to teachers and parent groups for information.	
Quality Improvement	• Review monthly data for trends and make adjustments as needed	
Community/ Public Health	• Continue screenings and referrals • **Ensure state immunization report completed by schools** • Schedule health education classes, as appropriate (tie into current events, season, school needs) • **Coordinate and encourage flu vaccinations of staff/students (with appropriate timing according to your location)**	
	NOVEMBER	COMPLETED/ NOTES
Standards of Practice	• Review an evidence-based practice that pertains to your students' needs	
Care Coordination	• Continue ongoing supervision of implementation of health care and procedure plans • Outreach to teachers regarding students' health concerns • **Continue Scoliosis Screenings for students in grades 6 & 8** • **Continue Vision and Hearing Screenings for Grade 3** • **Continue Vision Screenings for Grades 5 & 7** • **Check AED and submit report** • **Complete and submit Monthly Report of Services to Nurse Supervisor**	
Leadership	• Identify a professional development opportunity to meet your needs/goals	
Quality Improvement	• Review monthly data for trends and make practice adjustments as needed	
Community/	• Continue referrals and follow –up of screening results	

Public Health	• **Coordinate and encourage flu vaccinations of staff/students (with appropriate timing according to your location)**	
	DECEMBER	COMPLETED/ NOTES
Standards of Practice	• Review one new guideline or standard or evidence-based material related to your practice and identify one area to incorporate into practice	
Care Coordination	• Continue ongoing supervision of implementation of health care and procedure plans • Outreach to teachers regarding student health concerns • Review student progress on plan goals and adjust as needed • **Continue Scoliosis Screenings for students in grades 6 & 8** • **Continue Vision and Hearing Screenings for Grade 3** • **Continue Vision Screenings for Grades 5 & 7** • **Check AED and submit report** • **Complete and submit Monthly Report of Services to Nurse Supervisor**	
Leadership	• Prepare for upcoming legislative session/district yearly planning and advocating for policies impacting school nursing	
Quality Improvement	• Review monthly data for trends and make practice adjustments as needed • Identify particular groups who are seen more often as well as identify health disparities	
Community/ Public Health	• Complete referrals and follow up of screening results • Send health message to staff/parents on appropriate topic • Monitor flu/communicable diseases	
	JANUARY	COMPLETED/ NOTES
Standards of Practice	• Continue working on implementation plan	
Care Coordination	• Continue ongoing supervision of implementation of health care and procedure plans • Outreach to teachers regarding student health concerns • **Submit an updated Medical Alert List to Nurse Supervisor** • **Check AED and submit report** • **Complete and submit Monthly Report of Services to Nurse Supervisor**	
Leadership	• Participate, as appropriate, advocating for policies/legislature as related to student health and/or updated evidence-based guidelines	
Quality Improvement	• Review monthly data for trends and make practice adjustments as needed • Submit mid-year report to administration	
Community/ Public Health	• Monitor flu/communicable diseases • Submit short message for PTA/school newsletter regarding flu season • Continue to work with students at risk (absent, late/leave early, disparity)	
	FEBRUARY	COMPLETED/ NOTES
Standards of Practice	• Continue working on implementation plan	
Care Coordination	• Continue ongoing supervision of implementation of health care and procedure plans • Outreach to teachers regarding student health concerns • Work with teachers to identify students at risk	
Leadership	• Participate, as appropriate, advocating for policies/legislature as related to student health and/or updated evidence-based guidelines • Identify new community resources needed to meet student needs	
Quality Improvement	• Review monthly data for trends and make practice adjustments as needed. Look particularly at health disparities that can be addressed	
Community/	• Monitor flu/communicable diseases	

Public Health	• Provide classroom, staff and parent/guardian education on appropriate topics	
	MARCH	COMPLETED/ NOTES
Standards of Practice	• Continue working on implementation plan	
Care Coordination	• Continue ongoing supervision of implementation of health care and procedure plans • Outreach to teachers regarding student health concerns • Work with teachers to ensure appropriate accommodations for students participating in field trips/camps that may have health concerns.	
Leadership	• Identify new community resources needed to meet student needs • Continue to advocate for students needs and as appropriate budget for new school year	
Quality Improvement	• Review monthly data for trends and make adjustments as needed	
Community/ Public Health	• Provide classroom, staff and parent education on appropriate topics • Monitor flu/communicable diseases	
	APRIL	COMPLETED/ NOTES
Standards of Practice	• Continue working on implementation plan	
Care Coordination	• Continue ongoing supervision of implementation of health care and procedure plans • Outreach to teachers regarding student health concerns • Inventory supplies needed for next year • Work with teachers to ensure appropriate accommodations for students participating in field trips/camps that may have health concerns • **Check AED and submit report** • **Complete and submit Monthly Report of Services to Nurse Supervisor**	
Leadership	• Continue to advocate for students needs and (as appropriate) budget for new school year	
Quality Improvement	• Review monthly data for trends and make adjustments as needed • Set up an appointment with principal/district supervisor, board of education and local health department to share data and activities for the year	
Community/ Public Health	• Provide classroom, staff and parent/guardian education on appropriate topics • Continue to work with students at risk (absent, late/leave early, disparity)	
	MAY/JUNE	COMPLETED/ NOTES
Standards of Practice	• Evaluate implementation plan. Conduct environmental scan of potential standards or guideline updates that will be forthcoming for next year.	
Care Coordination	• Begin updating student care plans for summer programs and in preparation for next school year (including transition planning for students) • Work with teachers regarding appropriate student field trip/camp health concerns/accommodations • Send parental/guardian notification for updated chronic health conditions that occur during summer • **Return equipment to Nurse Supervisor** • **Notify parents to pick up student medication** • **Bring expired or unused medication and Biohazard (Sharps) container to Nurse Supervisor** • **Check AED and submit report** • **Complete and submit Monthly Report of Services to Nurse Supervisor**	

Leadership	• Send message to school staff and parents/guardians of year's health accomplishments and trends	
Quality Improvement	• Review year's data for trends and identify needs for next year • Submit Step Up! data to district • Meet with principal/district supervisor to share data, activities and plans for next year. • Meet with board of education and board of health/local health department to share data and trends.	
Community/ Public Health	• Send notification to parents/guardians of immunizations that will be needed for school entry in the fall. • Share tips with staff and parents/guardians for remaining healthy during summer • Evaluate plan with student at risk (absent, late/leave early, disparity)	

Back-to-School Checklist for School Nurses

All plans and procedures should be in compliance with local and state laws, rules, and regulations.

Standards of Practice

- ❑ Identify new laws for mandatory screenings or health-related activities.
- ❑ Confirm that equipment is in working order, e.g., eye chart, vision tester, and audiometer.
- ❑ Review new practice guidelines, policies, and documents. Identify any changes needed.

Care Coordination

- ❑ Set up desk and health room.
  - ❑ Identify place for proper secure storage for all medications.
- ❑ Bookmark nasn.org and SchoolNurseNet.NASN.org in your website browser.
- ❑ Identify which students need an individualized healthcare plan (IHP) and emergency care plan (ECP).
  - ❑ Obtain healthcare provider (HCP) orders for health procedures to be administered in school.
  - ❑ Collaborate with family and HCP to develop evidence-based IHP and ECP.
  - ❑ Train school staff as appropriate to implement IHP and ECP at school.
- ❑ Obtain HCP orders and any school forms for medications.
  - ❑ Develop a daily schedule, as needed for medication administration.
  - ❑ Train other school staff as appropriate regarding medications to be administered in school.

Leadership

- ❑ Identify student-based and personal growth goals for the school year.
- ❑ Identify and schedule required and self-imposed reporting deadlines for the year.
- ❑ Identify school committees of which you should be a member, e.g., wellness, IEP, and disaster planning.
- ❑ Send a message to teachers and parents and/or guardians introducing yourself and outline your role in keeping students and schools healthy.

Quality Improvement

- ❑ Set up documentation system for the year.
  - ❑ Include the Step Up! data points in your documentation system.

Community/Public Health

- ❑ Case-find and prioritize students with special health care needs and/or chronic conditions. Plan accordingly to work with those students, their parents and/or guardians, and appropriate staff.
- ❑ Provide training to school staff and others regarding universal precautions, CPR, first aid, disasters, and other potential health emergencies according to needs in your school, e.g., seizures, food allergies, and stock emergency medication.
- ❑ Distribute universal precaution supplies, as needed.
- ❑ Work with parents and/or guardians, school staff, and community HCP to identify and follow up with students needing required and recommended immunizations.

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NASN National Association of School Nurses

POLICIES and PROCEDURES

REQUESTING THE SERVICES OF A NURSE IN AN EMERGENCY

In addition to their regularly assigned schools, nurses are assigned to another school to provide assistance during an emergency. In order to ensure coverage during the absence of a nurse, the following guidelines should be employed in obtaining services:

- The principal (or individual designated by the principal) should contact the assigned paired school nurse. If she/he is unavailable, contact the Nurse Supervisor or Student Services Coordinator and inform them that a nurse is needed

- In emergencies that appear life-threatening, school personnel should contact EMS (911), consult with parents and advise the Nurse Supervisor or Student Services Coordinator of the steps taken.

- Emergency protocol personnel have received CPR and First Aid training. These persons · should be involved in the assessment of an emergency in the absence of the nurse

- Log all activity related to request for service with time, date and any anecdotal record applicable

Maintaining Emergency Addresses

Post in the principal's office and clinic of each school, a list of names, addresses and telephone number of

1. Hospitals
2. Emergency Clinics
3. Neighborhood physicians who may be called in an emergency

Sending Ill Students Home. When Deemed Necessary

1. Contact the parent or guardian, etc.
2. Inform the parents that they must make arrangements to get the student home and give the student the "Excused from School Pass."
3. Notify the teacher.

Maintaining Clinic Records

1. Secure and file a current health card for each student. A new card is required year. The card is usually issued by homeroom teacher during registration in August, and must be completed annually by the parent and returned to the school.

2, Check health cards early in the school year and identify any physical defects which could affect the student's work (epileptic seizures, diabetic reactions, etc.) Make teachers aware of these fmdings (with permission of the principal).

3. Maintain a daily log of students coming to the clinic, using the legal ledgers. This is to include:
   a. Time of arrival
   b. Complaint
   c. Treatment
   d. Disposition (sent back to class, home, etc.)

4. Complete accident report form for each injury sustained on school property. File a copy and send to Maintenance.

Assessment of Injuries and Medical Concerns in the School Setting

When a student has an accident or emergent medical condition that requires immediate medical care, the school nurse or other staff member with First Responder or first aid training can give first aid at the scene or in the clinic. The principal should be notified immediately. The student's clinic card should also be pulled and emergency instructions followed. School administration has the authority to call an ambulance for emergency transportation and to notify the parent. When the parent is notified, share as much information as possible about what happened, including where the student is being taken for emergency treatment. The immediate care of the child is the school nurse's first responsibility, so another staff member may be assigned to make the calls and assist the nurse. A written plan for emergency procedures should be available in the school, so that everyone involved will be aware of individual responsibilities and will communicate appropriately. Attention to standard precautions is always necessary. After an emergency situation is over, the school nurse and principal should review how well the plan worked and make adjustments as needed. Documentation should be completed and include details such as what happened and when, procedures done, whether parent(s) were called, whether the student left the premises and with whom, etc.

Initial Assessment

The process should be organized and systematic. History and physical assessment may be conducted simultaneously. Assessment of general appearance and the A-B-C's (Airway, Breathing and Circulation) should be completed first, with intervention as needed.

General Appearance	Assess overall impression of health, level of distress, emotional response and physical symptoms. Provide calm reassurance, safety of the area both for the first-responder and others in the area.
Airway	While completing the Airway Assessment, stabilize the head-neck if there is concern for a neck injury. Do this by instructing the student to lie still and by instructing an assistant to place hands on both sides of the child's head to prevent movement of the head and neck. Assess patency, ability to cry or talk, position, airway sounds, color. Open airway, perform obstructed airway maneuvers if needed.
Breathing	Assess work of breathing, rate, nasal flaring, retractions, difficulty speaking, breath sounds. Position for open airway, assist ventilations if needed.
Circulation	Assess perfusion of vital organs, skin color and temperature, active bleeding capillary refill, peripheral pulses. Initiate CPR if needed, control bleeding with direct pressure (using multiple sterile gauze pads with overlying barrier or gloves if available; if gauze is not immediately available, use a sufficient amount of child's clothing to prevent personal exposure to the child's blood). Position to maintain perfusion (legs elevated if shock symptoms).
Disability	Assess level of consciousness (alert or unresponsive), awareness of injury or illness, activity level, level of pain. Provide reassurance; orient to time, place and person as needed. Position to maintain comfort.
Expose/Examine	Open clothing as needed to observe breathing. Examine injuries, rashes as appropriate.
Fahrenheit	Check temperature, maintain temperature in a normal range using blankets (or undressing, sponging, fanning if hyperthermia is a concern).
Get Vital Signs	Obtain baseline HR, RR, BP (if possible), check capillary refill.
Head-to-Toe Assessment	Can be focused or complete, depending on student's health status, mechanism of injury and school policy.
Isolate	Provide isolation measures according to public health and school policy.

Triage

Triage literally means "to sort." It is a means of sorting multiple victims and/or determining the urgency of each individual's illness or injury. It is a way for the school nurse to decide the order of priority for emergency actions and treatment. The three commonly used triage categories are: Emergent, Urgent and Non-Urgent.

Emergent: Call EMS and notify parents	
This category represents an acute condition that is a potential threat to life or function and requires immediate medical attention. Examples include:	
• Cardiopulmonary arrest • Shock • Uncontrolled bleeding • Possible anaphylactic reaction even if respiratory symptoms (e.g., cough) or circulatory symptoms (e.g.,dizziness) appear mild • Severe respiratory distress/failure • Severe burns • Seizure lasting longer than five minutes or associated with cyanosis or first-time seizure	• Altered level of consciousness • Severe trauma • Limb trauma with loss of distal pulse or with obvious deformity • Spinal injury (suspected) • Severe pain, i.e. chest or abdomen • Femoral fracture • Heat stroke • Uncontrollable behavior that threatens self or others • Dental injury with avulsion of a permanent tooth • Ingestion of poison: call Georgia Poison Control Center (1-800-222-1222) for specific instructions • Child with diabetes - low blood sugar (with or without seizure) that requires glucagon

Urgent: Notify parent or guardian immediately	
This category represents a condition that is not severe or life-threatening, but requires medical intervention within two hours. Examples include:	
• Suspected fracture with pulses present and no obvious deformity • Lacerations requiring sutures without large amounts of blood loss • Head injury without loss of consciousness • Seizure (NOT first-time or status epilepticus) • Wheezing, unresponsive to medication • Diarrhea/vomiting	• Febrile illness with temperature greater than 100.4º F • Dental injury other than avulsion of a permanent tooth • Eye injury • Any abdominal pain after an injury • If moderate to large ketones are present in the urine, and/or the child is vomiting • If child has low blood sugar that requires treatment with more than two juices or glucose gel

Non-Urgent: Notify parent or guardian,	
This category represents a condition that is non-acute or minor. It may or may not require referral for medical care. Examples include:	
• Minor scrapes/bruises • Muscle sprains/strains (urgent if fracture suspected) • Headache without fever or vomiting or other symptoms • Wheezing that responds to treatment (without respiratory distress)	• Mild pain • Upper respiratory infection toothache • Child with diabetes - If small to trace ketones in the urine • Child with diabetes - If child has a low blood sugar requiring treatment

Note: Always notify parents or guardians of any unusual event. Always be alert for possible child abuse.

MEDICATION ADMINISTRATION

Richmond County Schools

Policy JGCD: Medication

All medications other than the exceptions listed in this policy, whether prescription or over-the-counter, may be administered only in accordance with the guidelines set forth by the principal of each school. All medications must be taken by the student, parent, or guardian to the school office immediately upon arrival at school and must be in original pharmaceutical containers, clearly labeled as to the name of the student, the name of the medication, the appropriate dosage, and the times for dosage. Any student possessing prescription or over-the-counter medication not in accordance with these guidelines will be considered in violation of the School System's drug policy and shall be subject to the discipline set forth in the student code of conduct and/or the student/parent handbook.

A student for whom the school has a file supporting medical documentation, may carry at all times with parental/guardian permission, inhalers for asthma, auto-injectable epinephrine for allergic reactions, and all necessary supplies and equipment to perform monitoring and treatment functions authorized by the student's diabetes medical management plan. Students authorized to self-administer such medications, shall be instructed not to permit any other student to handle, possess, or otherwise attempt to use his/her medication and shall be informed that violations of such instructions will be dealt with in accordance with the student code of conduct.

In order for the student to carry and self-administer such medications, or in order for the school to store and administer the medication for students who are unable to self-administer because of age or any other reason, parents must provide a written statement from a licensed physician confirming that the student is able to self-administer the medication, if applicable, and written permission from the parent for the nurse or designated employee to consult with the doctor regarding any questions that may arise concerning the medication. Such permission shall release the School System and its employees and agents from civil liability for administering such medication to students, or if the self-administering student suffers an adverse reaction as a result of self-administration of such medication. The terms of this paragraph may be met through a student's diabetes medical management plan developed and implemented pursuant to state law.

Parents are encouraged to provide to the schools duplicate medication and supplies in the event a student is unable to self-administer or fails to bring the medication or equipment to school.

Nurses or other school employees are authorized to administer auto-injectable epinephrine, if available, to a student who is having an actual or perceived anaphylactic adverse (allergic) reaction, regardless of whether the student has a prescription for epinephrine. Such persons also are authorized to administer levalbuterol sulfate, if available, to a student in perceived respiratory distress, regardless of whether the student has a prescription for levalbuterol sulfate. Any school employee who in good faith administers or chooses not to administer such medication to a student in such circumstances, shall be immune from civil liability.

Richmond County Schools

Date Adopted: 9/11/2008
Last Revised: 10/20/2015

Medication Protocol

Medications should be given at home whenever possible. Once a day medications should be given at home, before school. If medication must be taken with food, milk or toast can be given with it at home. If medication is taken twice a day, both doses should be given at home, before and after school, unless specified differently on prescription.

If a student must take medication at school, before any prescribed medications can be given, an Administration of Medication Form must be filled out completely by the prescribing physician and signed by both physician and parent/guardian. If medication changes (dose/strength, time) a new Administration of Medication Form must be filled out and signed by physician and parent.

If more than one medication is to be given, an Administration of Medication Form must be filled out and signed for each medication.

If a student needs to take any over the counter medication, a note from parent stating name of child, name of medication and the amount and time to be given must be signed by parent/guardian.

All medication, whether prescription or over the counter, must be in its original container with the name of medication and directions and child's name if prescription.

Medication cannot be brought to school by a student unless authorized for self-administration.

****ALL MEDICATIONS MUST BE PICKED UP BY THE LAST DAY OF EACH SCHOOL YEAR BY PARENT/GAURDIAN OR MEDICATION WILL BE DISPOSED.**

***Note*: If a student does not come at the appointed time for his/her medication, he/she should be called to the clinic so that a dose is not missed. The parent/guardian should be called if a student misses a dose or refuses to take a dose**.

Guidelines for Medication Administration in the School Setting

The following guidelines have been developed utilizing recommendations outlined in the National Association of School Nurses (NASN) policy statement on medication administration, the American Academy of Pediatrics position statement on the role of the school nurse and the American Federation of Teachers document on delineation of roles and responsibilities for the safe delivery of specialized healthcare in the educational setting.

General Guidelines

- Medication administration in schools should be discouraged unless medically necessary for the student's health, safety and optimal learning.
- Whenever possible, medications should be given at home, before or after school.
- The first dose of a new medication or new dosage should be administered at home where parents can monitor potential side effects and adverse reactions.
- School health personnel should not administer over-the-counter (OTC) medications unless prior written authorization is obtained from parent/guardian, including name of medication, dose, route, time and reasons to be administered. The parent should provide the medication in a new, sealed container with dispensing instructions on the label from the manufacturer.
- Some schools may use stock bottles of various dosages of OTC medications to avoid the storage and clutter of large numbers of bottles. The school district may want to specify that OTC medications that are given on a regular basis require an order by the healthcare provider. Non-prescription medications requested during school hours may be limited by requesting healthcare provider signature if given for more than one to two weeks.
- All information regarding medication and health status is and should be kept confidential.
- Unless the legal prescriber authorizes otherwise, only a licensed nurse *should* administer medications in the following circumstances:
  - Medications requiring blood pressure, radial or apical pulse before or after administration
  - Medications requiring clinical nursing to determine medication dosage
  - Injectable medications, except those needed in an emergency
  - Medications given by bladder installation.
- Prior to initial administration of a prescription medication, the school nurse should assess the student's health status and develop a medication administration plan which includes:
  - Student's name
  - Order listing name of medication, dose, route, time of administration and special instructions, if any
  - Signed authorization by parent/guardian per school policy
  - Contact numbers for parent/guardian
  - Known allergies to food or medications
  - Student's diagnosis, unless this would be a violation of confidentiality requested by parent/student
  - Any possible side effects, adverse reactions or contraindications
  - Quantity of medication to be received by the school

– Required storage conditions

– Duration of prescription to be in effect

– Designation of unlicensed school personnel, if any, who will administer the medication to the student, including back-up plans

– Parental permission to notify other designated staff members of medication administration and possible adverse effects

– When appropriate, the location of administration, if other than school health room, office or clinic

– Plan for monitoring the effects of the medication

– Provision for medication administration in the event of field trips and other short-term special school events.

- Medications needed on field trips and other short-term school events are best carried in a second pharmacy—labeled

  container, containing just the dose(s) needed. A school employee who has had the district-approved training can be designated to administer the medication during the trip. Parents can ask the pharmacist for an empty labeled container to be kept at

  school for this purpose, and the school nurse can prepare the second container and give it to the teacher. The person giving the medication should always document the dose given on the medication form upon returning to school (include time given, initials and signature).
- Medications ordered for after-school program hours should be given by designated school personnel who have received the district-approved training for assisting with medication administration.
- Documentation can be done on the same forms used during the school day or on a separate form per district policy. If a separate form is used, it should contain all pertinent information and be filed with the regular forms at the end of the day or week.
- Volunteers should not be asked or trained to give medications to students.

Parental Consent

- Ideally you want to collect parent consent forms as soon as the school year begins. A form letter can be included with the parent handbook during registration/orientation informing parents of the school policies on medication given to students during their school day. A sample letter is included at the end of this chapter for you to use.
- All medications should require signed parental consent before they can be administered in school.
- Parental consent should be updated annually for continuing long-term medications.
- Updated parental consent should be obtained for any changes in medication dosage and/or frequency, and the parent should request a new label from the pharmacy.
- Parent/guardian should be informed by the principal as to who will be administering medications, what training in medication administration they have received and what credentials and/or licensing this person has. This helps the parent/guardian avoid certain expectations they may have in what the clinic personnel is expected to know or be able to do for their student.
- The parent/guardian assumes responsibility for informing the school principal, nurse or designee of any change in the student's health and medication needs.
- Parent/guardian should be asked for consent for school health personnel to contact and obtain needed information about medications and their administration from the healthcare provider. The healthcare provider should be

contacted whenever questions or concerns arise about specific information or training necessary to administer, monitor or evaluate effectiveness of the medication and assure the safety of the student.

- Parents should be notified several days before the school supply of a prescription will need to be refilled. A letter may be sent home with the student, and a follow-up phone call may be necessary.

Packaging of Medications to be Administered in the School

- Prescription medications should be packaged in one of the following ways:
  - In an original container, labeled legibly with the student's name, physician's name and contact information, medication name and strength, amount given per dose, route and time of administration, dispensing pharmacy. Whenever possible, the parent may
    ask the pharmacist to divide the required medication into two labeled containers, one for home use and one for school use.
  - Dispensed in unit-dose packs with a prescription label, as above.
- Non-prescription medications should be packaged in a sealed container with dispensing instructions appropriate for the student's age clearly labeled on the outside. The student's name should be written on the outside of the container.

Transportation of Medications

- Parent/guardian or responsible adult designated by the parent should ideally deliver all medications to a designated school employee. In extenuating circumstances, as determined by the school nurse or administrator, the medication may be delivered by other persons, with advance notification by the parent.
- Medications should be accompanied by a completed parent authorization form and, if applicable, prescriber authorization.
- Student transportation of prescription and/or over-the-counter medications is specifically not allowed because of the potential for bullying and sharing on the way to school. Many drugs used for ADD/ADHD are controlled substances and have a street "value," creating the potential for abuse.
- During all school functions, including field trips, policies and procedures should be in place to protect the health of students. Students with special health care needs cannot be restricted from attending field trips, and provisions need to be made for all necessary medications, including emergency drugs, to be given in a safe manner while students are away from school.

Storage and Disposal of Medications

- **Medications should be stored in a securely locked cabinet, used exclusively for that purpose**. Keep locked (unless opened to obtain medications). Medications classified as scheduled or controlled substances should be stored according to the Controlled Substances Act, due to the potential for abuse. The Code of Federal Regulations can be found at deadiversion.usdoj.gov/21cfr/ cfr/2108cfrt.htm on the Drug Enforcement Administration's website or by contacting a local pharmacist. Rules and regulations
  for hours), include:
  - Drugs stored in a fixed and stationary, secure and substantially constructed locked cabinet
  - Cabinet located in a room or office not accessible to the general public or students

- Keys kept in control of an authorized person at all times.

- Access to stored medications shall be limited to personnel authorized to administer medications. Access to keys and knowledge of the location of the keys should be restricted to the maximum extent possible.
- Medications must be received in a pharmacy or manufacturer-labeled container. No more than a 30-day supply of the medication is recommended to be stored at school.
- The school nurse, or other designated person who is receiving medication from a parent/guardian, should document the quantity received. That person and the parent should agree and sign for the quantity delivered, particularly for controlled substances.
- Medications should be inventoried and counted by designated school health personnel.
- Proper temperature and storage conditions applicable to individual prescription medications should be maintained and monitored.
- **When refrigeration is recommended or required, medication should be separated from food items in a secure, separate container.**
- When these medications are controlled substances, the container should be locked. Refrigeration temperatures should be maintained at 38 to 42˚F.
- Medications that are out of date or have been discontinued should be picked up by the parent/guardian.
- All medications should be picked up at the end of each school year. Parental notifications should be sent home at these times.
- When medications are not picked up after parent notification, they should be delivered to the Nurse Supervisor at the end of the year for proper disposal. Read label for appropriate disposal instructions or review current FDA disposal guidelines at fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm
- All medications to be discarded must be processed so there is no access by the students and/or staff.

Documentation of Medication Administration

- Medication given should be properly documented as soon as possible after administration. This documentation should include the following:
  - Student's name
  - Medication name and strength
  - Dosage and route
  - Date and time of administration or omission, the reason for omission, such as student refusal or inability to take, absence, school holiday, reason for withholding dose, field trip, etc. (a code with a legend may be provided for ease of documentation and completeness)
  - Any medication allergies clearly identified on the student's medication sheet.
- When a form is used that has check boxes for staff members to initial each time a medication is given, each staff member who has initialed the form should provide a complete signature at the bottom of the same form.
- All documentation should be in ink and should not be altered. Never use any type of whiteout. Errors should be crossed out with one line only, initialed and the dated, correct entry made.
- **Whenever a student refuses medication, an administrator and parent/guardian should be notified immediately.**

- If a student receives medication while on a field trip, the person administering the medication should properly document this dose upon returning to the school.
- The school district should develop procedures and forms for documenting and reporting medication errors. These procedures should specify persons to be notified in addition to the parent/guardian. An error includes any failure to administer medication as prescribed for a particular student, including failure to administer the medication:
  - To the correct student.
  - Within appropriate time frames.
  - In the correct dosage.
  - In accordance with school policy and procedure.
- To assist non-licensed personnel in understanding the medication they may be dispensing to the student, a good practice to follow is to place with each child's MAR (medication administration record) an informational medication sheet for that specific medication. The informational sheet should contain the name of the medication (brand and generic names) and possible side effects, warnings, etc. for easy reference.
- If several students have the same medications, you can set up a separate section in the MAR book with just one copy of each medication you will be dispensing. This procedure can save on repetition and multiple copies of the same medications after each student's MAR, but will still provide information for personnel administering to your students.

Safety Procedures for Medication Administration

- A school nurse should be on duty in the school system whenever prescription medications are being administered by designated unlicensed school health personnel and available by telephone should consultation be required.
- Medications to be administered for p.r.n. (as needed) orders may be administered by designated unlicensed personnel after an assessment by or telephone consultation with the school nurse or parent for each dose.
- For each school, an updated list of unlicensed school personnel who have been trained in the administration of prescription medications should be maintained and training should be updated at least annually. This process is especially important for those trained to give epinephrine.
- Prior to administration of medications, the school nurse should review each medication authorization for completeness and compatibility with other medications the student may be taking.
- Proper hygiene practices should be used. Wash hands before administering medications and avoid handling pills by "pouring"a single dose into the cap of the vial, then "pouring" into student's hand.
- All school staff responsible for medication administration should be required to receive appropriate initial and refresher training (at least annually).
- Minimize distractions whenever medications are being given, as distractions can be a source of errors. Other job responsibilities should be put on hold when a designated school employee is administering medications. Students coming in for medications should line up and wait quietly until it is their turn.
- Expiration dates on medications should be checked on a monthly or bimonthly basis.
- Verbal orders are determined on the district level. Please consult your district policy.
- Medications should not be left out on counters, pre-poured in anticipation of student arrival, or pre-poured for another person to administer.
- In accordance with standard nursing practice, the school nurse may refuse to administer (or allow to be administered) any medication which, based on his/her individual assessment and professional judgment, has the

potential to be harmful, dangerous, or inappropriate, after consultation with parent/guardian and licensed prescriber. In these cases, the parent/ guardian and licensed prescriber should be notified immediately by the school nurse.

Standard Safety Mechanisms - "Five Rights"

Checking the "Five Rights" should be followed by all school employees who give medications:

1. Right Student

Ask the student to say his or her name (not "Are you Suzy Smith?") and compare this to the name on the medication label. If the student is unable to state his name, another staff member who knows the student should be asked.

2. Right Medication

Compare authorization with label on medication container when taking the medication from the storage area, when preparing the medication for the student, and when returning it to the storage area.

3. Right Dose

Compare the dose listed on the authorization form and the medication label when taking the medication from the storage area, when preparing the medication for the student, and when returning it to the storage area.

4. Right Route

Administer the medication by the route (oral, nasal, inhaled, etc.) specified on the authorization form and medication label.

5. Right Time

The medication should be given within 30 minutes of the time prescribed on the authorization form and medication label. For some medications, such as insulin, medication should be also timed appropriately with a meal.

The Sixth Right

6. Right Documentation

Each medication administered must be documented immediately as it is taken, refused or student is absent. Document per your district medication administration policies and procedures.

Medication Errors

Even the most experienced healthcare providers can make medication errors. Following the safety guidelines listed previously will minimize the chance of mistakes. Being distracted by other duties while giving medications is probably the most likely reason why errors happen in schools. Medication errors can include: an overdose of the right medication, an underdose of the right medication, giving the wrong medication, giving a medication at the wrong time or in the wrong way or omission of a scheduled medication dose.

Whenever an error in medication administration is recognized or discovered, the following steps should be taken:

- Keep the student in the office or clinic; if the student has already returned to class, have the student accompanied back to the office or clinic.
- Ask the student how he/she is feeling and if he/she has any feelings of stomach upset, dizziness, itching or any other symptoms.
- Identify the incorrect dose or type of medication taken by the student.
- Notify parents. Immediately notify the principal or school nurse of the error. If an under-dose was given, the remainder of the dose may either be omitted or administered, following medical advice received from parent, physician or school nurse. Complete the Accident/Incident Report Form to Parent

- If unable to reach the parents or child's physician, notify the Georgia Poison Control Center (GPCC) for instructions. GPCC staff will help you determine if further actions need to be taken.
  - Outside metro Atlanta, call 800-222-1222.
  - Inside metro Atlanta, call 404-616-9000.
- Carefully record all circumstances and actions taken, as well as the student's current status.
- Include the name of the student, parent name and phone number, as well as a specific statement of what the medication error was, who was notified and what remedial actions were taken.

Training School Personnel to Administer Medications in the School Setting

The principal may ask the school nurse to instruct other school district employees about the safe and proper administration of medication. The school nurse should provide training and feedback to the principal regarding the competency of those designated by the principal to perform the task. Medication administration cannot be delegated by a registered nurse to an unlicensed individual. However, the principal may delegate the task to an unlicensed individual. Medication training does not imply delegation.

- All medications should be administered only by properly trained and supervised school personnel, designated by the principal, according to school district policy.
- Student safety should be the primary concern of all employees in this area.
- The training curriculum for medication administration should be specified by school district policy.
- The school nurse should document the training and competency of unlicensed personnel designated to assume the responsibility for medication administration. Evaluation of competence should include at least successful post-testing, return demonstration and skills check-off.
- The school nurse should provide a required training review and informational update at least annually for designated school personnel.
- The school nurse should provide written feedback to the principal on the personnel trained, including any problems seen or anticipated.

Important Considerations for Training School Employees

The outline on the following pages may be used in the training of unlicensed personnel in medical administration. Training should include the following elements:

- orientation to the policies, procedures, documentation requirements/forms and documentation of understanding and competence
- safe medication administration practices
- guidelines for administration of medications by different routes of administration
- provision of hands-on practice whenever possible.

Suggested Outline for Training

- Introduction – importance of the task, definitions, consents and forms, consultation with nurse, overview of medications that will be given, sources of information.

- Preparation for administration – wash hands, compare label with written order, read label times, check expiration date, check student identity, give dose, document medication administration, secure medication area.
- Safety procedures – "Five Rights."
- Administration procedures – how to administer different types of medications.
- Medication errors – how to recognize, report and document.
- Emergency medications (if needed) – can use modules and websites listed with emergency medications.
- Medication administration skills checklist.
- Supervision and monitoring – per local district policy.
- Allow time for questions.

Important Reminders for All Staff Designated to Assist Students with Medications

- Familiarize yourself thoroughly with the guidelines for administration of medications.
- All drugs have the potential for causing side effects. Observe the student's response to medication and report to parents and supervisor any changes in behavior or awareness, rashes or anything else that possibly may be related.
- Make sure you understand the medication order and how to measure the medicine (i.e. tsp, cc, ml). Ask your school nurse before giving the medication if you need clarification.
- Give medication exactly as ordered by the healthcare provider and written on the authorization form. Check the authorization form for possible side effects.
- Ask students to line up in an orderly manner if several come at once, to minimize distractions and decrease the chance for errors.
- Encourage the student to drink a full glass of water after oral medications, unless otherwise ordered.
- A "no-show" is not acceptable, especially for seizure medication and antibiotics. A student should be called down if he /she does not come at the right time. Please check with your principal.
- If a student develops a rash, do not give the next dose of medication until you have contacted the parent and the parent has contacted the healthcare provider.
- Check storage requirements on the label of the medication. Most medications need to be stored in a cool, dry place; some require refrigeration. If medication needs to be stored in the refrigerator, it should be one that is not available to students. Medications always should be kept in a separate container, away from food and nourishments.
- Before giving medication, check the name of the student, the name of the medication and the dosage three times:
  - when taking it from the storage area
  - before giving it to the student
  - when charting the dose given and returning it to the storage area.
- When administering medications, remember the Five Rights of Medication Administration:
  - Right Student
  - Right Medication
  - Right Dose
  - Right Time
  - Right Route
  - Right Documentation

- Never use one student's medication for another student.
- Avoid distractions while giving medications.
- Document what was done on the student's medication log immediately after administering.
- If a medication error is made, follow procedures for notification and document the occurrence.
- Notify parent/guardian when medicine supply is running low or when only a few doses are left.

Safe Medication Administration

These guidelines may be applied to any medication administered in the school setting. They can also be used as the basis for training and supervision if other school employees and/or unlicensed health personnel will be administering medication, in accordance with school district policy.

- Wash hands before and after administering medications. Wear gloves, if deemed appropriate.
- Compare labeled medication container with written order.
- Read label three times—when taking it from the storage area, before giving it to the student, and before returning it to the storage area.
- Check expiration date on label.
- Confirm that student's identity matches the name on the medication label. Ask him to say his name; don't ask "Are you Johnny Smith?" Consider asking for a second identifier, such as date of birth, address or telephone number depending on school policy.
- Give the prescribed dose, using the prescribed route (i.e. by mouth) and at the prescribed time.
- Observe the student as he takes the medication. Always have water and cups available.
- Record medications given on the medication log and initial each time a dose is given. Provide full signature once, per school policy.
- Relock the cabinet whenever it is not open for obtaining medications.
- Minimize distractions when medications are being given to prevent errors.
- All medications should be assessed periodically for expiration dates and parents should be notified. Expired medications should not be sent home with students.
- Under no circumstances should a medication be given in a different way than that written on the authorization form.
- Correct timing is always important as some medications need to be given either with food or on an empty stomach.
- Allergic reactions and other side effects can occur even after the student has been taking the medication for a while.
- If any side effects such as a rash, hives, itching, dizziness, cough, wheezing or any breathing difficulty occur, do not give another dose. Call the parents immediately. If the student exhibits significant or increasing breathing difficulty, call 911.

Prescription and Nonprescription Medications

Oral medications

- Student should be sitting or standing.
- Prior to administration, inspect medication for any signs of damage or degradation. If consistency or product color has changed, contact parents immediately and do not give dose.
- Pour the tablet from the bottle into the lid of the container, and then into the medicine cup or the child's hand. Avoid touching the tablet yourself. Be aware that some medications may require gloves for administration.
- Pour liquid medicine by setting the medicine cup on a firm surface at eye level and pouring to the prescribed level, reading the fluid level carefully. Place the lid upside down on the table to avoid contamination. Wipe the bottle off with a tissue or clean cloth before replacing the cap.
- Unless contraindicated, offer a fresh cup of water to aid in swallowing.
- Make sure the student swallows the medication.
- Return medication to the cabinet or refrigerator. Lock cabinet.
- Record the medication on the log.
- If any side effect such as a rash, hives, itching, dizziness, cough, wheezing or any breathing difficulty, call the parents immediately. If the student exhibits significant or increasing breathing difficulty, call 911.

Topical medications (ointments and creams)

- Gather necessary equipment including gloves or a tongue blade as needed.
- Squeeze medication from the tube, or use a tongue blade and remove ointment from jar.
- Spread the quantity of medication prescribed, using a tongue blade, in a layer on the skin or on a bandage to be placed on the skin.
- If ordered, protect the skin surface with a dressing. Use tape or gauze to secure in place.
- Remove gloves and wash hands.
- Return medication to storage cabinet.
- Record the medication on the log.
- Observe the student for any immediate medication reaction or side effect.
- If any side effect such as a rash, hives, itching, dizziness, cough, wheezing or any breathing difficulty, call the parents immediately. If the student exhibits significant or increasing breathing difficulty, call 911.

Eye medications

EYE DROPS

- Explain procedure to student.
- Clinic personnel and student should both wash hands.
- Give student tissue for wiping off excess medicine.
- Have student tilt head back and look up.
- Measure the correct amount in the dropper.
- You can have the student keep his eyes closed and drop the medicine in the inner corner of his eye (one at a time). Then, keeping his head back, have student open his eyes slowly, and the medicine will go in.
- Or you can gently pull the lower lid down, and instill the drops in this space.
- If more than one drop is needed, try one drop at a time in each eye, then go back and give the second drop in the same way.
- Repeat the procedure if the drop falls to the cheek.
- Remove excess medicine with clean tissue and ask student not to rub his eyes.
- Wash hands.
- Return medication to storage area.
- Record the medication on the log.
- Observe the student for any immediate medication reaction or side effect.
- If any side effect such as swelling of the eye, rash, hives, itching, dizziness, cough, wheezing or any breathing difficulty, call the parents immediately. If the student exhibits significant or increasing breathing difficulty, call 911.

EYE OINTMENT

- Same steps as the above except the following
- Gently pull lower lid down, and have student look up.
- Apply eye medicine along the inside edge of the lower eyelid.
- Have student close his eyes and avoid rubbing them.
- If any side effect such as swelling of the eye, rash, hives, itching, dizziness, cough, wheezing or any breathing difficulty, call the parents immediately. If the student exhibits significant or increasing breathing difficulty, call 911.

<u>Be aware that eye preparations (i.e. eye drops, eye ointments) may temporarily blur vision or cause burning/stinging sensations. Administration of multiple eye preparations may require spacing of up to 10 minutes between products.</u>

Ear drops

- Have the student lie down on his side, with the ear to be treated "up."
- Fill the medication dropper with prescribed amount of medication.
- Gently lift the ear upward and outward.
- Instill drops, holding dropper near the ear canal.
- Have student lie on that side for 1-2 minutes to allow drops to flow down the ear canal.
- Wash hands.
- Return medication to storage area.
- Record the medication on the log.
- Observe the student for any immediate medication reaction or side effect.
- If any side effect such as rash, hives, itching, dizziness, cough, wheezing or any breathing difficulty, call the parents immediately. If the student exhibits significant or increasing breathing difficulty, call 911.

Nose drops/sprays

- Student may be lying on his back or sitting up, with head tilted back.
- Fill dropper with prescribed amount of medication.
- Place dropper just inside the nostril and instill correct number of drops.
- Repeat procedure in other nostril.
- Instruct student to keep head tilted back and not rub the nose for 3-5 minutes.
- Nasal sprays can be instilled with the student sitting up. Spray or squeeze the prescribed number of times, instructing the student to gently and slowly breathe in through his nose each time. Repeat on the other nostril. Be aware that some nasal sprays (i.e. steroid nasal sprays) should be sprayed tilting outward to be absorbed into the nasal mucosa, rather than straight back into the nasal canal. Clarify with parents regarding specific administration technique.
- Wash hands.
- Return medication to storage area.
- Record the medication on the log.
- Observe the student for any immediate medication reaction or side effect.
- If any side effect such as rash, hives, itching, dizziness, cough, wheezing, chest tightness or any breathing difficulty, call the parents immediately. If the student exhibits significant or increasing breathing difficulty, call 911.

Experimental (or Off-Label) Medications

- A written policy should be in place that addresses the administration of experimental medications to students, if medically necessary, during school hours. However, children are fairly commonly treated with medications that are not officially approved for use in children. This practice occurs for many reasons, including the following:
  - The medication is part of an experimental protocol in which the family has voluntarily agreed to participate.
  - The medication is commonly used by and approved for adults. Frequently sufficient scientific or experiential evidence exists to support use in pediatric patients, but the FDA has not yet ruled officially on the issue.
  - The medication is approved for use to treat one condition but is being used to treat another condition for the same reasons stated above.

The following resources should be made available by the parents to the school when giving these medications:

- current medical information regarding the condition for which the medication is prescribed
- current drug information, provided by the healthcare provider or pharmacist, including side effects and precautions.

Inhalers (With and Without Spacers)

Metered dose inhaler (MDI) with spacer (aerochamber)—Students using inhalers should have been taught to use them properly, but they still should be monitored to ensure they are not missing steps.

- Have the student sit up straight or stand to use the MDI.
- Remove the caps from the spacer and inhaler.
- Shake the inhaler well (for about two seconds).
- Attach the inhaler to the spacer.
- Have the student exhale.
- Have the student place the mouthpiece of the spacer in his mouth. Check to make sure the student's lips have sealed around the mouthpiece for proper medication delivery.
- Press the inhaler to spray the medicine into the spacer.
- Have the student take a slow deep breath from the spacer, hold it for a count of 10 and then exhale. If a whistling sound is heard on inhalation, the student is inhaling too rapidly.
- Younger students may need to use a spacer with a mask. In that case, eight breaths should be taken after one puff, and one should observe to ensure the valve on the top of the mask rises and falls with each breath.
- If two or more "puffs" are ordered, wait one minute, then repeat the above steps from "Press the inhaler."
- Wash hands.
- Return medication to storage area.
- Record the medication on the log.
- Observe the student for any immediate medication reaction or side effect.
- If any side effect such as rash, hives, itching, dizziness, cough, wheezing, chest tightness or any breathing difficulty, call the parents immediately. If the student exhibits significant or increasing breathing difficulty, call 911.

Metered Dose Inhaler Without Spacer

Spacers are always recommended for optimal medication administration. Students and parents should be encouraged to contact their physician for a spacer. However, if a spacer is not available, it is even more important to monitor use of an inhaler without a spacer, as this is a more difficult task of coordination.

- Remove cap from mouthpiece.
- Shake inhaler well before use (at least two seconds).
- Have the student breathe out completely.
- Hold inhaler in upright position with mouthpiece directly in the mouth; close lips tightly around the inhaler.
- Open mouth and press top of inhaler firmly to release medicine. At the same time, take a deep breath in and hold it for a count of 10 if possible.
- Have the student exhale.
- Wait 1-2 minutes before taking a subsequent puff, if ordered.
- Wash hands.
- Be aware that some inhalers require the student to rinse mouth after administration. Please provide cups and fresh water for this use.
- Return medication to storage area.
- Record the medication on the log.
- If any side effect such as rash, hives, itching, dizziness, cough, wheezing, chest tightness or any breathing difficulty, call the parents immediately. If the student exhibits significant or increasing breathing difficulty, call 911.

Self-Administration of Asthma Medications and Other Student-Controlled Medications

Consistent with school policy, students may be allowed to self-administer certain medications. In July 2002, Georgia SB 472 was enacted allowing asthma inhalers, especially those used for quick relief of an acute episode, to be carried and used by the student as needed. See also digestive enzymes taken with every meal by a student with cystic fibrosis and insulin taken by a student wearing an insulin pump or use of the EpiPen® and EpiPenJr.® or other epinephrine auto-injectors in the case of a severe allergy attack.

Local boards of education in Georgia are directed by SB 472 to adopt a policy authorizing the possession and self-administration of asthma medication by a student while in school, at school-sponsored activities, while under supervision of school personnel and while in before-school or after-school care on school-operated property. The Report from the Capitol, produced by the Georgia School Superintendents Association in 2002, additionally indicates these requirements, in regard to SB 472, which can be found in the Asthma section of Chapter 5, Chronic Health Conditions.

In order for a student to possess an asthma inhaler, the following is required:

- Written authorization from parent or legal guardian
- Written authorization from a parent or legal guardian for the school to seek emergency medical treatment for the student when necessary and appropriate.

The specifics of the asthma policy are left up to the district. Some guidelines for the self-administration of medications for asthma, allergy or other include the following:

- Self-administration of medications should be specific to the student's abilities and level of understanding.
- A student self-administration form, developed by the school district, should be completed and signed per school policy with signatures from the parent, healthcare provider and student.
- The school nurse should evaluate the student's health status and abilities for safe and appropriate self-administration (including method, frequency and reasons to take the medication) and should observe the student's technique. These issues should be reevaluated at specified times and whenever problems occur. The student also should be able to verbalize what he will do when he needs assistance or is not responding to the medication in the usual way.
- Whenever possible, a back-up supply should be kept in the health room or clinic.
- With parental permission, teachers who are with the student during the day should be aware that the student is self-administering the medication and also should have training in the correct way for the student to take the medication.
- The school nurse should maintain contact periodically with the student to reevaluate his health condition and his success with self-administration. It is important for the nurse to know approximately how often the student is having to use his inhaler, in order to assist in monitoring his asthma.
- A written statement may be required, signed by the parent/guardian, stating that the parent assumes responsibility for:
  - asthma medications, since the school will not be responsible for the supervision
  - ensuring the student always carries his/her asthma medication on his/her person
  - deciding if back-up medication will be kept at school and providing the back-up inhaler
  - informing school staff in writing of any changes in the student's treatment or asthma management
  - informing the school of any asthma exacerbations, hospital visits and new or changed student medical information
  - informing the school staff in writing of any medication side effects that warrant communication with the parent/guardian
  - coordinating distribution of the student's asthma emergency management plan to school staff through the school nurse.

Emergency Medications

Emergency medications for students or staff may be needed during school hours, most commonly for severe allergic reactions, complications of diabetes or prolonged seizures. These medications can be absolutely lifesaving. If the medication is ordered by the healthcare provider for the student's safety and is provided by the family, school administration and staff should be prepared to comply with the plan, per district policy.

Activating EMS or calling 911 is an option that may be considered, but time delays often pose an unacceptable risk to the student in situations which can be alleviated with emergency medications. An individual health plan and emergency plan should be completed for any student with an order for such medications, which includes:

- Appropriate information about the medication
- Specific indications for use
- The names of staff members trained to administer
- The location of the medication
- The procedure and necessary aftercare
- Plan for field trips and other activities
- Any allergies listed.

The plan should be updated annually and whenever changes occur. Parents should, of course, be notified whenever these medications are given.

The medication should be authorized in the manner specified by district policy, and should be provided by parents. School policy should address which staff members will be trained to administer these medications and how this will be done. When a school nurse is not in the building during school hours, at least two other school personnel should be identified and trained in when and how to administer the medication and any other actions that should be taken. Whenever possible, this training should include hands-on practice. The school nurse, healthcare provider or the parents may provide this training, depending on district policy.

School personnel designated and trained to give emergency medications should be listed on the student's emergency care plan. Especially in large schools, the medication should be kept close to the student whenever possible. The teacher who is with the student may keep the medication in a "fanny-pack." The student may be able to self-administer the medication; but often, if an emergency has occurred, he will not be physically able to self-administer. Encourage any student with allergies, especially to any medications, to wear an allergy bracelet, and one should check for one of these before any emergency medications are administered.

For minor allergies, often the student will have doctor orders for an oral antihistamine (ex. Benadryl®) which should be given with water. For the younger student or one who has difficulty swallowing pills or liquids, a melt-away antihistamine can be used. Again, use these medications only with parent/doctor approval.

The emergency drug most commonly used for severe allergic reactions is epinephrine. The drug that may have to be used with extreme hypoglycemia in a student that has diabetes who cannot swallow or cooperate is glucagon, an injectable medication given with a prepackaged syringe and needle. There are two drugs currently used for management of seizures. The drug that may have to be used for a student with a prolonged seizure (or sometimes clusters of seizures) is Diastat®, a rectal preparation of Valium®. Another option for treatment of seizures is intranasal Versed. Other emergency medications may, of course, be needed by individual students or may be introduced in the future.

Medications Commonly Given in Schools

The following list of medications is arranged in categories related to their therapeutic uses. Please note that these are only a few of the most commonly prescribed medications seen in the school setting. Due to the fact that medications are constantly changing and newer ones are developed and approved, the full information on available forms of medications, indications and dosing, actions, adverse reactions, interactions, contraindications and cautions, and patient teachings are not listed here. To get the most current and accurate information, it is recommended that you use the medication resources listed at the end of this section and/or your own trusted resources for this detailed information, as well as instructions from the healthcare provider prescribing the medication for your student(s).

ADD/ADHD Medications (CNS stimulants)

- amphetamines (Dexadrine®, Desoxyn®)
- dextroamphetamine (Adderall , Adderall XR®)
- methylphenidates (Ritalin®, Concerta®)
- Strattera®

Analgesic / Antipyretic Medications

- acetaminophen (Tylenol®)

Antibiotics

- amoxicillin (Amoxil®, Polymox®, Trimox®)
- cephalosporins (Cephalexin®, Keflex®)
- Penicillin V®

Anticonvulsants (Seizures)

- carbamazepine (Tegretol®)
- clonazepam (Klonopin®)
- diazepam (Diastat®)
- Keppra®
- phenytoin (Dilantin®)
- Trileptal®
- valproic acid (Depakene®, Depakote®)
- Zonegran®

Antidepressants

- bupropion (Wellbutrin®, Zygan®)
- citalopram (Celexa®)
- duloxetine (Cymbalta)
- escitalopram (Lexapro)
- fluoxetine (Prozac®)
- paroxetine (Paxil®)
- sertraline (Zoloft®)
- venlafaxine hydrochloride (Effexor®)

Anti-Hypertensive Medications

- clonidine (Catapres®)

Antipsychotic

- Aripiprazole (Abilify)
- Olanzapine (Zyprexa)
- Quetiapine (seroquel)
- Risperidone (Risperdal)®
- Ziprasidone (Geodon)

Asthma / Respiratory Medications

- Antihistamines: diphenhydramines (Benedryl®), certirzine (Zyrtec®), loratidine (Claritin®), hydroxyzine (Atarax), Fexofenadine (Allegra)
- Bronchodilators: albuterol (ProAir® HFA, Ventolin® HFA, Proventil®HFA); ipratropium (Atrovent®); pirbuterol (Maxair®); levalbuterol Xopenex® HFA;epinephrine injection (EpiPen®, EpiPen Jr.®)
- Combination medications of long-acting bronchodilators and inhaled anti-inflammatories: Fluticasone and salmeterol (Advair®), budesonide and formoterol (Symbicort®), mometosone and formoterol (Dulera)
- Inhaled anti-inflammatories: Beclomethasone (Qvar®), fluticasone (Flovent® HFA), budesonide (Pulmicort Flexhaler™), mometasone (Asmanex® Twisthaler)

Corticosteroids

- Prednisone®

Diabetic Medications

- Glucagon®
- Insulins

Mood Stabilizers

- Lithium (Eskolith®, Lithobid®)

NSAID's (Non-Steroidal Anti-Inflammatory Drugs)

- Ibuprofen (Advil®)
- Naproxen (Naprosyn®)
- Toradol®

Sedative Medications

- Phenobarbital (Luminal®)

COMMON COMMUNICABLE DISEASES

More detailed and specific information about various communicable diseases is available in the Georgia School Health Manual

https://www.choa.org/medical-professionals/nursing-resources/school-health-resources

Infection Control in the School Setting

Schools, by their very nature, can be considered incubators for many viral and bacterial infections. Young school-age children still have developing immune systems and are more vulnerable to common infections. Children's natural affinity for each other and school activities that promote the values of sharing, cooperation and collaboration also add to the potential spread of infections.

Cleaning for Healthier Schools, Infection Control Handbook, 2010 – Connecticut Department of Public Health
ct.gov/dph/lib/dph/environmental_health/eoha/pdf/cleaning_for_healthier_schools_final_2.4.11.pdf

Hand Hygiene

Hand hygiene is the single most important activity to decrease the spread of infections of all kinds. Contact with body secretions can expose school employees to bacteria and viruses that are potentially infectious to themselves and others. An effective hand hygiene program has been proven to decrease illness and absences for both students and staff. The three necessary requirements for an effective program are:

- An accessible hand hygiene facility for all staff and students with warm water, soap and paper towels. Waterless alcohol-based hand sanitizers are also effective if there is no visible soiling on hands or under nails.
- Students and staff taking and being allowed to take the time to perform hand hygiene several times during the day (especially before lunch and snacks, after outside activities and after bathroom breaks).
- Annual instruction for staff and class discussions of proper methods for hand hygiene–using friction, washing all hand surfaces and nails, rinsing and drying well. The hand hygiene lesson plan that can be used for a staff in-service can be found in Chapter 9, Health Education.

Important hand hygiene tips for the school nurse and staff

- Take every opportunity possible to teach the importance of hand hygiene.
- Model appropriate hand hygiene for students and staff in the clinic and the classroom.
- Ask students to perform hand hygiene when they come to the clinic. This gives the nurse an opportunity to monitor their practice and teach when necessary.
- Eliminate barriers to effective hand hygiene in the school setting by addressing the need for warm water, soap and paper towels in restrooms and waterless alcohol-based hand sanitizers in classrooms.

Hand hygiene is necessary before and after situations where hands are likely to become contaminated, even before and after wearing gloves. When in doubt, perform hand hygiene. Posting signs in appropriate places helps everyone remember what they should do. Adults and children should be taught when, where and how to perform hand hygiene. These situations include:

- Before – preparing or eating food, treating a cut or wound, taking care of someone who is sick or injured, inserting or removing contact lenses.
- After – using the bathroom; helping a child use the bathroom; contact with blood or body fluids or objects soiled with them; removing protective equipment such as gloves; handling raw meats, poultry or eggs; touching pets, especially reptiles; sneezing or blowing your nose (or a child's nose); handling garbage; caring for someone who is sick or injured.

Correct hand hygiene methods should include the following:

- Remove jewelry first, and store it in a safe place.
- Use warm water and liquid soap.
- Apply a dime-sized amount of soap to wet hands.
- Rub hands together vigorously for 10-15 seconds. Scrub between fingers, under fingernails, palms, tops of hands and wrists.
- Students can be taught to sing "Yankee Doodle" or another short song while handwashing to ensure that enough time is spent on the activity.
- Rinse in a flowing stream of water. Leave the water running while drying hands thoroughly with a paper towel.
- Turn off the faucet with the same paper towel before disposing of it.

Liquid soap is recommended in hand hygiene areas. Antibacterial soap is not necessary. Alcohol-based sanitizers can be used when there is no visible soiling of hands.

A hand hygiene program that becomes a habit for everyone in the school has been proven to positively affect student and employee attendance, which will improve educational outcomes.

Communication

Communication with parents is very important. When outbreaks of illnesses in classes or groups occur, letters may be sent home. Parents should be notified when a child becomes ill at school and assisted with referrals if healthcare is not readily available to the family. School nurses and teachers also should be alert to patterns of illness that may emerge. Clinic personnel can help by giving reminders in staff meetings, doing bulletin boards to teach children, and being a good role model for children and other staff.

Education

One of the goals of student health services is to assist the child in maintaining a level of health that enables him to learn. Attention to infection prevention and control by all school employees will help all students to reach that goal. Health education programs and "train the trainer" classes can be offered by the school nurse to make sure all school personnel understand the importance and correct procedures for controlling infections. See Chapter 9, Health Education for other resources that may be used.

Infection Prevention and Control Procedures

Whenever it is necessary to handle or clean up anything contaminated with blood or other body fluids, the following simple and effective procedures should be observed. These measures can be adopted as standard procedure for every spill or wound involving blood or other body fluids to avoid potential transmission of any communicable disease.

Standard Precautions for Handling of Blood and Other Body Fluids

- Many different infections may be spread from person to person through contact with blood and other body fluids.
- Both students and staff members can transmit infections, even when there is no knowledge of or appearance of illness. Standard precautions are based on the premise that anyone may potentially transmit an infection.
- Anticipating potential contact with infectious materials in routine and emergency situations is the first step in preventing exposure to and transmission of infections.

- Essential techniques used to control infections are:
  - effective hand hygiene
  - using gloves and other barriers as needed
  - disposing of waste appropriately
  - cleaning spills promptly and carefully.
- Standard precautions should be observed by anyone involved in handling blood or other body fluids such as vomit, fecal matter or urine; or cleaning facilities or equipment that may have been contaminated. Standard precautions are for the protection of everyone.

Observance of these guidelines will make the school a safer environment for students and staff:

- When applying pressure to stop a bleeding wound, disposable gloves should always be worn.
- If at all possible, the injured person should hold the pressure on the wound himself, but many students will not be able to do this effectively.
- Personnel cleaning up spills should avoid any exposure of their open skin lesions or mucous membranes such as the eyes, nose and mouth.
- Disposable gloves should never be reused.
- Surfaces soiled with the above substances should be promptly disinfected, using a 10 percent bleach solution (one part bleach to nine parts water) or school district-approved disinfectant for colorfast surfaces, and other EPA (Environmental Protection Agency)-approved disinfectant or germicide for surfaces that will fade. The bleach solution should be made freshly each day (1/3 cup bleach to one quart water).
- Whenever possible, disposable towels, tissues or similar materials should be used in the cleanup process. These disposables, including the gloves, should be sealed in one plastic bag, double-bagged in a second bag and then discarded.
- Non-disposable cleaning equipment and materials, such as mop heads, should also be disinfected with bleach or other EPA-approved disinfectant or germicide.
- Linens should be stored in a plastic bag until laundered. Linens that are not disposable, such as towels, may be cleaned in a normal hot water laundry cycle.
- Thoroughly wash hands afterwards, using soap and water.
- All sharp or blood-contaminated objects, such as lancets, needles, glass ampules, razor blades and strips used for blood or urine testing, should be disposed of in a puncture-proof and leak proof container. All needles should be disposed of without being bent or recapped. Schools should identify students whose medical condition requires use of these sharps and ensure that they are instructed in the proper disposal of such items. See below for additional information.
- If exposure to blood or other body fluids occurs, a report to the school office will dictate what possible further medical attention is needed by district policy. Contact your local public health department for guidance.

Disposal of Infectious Waste

- Contaminated Supplies

  Used or contaminated supplies like gloves, barriers, sanitary napkins and band-aids should be placed into a plastic bag and sealed. This bag then can be thrown into the garbage so it is out of reach of children or animals.

- Used Needles, Syringes and Other Sharp Objects

  As of the printing of this manual, Georgia does not provide guidance for the safe disposal of community sharps. Listed below are some general guidelines:

  – Needles should not be recapped, bent or removed from the syringe before disposal.

- If a purchased red biohazard sharps container is not used, these objects should immediately be placed in a metal, or other rigid, strong plastic puncture-proof and leak-proof container with a screw-on or tightly secured cap, such as a laundry detergent bottle.
- Be sure the container is opaque so needles cannot be seen from the outside of the container.
- Once the container is three-fourths full, it should be sealed with heavy duty tape, bagged and kept out of the reach of children until it can be disposed of properly. Reinforce the cap with heavy duty tape. Mark clearly and noticeably on the outside of the container "Do Not Recycle."
- Arrangements can be made to dispose of used needles, syringes and other sharp objects contained in an approved red biohazard sharps container at a local medical facility, fire department or health department.

Outbreaks of Illness

Clusters of illnesses such as vomiting, diarrhea, fever, flu-like complaints and an unexplained rise in absenteeism should be reported to the local health department.

The Notifiable Disease/Condition Reporting Form is located at:
dph.georgia.gov/disease-reporting
dph.georgia.gov/reporting-forms-data-requests

Resources

Handwashing: Clean Hands Save Lives

cdc.gov/handwashing

Healthy Schools, Healthy People, It's a SNAP!

itsasnap.org

IDENTIFIABLE DISEASE / CONDITION REPORTING

Georgia Department of Public Health

All Georgia physicians, laboratories, and other health care providers are required by law to report patients with the following conditions. Both lab-confirmed and clinical diagnoses are reportable within the time interval specified below.

Reporting enables appropriate public health follow-up for your patients, helps identify outbreaks, and provides a better understanding of disease trends in Georgia. For the latest information from the DPH, Department of Public Health, visit their web site at: dph.georgia.go

To Report Immediately

Call: District Health Office or
1-866-PUB-HLTH (1-866-782-4584)

any cluster of illnesses
animal bites
anthrax
all acute arboviral infections:
- -Eastern Equine Encephalitis (EEE)
- -LaCrosse Encephalitis (LAC)
- -St. Louis Encephalitis (SLE)
- -West Nile Virus (WNV)

botulism
brucellosis
cholera
diphtheria
E. coli O157
*Haemophilus influenzae (invasive)**
hantavirus pulmonary syndrome
hemolytic uremic syndrome (HUS)
hepatitis A (acute)
measles (rubeola)
meningitis (specify agent)
meningococcal disease
novel influenza A virus infections
pertussis
plague
poliomyelitis
Q fever
rabies (human & animal)
severe acute respiratory syndrome (SARS)
shiga toxin positive tests
S. aureus with vancomycin MIC ≥ 4µg/ml
smallpox
syphilis (congenital & adult)
tuberculosis
latent TB infection in children<5 years old
tularemia
viral hemorrhagic fevers

Potential agent of bioterrorism.

* Invasive = isolated from blood, bone, CSF, joint, pericardial, peritoneal, or pleural fluid.

To Report Within 7 Days

Report cases electronically through the State Electronic Notifiable Disease Surveillance System at http://sendss.state.ga.us (SEE REPORTING FOOTNOTES BELOW.)

AIDS[#]
aseptic meningitis
blood lead level (all)
campylobacteriosis
chancroid
Chlamydia trachomatis
(genital infection)
Creutzfeldt-Jakob Disease (CJD),
suspected cases, under age 55
cryptosporidiosis
cyclosporiasis
ehrlichiosis
giardiasis
gonorrhea
HIV[#] infection and perinatal HIV exposure
hearing impairment[†]
(permanent, under age 5)
hepatitis B
-acute hepatitis B
-newly identified HBsAg+ carriers**
-HBsAg+ pregnant women
hepatitis C virus infection
(past or present)
influenza-associated death
(all ages)
legionellosis
leptospirosis
listeriosis***
leprosy or Hansen's disease
(*Mycobacterium leprae*)
Lyme disease
lymphogranuloma venereum
malaria
maternal deaths[##]
(during pregnancy or within 1 year of end of pregnancy)[##]
mumps
psittacosis
Rocky Mountain spotted fever
rubella (including congenital)
salmonellosis
shigellosis
streptococcal disease, Group A or B
(invasive)*
Streptococcus pneumoniae
(invasive)*
-report with antibiotic-resistance information
tetanus
toxic shock syndrome
toxoplasmosis
typhoid
Varicella (Chickenpox)
Vibrio infections
yersiniosis

* Invasive = isolated from blood, bone, CSF, joint, pericardial, peritoneal, or pleural fluid.
** HBsAg+ = hepatitis B surface antigen positive.
*** *L. monocytogenes* isolated from blood, bone, CSF, joint, pericardial, peritoneal, or pleural fluid, or other normally sterile site; or from placenta or products of conception in conjunction with fetal death or illness. Infant mortality is reportable to Vital Records.

REPORTING HIV/AIDS:

[#] Report forms and reporting information for HIV/AIDS available by telephone (1-800-827-9769) OR at http://dph.georgia.gov/georgias-hivaids-epidemiology-surveillance-section. For mailing HIV/AIDS reports, please use double envelopes marked "confidential", addressed to Georgia Department of Public Health Epidemiology Section, P.O.Box 2107, Atlanta, GA 30301

[##] Report forms and reporting information for maternal deaths are available at http://dph.georgia.gov/documents/forms-surveys-and-documents

[†] Report forms and reporting information for **hearing impairment** available at http://dph.georgia.gov/documents/forms-surveys-and-documents

REPORT WITHIN 1 MONTH

birth defects (under age 6)

Report forms and reporting information for **birth defects** available at http://dph.georgia.gov/documents/forms-surveys-and-documents

Healthcare-associated Infections (HAIs)
For facilities required to report HAI data to CMS via NHSN. Report in accordance with the NHSN protocol. Reporting requirements and information available at http:/dph.georgia.gov/notifiable-hai-reporting.

REPORT WITHIN 6 MONTHS

benign brain and central nervous system tumors
cancer

Report forms and reporting information for **tumors and cancer** found at http://dph.georgia.gov/georgia-comprehensive-cancer-registry.

Chicken Pox & Shingles

Chickenpox (Varicella)

Chickenpox, also referred to as varicella, may present differently depending on the vaccination status of the child. In the unvaccinated child, chickenpox will result in an itchy, vesicular, blister-like rash, tiredness and fever. The child will develop greater than 200 maculopapular to vesicular lesions which start on the trunk and face and can spread to the entire body. In contrast, the vaccinated child most likely will experience few if any symptoms when exposed to chickenpox. If the vaccinated child does experience symptoms, he may have a low grade fever, less than 50 blisters which appear more macular than vesicular, and a shorter duration of illness. The vaccinated child presenting with these symptoms greater than 42 days post vaccination may be experiencing "breakthrough" disease.

Vaccination

In 2006, the Advisory Committee on Immunization Practice recommended children receive two doses of the varicella vaccine. The first dose should be given at 12 months of age. The second dose should be given at four years of age. If the child is catching up on both doses of the vaccine and is older than four years of age, the second dose should be given three months or more after the first dose. For additional information, visit "Chickenpox Vaccination: What Everyone Should Know" at cdc.gov/vaccines/vpd-vac/varicella/default-basic.htm or at vaccineinformation.org/varicel/qandavax.asp.

Prior to 2006, children were not routinely given two doses of varicella vaccine. According to the Centers for Disease Control (CDC), the one dose of varicella vaccine does protect against disease; however, 15 to 20 percent of vaccinated children will report symptoms of chickenpox, and 25 to 30 percent of those reporting symptoms will report symptoms similar to those of unvaccinated children. The CDC references a clinical trial in which children who received two doses of the varicella vaccine showed 100 percent protection against severe disease and a 98 percent overall efficacy rate.

Chickenpox is highly contagious and treatment consists mainly of symptom management. It is spread through direct person to person contact or airborne transmission through an infected person's coughing, sneezing or breathing. An infected child is contagious one to two days before the rash appears and until all sores are crusted over. In the unvaccinated child, this process may take up to 10 days.

The vaccinated person experiencing "breakthrough" disease (less than 50 lesions) is one-third as infectious as an unvaccinated person. However, if someone presents with more than 50 lesions, he is considered just as contagious as the unvaccinated person with chickenpox. Regardless of vaccination status, anyone with chickenpox lesions is considered infectious until all lesions have scabbed over.

Chickenpox (varicella) cases should be reported to public health within seven days by calling 1-866-PUB-HLTH (866-782-4584) or by calling your local health department. For more information about reporting requirements, please visit dph.georgia.gov/disease-reporting.

Lesions can be treated with:

- Oatmeal or baking soda baths
- Calamine lotion and Benadryl for itching
- Acetaminophen for a fever
- Plenty of fluids to prevent dehydration.

Additionally:

- Avoid hydrocortisone creams, ibuprofen and aspirin as these can lead to complications.
- Discourage the child from scratching as this can lead to secondary skin infections and scarring.

Shingles

Shingles develops from the same virus, varicella zoster virus (VZV), which causes chickenpox. Shingles is also called herpes zoster or zoster. Shingles can develop any time after someone has recovered from chickenpox because the virus stays in your body.

Shingles can occur in children, but most people who develop the disease are 50 years of age and older. Shingles presents first as an itching and tingling at the site where the rash will develop followed by fever, headache and chills. The rash can appear as a blister on one side of the face or body. It takes three to five days for the blister to scab, and the outbreak can last two to four weeks.

A serious complication of zoster is postherpetic neuralgia (PHN), which can last months or years and cause tremendous pain as well as significantly impact the person's day-to-day activities. For those who develop zoster, 10 to 18 percent will develop PHN, and 10 to 25 percent will develop eye involvement which can result in prolonged or permanent pain, facial scarring and loss of vision. Persons who have experienced either of these complications overwhelmingly report the zoster vaccine is well worth it and that they wish they had known about the zoster vaccine.

Shingles is spread only through direct person-to-person contact with an open lesion. The person is not contagious through coughing or sneezing. Someone who has not received the varicella vaccine or been exposed to chickenpox in the past may develop chickenpox from a shingles exposure; however they will not develop shingles. A person is not contagious until the blisters develop. A person with shingles should keep the blisters covered until they have scabbed over. Oral treatments for shingles are available, and the patient should consult a doctor about taking these medications.

Vaccination

A single dose of zoster vaccine is recommended for everyone over 60 years of age who has no contraindications. For additional information about the shingles vaccine, visit cdc.gov/vaccines/vpd-vac/shingles/default.htm or at vaccineinformation.org/zoster/qandavax.asp.

Resources

Centers for Disease Control and Prevention. Use of Combination Measles, Mumps, Rubella, and Varicella Vaccine Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2010; 59(No. RR-3).
cdc.gov/mmwr/pdf/rr/rr5903.pdf

Chickenpox (Varicella)
cdc.gov/chickenpox/index.html

Supplemental and Archived Zoster (Shingles) ACIP Recommendations, *MMWR*, August 22, 2014, Vol 63, #33 August 2014
cdc.gov/mmwr/preview/mmwrhtml/mm6333a3.htm

Vaccine Information Statement – Shingles
cdc.gov/vaccines/hcp/vis/vis-statements/shingles.html
immunize.org/vis/shingles.pdf

Vaccine Information Statement – Varicella
immunize.org/vis/varic07.pdf

Varicella – The Pink Book: Course Textbook – 12th Edition Second Printing (May 2012)
cdc.gov/vaccines/pubs/pinkbook/downloads/varicella.pdf

Impetigo

Impetigo is a common skin infection caused by streptococcal or staphylococcal bacteria, which usually enter the body through an injured area of skin, such as a cut or scratched mosquito bite. Impetigo frequently appears on the face, especially around a child's nose and mouth. It can be spread easily by the individual's hands to other parts of the body. Impetigo starts as a red sore that quickly ruptures, oozes infected fluid for a few days and then forms a yellowish-brown crust that looks like honey or brown sugar. The disease is highly contagious, and scratching or touching the sores is likely to spread the infection to other parts of the body as well as to other people. It is contagious as long as lesions are oozing. The scabs are also infectious. This infection is seen most often in the warm months.

Impetigo is usually treated with soap and water, an antibiotic ointment and sometimes an oral antibiotic when the infection is spreading. Prevention involves careful cleaning of any skin injury and routine handwashing. Any contact with the lesions requires diligent handwashing to prevent the spread of the infection. Students suspected of having impetigo should wash the rash area with soap and water and, if possible, cover the area lightly. Parents should be notified, but the child does not need to be sent home in the middle of the day. Affected students and staff may return to school after treatment is initiated, and should keep the lesions covered until completely dry.

A parent should contact their child's doctor if:

- The sores have not started to heal after three days of treatment.
- Child develops a temperature over 100.3°F.
- You see signs of cellulitis (deeper skin infection) or an abscess such as:
  - Increasing redness or swelling
  - Red streaks
  - Tenderness
  - Affected area feels hot.
- A change in urine color is noted.

Resources

Impetigo – Children's Healthcare of Atlanta

- English version: choa.org/Menus/Documents/Wellness/teachingsheets/impetigo.pdf
- Spanish version: choa.org/Menus/Documents/Wellness/teachingsheets/impetigoSP.pdf

Influenza

Influenza (Seasonal Flu)

Influenza (flu) is a viral infection characterized by high fever, chills, congestion, coughing and muscle aches. It is most often seen from October through May, with peaks in January or February.

The flu is spread by respiratory droplets in the air and on surfaces which are touched. People are contagious from a few days before symptoms develop and for several days after the illness begins, so the virus is likely to spread before it is even recognized. Most people with the flu feel too sick to go to work or school during parts of the illness.

Healthcare providers usually recommend treatment with rest and lots of fluids, and antiviral medication may be used for anyone over the age of one, but must be taken within 24 hours of getting the flu in order to be effective. Antiviral medications shorten the length and severity of illness. When a person feels well enough to resume normal activities and has been without fever for 24 hours, he/she can return to work or school.

Vaccination

Recommendations for the flu season change each year. Children 6 months through 8 years of age receiving influenza vaccine for the first time should receive two doses administered at least 28 days apart. As a healthcare provider, it is important to educate yourself each year about which flu vaccines are recommended and which vaccines are contraindicated for certain groups. Vaccination during the flu season should begin in October and continue through May.

Each year, everyone 6 months of age and older should receive a flu vaccine. For additional information on preventing influenza with vaccination, please visit vaccineinformation.org/flu/qandavax.asp.

Seasonal Influenza Resources

FluView: A Weekly Influenza Surveillance Report
cdc.gov/flu/weekly

Prevention and Control of Influenza with Vaccines
cdc.gov/mmwr/preview/mmwrhtml/rr5908a1.htm

Recommendations for Prevention and Control of Influenza in Children, 2014–2015 – American Academy of Pediatrics
pediatrics.aappublications.org/content/134/5/e1503.full.pdf

Seasonal Flu – Information for Schools
cdc.gov/flu/school/qa.htm

Seasonal Flu – Information for Schools and Childcare Providers
cdc.gov/flu/school/index.htm

Seasonal Influenza – CDC
cdc.gov/flu

Seasonal Flu (Influenza) – GDPH
dph.georgia.gov/seasonal-flu-influenza

Vaccination and Vaccine Safety – Flu.gov
flu.gov/prevention-vaccination/vaccination/index.html

Ringworm of the Skin and Scalp

Ringworm is a common childhood skin disease that is a fungus infection. This often can be spread to children by a pet or another child that is infected with ringworm. Ringworm gets its name from the ring-shaped rash that appears on the skin.

Ringworm of the Skin

Ringworm of the skin, also known as tinea corporis, is a fungus infection that can occur anywhere on the skin. Ringworm appears as a ring-shaped pink patch on the skin. The patch is usually .5 to 1 inch in size. The area is usually somewhat scaly with raised borders and a clear center. The area will slowly get larger in size and may itch. Other rashes can mimic tinea. It is contagious if direct skin-to-skin contact occurs before treatment is started. After 48 hours of treatment, the ringworm is usually considered no longer contagious. The rash may take up to four weeks to clear.

Ringworm of the Scalp

Ringworm of the scalp, also known as tinea capitis, is a fungus infection of the scalp, involving hair follicles. The scalp may have round patches of hair loss that will slowly increase in size. Scaling, mild itching and secondary infection may occur on the scalp. The fungus can be spread by combs, brushes, hats, barrettes, seat backs, pillows and bath towels.

Treatment

Ringworm of the skin is treated with an antifungal cream, as recommended by a child's primary healthcare provider. If there is no improvement or the condition worsens, the child should return to his or her healthcare provider.

Antifungal creams are not an effective treatment for ringworm of the scalp. The cream cannot get deep into the hair roots where the fungus is living. Ringworm of the scalp usually requires several weeks of an oral antifungal medication. Hair regrowth will occur, but may take up to six to 12 weeks after treatment. Follow your school policy or local health department for recommendations for returning to school. Generally once children with either type of ringworm are on antifungal medication for 24 hours, they are not contagious and can return to school.

If you suspect a student in your school has ringworm, here are a few helpful tips:

- Notify that student's parents and ask them to contact the child's primary healthcare provider for diagnosis and treatment.
- Encourage good handwashing techniques among all children and adults.
- Prohibit the sharing of personal items such as hair care articles, towels and clothing, including the "dress-up" corner for young children.

Resources

Children's Healthcare of Atlanta – Ringworm

English version: choa.org/Menus/Documents/Wellness/teachingsheets/ringworm.pdf

Spanish version: choa.org/Menus/Documents/Wellness/teachingsheets/ringwormSP.pdf

Dermatophytes – CDC

cdc.gov/fungal/diseases/ringworm/index.html

Scabies

Scabies is a highly communicable skin disease caused by a tiny parasite called a mite. The mite penetrates the skin, causing a rash and intense itching, especially at night. Transfer frequently occurs by direct skin-to-skin contact and less often by exposure to infested clothing or bedding. The longer and more frequent the contact, the more likely the transfer. The mite feeds on skin cells and can only move by crawling. Symptoms may not appear for two to six weeks after contact, so the mites may be widespread before they are recognized. It is possible for mites to spread disease, and secondary infection may occur from scratching. Scabies occurs worldwide and affects all socioeconomic groups.

The scabies rash may present as small red spots, occurring most commonly on the hands and wrists. The elbows, underarms, waist, thighs, abdomen, genitalia and buttocks also can be affected. A teacher most likely would observe that the student is scratching frequently. Look for a rash, often with burrows under the skin.

Treatment

Treatment is relatively simple, safe and effective. Referral to the student's healthcare provider is necessary for the prescription lotion, which is applied at night over the entire body from the chin down. After eight to 12 hours, the preparation is washed off the skin. All family members may need treatment. Some medications require a re-treatment in one week. Follow recommendations of the healthcare provider and pharmacist carefully. The morning after the treatment, all clothing and bedding used and worn within the last three to four days should be laundered or dry-cleaned. Spraying of the home or school is not necessary. Freshly laundered clothing and bedding should be used after each application of medication.

Control Measures in School

When a teacher suspects the presence of scabies, the student should be sent to the clinic or office. Clinic/office personnel should:

- Confirm the presence of a skin rash, taking care to maintain the student's dignity and privacy.
- Notify parents and send student home with letter of recommendations for treatment.
- Check siblings who attend the school and any other children with symptoms of itching.
- Confirm that treatment has been initiated when child returns to school. If re-treatment is ordered, make a note to confirm this at the appropriate time.
- If treatment has not been initiated, call parents and send the child home again with a second letter.
- Notify the school social worker if a child misses more than two to three days of school.

Resources

Parasites, Scabies – CDC

cdc.gov/parasites/scabies

Scabies – Children's Healthcare of Atlanta

English Version: choa.org/Menus/Documents/Wellness/teachingsheets/scabies.pdf

Spanish Version: choa.org/Menus/Documents/Wellness/teachingsheets/scabiesSP.pdf

Fever Protocol

Fever is defined as having a measured temperature of 100.4 or greater. If a student has a temperature of 100.4 or greater, he/she must be kept home, and remain at home until fever free for 24 hours without the use of a fever reducing medication.

Should a student develop a fever during school, the parent/guardian will be contacted to pick up the student and the student must again remain home until fever free for 24 hours without the use of a fever reducing medication.

Vomiting and Diarrhea Protocol

If a student is experiencing vomiting or diarrhea before school, he/she should stay home. If vomiting or diarrhea is accompanied with fever he/she should stay home until after 24 hours fever, vomiting and diarrhea free. If no fever with vomiting or diarrhea, the student may return to school 24 hours after last episode.

If a student develops vomiting or diarrhea during school, the following steps will occur:

- The student will be assessed by nurse/school personnel to include temperature taken, asked the number of times vomited/diarrhea, the amount of emesis and how student feels now.
- Parent/guardian will be notified to inform of findings. If the student does not have a fever (Temperature less than 100.4) and has had only one episode of vomiting/diarrhea and student states he/she feels better, the student may return to class. It is up to the parent/guardian if they want to pick the student up. If however, fever is present, and/or the student had more than one episode of vomiting/diarrhea, or the student states he/she has stomach or body aches, the parent will be informed of such and must pick the student up.
- The student may return to school when fever free for 24 hours, without the use of fever reducing medication, and vomiting and diarrhea free for 24 hours.

Head Lice Protocol

If head lice is suspected, the student is to be sent to the clinic to be checked by the nurse or designated school personnel. If the student has an active case of head lice, any siblings or others living in the same household, will need to be examined. The parent/guardian will be called and informed of findings and the need to pick up the student. The parent/guardian should also be informed of the need for treatment before the student is allowed to return to school. The parent/guardian will also be assessed for need of head lice education and treatment. The student should remain in the clinic or front office until parent/guardian picks him/her up. Upon return to school, the student will be checked by the nurse or designated personnel prior to going to class. The parent/guardian must wait until clearance is given for student to return to class. If head lice is still noted, the parent/guardian will be notified and the student will be sent home again. In the event that two or more students are found with head lice in one class, the entire class should be checked for head lice by the nurse. A letter notifying parents of possible exposure to head lice and precautions should be sent home with students in the affected class.

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Frequently Asked Questions (FAQs)

What are head lice?

The head louse, or *Pediculus humanus capitis*, is a parasitic insect that can be found on the head, eyebrows, and eyelashes of people. Head lice feed on human blood several times a day and live close to the human scalp. Head lice are not known to spread disease.

Who is at risk for getting head lice?

Head lice are found worldwide. In the United States, infestation with head lice is most common among pre-school children attending child care, elementary schoolchildren, and the household members of infested children. Although reliable data on how many people in the United States get head lice each year are not available, an estimated 6 million to 12 million infestations occur each year in the United States among children 3 to 11 years of age. In the United States, infestation with head lice is much less common among African-Americans than among persons of other races, possibly because the claws of the of the head louse found most frequently in the United States are better adapted for grasping the shape and width of the hair shaft of other races.

Head lice move by crawling; they cannot hop or fly. Head lice are spread by direct contact with the hair of an infested person. Anyone who comes in head-to-head contact with someone who already has head lice is at greatest risk. Spread by contact with clothing (such as hats, scarves, coats) or other personal items (such as combs, brushes, or towels) used by an infested person is uncommon. Personal hygiene or cleanliness in the home or school has nothing to do with getting head lice.

What do head lice look like?

Head lice have three forms: the egg (also called a nit), the nymph, and the adult.

Actual size of the three lice forms compared to a penny. (CDC Photo)

Illustration of egg on a hair shaft. (CDC Photo)

Egg/Nit: Nits are lice eggs laid by the adult female head louse at the base of the hair shaft nearest the scalp. Nits are firmly attached to the hair shaft and are oval-shaped and very small (about the size of a knot in thread) and hard to see. Nits often appear yellow or white although live nits sometimes appear to be the same color as the hair of the infested person. Nits are often confused with dandruff, scabs, or hair spray droplets. Head lice nits usually take about 8–9 days to hatch. Eggs that are likely to hatch are usually located no more than ¼ inch from the base of the hair shaft. Nits located further than ¼ inch from the base of hair shaft may very well be already hatched, non-viable nits, or empty nits or casings. This is difficult to distinguish with the naked eye.

Nymph form. (CDC Photo)

Nymph: A nymph is an immature louse that hatches from the nit. A nymph looks like an adult head louse, but is smaller. To live, a nymph must feed on blood. Nymphs mature into adults about 9–12 days after hatching from the nit.

Adult louse. (CDC Photo)

Adult: The fully grown and developed adult louse is about the size of a sesame seed, has six legs, and is tan to grayish-white in color. Adult head lice may look darker in persons with dark hair than in persons with light hair. To survive, adult head lice must feed on blood. An adult head louse can live about 30 days on a person's head but will die within one or two days if it falls off a person. Adult female head lice are usually larger than males and can lay about six eggs each day.

Adult louse claws. (CDC Photo)

Where are head lice most commonly found?

Head lice and head lice nits are found almost exclusively on the scalp, particularly around and behind the ears and near the neckline at the back of the head. Head lice or head lice nits sometimes are found on the eyelashes or eyebrows but this is uncommon. Head lice hold tightly to hair with hook-like claws at the end of each of their six legs. Head lice nits are cemented firmly to the hair shaft and can be difficult to remove even after the nymphs hatch and empty casings remain.

What are the signs and symptoms of head lice infestation?

- Tickling feeling of something moving in the hair.
- Itching, caused by an allergic reaction to the bites of the head louse.
- Irritability and difficulty sleeping; head lice are most active in the dark.
- Sores on the head caused by scratching. These sores can sometimes become infected with bacteria found on the person's skin.

How did my child get head lice?

Head-to-head contact with an already infested person is the most common way to get head lice. Head-to-head contact is common during play at school, at home, and elsewhere (sports activities, playground, slumber parties, camp).

Although uncommon, head lice can be spread by sharing clothing or belongings. This happens when lice crawl, or nits attached to shed hair hatch, and get on the shared clothing or belongings. Examples include:

- sharing clothing (hats, scarves, coats, sports uniforms) or articles (hair ribbons, barrettes, combs, brushes, towels, stuffed animals) recently worn or used by an infested person;
- or lying on a bed, couch, pillow, or carpet that has recently been in contact with an infested person.

Dogs, cats, and other pets do not play a role in the spread of head lice.

How is head lice infestation diagnosed?

The diagnosis of a head lice infestation is best made by finding a live nymph or adult louse on the scalp or hair of a person. Because nymphs and adult lice are very small, move quickly, and avoid light, they can be difficult to find. Use of a magnifying lens and a fine-toothed comb may be helpful to find live lice. If crawling lice are not seen, finding nits firmly attached within a ¼ inch of base of the hair shafts strongly suggests, but does not confirm, that a person is infested and should be treated. Nits that are attached more than ¼ inch from the base of the hair shaft are almost always dead or already hatched. Nits are often confused with other things found in the hair such as dandruff, hair spray droplets, and dirt particles. If no live nymphs or adult lice are seen, and the only nits found are more than ¼-inch from the scalp, the infestation is probably old and no longer active and does not need to be treated.

If you are not sure if a person has head lice, the diagnosis should be made by their health care provider, local health department, or other person trained to identify live head lice.

How is head lice infestation treated?

More on: Treatment(https://www.cdc.gov/parasites/lice/head/treatment.html)

Is infestation with head lice reportable to health departments?

Most health departments do not require reporting of head lice infestation. However, it may be beneficial for the sake of others to share information with school nurses, parents of classmates, and others about contact with head lice.

I don't like my school's "no-nit" policy; can CDC do something?

No. CDC is not a regulatory agency. School head lice policies often are determined by local school boards. Local health departments may have guidelines that address school head lice policies; check with your local and state health departments to see if they have such recommendations.

More on: Head Lice Information for Schools(https://www.cdc.gov/parasites/lice/head/schools.html)

Do head lice spread disease?

Head lice should not be considered as a medical or public health hazard. Head lice are not known to spread disease. Head lice can be an annoyance because their presence may cause itching and loss of sleep. Sometimes the itching can lead to excessive scratching that can sometimes increase the chance of a secondary skin infection.

Can head lice be spread by sharing sports helmets or headphones?

Head lice are spread most commonly by direct contact with the hair of an infested person. Spread by contact with inanimate objects and personal belongings may occur but is very uncommon. Head lice feet are specially adapted for holding onto human hair. Head lice would have difficulty attaching firmly to smooth or slippery surfaces like plastic, metal, polished synthetic leathers, and other similar materials.

Can wigs or hair pieces spread lice?

Head lice and their eggs (nits) soon perish if separated from their human host. Adult head lice can live only a day or so off the human head without blood for feeding. Nymphs (young head lice) can live only for several hours without feeding on a human. Nits (head lice eggs) generally die within a week away from their human host and cannot hatch at a temperature lower than that close to the human scalp. For these reasons, the risk of transmission of head lice from a wig or other hairpiece is extremely small, particularly if the wig or hairpiece has not been worn within the preceding 48 hours by someone who is actively infested with live head lice.

Can swimming spread lice?

Data show that head lice can survive under water for several hours but are unlikely to be spread by the water in a swimming pool. Head lice have been seen to hold tightly to human hair and not let go when submerged under water. Chlorine levels found in pool water do not kill head lice.

Head lice may be spread by sharing towels or other items that have been in contact with an infested person's hair, although such spread is uncommon. Children should be taught not to share towels, hair brushes, and similar items either at poolside or in the changing room.

Swimming or washing the hair within 1–2 days after treatment with some head lice medicines might make some treatments less effective. Seek the advice of your health care provider or health department if you have questions.

Bed Bugs Go to School
A Guide for Teachers and Staff

Bed bugs can hitchhike into your school creating challenges for administrators and facilities managers. Education and preparation are the formula for success in dealing with bed bugs. Learn what your school can do to prepare and respond to the bed bug challenge.

Develop a Plan

Develop a school-specific written "bed bug action plan" in advance of any problems. It should include specific procedures and responsibilities for responding to bed bug sightings, incidents, and suspected bites. Proactive monitoring, early detection, and prompt response can avoid larger, more costly problems.

Educate Everyone

Bed bugs are brought into buildings on personal belongings. Anyone can bring in bed bugs. The key is to educate the entire school community by teaching the administration, maintenance and custodial staff, faculty, support staff, students and parents about:

- Basic bed bug biology, identification and habits;
- Roles and responsibilities regarding bed bug control;
- The school district's philosophy about being proactive on bed bug issues;
- Actions needed to reduce the risk of bed bugs spreading; and
- Who to contact with questions.

Bed Bug Life Stages

Let Parents and Guardians Know

- The school recognizes there is a national bed bug resurgence, and the district has a bed bug action plan.
- They play an important role in keeping the school bed bug free.
- They should advise the school if bed bugs are found in their home.

Things to Avoid

- Over reacting - a sighting does not necessarily mean an infestation.
- Closing school - there is usually no need to close the school or to send students home.
- Stigmatizing or excluding students who you suspect may have brought bed bugs to school.
- Immediate pesticide applications - pesticides may not be needed to achieve control, so review your school's pest control program and work with your pest control provider.

Responding to Bed Bug Incidents

- If bed bugs are found, avoid damaging them. Instead, catch and contain them with clear tape for expert identification.
- Get a positive ID as many insects are easily mistaken for bed bugs.
- Check the surrounding area for more bed bugs, then arrange for an inspection by a pest management professional.
- Have a trained professional inspect the area where the bed bug was found - including desks, floors, walls, and storage areas where student belongings are kept - to determine if you have an infestation or a lone bed bug.
- Map bed bug sightings and confirmed findings.

Students and Bed Bugs

- Discreetly take students to the school nurse for inspection of their clothing and belongings.
- School health professionals should manage the case, including re-inspecting belongings, desks and classrooms until the problem is resolved.
- Isolate student belongings in tight-sealing containers or plastic bags in the nurse's office to reduce the chance of bed bugs spreading while the problem is being resolved.

Pesticides used in schools must:

Comply with state and local IPM and pesticide notification laws/regulations.

Be applied only by appropriately licensed applicators.

Be labeled for use against bed bugs and applied according to label directions.

EPA
United States Environmental Protection Agency
Office of Pesticide Programs (7511P)
EPA 730-F-15-002 November 2015

Prevention

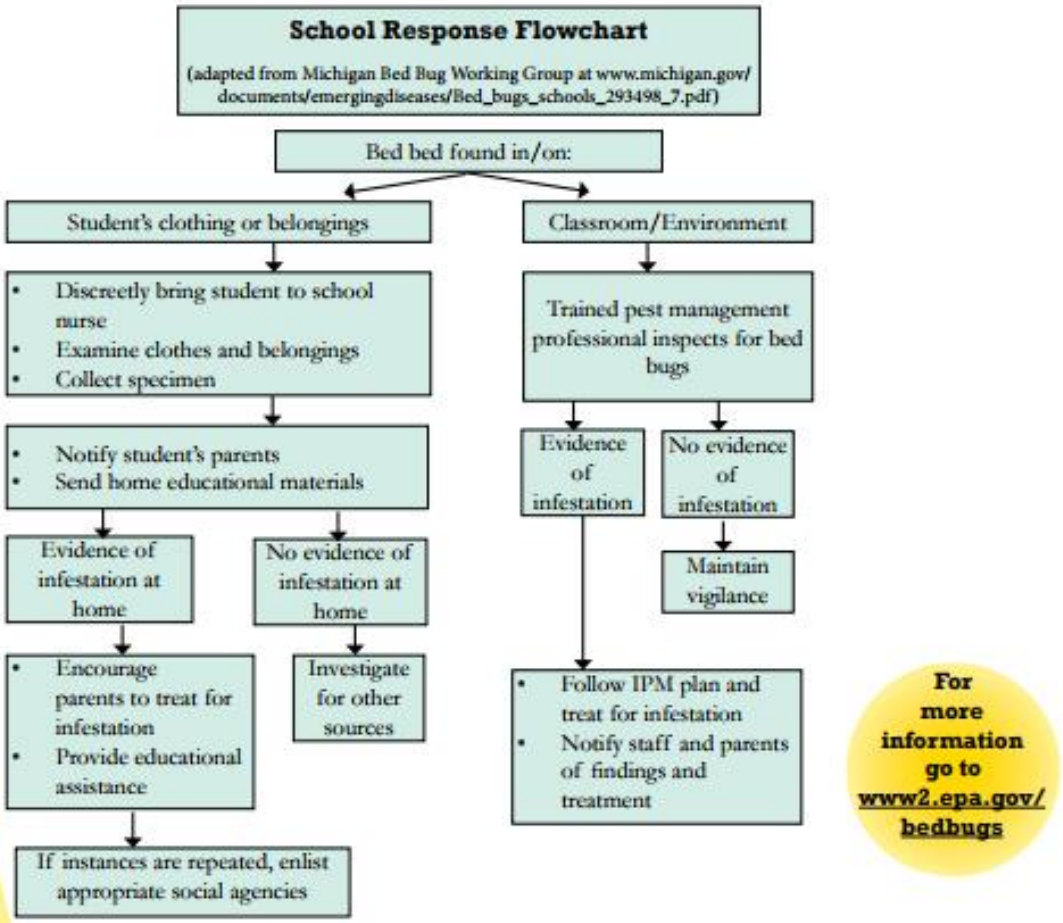
- Avoid storing students' jackets, backpacks, and other personal items in close contact with each other.
- Limit items students transport back and forth to school.
- Regularly reduce the classroom clutter and remove cardboard.
- Store teaching aids in clear, lidded boxes.
- Seal crevices and utility conduits.

Management

- Use control tactics consistent with your school's integrated pest management plan and state/local regulations.
- Vacuum to remove bed bugs from cracks and crevices in furniture, equipment, walls, and floors.
- Put items in a dryer at high temperature for 30 minutes to kill bed bugs.
- Use other non-chemical approaches to eliminate bed bugs such as steam or heat treatment, sanitation, and trapping.
- If pesticides are needed, ensure that they are labelled for use against bed bugs, applied according to label directions by a licensed applicator, and that your school complies with all state pesticide laws.

Inspection

- Use a strong flashlight and magnifying glass when conducting bed bug inspections.
- Regularly inspect clothing, backpacks, boxes, lockers, and desks.
- Have rooms with repeated bed bug sightings inspected by a pest management professional or other trained staff.
- Check faculty lounges, offices and the nurse's office, as spaces with upholstered furniture or cots may become infested
- Pay close attention to child care facilities, nap areas, and handicapped equipment - these may be bed bug hot spots.



School Health Clinic Guidelines for Sending Students Home

Communicable or infectious diseases are not uncommon in school-age children. Communicable means easily spread to others. For this reason, when a student is suspected of having a communicable (or infectious) disease, you may need to send the student home. Some of the diseases easily transmitted between students are chickenpox, measles, mumps, parvovirus, tuberculosis, hepatitis, Fifth disease, impetigo, mononucleosis, ringworm, sexually transmitted infections, gastroenteritis, influenza, Pertussis, etc.

To help you, the clinic personnel, decide if a student should be excluded from school, please refer to your district policies regarding exclusion from school and use the following checklist to assist you in the decision process. The list of signs and symptoms below may indicate the possibility of an infectious disease. If the symptoms point to possible infectious disease process, call the parent and send the student home for further medical follow-up. Write a progress note on any student that presents with these symptoms and be specific in your observations. Use back of this form for any additional notations.

_____Confusion Describe: _____

_____Fever (>____°F) Temperature: _____

_____ Head Lice Describe: _____

_____Loss of appetite/stomachache (more than one day) Comments: (see back of page)

_____Persistent cough Comments: _____

_____Persistent itching Describe: _____
(include location)

_____Persistent lethargy (tiredness) Comments: _____

_____Persistent diarrhea Comments: _____

_____Rash or blisters (especially if draining) _____
(include location)

_____Describe: Ringworm Describe: _____
(include

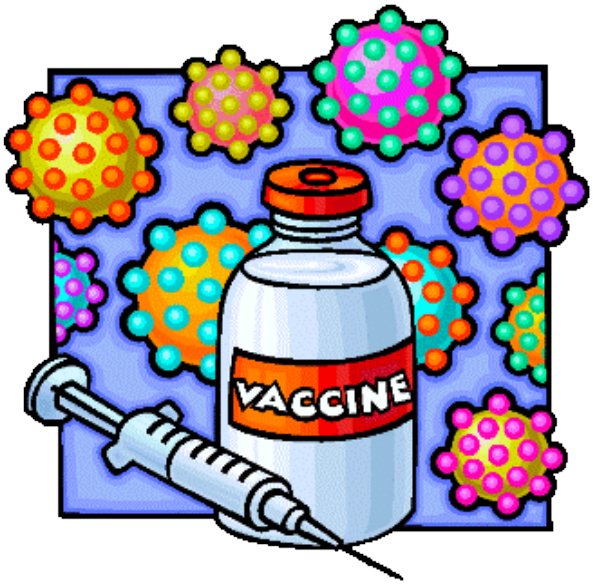
location)

_____Runny nose with green drainage (not on any treatment) Comments: (see back of page)

_____Vomiting more than once Comments: _____

These are only a few symptoms to be aware of and treatments vary for each disease or illness. It should be recommended to the parent(s)/guardian(s) that the student be seen by the doctor to determine if he/she has an infectious disease or illness. When excluding a child from school, send home with them any appropriate paperwork that may need to be signed by their doctor and/or parent/guardian. Informational material should be sent as well to assist the parent. Report to the Health Department if indicated

IMMUNIZATION & SCREENINGS



Community-Acquired Required Health Certificates

Required health certificates for school include:

- Form 3300 Certificate of Vision, Hearing, Dental and Nutrition Screening
  gachd.org/Form%203300%20Revised.pdf
- Form 3231 Certificate of Immunization
  dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Sample%20revised%203231%20School-and-Childcare-GA-DPH-Certificate-of-Imm.pdf

Georgia Immunization Requirements

The State of Georgia requires up-to-date or completed immunizations for school attendance. Prevention of vaccine-preventable diseases requires vigilance by healthcare providers, school and childcare personnel and parents. All students entering school (through 19 years of age) must be immunized according to the rules and regulations established by the Georgia Department of Public Health (DPH).

Most children will complete the immunization schedule they need to enter school when they are between four and six years of age. At this time, the child's healthcare provider will complete the Certificate of Immunization, Form 3231. Georgia immunization requirements are based on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP). In addition to the immunizations that are required for entering schools, other immunizations are "recommended" for each child to receive. Each year, the Recommended Immunization Schedule by the ACIP is updated and includes all recommended immunizations. Each state then determines which of those recommended vaccines will be required for entry into schools. Therefore, it is still important to encourage children and parents to receive the "recommended but not required" vaccines.

Make it a point to annually review and print the immunization schedules for children, teens and adults by visiting cdc.gov/vaccines/schedules/index.html

Schools' Responsibilities Regarding the Immunization Program

- Know and enforce immunization requirements as outlined in the Policy Guide 3231 REQ. Review the certificates for validity, according to the guidelines, prior to enrolling students.
- All medical exemptions must be reviewed annually and a new certificate issued.
- Develop a system for immunization certificate management. Keep certificate files current. Notify parents before a certificate expires to give them time to obtain the needed services. If 30 days or more have passed after a certificate has expired, the child should not be attending school.
- Have certificates available for inspection and audit by health officials.
- When a child leaves or transfers to another school the Certificate of Immunization or religious exemption statement should be given to the parent/guardian or sent to the new school. This process should include the moves from elementary to middle to high school as well.
- Report the occurrence of any cluster of cases of a disease listed on the notifiable disease list. Use and teach handwashing as an effective way to decrease the spread of bacteria and viruses.
- Utilize and teach standard precautions to all staff. See Chapter 4, Communicable Diseases and Infection Control.

The Vaccines for Children Program (VFC) is coordinated by the Georgia Immunization Program and provides free vaccines to public and private healthcare providers for children who are Medicaid- or PeachCare-enrolled, American Indian/Alaska Native, uninsured and insured but whose vaccines are not covered by insurance. Providers may charge an administration fee.

Schools can assist parents by providing them with information about state requirements, local health departments and other resources for immunizations at registration and when new students enroll. It is helpful to healthcare providers and parents to let them know that the earlier they go to complete their immunizations or obtain the certificates, the easier it will be. In some cases, health departments may work with schools to provide some immunizations at school, such as the seventh grade-required immunizations.

The Georgia Registry of Immunization Transactions and Services (GRITS) project was mandated by the legislature (OCGA 32-12-3.1) in 1996. Among other functions, the registry is used to assist public health officials in assessing and improving the immunization status of the community, and by providers to access up-to-date immunization records of Georgians. The registry database allows enrolled healthcare providers to print the required immunization certificates. In addition, most school health nurses have been trained to locate and view student records in the system. If the child is Complete for School, a 3231 can be printed. If he/she is not up-to-date, the school can print an "Immunizations Needed" report to give to the parents so they can have their child immunized and obtain an up-to-date 3231.

Vision, Hearing, Dental and Nutrition Screening (Form 3300)

On August 2, 2013, the Georgia Department of Public Health (DPH) announced the revised Form 3300: Certificate of Vision, Hearing, Dental and Nutrition Screening. The Form 3300 was revised to include the School Registered Nurse an approved examiner.

While the public health nurse is required to complete the post-test to document completion of training, the public school nurse does not require certification to complete the training.

You may receive training for the Form 3300 and others by visiting dph.georgia.gov/form-3300-school-nurse-trainings

7th Grade Vaccination Requirements Handouts (see next page)

dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Tdap_Meningitis_ParentsFactSheet_031214_0.pdf

Immunization Exemptions

Georgia law allows for two types of exemptions from the immunization requirements: medical and religious. Each child must have one of two items on file—either a valid Georgia Immunization Certificate (Form 3231) or a signed, notarized statement, which is called an affidavit of religious exemption.

Medical exemption

Medical exemptions are used only when a child has a medical condition that keeps him from being able to receive a specific vaccine(s), not all vaccines.

A medical exemption must be marked on the Georgia Immunization Certificate (Form 3231). A letter from a physician, Advanced Practice Registered Nurse (APRN) or physician assistant (PA) attached to the certificate will not be accepted as a medical exemption. It must be marked on the certificate.

A physician, APRN or PA must re-evaluate the need for a medical exemption at least once each year and issue a new certificate of immunization at that time. The date of expiration on the section of the certificate marked "medical exemption" should be one year from the date of issue and never be longer than one year.

New Georgia (DPH form 2208) Affidavit of Religious Objection to Immunization Exemptions

Became effective June 16, 2015.

According to Garry W. McGiboney, PhD, Deputy Superintendent of External Affairs with the Georgia Department of Education, the new form is to be used by parents filing a new religious exemption for the 2015-2016 school year and subsequent school years. Those students who already have a notarized affidavit on file do not have to use the new form. Religious exemptions do not expire.

Please note the requirements for the new Georgia Immunization Religious Exemption form to be used moving forward. Below is an excerpt from the email sent by Garry McGiboney, PhD., Deputy Superintendent of External Affairs with Georgia Department of Education, to all Georgia School Superintendents on July 20, 2015.

The new form is on the State of Georgia website at dph.georgia.gov/schools-and-childcare As religious exemptions do not expire, students who have a religious exemption for immunizations already on file at their school do not need to update their religious exemption form. The new form will be for parents filing a new religious exemption form for their child.

Please direct any questions you may still have to the Immunization Program at Georgia Department of Public Health at 404-657-3158.

Assessment of Immunization Documentation

Immunization documentation from church and other private childcare programs are also reviewed.

- Immunization documentation must be available at the school or childcare facility and be accessible for review during business hours. The school or childcare facility staff must assist the public health or school official in locating the immunization documentation for each child.
- In addition to yearly reviews from public health, a staff member from the Georgia Immunization Office will review immunization documentation from randomly selected schools and childcare facilities annually. The following information is recorded:
  - Number of children enrolled
  - Number of children who have valid current certificates
  - Number of children with expired certificates
  - Number of children with current 30-day waivers
  - Number of children with religious exemptions
  - Number of children with medical exemptions
  - Number of children with certificates marked "complete" but missing required doses
- When the certificates are reviewed, 100 percent of children attending the school or childcare facility must have appropriate immunization documentation to meet the requirements of the law.
- According to the Official Code of Georgia Annotated (OCGA) 20-2-771, "Any responsible official permitting any child to remain in a school or facility in violation of this Code section, and any parent of guardian who intentionally does not comply with this Code section, shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than $100.00 or by imprisonment for not more than 12 months."
- Noncompliant childcare facilities will be reported to the Georgia Department of Early Care and Learning (DECAL). Noncompliant private and public schools will be reported to the Georgia Department of Public Health's Office of the Inspector General. In addition, noncompliant public schools will be reported to the Georgia Department of Education (DOE).

Check Each Certificate

The school or childcare facility must check each child's certificate to be sure it is complete, current and includes the following information:

- Name
- Birth date
- Check complete for K through 6th grade if child is 4 years or older and have met all requirements for school attendance. If additional vaccine(s) are needed, enter date of expirations when the next required vaccine is due.
- An expiration date in the future that is entered by a physician or public health official for children younger than age 4. The expiration date should coincide with when the next required vaccine is due.
- Dates that vaccines were given
- Month, day and year for all dates except serology, diagnosis and history of disease dates (Serology, diagnosis and history of disease dates may be documented by entering the year only.)

Immunization certificates marked with an expiration date must be replaced no later than 30 days after the date of expiration.

- The child cannot be allowed to attend the school or childcare facility until he brings a new certificate.
- According to the Official Code of Georgia Annotated (OCGA) 20-2-771, "Any responsible official permitting any child to remain in a school or facility in violation of this Code section, and any parent of guardian who intentionally does not comply with this Code section, shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than $100.00 or by imprisonment for not more than 12 months."
- Noncompliant childcare facilities will be reported to DECAL. Noncompliant private and public schools will be reported to the Georgia Department of Public Health's Office of the Inspector General. In addition, noncompliant public schools will be reported to the Georgia Department of Education (DOE).

Each certificate must:

- Be signed by a physician, APRN or PA licensed in Georgia or a public health official. A stamp of a physician, APRN or PA's written signature is permissible when cosigned by an office staff member.
- Have a printed, typed or stamped name and address of the physician, APRN, PA, health department or Georgia Registry of Immunization Transactions and Services (GRITS) official issuing the certificate.
- Have a complete date of issue with the month, day and year. A photocopy or faxed copy of a certificate is acceptable.

NOTE: The Georgia Immunization Certificate (Form 3231) is not a substitute for a personal immunization record, which should be kept as a permanent record by parents. A personal immunization record should include all immunizations received to date, both recommended and required, as well as any religious exemption paperwork.

Resources

Immunization Guidelines

dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/Immunization%20Guidelines%20for%20Schools%20and%20Childcare%20Facilities%20FINAL%202015%20(2).pdf

Policy Guide 3231INS Standards for Issuing and Filing Certificates of Immunization [Form 3231 (Rev. July 2014) For Georgia Facilities and Schools
dph.georgia.gov/sites/dph.georgia.gov/files/Immunizations/3231%20INS%207.1.14_0.pdf

Make it a point to annually review and print the immunization schedules for children, teens and adults by visiting cdc.gov/vaccines/schedules/index.html.

For further guidance on the use of the vaccines, see:
cdc.gov/vaccines/hcp/acip-recs/index.html.

Training/Education (for access to IPC, Train the Trainer and Educational Training Presentations contact DPH-immunization@dph.ga.gov)

NASN Immunization Position Statement
nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/8/Immunizations-Revised-January-2015

New Student Requirements
gadoe.org/External-Affairs-and-Policy/AskDOE/Pages/New-Student-Requirements.aspx

Vaccinations required for oversees travel
nc.cdc.gov/Travel

Form 3258, Immunization Guidelines for School and Childcare Facilities – Georgia Department of Public Health
health.state.ga.us/pdfs/prevention/immunization/Immunization%20guidelines%20101711.pdf

"Hop to It!" Brochure
health.state.ga.us/pdfs/prevention/immunization/HopToIt_FINAL%20web%20friendly.pdf

School and Childcare Resources - Immunization Section, Georgia Department of Public Health
health.state.ga.us/programs/immunization/schools.asp

7th Grade Vaccination Requirements

What is the pertussis booster requirement?

All students born on or after January 1, 2002 and entering or transferring into 7th grade need proof of an adolescent pertussis (whooping cough) booster immunization (called "Tdap"). Proof of Tdap immunization must be documented on the Georgia immunization certificate (Form 3231).

What is Tdap and what are the diseases that the Tdap vaccine prevents?

Tdap is a booster vaccine for older children, adolescents, and adults. It safely protects against 3 dangerous diseases: tetanus, diphtheria, and pertussis (also called whooping cough).

- Pertussis – also known as whooping cough is a contagious disease that causes violent coughing fits that make it hard to breathe. It spreads easily when someone with the disease coughs or sneezes. The cough can last for months. Pertussis is particularly dangerous for young babies.
- Tetanus – causes a severe, painful tightening (spasms) of muscles, including of the jaw ('lockjaw'), which can limit swallowing and breathing.
- Diphtheria – is a throat infection that can lead to breathing problems, paralysis, heart failure and death.

Do ALL 7th grade students need to get the pertussis immunization (Tdap)?

Yes. Unless they have an exemption, all students born on or after January 1, 2002 and entering 7th grade must have proof having received the Tdap booster shot. This includes current and new students in both public and private schools. Students who have already received the Tdap vaccine will need to show proof with a new Georgia immunization certificate (Form 3231), so check with your doctor or health care provider.

Why does my child need Tdap?

The Centers for Disease Control and Prevention (CDC) recommends Tdap for preteens at ages 11 or 12 years for protection against tetanus, diphtheria and pertussis (whooping cough). Protection provided by the DTaP vaccine received in childhood wears off as kids get older, so preteens and teens need a booster shot known as Tdap. Getting this booster not only protects preteens and teens, but also the people around them.

When should my child get vaccinated with Tdap?

The Centers for Disease Control (CDC) recommends Tdap booster immunization for:

- Adolescents age 11-12 years
- Adolescents age 13-19 years, who have not yet received it

What if my child had whooping cough recently or in the past?

Any protection (immunity) developed after having pertussis disease wears off, leaving your child at risk for getting pertussis again. A pertussis booster shot is needed to protect your child in the future and to meet the school requirement.

Instead of getting a Tdap booster to meet the requirement, can my child get a blood test to check for protection (immunity) against pertussis?

No. Testing for immunity to pertussis is not reliable and will not meet the school requirement.

What if my child does not have proof of a Tdap shot before school starts?

Your child may not be able to attend school until you submit the documentation for the Tdap requirement to the school.

How long do you have to wait after your last tetanus shot (Td) before getting Tdap?

According to the CDC recommendations, the dose of Tdap required for the school law may be given at any time after the last tetanus shot.

Where can my child get vaccinated?

Your child can visit their doctor or health care provider to get their Tdap shot. Local Health Departments also offer the Tdap vaccine. To find a Health Department near you visit: http://dph.georgia.gov/public-health-districts.

Are there other vaccines recommended for adolescents and teens? Yes, CDC recommends a seasonal influenza (flu) vaccination to protect teens from the flu, and HPV vaccination to protect them from most of the cancers caused by human papillomavirus (HPV) infection. Although not required for school attendance in Georgia, they are strongly recommended. They can be given at the same time as other vaccines.

Where can I go for more information? For more information, visit the Georgia Department of Public Health, Immunization Office website at http://dph.georgia.gov/immunization-section or CDC's website at http://www.cdc.gov/vaccines/vpd-vac/pertussis/.

DPH Georgia Department of Public Health

Have questions?

Talk with your Healthcare Provider.

http://dph.georgia.gov/immunization-section

7th Grade Vaccination Requirements

What is the meningococcal disease (meningitis) vaccination requirement?

All students born on or after January 1, 2002 and entering or transferring into 7th grade need proof of an adolescent meningococcal (meningitis) vaccination. Proof of meningitis vaccination must be documented on the Georgia immunization certificate (Form 3231).

What is meningococcal disease?

Meningococcal disease is a serious bacterial illness. It is a leading cause of bacterial meningitis in children 2 through 18 years old in the United States. Meningitis is an infection of the covering of the brain and the spinal cord. High fever, headache, vomiting, stiff neck and a rash are symptoms of meningococcal disease. Meningitis can cause shock, coma, and death within hours of the first symptoms. Among people who develop meningitis, 10 to 15 percent die, in spite of treatment with antibiotics. Of those who live, permanent brain damage, hearing loss, kidney failure, loss of arms or legs, or chronic nervous system problems can occur. This is why preventing the disease through use of meningococcal vaccination is important.

Do ALL 7th grade students need to get the meningitis vaccination?

Yes. Unless they have an exemption, all entering 7th grade must have proof of having received a meningococcal vaccination. This includes current and new students in both public and private schools. Students who have already received the meningococcal vaccine will need to show proof with a new Georgia immunization certificate (Form 3231), so check with your doctor or health care provider.

Why does my child need the meningitis vaccine?

Vaccination is one of the most effective ways to prevent most meningococcal diseases and this requirement will help protect your child. Seventy-six percent of meningococcal cases among 11-19 year olds are vaccine preventable. In addition to it being a requirement for school, children who get a meningococcal shot will be better protected during their school years.

When should my child get vaccinated with the meningococcal vaccine?

The Centers for Disease Control and Prevention (CDC) recommends that children age 11 - 12 years be routinely vaccinated with a meningococcal vaccination and receive a booster dose at age 16 years.

What if my child had meningitis recently or in the past?

A meningococcal vaccination is needed to both protect your child in the future and to meet the school requirement.

Instead of getting a meningococcal shot to meet the requirement, can my child get a blood test to check for protection (immunity) against meningococcal disease?

No. Testing for immunity to meningococcal disease is not reliable and will not meet the school requirement.

What if my child does not have proof of a meningococcal shot before school starts?

Your child may not be able to attend school until you submit the documentation (Form 3231) for the meningococcal vaccination requirement to the school.

Where can my child get vaccinated?

Your child can visit their doctor or health care provider to get their meningococcal shot. Local Health Departments also offer the meningococcal vaccine. To find a Health Department near you visit: http://dph.georgia.gov/public-health-districts.

Are there other vaccines recommended for adolescents and teens? Yes, CDC recommends a seasonal influenza (flu) vaccination to protect teens from the flu, and HPV vaccination to protect them from most of the cancers caused by human papillomavirus (HPV) infection. Although not required for school attendance in Georgia, they are strongly recommended. They can be given at the same time as other vaccines.

Where can I go for more information? For more information, visit the Georgia Department of Public Health, Immunization Office website at http://dph.georgia.gov/immunization-section or CDC's website at http://www.cdc.gov/meningococcal/vaccine-info.html

DPH Georgia Department of Public Health

Have questions?

Talk with your Healthcare Provider.

http://dph.georgia.gov/immunization-section

Health Screenings

Students who are hearing and seeing well, and have no dental pain, are more successful in the classroom; they have better attendance, test scores and graduation rates. During the school-age years, lifelong health habits are being established, and primary interventions at this time to screen for and prevent obesity can have the most benefit. Identifying children with scoliosis is also important as this condition may need observation as a child continues to grow. Often it is necessary for the school to assess these areas through screenings.

The information provided in this chapter is to be used in conjunction with the current manuals and guidelines available from the Georgia State Department of Education (DOE) and the Georgia Division of Public Health.

Certificate of Vision, Hearing, Dental and Nutrition Screening – Form 3300

Georgia law requires that every student entering a Georgia public school for the first time, regardless of age, have a Certificate of Vision, Hearing, Dental and Nutrition Screening - Form 3300 on file. The purpose of the form is to alert parents of problems their children may have in these areas.

Parents must comply with this rule. The screenings reported on the form must have been conducted within one year prior to the time that the child is admitted for the first time to a public school. Any child admitted to a public school without a certificate must provide one to the school within three months following admission. When a child transfers to another school within Georgia, the Certificate and any related follow-up documentation must be forwarded to the new school.

A local health department may accept written records of screenings performed by private practitioners in a state other than Georgia, provided the screenings were conducted within one year prior to the time that the child is admitted for the first time to a Georgia public school. In such a case, the Health Department shall sign and issue a Certificate based upon the received information.

An authorized screener, qualified to conduct the particular tests, must sign each section of the Form 3300. Signature indicates that all rules and regulations for examination and screenings have been followed as well as the recommended screening procedures found in these guidelines. Each section of the form lists who is authorized to sign that particular section.

Refer to additional information on form 3300 in Chapter 1.

Additional Screening Considerations

Some schools require annual mass hearing and vision screenings of certain grades or the entire school. These screenings at schools can be organized and completed by school nurses with the help of volunteers. Screeners should be adequately trained in appropriate screening procedures and follow recommended criteria for referral. Oversight should ensure that screeners are competent. Training should be documented to show that screeners possess the skills necessary to perform screening procedures.

School nurses are among those who possess the necessary skills for the development and implementation of school hearing and vision screening programs at the local level. School screening programs may involve screening an individual student or large numbers of students in a routine health screening.

To facilitate development, implementation and evaluation of a successful screening program, the following points should be considered:

- Number of students to be screened
- Minimizing academic interruption
- Availability of trained screening personnel
- Size of groups of students to be screened
- Selection of screening location within schools
- Community resources available for follow-up

- Frequency of routine screening.

In addition to routine or mass screenings, a screening may also be performed when a child:

- Enters a new school system
- Repeats a grade
- Is being evaluated as part of the Student Support Team (SST) process and per local school district policy
- Is being evaluated for Special Education or required under IDEA (Individuals with Disabilities Education Act) regulations
- Displays symptoms or difficulties with hearing, speech, language or learning which are of concern to parent, guardian, healthcare provider, teacher or other school staff
- Experiences head trauma with loss of consciousness
- Receives exposure to potentially damaging noise levels
- Takes medications that can cause hearing loss
- Begins Driver's Education training.

Parent permission is not required for mass school screening. However, it is suggested that parents be notified of upcoming screenings via school letter, newsletter, school marquee or other communication strategies. Permission is required for screening of individual students who are being screened as part of a special education or Student Support Team (SST) evaluation or because of specific concerns noted by school staff.

Children with Special Healthcare Needs

Some children have difficulty performing the required tasks necessary for screening. Screening children with physical, emotional, cognitive or developmental delays may require extra planning and preparation. Screening personnel may benefit from the assistance of the child's parent, teacher or paraprofessional.

It is important for screeners to be familiar with ways of proper approach or management techniques needed in order to obtain reliable and valid results.

Some children may be uncomfortable in new and unfamiliar situations. Parents and teachers can incorporate practice sessions to familiarize the child with the process. It may be helpful for some children to observe other children during the screening process. If you are unable to gain cooperation during this initial screening, plan to screen another time.

Other children may be unable to understand or follow directions. They may forget the response they were taught during the demonstration period, or they may respond inappropriately. It is preferable to work with such children on an individual basis. Remember, praise and positive reinforcement work well for all children.

Below are additional considerations for screening children with special healthcare needs:

- Does the screening location accommodate children in wheelchairs, walkers and other assistive devices?
- How does the screening accommodate the needs of the technology-dependent child?
- Can the child move his arms?
- Is the environment conducive to the type of screening being given, i.e., quiet room with no extraneous noise for hearing screening?

Sample Special Education Forms – Georgia Department of Education

doe.k12.ga.us/Curriculum-Instruction-and-Assessment/Special-Education-Services/Pages/Sample-Special-Education-Forms.aspx

Referral Considerations

Children who do not pass the initial screening M be re-screened. A temporary illness, lack of understanding, fatigue, apprehension, allergies, etc., may cause initial failure. For a school-based screening program, re-screen in two to three weeks. For office and clinical settings, re-screen in six to eight weeks before making a referral.

Referral can be described as the process by which individuals or agencies ensure that action is taken to meet identified problems. The referral process helps match parents/guardians with health professionals and should include the following considerations:

- In a school setting, when a child does not pass the second screening, referral letters should be mailed to the parent or guardian within two weeks. Assess the need for financial assistance with the referral.
- Families should be encouraged to seek professional examination in determining the extent and the need for further care. Where necessary, the health professional should assist the family to access the appropriate professionals in the healthcare system. It is important to identify the individual(s) responsible for ensuring follow-up as appropriate.
- If after approximately four weeks the results of an examination have not been received, mail follow-up letters.
- Documentation of professional examination and any recommended treatment should be communicated to school personnel within three calendar months of the screening date. School nurses should update the school health record and communicate recommendations made during professional examination to teachers and other school personnel involved with the child.
- If families are noncompliant with follow-up, make referrals to the school counselor, school social worker or school principal. If the school personnel are unable to get response from the family, consider a DFACS referral for medical neglect.

When the examination results have been obtained, note the following points:

- Correction is necessary, or if the child has any special needs or concerns.
- Child has been referred for further medical, surgical, hearing or vision evaluations.
- The child requires medication, especially during school hours.
- The child must be referred to Special Education or receive further medical care.

Parents and guardians should communicate findings and recommendations to the child's school. It is in the best interest of the child for the faculty and staff to make any necessary accommodations the child may need, whether or not the child is eligible for Special Education:

- Assist families with breaking down barriers to accessing the medical care their child needs. Keep in contact with parent to ensure the child receives the care he needs.
- *PeachCare for Kids* is a low cost medical insurance for uninsured children who are eligible, and should be recommended for those in need of financial assistance. Parents, healthcare providers, school nurses and other school personnel can assist families in making an application online at peachcare.org. Call 1-877-GA PEACH for an application. If the child is not eligible for PeachCare, he may be eligible for Medicaid. Access to a computer with the Internet and some basic financial information is all that is needed. The Internet is available free of charge at public libraries. See also Chapter 11 for additional information on PeachCare for Kids.

Resources

Georgia Department of Public Health – Form 3300 Online Training for the School Nurse
dph.georgia.gov/form-3300-school-nurse-trainings

Georgia Department of Public Health
Form 3300
Certificate of Vision, Hearing, Dental, and Nutrition Screening

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

Georgia Department of Public Health

FILE THIS FORM WITH THE SCHOOL WHEN YOUR CHILD IS FIRST ENROLLED IN A GEORGIA PUBLIC SCHOOL
SCREENER CONTACT INFORMATION IS REQUIRED

Parent/ Guardian Name: _____
first middle last

Child's Name: _____
first middle last

Parent/ Guardian Contact Information:

Daytime phone number:_____
Evening phone number:___
Cell phone number:

Date of Birth: / / **Gender:** ❑Male ❑Female

Child's Home Address:

street city state zip code county

VISION

❑ Unable to screen (explain why below)
❑ Uses corrective lenses
❑ Worn for testing

❑ Passed (20/30 in each eye for age 6 and above, 20/40 in each eye for below age 6)
❑ Needs further evaluation
❑ Under professional care (explain below)

Screening completed by:
❑ Physician
❑ Local Health Department
❑ Optometrist
❑ "Prevent Blindness Georgia" employee
❑ School Registered Nurse

Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

HEARING

❑ Unable to screen (explain why below)
❑ Uses hearing aid / assistive device

❑ Passed at 500, 1000, 2000, and 4000 Hz with audiometer at 20 or 25 dB
❑ Needs further evaluation
❑ Under professional care (explain below)

Screening completed by:
❑ Physician
❑ Local Health Department
❑ Audiologist
❑ Speech-Language Pathologist
❑ School Registered Nurse

Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

DENTAL

❑ Unable to screen (explain why below)

❑ Normal appearance
❑ Needs further evaluation
❑ Emergency problem observed
❑ Under professional care (explain below)

Screening completed by:
❑ Physician
❑ Dentist
❑ Local Health Department Registered Nurse
❑ Registered Dental Hygienist
❑ School Registered Nurse

Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

NUTRITION

❑ Unable to screen (explain why below)

Height:_____ Weight: _____
BMI:_____ BMI%: _____

❑ 5th to 84th percentile - Appropriate for age
❑ < 5th percentile - Needs further evaluation
❑ ≥ 85th percentile - Needs further evaluation
❑ Under professional care (explain below)

Screening completed by:
❑ Physician
❑ Local Health Department
❑ Registered Dietician
❑ School Registered Nurse

Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

Vision Screening

Children who do not see well do not learn at their optimum level. Young children may have, or be at risk for, amblyopia or lazy eye blindness and may literally lose vision in one eye if the problem is not diagnosed and treated by age six. For other children, vision changes may begin in third, fourth, fifth and sixth grade during growth spurts. It is important to identify these children and make sure parents are aware that their child needs a visit to the eye doctor and/or glasses. Many times a problem comes as a complete surprise to both child and parent. Careful follow-up for those identified children by the nurse can ensure that needed medical care is obtained with referrals (for assistance) if necessary.

Equipment for vision and hearing screenings should be requested from the Nurse Supervisor.

When a child does not pass the second screening, send a referral letter home to the parent or guardian within one week. Contact the parent within one week to confirm receipt of the referral letter, discuss concerns and encourage follow-up.

If a child is unable to participate in routine vision screening procedures, or the results are inconclusive, refer the child to an eye care professional.

Parents should check insurance requirements to see if a referral is needed to see an ophthalmologist or optometrist.

For the most current and comprehensive updates on vision recommendations in Georgia and resources for school nurses, please visit the Prevent Blindness Georgia website at georgia.preventblindness.org/childrens-vision-screening-training-certification-supplies

This link will also carry you to the document "Our Vision for Children's Vision: A National Call to Action for the Advancement of Children's Vision and Eye Health," which provides great resources such as "Common Children's Vision and Eye Problems" and "Eye Safety Tips."

Hearing Screening

Children who do not hear well do not learn at their optimum level. Hearing screening programs screen children for two types of hearing loss—sensorineural hearing loss and conductive hearing loss. Sensory hearing loss may be present at birth or acquired later as a result of illness or injury. Conductive hearing loss is usually from a medical issue, i.e. chronic ear infections.

Most children with severe to profound hearing loss are identified and fit with amplification before they reach school age. However, some children may reach school age without a severe hearing loss being diagnosed and treated. Some children have hearing sensitivity in the borderline normal, mild hearing loss range. Even this "mild" degree of hearing loss can impact communication and learning and may be a contributing factor in the inability to sustain appropriate attention levels. One in every five children has a hearing loss (conductive, sensorineural or mixed) in one or both ears. Children with mild to moderate or unilateral hearing loss are often overlooked or misdiagnosed. Hearing screening programs are often the first to identify these hearing problems.

A licensed audiologist, speech-language pathologist, nurse or physician should provide oversight to the administration of hearing screenings by unlicensed personnel. In the school setting, certified speech-language pathologists may provide oversight.

For children unable to participate in a hearing screening using conditioned play audiometry or sweep audiometry, a referral to an audiologist or physician is indicated. Check to see if your school district employs an audiologist. Generally, a referral from a primary care provider will be required to schedule an appointment with an audiologist in private practice.

Parents should check insurance requirements to see if a referral is needed to see an audiologist.

For hearing referrals, parents may contact the school audiologist in school districts with an audiology program for a hearing evaluation. In an office setting, or local health department, it may be helpful to remind families to return for a re-screen. After making a referral, follow up with the care provider and make sure to request documentation of screening results, outcome of medical examination, referrals to specialist and any ongoing care.

If a child does not pass the second screening, referral letters should be mailed to the parent or guardian within one week. Contact parents within a week to confirm receipt of the letters. A sample referral letter is located at the end of this section.

Children who are followed by an Ear, Nose and Throat physician or audiologist need not participate in a screening program. In place of screening, follow up with parents/guardians to ensure the child continues to receive professional care. Recommend referral and provide follow-up for those children who have not had a professional examination in the last year. Examinations and evaluations should be at least annual or as recommended by their provider. Document date of last audiological evaluation, provider and current recommendations for amplification. Referral and follow-up is indicated for hearing-impaired children without an evaluation within the last year.

In the Missouri Guidelines for Hearing Screening document at the link below, there are some sample forms that can be used.
health.mo.gov/living/families/schoolhealth/pdf/HearingScreeningGuidelines.pdf

The "Childhood Hearing Screening Guidelines - American Academy of Audiology" (September 2011) provides comprehensive information for your review.
cdc.gov/ncbddd/hearingloss/documents/AAA_Childhood%20Hearing%20Guidelines_2011.pdf

Visual inspection of the outer ear should be done prior to screening with the audiometer. Do not screen if any of the following are noted. Refer the child to a physician if there are:

Structural defects of the ear, such as:

- Abnormal positioning of the ear
- Malformed ear
- Absence of ear
- Extremely narrow ear canal
- Ear pits or tags
- Lobes reddened or infected from piercings
- Swelling around the ear
- Ear pain both internally and externally

Ear canal abnormalities, such as:

- Ear drainage
- Odor
- Foreign object
- Swelling

Signs and Symptoms of Hearing Problems

Physical/Medical Symptoms

- Frequent earaches/ear infections
- Ear drainage
- Problems with equilibrium (balance)
- Complaints of "noise" (ringing, buzzing, hissing) in ears.

Speech, Language and Voice Symptoms

- Omission of certain sounds in speech
- Mispronouncing common words
- Other speech defects (including language delay)
- Voice lacks intonation pattern
- Confuses words that sound alike
- Habitually speaks too loudly or too softly.

Behavioral Reaction in the Classroom

- Requests repetition of words
- Turns one side of head (better ear) toward speaker
- Watches speaker's lips
- Shows strain in taking notes
- Unusual mistakes in taking direction or instructions
- More than normal use of gestures to make wants known
- Frequent mistakes in following verbal directions
- Appears unaware when spoken to, if not watching the speaker
- Inappropriate/irrelevant answers to questions
- Seems more aware of movement than sound
- Frequently watches others before beginning a task and has a tendency to imitate actions of others.

Other signs that may be indicative of impaired hearing

- Child may appear more intelligent than his work indicates (underachieving)
- Withdrawal
- Irritability
- Temper tantrums
- Low self-esteem.

Dental Screenings -- Legal Responsibility of Schools

A dental or oral screening survey is a collection of visual information of the pathology present in groups of people that help identify the needs of a population, from which their "treatment" services can then be planned. Measurement of oral health status and changes in status over time require the screening of samples of the population, and more than one screener usually participates. Standardization of the screeners on the basis of defined criteria reduces the human nature of bias, which exists in part as a result of clinical education and experience. It is the means by which we can help ensure the results of the oral screening are valid (correctly categorizes persons into disease/no disease categories) and reliable (criteria have been applied consistently). Screening in an accurate, consistent way will help in the accurate assessment of a population while still providing a valuable referral to the person for oral conditions requiring follow-up. However, the oral screening is not a substitute for a comprehensive diagnostic oral examination and/or x-rays.

Screening for dental defects should be part of the total health screening as stated as part of "Rules and Regulations for Eye, Ear and Dental Examination of Children Entering Public Schools," i.e., kindergarten and first grade. A high percentage of kindergarten and first grade children are in need of dental care, and each child referred for further dental care will require a dentist's diagnosis of his or her dental problems. Screening guidelines are presented later in this chapter.

Georgia law (Chapter 290-5-31-02) states:

(a) Every child being admitted initially to a public school operating in this State shall furnish to the school authorities a Certificate of Eye, Ear and Dental Examination signed by a private practitioner or qualified representative of a local department of health on forms provided by the Department of Human Resources and approved by the Department of Education.

(b) To be valid, the eye, ear and dental examination must have been received within the one-year period prior to enrollment in school or the child must be eligible for Certificates of Eye, Ear and Dental Examinations because of some physical disability as provided for in Paragraph 290-5-31.06.

(c) Any child admitted to school without a certificate shall present a Certificate of Eye, Ear and Dental Examinations within four months following entrance of school.

"..... a qualified representative of a local department of health....." is interpreted by the Georgia Department of Public Health to include registered nurses (RNs), who are public health and school nurses; public health dental hygienists; and dentists and physicians, either private or public, providing dental screening. That these designated screeeners are not all licensed dentists, in the Department's opinion, in no way violates the Dental Practice Act of Georgia and is not to be construed as the practice of dentistry. The Georgia Board of Dentistry has agreed with this interpretation. Dental hygienists in private practice may provide dental screening for health departments and health fairs as long as no fees are exchanged and an appropriate written notice explaining the screening does not take the place of an examination and is given to the person, parent or guardian. (HB 223: 2001). The Board has stated dental assistants, licensed practical nurses (LPNs) or other health professionals may not perform dental screenings.

Screening for dental defects should be part of total health screening, and the personnel should be those involved with the overall responsibility for health defects. Screening for dental disease should require relatively little time. A set routine should be followed so as not to omit necessary aspects of the screening process. If one defect is found, the screening procedure should be terminated and the child referred to the family dentist or to the local health department dentist where available. The law does not require care be provided before a screening certificate can be issued.

Dental Development & Tooth Eruption

mouthhealthy.org/~/media/MouthHealthy/Files/Kids_Section/ADAPrimaryToothDev_Eng.ashx

mouthhealthy.org/~/media/MouthHealthy/Files/Kids_Section/ADAPermanentTeethDev_Eng.ashx

Scoliosis Screening

Scoliosis is a physical condition characterized by a lateral deviation of the spine away from the midline of the body. Its cause is unknown in most cases. The amount of curvature is measured in degrees after an x-ray and can vary from mild to severe. Eighty-five percent of idiopathic scoliosis develops in the middle school age group, when rapid growth is occuring. Both girls and boys may be affected, but girls' curves tend to progress five times more frequently.

Treatment ranges from observation by a pediatric orthopedic physician to bracing to corrective surgery in severe cases. After scoliosis is identified or suspected, follow-up is essential to measure the degree of curvature and determine treatment options. Kyphosis, exaggerated roundness and lordosis, or swayback, may occur independently or in conjunction with scoliosis.

Screening for scoliosis is recommended annually during the middle school years, and Georgia mandates screening for a minimum of two grades between the age group of 10 through 15 years,with presumed or passive parental consent (i.e. parent must sign to decline permission to screen). Every student in the designated grade will be screened, unless parents refuse by signing and returning a form that will be sent home.

Screening consists of examining the student's unclothed back. Female students can be screened wearing just a bra above the waist (preferred) or can wear a bathing suit under their clothes for the day of screening. The student will be asked to stand straight and then bend forward while the examiner looks from the front, the back and the side. The screener looks for obvious curves, rib humps or uneven shoulders, waist or hips. Specially-trained PE teachers, clinic personnel or volunteers can complete or assist school nurses with primary screening. Female examiners are preferable for female students. See The Five Step Screening Process.

Students with questionable findings upon initial screenings by volunteers require secondary screenings by the public health authority or other consultants for secondary screening. Referrals can be done easily on the same day, if secondary screeners are available. If signs of scoliosis are confirmed on the secondary screening, notify the parents in writing.

Offer assistance when access to healthcare is a barrier for the family. The child's primary healthcare provider can complete a further examination or refer the child to a specialist. In some areas of the state, parents may set up a tertiary screening exam through a state-funded program if available or through Children's Healthcare of Atlanta Scoliosis Screening clinics (404-785-7553). Additional information for parents, children, teens and healthcare professionals is available at choa.org/Childrens-Hospital-Services/Orthopaedics/Programs-Services/Scoliosis-Screening.

Tips for Setting up a Successful Scoliosis Screening

- Training for volunteers and new staff, as well as a refresher for experienced screeners, should be done shortly before the screening date.
- A video and training manual, updated in 2011, is available from Children's Healthcare of Atlanta by calling 404-785-7553. An annual conference for healthcare professionals on scoliosis screening is provided by Children's. choa.org/Childrens-Hospital-Services/Orthopaedics/Programs-Services/Scoliosis-Screening/Scoliosis-Screening-Conference-Form
- Schedule the screening so that it does not conflict with testing, field trips, etc.
- Schedule when secondary screeners can be available if possible.
- Send letters/permission forms home one to two weeks before the screening is scheduled. It may be helpful to put information in the school newsletter or on the school website.
- Have teachers collect and save the "Do Not Screen" letters.
- Prepare students the day before screening, discussing the procedure that will be followed. A video for students "A Student's

Guide to Scoliosis Screening" is available from Children's Healthcare of Atlanta at 404-785-7553. It also can be viewed online at choa.org/scoliosis.

- Remind female students the day before to wear bras or bathing suits under clothes.
- Students or teachers should complete the personal information on the screening forms, and the student should bring the completed form to the screening.
- Many middle schools schedule screenings during PE or exploratory periods on one day, and reschedule lunch periods if necessary to complete screenings.
- It is very important to manage the screening area so that the student's privacy is maintained—utilizing boys' and girls' locker rooms, shower areas, screens, etc. This practice will make screening go more smoothly and quickly.
- The setting chosen for screening should be checked for good lighting, the floor should be free of uneven areas, and the temperature of the room should be comfortable for students who will be undressing.
- It is important to screen with the student's entire back exposed (no T-shirts around the neck; bra is OK). An adequate exam cannot be done otherwise.
- Volunteers will be helpful to control "traffic," call classes down, get students to secondary screeners, etc.

CHRONIC HEALTH CONDITIONS

More detailed and specific information about various chronic health conditions is available in the Georgia School Health Manual
https://www.choa.org/medical-professionals/nursing-resources/school-health-resources

Chronic Health Conditions

In 1975, Congress passed legislation mandating that all children, including those with special healthcare needs, be educated with their peers. Case management for medically fragile and special needs children involves coordination of multiple health and education services. The school nurse functions as a case manager by interpreting health information to school personnel, providing direct services, advocating for needed accommodations, and educating staff. Students with chronic health conditions can experience difficulties with learning related to medications or treatments, frequent or prolonged absences, or effects of the condition itself. The school nurse can also help to promote a psychologically supportive learning atmosphere and help students with chronic health conditions develop strategies to attain personal success in school.

Sometimes the nurse may be the one to notice that a student is exhibiting some early symptoms of illness. If the nurse observes a student coming to the clinic with the same complaint several times or a new complaint that seems more serious, he/she should alert the parent to the problem. Ensure that the family has a primary care provider (PCP) or other referral information if they need it. The nurse should always be able to provide this information for families and work with the school social worker if possible to help the family obtain the needed care. Refer to this chapter for information on general management of specific chronic health conditions, but always get individual instructions and guidance from the child's family and healthcare provider.

Information is also included in this chapter on the Individuals with Disabilities Education Act (I.D.E.A.), Individualized Education Plans (IEPs) and Section 504 plans that may involve the school nurse. Samples of an Individualized Health Plan (IHP) form and 504 plan are included as well. The school nurse's commitment to maintaining confidentiality and obtaining parent permission before sharing health information is very important.

The school nurse's position as an advocate for these children in the educational setting also will depend on good communication with parents, teachers and staff. Remember that the school-age siblings of these students probably have feelings and issues with which they may be dealing when one child in the family is sick and requiring extra attention. School nurses can also model for staff and students their commitment that the illnesses are part of these children, but do not define them. Teasing should not be tolerated, and the natural compassion of other students can be brought out by honest, open communication.

A web resource for Georgia Resources for Children with Special Needs can be found at:
pediatrics.emory.edu/divisions/neonatology/dpc/georgia.html

A web resource for Children with Special Healthcare Needs: Provider Manual can be found at:
dph.georgia.gov/children-and-youth-special-healthcare-needs-cyshn

Asthma

Condition

Asthma is a chronic lung disease in which an individual's airways are inflamed (irritated) and overactive. This condition is sometimes known as reactive airway disease. During an episode, the lining of the airway swells which causes mucus production, then the muscles which surround the airway contract. As a result, the airway is partially blocked and asthmatic symptoms such as wheezing, chest tightness, coughing and shortness of breath begin.

It is estimated that over 10 percent of school-age children in Georgia have asthma. Asthma is the most common chronic disease of childhood and the leading cause of school absence from chronic illness. Exercise-induced asthma (EIA) occurs when physical activity causes bronchoconstriction, which can lead to wheezing, coughing, chest tightness or shortness of breath during and after exercise. Most children with asthma will also have EIA, and some children can have EIA without having chronic asthma.

Asthma education in schools can help to improve self-management skills and lead to decreased absenteeism. The school nurse plays a key role in monitoring and assessing asthma control in the student. Indicators of poor asthma control in the student need to be identified and communicated to the parent, including advising medical follow-up. In addition, the school nurse should be alert to children who have signs and symptoms of asthma but have not been diagnosed; nurses should educate and encourage families to seek medical attention.

Guidelines for the care and management of asthma were released in August 2007 by the National Heart Lung and Blood Institute (NHLBI) (nhlbi.nih.gov/guidelines/asthma/asthgdln.htm). These guidelines emphasize the importance of asthma control and introduce recommendations for managing asthma in three age groups (0-4 years of age, 5-11 years of age and youths>12 years of age). The classification of asthma severity is determined at the time of diagnosis with the goals of asthma therapy aimed at reducing impairment caused by symptoms and risk of future exacerbations from poor control. The classifications of asthma severity are as follows:

- Intermittent asthma – Daytime symptoms less than or equal to two times a week; brief exacerbations requiring the use of quick relief medication less than or equal to two times a week; nighttime symptoms less than or equal to two times a month; no interference of normal activity.
- Mild persistent asthma – Symptoms greater than twice a week, but not daily; nighttime symptoms three to four times a month; need for quick relief medication more than two times a week but not daily; minor limitation of normal activity.
- Moderate persistent asthma – Daily symptoms; daily use of quick relief medicine; exacerbations affect activity; exacerbations occur twice a week and may last days; nighttime symptoms greater than once a week.
- Severe persistent asthma – Continual symptoms; frequent exacerbations; frequent nighttime symptoms; limited physical activity.

The presence of one clinical feature of severity is sufficient to place a student in that category and initiate treatment accordingly. The ultimate goal of treatment is to enable the student to live free of limitations. Ongoing monitoring is essential to this end as asthma is a highly variable disease.

Causes

The cause of asthma is a sensitive and over-reactive airway. The airway of an individual with asthma can be triggered by a variety of factors. The airway can be triggered by allergens such as molds, dustmites, pollen or weeds; irritants like smoke, air pollution or strong odors; or other factors such as exercise, weather changes or cold air.

Management at School

Controlling asthma requires a comprehensive approach including consistent and appropriate medical treatment, comprehensive patient and family education, patient and family compliance, and environmental risk factor evaluation and reduction. Asthma attacks may be frightening, but they are treatable. Early recognition of symptoms and prompt treatment can shorten the course of an asthma episode and prevent hospitalization. A written asthma action plan is a necessary tool that includes instruction for daily management, as well as recognizing and handling worsening asthma with appropriate dosages of medication.

Early warning signs may include one or more of the following:

- Coughing
- Runny or stuffy nose
- Mild wheezing
- Itchy, watery eyes
- Itchy or sore throat
- Lethargy or fatigue
- Irritability or headache
- Waking at night with symptoms (per report)
- Activity intolerance
- Complaint of chest tightness or stomach ache (for younger kids)

These early warning signs are indicative of the child's "yellow zone" in their asthma action plan and may indicate that an asthma episode is imminent and treatment with a quick relief medication is necessary. It is important to note that all asthma flare-ups are not accompanied by wheezing on auscultation. Assess for any of the symptoms of an asthma exacerbation and treat accordingly.

More severe symptoms that require prompt action are:

- Persistent coughing or wheezing
- Rapid breathing rate
- Extreme shortness of breath
- Increased work of breathing
- Chest tightness or pressure
- Change in behavior (anxiety)
- Difficulty speaking without stopping to breathe
- Skin around chest and neck pulled in with breathing (retractions)
- Pale/blue color of skin, lips or nail beds

These symptoms are indicative of a child's "red zone" from the asthma action plan and necessitate immediate treatment with a quick relief inhaler. Emergency help (9-1-1 call) may be necessary if these symptoms are noted and/or there is no improvement in symptoms 15-20 minutes after treatment.

A bill, passed in 2015 in the Georgia legislature (HB 362), states that schools may stock albuterol for use in identified respiratory distress. School personnel may administer albuterol to a student or staff member with respiratory distress regardless of prescription. Any school personnel who acts in good faith is immune from civil liability.

A bill, passed in 2002 in the Georgia legislature (SB 472), provides for self-administration of prescribed asthma medications by minor children in school settings. Supportive school policies are necessary to assure that students with asthma have access to their quick relief medication.

Asthma cannot be cured, but it can be controlled. Signs that may indicate that asthma is poorly controlled include:

- Persistent cough
- Coughing, wheezing, chest tightness, shortness of breath after physical activity
- Low level of stamina during physical activity
- Reluctance to participate in school activities or physical activity
- Excessive (more than one day/month) absences from school due to asthma.
- Frequent visits to the clinic for respiratory symptoms
- Frequent use of quick relief medication for symptom relief (more than two times/week or more than two nights/month).

Treatment

Effective treatment of asthma will allow a student to participate in school activities. Avoiding known asthma triggers and treating symptoms early are the keys to control. Medications that are used in the treatment of asthma are categorized into two general classes according to their mechanism of action – quick relief and long-term control medicines.

Quick relief medications work rapidly to relax the tight muscles around the airways, increasing airflow into the lungs and reducing asthma symptoms. Usually these medications are the ones used at school.

Examples include:

- Albuterol (also called Proventil®, Ventolin®, ProAir®) available as a metered dose inhaler (MDI) or solution for the nebulizer
- Xopenex® (available in MDI or nebulizer solution)
- Maxair® (inhaler)

There may be circumstances when an asthmatic child needs his/her quick relief inhaler and may not be experiencing acute symptoms. This can happen if pre-treating before exercise or play, or if experiencing symptoms of an early exacerbation and he/she needs to take a short-acting beta agonist (quick relief medication) every four hours as part of their yellow zone regimen.

Long-term control medications are given on a regular basis, even in the absence of symptoms, to reduce inflammation of the airways. These may be ordered once or twice a day to prevent symptoms, either year-round or seasonally. It is important for the school nurse to know about controller medicines the child takes at home, even though these usually are not needed during school hours. This information will help the nurse educate the student and family on the important role that controller medications play in the student's asthma control. Examples include:

- Inhaled corticosteroid (Examples: Aerobid®, Asmanex®, Azmacort®, Flovent®, Pulmicort® and Qvar®)
- Long acting bronchodilator (Serevent®, Foradil®)
- Leukotriene modifier (Singulair®, Accolate®)
- Inhaled non-steroid (Tilade®)
- Combination drugs: inhaled corticosteroid and long-acting bronchodilator (Advair®, Symbicort® and Dulera).

Asthma Equipment

- Asthma medications are delivered by metered dose inhalers (MDI), dry powdered inhalers (DPI) or nebulizer treatments. The nebulizer or compressor is used to aerosolize liquid medication for breathing treatments.
- Children who use metered dose inhalers (MDIs) should use a "spacer" or holding chamber (example: Aerochamber®, InspireEase®) which assists them to use the inhaler correctly. Medications that are supplied in a discus, dry powder inhaler (DPI) or breath-actuated inhaler form do not require a reservoir device.

- The peak flow meter is a small device that measures how well air moves out of the lungs. It also helps a student or caregiver determine changes in their asthma and identify appropriate actions to take.

Inhaler Procedure with Spacer

Spacers or holding chambers are necessary since they increase medication delivery when using a MDI. The holding chambers are available with either a mouthpiece or a mask. Generally, younger children (under age 4) will need to use a mask. The child's healthcare provider determines the medication dosage as well as how often to give. Dosages will vary with each child and should be stated clearly on the medication label as well as in the Asthma Action Plan.

The spacer is a hollow tube, which traps the medicine. It can hold the medicine so that the child can take more than one deep breath from it (six breaths may be required if used with a mask for younger or special needs students). If using a spacer with a mask, the mask should fit tightly against the child's face. If using a spacer with a mouthpiece, it is best if the child takes a slow deep breath and holds his breath for up to 10 seconds to allow the medicine to reach all the parts of his lungs. When more than one puff is prescribed, it is best to wait one full minute between puffs to allow maximum absorption of medication. Coughing after medication administration with a bronchodilator is normal.

Inhaler Procedures Without Spacer

Although using a MDI without a spacer is not recommended, there may be circumstances when an aerochamber is not available. In that case, it is important to use proper technique. A school nurse should recommend a spacer for children who take MDI medication in order for them to receive proper benefit from their medication. Closed mouth technique is the proper method when using an inhaler without a spacer.

Diskus Procedure (DPI-Dry Powder Inhaler)

Using a DPI requires a rapid deep inhalation and is not recommended for children less than 4 years old because they generally cannot generate a deep enough inspiration to activate the device. In addition, a dose is lost if the child exhales through the device after actuating.

See attachment for the proper use of a diskus (see page 15).

Aerosol Therapy by Nebulizer

The student may use an air compressor with a nebulizer medication cup to receive his breathing treatment. The air compressor provides the air for the treatment. The nebulizer is the part that holds the medicine. When the air from the compressor goes through the tubing and meets the medicine inside the nebulizer, it forms the mist. The child inhales the mist until it is gone (which usually takes about 10 minutes). Prescribed medicine is usually pre-measured (unit-dosed) and placed into the medication cup. The medicine from the nebulizer is inhaled through a mask or a mouthpiece using slow tidal breathing. A tight-fitting face mask is necessary for those unable to use a mouthpiece. This medication delivery system is less dependent on a child's coordination or cooperation. The disadvantages to its use are its decreased portability and need for a power source, increase in time needed for a treatment, and potential for bacterial infections if not cleaned properly.

Using a Peak Flow Meter

The peak flow meter is a small device that measures how well air moves out of the lungs. Peak flow monitoring can be a useful tool in the long-term management of asthma. However, early symptom recognition is a better indicator of uncontrolled asthma or an asthma flare-up. Also, the peak flow maneuver may be difficult for the child to perform during an acute exacerbation. It should not be used as a substitute for clinical assessment of symptoms during an acute asthma attack. The peak flow meter can detect narrowing of the airways hours, sometimes even days, before the onset of any asthma symptoms. The peak flow measurement is dependent upon user technique and effort, and all results need to be compared with the individual's personal best. This information may be incorporated into the child's asthma action plan.

How to Clean Asthma Devices

HFA inhalers need to be kept clean. After use, excess medication can accumulate around the exit hole where the medication comes out. When dried medication accumulates around the exit hole of the actuator, less medication can be delivered to the airways. It is also may be important to prime the inhaler if it is not used on a regular basis. It is important to follow the manufacturer's instructions, but generally, the actuator needs to be washed on a weekly basis.

In addition, regular care needs to be given to the devices used in the administration of asthma medications. It is recommended that the device be cleaned and stored according to manufacturer's instructions. Most devices can be cleaned by soaking for 15 minutes in warm water with mild dishwashing detergent. Never wipe the inside of a spacer as it can damage the lining and inhibit medication delivery. The device is then rinsed with clean water and allowed to air dry.

The parts that need to be washed regularly are: spacers, nebulizer medication cups, masks and mouthpieces. Never wash the nebulizer tubing as it never dries completely.

To disinfect, soak parts for 20 minutes in a solution of one part white vinegar to three parts water. Rinse with clean water and allow to air dry. The disinfection process should be done every third day if used frequently.

Spacers should never be stored in a plastic bag as this can increase static electricity in the device and lead to decreased medication delivery.

See attachments "Metered Dose Inhaler with Holding Chamber (Spacer) and Mouthpiece" for how to clean a spacer and mouthpiece and "Metered Dose Inhaler with Holding Chamber (Spacer) and Mask" for how to clean a spacer and mask.

Educational Considerations

- Develop IHP/504/IEP and emergency plans; request asthma action plan from healthcare provider.
- Educate faculty and staff on early and late warning signs and triggers.
- Adapt activity level for recess, physical education if needed.
- When exercise-induced asthma is a concern: pre-treatment with bronchodilator if ordered, hydration, adequate warm- up time, avoiding exercise during hottest part of the day, avoiding outside exercise when air quality is bad.
- Provide inhalant therapy assistance; educate student and staff in proper medication administration.
- Remove allergen triggers from child's classroom areas.
- Avoid pets in classroom, including fish (tanks may have mold growth).
- Promote attention to indoor air quality of the school.
- Accommodate medical absences, with make-up work, etc. as needed.
- Decrease absenteeism due to asthma by assuring asthma action plan is followed during yellow zone, even in the absence of clinical symptoms (i.e., student reports night awakenings due to symptoms the previous night).
- Provide access to water to ensure adequate hydration.

- Make healthcare needs known to appropriate staff.
- Provide indoor space for before and after school activities, recess and PE when outdoor air quality is bad.
- Be aware of the outdoor air quality index and inform staff to make adjustments in schedule and/or location as needed for more information).Make arrangements for self-administration of medications in consultation with family and student, as per school district policy.

Resources

American Academy of Asthma Allergy and Immunology
aaaai.org

American Lung Association
lung.org

Asthma and Allergy Foundation of America
aafa.org

Asthma and Allergy Network
allergyasthmanetwork.org/main

Asthma – Centers for Disease Control and Prevention
cdc.gov/asthma

Asthma Center – Children's at Hughes Spalding
choa.org/asthma

Asthma-Friendly Schools Initiative
lungusa.org/lung-disease/asthma/in-schools/asthma-friendly-schools

Asthma Guidelines and Strategies
cdc.gov/HealthyYouth/asthma/strategies.htm

At School with Asthma – Asthma and Allergy Foundation of America
aafa.org/display.cfm?id=8&sub=104&cont=710

"How Asthma-Friendly is Your School?" – National Asthma Education and Prevention Program
nhlbi.nih.gov/health/public/lung/asthma/friendly.pdf

Managing Asthma in the School Environment – Environmental Protection Agency
epa.gov/iaq/schools/managingasthma.html

Autism Spectrum Disorder (ASD)

Autism spectrum disorder (ASD) is a group of developmental disabilities that can cause significant social, communication and behavioral challenges. There is often nothing about how people with ASD look that sets them apart from other people, but people with ASD may communicate, interact, behave, and learn in ways that are different from most other people. The learning, thinking, and problem-solving abilities of people with ASD can range from gifted to severely challenged. Autism spectrum disorder is a life-long condition; some people with ASD need a lot of help in their daily lives; others need less and this need can change over time. A diagnosis of ASD now includes several conditions that used to be diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called autism spectrum disorder.

Signs and Symptoms

People with ASD often have difficulties with social, emotional, and communication skills. They might repeat certain behaviors and might not want change in their daily activities. Many people with ASD also have different ways of learning, paying attention, or reacting to things. Signs of ASD begin during early childhood and typically last throughout a person's life.

Children or adults with ASD might:

- Not point at objects to show interest (for example, not point at an airplane flying over)
- Not look at objects when another person points at them
- Have trouble relating to others or not have an interest in other people at all
- Avoid eye contact and want to be alone
- Have trouble understanding other people's feelings or talking about their own feelings
- Prefer not to be held or cuddled, or might cuddle only when they want to
- Appear to be unaware when people talk to them, but respond to other sounds
- Be very interested in people, but not know how to talk, play, or relate to them
- Repeat or echo words or phrases said to them, or repeat words or phrases in place of normal language
- Have trouble expressing their needs using typical words or motions
- Not play "pretend" games (for example, not pretend to "feed" a doll)
- Repeat actions over and over again
- Have trouble adapting when a routine changes
- Have unusual reactions to the way things smell, taste, look, feel, or sound
- Lose skills they once had (for example, stop saying words they were using)

Diagnosis

Diagnosing ASD can be difficult since there is no medical test, like a blood test, to easily get a yes/no answer. In addition, the same person with ASD will change over time, so professional evaluation is needed. Doctors look at the child's behavior and development to make a diagnosis. ASD can sometimes be detected at 18 months or younger. Research has shown that by age 2, a diagnosis by an experienced professional can be considered reliable, valid and stable. Studies have shown that parents of children with ASD notice a developmental problem before their child's first birthday. Concerns about vision and hearing were more often reported in the first year, and differences in social, communication, and fine motor skills were evident from 6 months of age. Unfortunately, many children do not receive a final diagnosis until much older. CDC prevalence studies found that children identified with ASD were not diagnosed until after age 4. This delay means that children with ASD might not get the early help they need. Studies suggest that starting treatment early, ages 2-3 could save $1.28M over the lifetime of a child, when compared to starting treatments at 5-6 years old. These costs primarily occur in non-medical costs like housing and employment supports.

Treatment

Research shows that early intervention treatment services can improve a child's development. Early intervention services help children from birth to 3 years old (36 months) learn important skills. Services can include therapy to help the child talk, walk, and interact with others. Children under the age of 3 years (36 months) who are at risk of having developmental delays may be eligible for services under Individual with Disabilities Education Act (IDEA) Part C. These services are provided through an early intervention system in every state. Through this system, parents can request an evaluation. In addition, treatment for particular symptoms, such as speech therapy for language delays, often does not need to wait for a formal ASD diagnosis.

The American Academy of Pediatrics is currently revising their Clinical Report on Management of Children with Autism Spectrum Disorders. The new report is expected to be released in 2016 and will include updated information on medical management of seizures, GI problems, sleep disturbances and medication option.

Prevalence

ASD occurs in all racial, ethnic, and socioeconomic groups. More people than ever before are being diagnosed with ASD. Scientists believe that the increase in ASD diagnosis is likely due to a combination of factors: broader definition of ASD, removing the stigma from receiving a diagnosis, and better efforts in standardizing criteria for ASD. However, a true increase in the number of people with an ASD cannot be ruled out.

- About 1 in 68 children in the US are estimated to meet the criteria for diagnosis of autism spectrum disorder (ASD) according to estimates from CDC's Autism and Developmental Disabilities Monitoring (ADDM) Network.
- ASD is over 4 times more common among boys (1 in 42) than among girls (1 in 189).
- Studies in Asia, Europe, and North America have identified individuals with ASD with an average prevalence of about 1%. A study in South Korea reported a prevalence of 2.6%.

Causes

While not all of the causes of ASD are known, there is some evidence that the critical period for developing ASD occurs before, during, and immediately after birth. In addition, we have learned that many different factors interact in complex ways to make a child more likely to be diagnosed with ASD, including environmental, biologic and genetic factors. Right now, scientists' best estimates are that about half of a person's risk for developing ASD comes from genes, and about half from environmental factors.

Risk Factors and Characteristics

- Parents who have a child with ASD have a 7-20% chance of having a second child who is also affected.
- Children born to older parents are at greater risk for having ASD.
- A small percentage of children who are born prematurely or with low birth weight are at greater risk for having ASD.
- Studies have shown that among identical twins, if one child has ASD, then the other will be affected about 36-95% of the time. In non-identical twins, if one child has ASD, then the other is affected about 0-31% of the time.
- ASD tends to occur more often in people who have certain genetic or chromosomal conditions. About 10% of children with autism are also identified as having Down syndrome, fragile X syndrome, tuberous sclerosis, or other genetic and chromosomal disorders.
- Almost half (46%) of children identified with ASD has average to above average intellectual ability.
- ASD commonly co-occurs with other developmental, psychiatric, neurologic, chromosomal, and genetic diagnoses. The co-occurrence of one or more non-ASD developmental diagnoses is 83%. The co-occurrence of one or more psychiatric diagnoses is 10%.
- About 20-30% of children with autism have seizures, and children with ASD are four times more likely to report gastrointestinal issues. They can also have feeding disorders or food selectivity, which can lead to serious nutritional deficits.

Resources

American Academy of Pediatrics Clinical Report

Myers, SM & Johnson, CP. Management of Children With Autism Spectrum Disorders. Pediatrics. Vol. 120, No. 5, November 2007. 1162-2362.

pediatrics.org/cgi/doi/10.1542/peds.2007-2362

American Psychiatric Association Fact Sheet

Autism Spectrum Disorder (DSM-5 revised diagnosis)

dsm5.org/Documents/Autism%20Spectrum%20Disorder%20Fact%20Sheet.pdf

Centers for Disease Control and Prevention

National Center on Birth Defects and Developmental Disabilities

cdc.gov/ncbddd/autism/index.html

cdc.gov/ncbddd/autism/facts.html#ref

Marcus Autism Center

marcus.org

Childhood Cancers and Transplants

Successful treatment of childhood cancers has increased dramatically, and children with cancer are returning to normal school activities. A child who has received an organ transplant will also return to school, and school reentry issues will need to be addressed. Both of these types of students will probably be on medication to suppress the immune system. Risk of infection, body image concerns, fatigue, absenteeism due to treatment and possible late effects of treatment are the main considerations. Communication with parents is the key to a smooth transition for these students.

Childhood cancers affect about 15 children in 100,000, but the prognosis for these children is improving each year. Cancers are usually treated by one (or a combination) of the following: surgery, radiation and/or chemotherapy. Each type of cancer is different, and the treatment regimens vary according to the type. There are two main types: those involving the blood-forming tissues (lymphomas and leukemias) and those affecting bone, brain or internal organs (solid tumors). About one third of childhood cancers are leukemias. The most common solid tumors are brain tumors (e.g. gliomas and medulloblastomas), followed by the other solid tumors (e.g. neuroblastomas, Wilms' tumors and rhabdomyosarcomas).

A child may receive a kidney, heart, liver, bone marrow or heart-lung transplant for a variety of reasons, including: congenital malformations and illnesses, acquired organ failures or cancer. For these students, anti-rejection drugs will cause the same concerns with immunosuppression and body image.

Management at School

A child's resistance to infection is usually reduced significantly by treatment (immunosuppression). Thus, even one case of chicken pox, shingles or measles, as well as any widespread outbreaks of infectious diseases, becomes a particular concern and should be reported immediately to parents. Symptoms include fever above 100°F, lethargy and rashes. Emergency intervention may be required, as infection in these children can be life-threatening. When a child is known to have a medical history of cancer and/or transplant, school personnel should react quickly to these symptoms, notifying parents immediately.

If parents cannot be reached, a plan should be in place to obtain emergency care without delay. If the child is exposed to chicken pox in the school, notify the parents immediately. Medicine can be administered to prevent or lessen the severity of the chicken pox if given to the child within 48 to 72 hours after exposure. During outbreaks of certain diseases, a doctor may suggest that the child remain at home as a preventive measure against infections.

Children who are receiving chemotherapy will often have a central venous access line implanted for chemotherapy and lab monitoring. This line may be an implanted port (surgically placed under the skin) or a central venous line that is usually placed through the chest wall. The latter would be capped off during school hours and covered by clothing. The school nurse can assist in monitoring, to observe for early signs of infection. Students undergoing chemotherapy and radiation also will often experience a decreased energy level due to the effects of treatments, producing such symptoms as anemia. School schedules may need to be modified and made flexible to accommodate the student's treatment. The schedule of treatment, and the student's response to it, will necessitate frequent absences of varying lengths.

Homebound teaching may be needed from time to time. Bleeding and bruising may be problems as well since treatment can affect the body's ability to control bleeding. These incidents should also be promptly reported to parents. Issues of body image changes (hair loss, growth retardation, consequences of surgery such as amputation) are of utmost importance for children of all ages. With family and student permission, classmates should be prepared honestly for these changes and given concrete ideas for how to treat their friend when he or she returns. Ongoing communication with parents is always important, and school staff should never make assumptions about the child's knowledge and understanding about the disease.

Educational Considerations

"School is an essential part of a child's life and well-being. It's important to maintain the continuity of education even if the type of schooling varies. To promote a sense of normalcy…education should continue as smoothly as possible, both for learning and for social reasons, such as maintaining friendships…Not all of the changes a child undergoes as a result of this diagnosis are negative. By getting support from parents, teachers, school nurses and classmates, and by facing and overcoming obstacles, and by learning to accept and process difficult news, many children can grow and mature socially and emotionally far beyond their years." (The Home Care Guide: Caring for Young Persons with Cancer at pennstatehershey.org/c/document_library/get_file?folderId=135815&name=DLFE-2703.pdf).

Students may be unable to attend school for periods of time during treatments. Hospital school programs and homebound instruction may be ordered if the child can tolerate these. "Late effects" can be associated even with successful cancer treatment, some of which can influence a child's ability to process, learn and retain new information. School staff should be aware of these possibilities and evaluate with parents the child's progress and the need for learning support services, during and after this critical period.

When the child returns to school, there may need to be:

- Development of an IHP/504/IEP and emergency plan
- Adaptations in the length of the day or schedule of classes and activities
- Support of increased dietary supplement needs
- Medications or treatments needed during school hours (central lines, etc.)
- Parent/student permission, education of staff and peers. Anticipated peer questions include:
  - What's wrong with _____?
  - Is this disease contagious?
  - Will _____die from it?
  - Should we talk about it or should we ignore it?
  - Should we treat _____differently?
  - Why did _____lose his hair?
- Set of textbooks at home or hospital
- Adaptation of physical education
- Access to professional school health services
- Peer tutoring
- Heightened awareness of potential problems from minor infectious illnesses of classmates.

Resources

Aflac Cancer and Blood Disorders Center

choa.org/childrens-hospital-services/cancer-and-blood-disorders

American Cancer Society

cancer.org or call your local chapter

Band-aides and Blackboards

lehman.cuny.edu/faculty/jfleitas/bandaides

Cells Alive (instructional site on cells)
cellsalive.com/toc.htm

Children's Brain Tumor Foundation
cbtf.org

CURE Childhood Cancer
curechildhoodcancer.org

Heart Transplant Handbook – Children's Healthcare of Atlanta
choa.org/Menus/Documents/OurServices/HeartTransplantGuide.pdf

Kidney Transplant Handbook – Children's Healthcare of Atlanta
choa.org/Menus/Documents/OurServices/KidneyTransplantManual.pdf

Liver Transplant Guide – Children's Healthcare of Atlanta
choa.org/Menus/Documents/OurServices/LiverTransplantGuide.pdf

National Cancer Institute
cancer.gov/cancertopics/types/childhoodcancers

Camp Information

Camp Sunshine
mycampsunshine.com

Diabetes Type 1 and Type 2

Approximately 18.8 million Americans have diabetes—a condition in which the body is unable to use food properly. When food is digested, it breaks down into a sugar called glucose. Glucose is absorbed into the blood and is carried by the bloodstream to body cells, where it will be used for energy. Glucose requires the assistance of a hormone called "insulin" to enter into the cell. The pancreas, a gland behind the stomach, produces insulin. The production or utilization of insulin is decreased or absent in diabetes. Without sufficient insulin, the body cannot use glucose for energy, and high blood sugars (hyperglycemia) result.

Currently, diabetes cannot be cured, but it can be managed. The goals of diabetes self-management include promoting normal growth and development, maintaining overall health and emotional well-being, and normalizing blood sugar levels.

Two main types of Diabetes

Type 1 Diabetes (insulin dependent)

The pancreas stops producing insulin. Type 1 diabetes requires daily insulin injections for survival. Although type 1 diabetes typically starts in children or young adults (previously known as juvenile-onset diabetes), it can occur at any age.

The cause of type 1 diabetes is not known, but research indicates it may involve a disorder in the functioning of the body's immune system. The immune system protects the body against disease. When this system malfunctions, the body can destroy one of its own parts. This is called an autoimmune response. In type 1 diabetes, the body destroys its own insulin-producing beta cells. Genetics and the environment may also play a part. At this point, type 1 diabetes cannot be prevented and onset is not related to poor diet.

Type 2 Diabetes

In type 2 diabetes, the pancreas still makes insulin, but the body does not use the insulin normally (insulin resistance).This type of diabetes typically develops in adults over 40 years of age, but there is an increasing incidence of newly diagnosed type 2 diabetes in youth in the United States.

Students at greatest risk for developing type 2 diabetes have one or more of these factors:

- Obesity
- Physical inactivity
- Family history of type 2 diabetes
- Exposure to diabetes in utero
- Non-European origin (Hispanic, African-American, Native American)
- Signs of insulin resistance called acanthosis nigricans (dark, velvety patches on the skin around the neck or armpits)

Obesity is a growing epidemic in the school-age population and should be addressed as a public health issue by healthcare providers and school health personnel. "Teaching a healthy lifestyle—one that includes good nutrition and physical activity—can reduce the risk of type 2 diabetes more effectively than medication designed to decrease the risk of diabetes." (from Health in Action: Diabetes and the School Community, a 2002 publication of the American School Health Association)

Schools can focus on:

- Supporting increased physical activity in the school setting and promoting activities which can be maintained throughout the lifespan by individuals.

- Offering healthy food choices in school for breakfast, lunch and vending machines, especially removing sugared soft drinks, sports drinks or vitamin waters with sugar, and containers of juice more than 4-6 ounces.
- Reducing school-based social stigma associated with weight issues.
- Offering health education on health risks associated with obesity and inactivity.
- Encouraging students and families to turn off TV, video and computer games to allow more time for an active lifestyle.
- Offering counseling as needed to address the impact of negative body image, social development and personal health challenges.

Symptoms of Hyperglycemia (High Blood Sugar)

- Frequent Urination
  Decreased insulin production causes the blood sugar (glucose) level to rise (hyperglycemia) and spill into the urine. The glucose pulls body fluid along with it into the urine, resulting in the formation of large volumes of urine and frequent trips to the bathroom. This is the body's way of attempting to remove excess sugar.
- Excessive Thirst
  Due to the body fluid loss caused by frequent urination, the body becomes dehydrated. The brain signals its thirst center for additional fluid.
- Increased Hunger
  Since the body is unable to utilize the glucose circulating in the blood for energy, the brain sends out a signal for more food.
- Weight Loss
  The body, unable to use blood sugar for energy, utilizes stored body fat and muscle, which decreases body weight. As the body uses fat, ketones (a waste product of fat utilization) accumulate in the blood and urine. Ketones cause diabetic ketoacidosis (DKA) a serious condition, which can be life-threatening.
- Fatigue
  The pancreas does not produce enough insulin to allow glucose to be used for energy.
- Blurry Vision
- Dry Skin
- Slow Wound Healing

Managing Diabetes at School

A written Diabetes Management Plan should be provided by the parent and child's healthcare provider for each individual child. It should be reviewed at least quarterly. The diabetes management components outlined here are guidelines only.

It is important to allow the student with diabetes to participate fully in all school and extracurricular activities. Treatment for students diagnosed with type 1 diabetes is primarily insulin. They will need regular monitoring of blood sugar levels, as well as ketone testing when necessary. The only restrictions to diet are usually no sugared drinks or fruit juices, unless treating a low blood sugar. See Diabetes Management Plan for specifics.

Treatment of students diagnosed with type 2 diabetes includes regular monitoring of blood sugar levels, eating reasonably and on schedule, exercising regularly, ketone testing and adjusting diabetes medication as needed. Students can be treated with behavioral lifestyle changes, but they often need oral medications and occasionally insulin.

Students with type 2 diabetes are often on a "fixed carb" diet, where the grams of carbohydrates per meal are specified. They may also have other restrictions for fat or sodium. See Diabetes Management Plan for specifics.

In summary, the management components of type 1 and type 2 diabetes are:

- Blood sugar testing
  Before meals, before and after physical activity, whenever symptoms of high or low blood sugar levels are noted, student is "not acting right" or feels ill. A student will also need to check blood sugar levels before and after PE until a pattern in how their body responds and a plan for adjusting their regimen can be established. This will need to be done in collaboration with their endocrinologist.
- Insulin administration
  According to the Diabetes Management Plan
- Oral diabetes medications
  According to the Diabetes Management Plan (type 2)
- Regularly scheduled meals and snacks
  Allow at least two hours between foods with carbs and the pre-meal blood sugar test.
- Ketone testing
  When blood sugar level is over 300 or student is ill.
- Identifying and quick response to low blood sugar levels
  All school personnel that come in contact with a student who has diabetes need to know signs and symptoms of hypoglycemia and what actions to take.

Nutrition Management

A diet with a variety of nutrient rich foods is recommended for children with diabetes and their families. Following the USDA Dietary Guidelines, below, is one way to meet your nutrient needs:

- Make half of your plate fruits and vegetables
- Enjoy your food, but eat less
- Drink water instead of sugary drinks
- Make at least half of your grains whole grains
- Avoid oversized portions
- Compare sodium in foods and choose foods with lower sodium
- Switch to fat-free or low fat (1%) milk
- Limit solid fats such as butter, margarine, shortening and lard, as well as foods that contain solid fats.
- Find your balance between food and physical activity to maintain a healthy weight.

Balancing children's plates will help them receive the nutrients they need for growth and maintaining optimal blood sugar levels: ¼ with starch or grain; ¼ with lean meat, poultry or fish; ¼ with non-starchy vegetables or salad; ¼ with fruit. These nutrients are carbohydrates, protein, fats, vitamins, minerals and fiber. Three of these nutrients, carbohydrates, proteins and fats, have the greatest impact on blood sugars.

Carbohydrate foods, such as grains, pasta, bread, cereal, starchy vegetables (like potatoes, beans, corn, peas and butternut and acorn squash), fruit, milk, yogurt, snack foods, desserts and sweets raise blood sugar levels, so the child needs to pay attention to how much of these foods they eat. However, carbohydrates also provide energy needed to grow and to do everyday activities, so it is important for children with diabetes to eat foods that contain carbohydrates.

Protein is found in meats, cheese, fish, poultry, eggs and nuts. Protein helps grow and repair body tissue such as muscle and bones, but it does not affect blood sugar levels. Many foods high in protein are also high in fat.

Fats are foods such as margarine, butter, oils, salad dressings, nuts, cheese and meat. Fat does not affect blood sugar levels, but that does not mean a child can eat all they want. Too much fat can cause weight gain and other problems like elevated cholesterol. The healthiest fats are monounsaturated or polyunsaturated fats that protect the heart. Some examples of monounsaturated fats include: canola and olive oils, nuts, avocado and seeds. Examples of polyunsaturated fats include: corn oil, soybean oil and sunflower oils, as well as Omega-3 (fish) oils.

Since carbohydrates affect (raise) blood sugar levels, accurately estimating how much a student eats is a required skill of nurses.

There are two ways to count carbohydrates:

1. Carbohydrate Serving List
2. Reading Food Labels

Carbohydrate Serving List

The school nutrition director or coordinator can provide the school nurse with the nutrition information including the grams of carbohydrates in the individual foods served at their cafeteria.

EXAMPLE OF A CARBOHYDRATE SERVING LIST

Food	kcal	Protein	*CHO	Fat
4 oz. orange juice, Ocean Spray	60	0	15	0
1 sandwich bun, Flowers Foods	120	5	24	1.5
1 slice white bread, Sunbeam	55	2	11	1
Baked french fries, 10 pieces	100	1.5	17	3
1 medium fresh apple	72	0.4	19	0
1 medium fresh orange	62	1	15	0.16
8 oz. 2% milk	130	8	12	5

*CHO = carbohydrates

EXAMPLE OF A SAMPLE SCHOOL LUNCH AND AN ESTIMATE OF THE GRAMS OF CARBOHYDRATES

Food	Grams of carbohydrate
One medium apple	19 grams
Hamburger on bun	24 grams
Lettuce and tomato	do not count-negligible carbohydrate
Baked fries (serving of 10 shoestring fries)	17 grams
Milk, 2%, 1 carton	12 grams
Total CHO	72 grams

Reading Food Labels

Food labels found on containers give the carbohydrate content information listed under the Nutrition Facts. So if a nutrition analysis is not available, but a food label is, the nurse can refer to it.

There are three steps to reading the "Nutrition Facts" on a food label:

1. Determine the serving size of the product.
2. Find the servings per container.
3. Look at the total grams of carbohydrate (in one serving).

Nutrition Facts	
Serving Size 1 Cup (228g)	◀ this serving size is 1 cup
Servings per Container 2	◀ there are 2 servings per container
Amount per Serving	
Calories 260 Calories from Fat 120	% Daily Value
Total Fat 13g	20%
Saturated Fat 5g	25%
Cholesterol 30 mg	10%
Sodium 660 mg	28%
Total Carbohydrate 31g	10% ◀ there are 31 grams carbohydrate for 1 cup
Dietary Fiber 0g	0%
Sugar 5g	
Protein 5g	

The above food label shows that one cup is the serving size and there are 31 grams of total carbohydrate in that amount. If the child chose to eat the entire container (2 servings), the student would have eaten two cups and 62 grams of carbohydrates.

A child's appetite and intake may vary greatly depending on his or her activity level. Therefore, the daily carbohydrate intake can vary as well. School-age children should use their dietitian/healthcare provider's recommended range for grams of carbohydrate per meal. This will allow adequate growth and development.

Other resources for carbohydrate counting include:

Diabetic Exchange List for Meal Planning
mayoclinic.com/health/diabetes-diet/DA00077

CalorieKing
calorieking.com

Nutri-Café
nutri-cafe.com

"The CalorieKing Calorie, Fat & Carbohydrate Counter 2012" Allan Borushek. Hudsonville, Mich: Family Health Publications, 2011.
amazon.com/CalorieKing-Calorie-Carbohydrate-Counter-2012/dp/1930448368

USDA Nutrient Database Web site
ndb.nal.usda.gov

Blood sugar level monitoring

- Target blood sugar levels

  Although it differs among individuals, a general blood sugar target range is 70-150 (may be higher for younger children). Healthcare providers set target ranges. When the blood sugar level is over 180, glucose begins to spill into the urine. When the blood sugar level is greater than 300 or during illness, ketones can accumulate in the blood and urine.

- Procedure

  Testing the blood sugar level provides information needed to continually adjust the management program and prevent complications. Testing is done by obtaining a blood sample by performing a finger stick. A drop of blood is placed on a test strip and read by the blood sugar monitor. Blood sugar monitors and strips require a quality control system to ensure accuracy. It is necessary to test the first strip from each strip container using a control solution. Some monitors also require coding of the monitor with each new vial of strips. Parents are responsible for teaching school personnel the method of quality control. It is also the responsibility of the parent to provide all equipment and supplies.

- When to test

  Testing is usually done before meals, whenever symptoms of hypoglycemia or hyperglycemia occur, and as directed by the physician and/or parent. When children have symptoms of high or low blood sugar, they should always have an adult accompany them to the health clinic who can call for help in case they become sick on the way. It is recommended that monitoring and treatment be completed with as little loss of class time as possible. Treatment of a low blood sugar level requires supervision for all children. Results can be sent home or called to the parent daily or before follow-up appointments are scheduled.

Note: Wherever glucose monitoring or insulin administration is done, there should be provision for disposal of the sharps in an appropriate container.

To minimize learning disruption, blood sugar checks should be allowed in the classroom for students who can demonstrate the ability to check independently. Students who demonstrate accurate technique, appropriate infection control, disposal of sharps, and ability to interpret results and seek appropriate treatment can be considered for self-testing without constant supervision.

To facilitate this, a meeting with the family, classroom teacher, principal and clinic personnel should be held. A letter from the student's physician requesting that this procedure be done in the classroom may be presented at this meeting. It is a good idea for parents to demonstrate monitoring with their child for school personnel. This helps school personnel observe the child's reaction and ability. Most students will need some supervision to ensure upkeep of adequate supplies and compliance with their diabetes management. The pre-lunch blood sugar may be done in the school clinic to facilitate correct lunchtime insulin dose if the child is receiving insulin for carbs eaten and/or for correcting elevated blood sugar levels.

Ketone Monitoring

Urine ketones are usually monitored any time the blood sugar level is over 300 or when a child with diabetes is sick. Testing is done by obtaining a urine sample and using a test strip visually matched with a color guide. In addition to urine samples, there are blood sugar monitors that can test for blood ketones.

Parents need to review the procedure with school personnel and provide the needed supplies:

- When the blood sugar level is over 300 or the student is sick, they will need access to water and sugar free fluids.
- Students with trace or small ketones should be allowed to stay in class.
- Ketone testing should be repeated in three to four hours.
- Moderate to large ketones results should be called immediately to parents first and doctor if parents cannot be reached.
- If ketones are positive, the student should not participate in PE or other physical activity.

Exercise

Regular exercise is important. Children will need to check their blood sugar levels and may need a carbohydrate snack before and/or after exercising. Refer to student's health care plan for specifics on blood sugar testing and snacks with exercise.

Insulin

There are four types of insulin:

1. Rapid acting insulin (Humalog®, Novolog®, Apidra®)
- Used to help move glucose into the cells after eating
- Used to fix high blood sugars
- Usually given with meals or right before

2. Short acting insulin (Regular)
- Used to help move glucose into the cells after eating
- Used to fix a high blood sugar
- Less expensive alternative to rapid acting insulins
- Usually taken 30 minutes prior to meals

3. Intermediate acting insulin (NPH, 70/30, 75/25)
- Usually taken twice a day, at breakfast and dinner
- A "cloudy" insulin that can be mixed with a clear fast-acting insulin
- Because the peak action is delayed, regular timing of meals and snacks is important when using intermediate acting insulin.
- Usually used in combination with a rapid acting insulin

NOTE: Intermediate acting insulins also require a consistent amount of carbohydrates be eaten at meals and snacks. Students on this insulin regimen may not "skip" lunch, or they will be at risk for severe low blood sugar levels. They may only need rapid acting insulin to correct a high blood sugar level at lunch. If blood sugar level is in range, the student will not need an insulin injection with lunch.

4. Long acting insulin (Lantus®, Levemir®)
- Is usually given once a day
- Is considered a "peakless" insulin
- Cannot be mixed in a syringe with other insulins

Insulin	Begins Working	Peaks At	Stops
Novolog®, Humalog®, Apidra®	5 - 15 minutes	30 - 90 minutes	3 - 4 hours
Regular	30 - 60 minutes	2 - 4 hours	6 hours
Lantus®, Levemir®	1 - 3 hours	almost or no peak	18 - 26 hours
NPH, 70/30, 75/25*	30 - 60 minutes	1 hour, 6 - 8 hours*	1 hour, 6 - 8 hours*

*70/30 and 75/25 have two "peaks" of insulin action.

Note: Different types of insulin have different peak action times which may dictate timing of insulin and meals. It is ideal to give rapid acting insulin right before meals so that its action is peaking simultaneously with food digestion.

Insulin administration

Insulin is usually given in two to six injections per day, prior to breakfast, lunch, dinner, snacks and sometimes bedtime. At times, insulin may not be required prior to lunch and snacks. Refer to student's Diabetes Management Plan for specific instructions on insulin administration.

Insulin may be given with a pre loaded insulin pen, with the dose "dialed" in, or with a regular syringe. Insulin may also be administered continuously by the use of a battery-operated portable infusion pump. See Medication Administration, Chapter 3.

Insulin storage and expiration

After opening, insulin generally may be stored 30 days at room temperature, or under refrigeration. Label insulin vials with the date it will expire. Expiration dates need to be checked regularly. If allowed to reach 85 degrees or higher, insulin should be considered as spoiled and replaced.

Insulin dosing

Dosing insulin is different for each student. Based on the type of insulin that is prescribed, students will have different dosing schedules. The students' diet is determined by their insulin regimen. Some students may have a set or "fixed" number of carbohydrates allowed for each meal, and others may have a flexible number of carbohydrates allowed at meals.

For instance, a student using intermediate and rapid acting insulins, will take intermediate acting insulin at breakfast and dinner that will provide coverage for the food that is eaten at meals and snacks. These students are usually on a "fixed" carbohydrate diet, meaning they should only eat the number of carbohydrates at meals and snacks that is in their carbohydrate range (for example: 60-75 grams of carbohydrates at lunch). These students will also require rapid-acting insulin for correcting a high blood sugar level at meals.

A student using rapid and long acting insulins will take rapid acting insulin at each meal based on the number of carbohydrates eaten (flexible) and for correcting a high blood sugar level. These students do not have a limit on the number of carbohydrates allowed because they take insulin based on advanced carbohydrate counting. Meals and snacks should be scheduled at least two hours apart.

Students will require insulin at meals and snacks as directed by the Diabetes Management Plan.

Insulin for food

Advanced carbohydrate counting is a method used to dose rapid acting insulin based on the amount of carbohydrates eaten at a meal or snack. Students that require advanced carbohydrate counting methods are those that are on a pump (it uses rapid acting insulin) and those that take both rapid and long acting insulins. Students that take intermediate acting insulin do not require advanced carbohydrate counting insulin dosing. If short acting insulin is prescribed, see Diabetes Management Plan in regards to advanced carbohydrate counting.

First, the student/nurse will determine what food items will be eaten and what the carbohydrate content of each food is by referring to the school cafeteria nutrition analysis or food labels. Once the "total carbohydrates" in the meal or snack have been determined, the nurse will divide this total by the insulin-to-carbohydrate ratio prescribed by the physician. For example, a ratio of 1:15 means for every 15 grams of carbohydrates eaten, the student will receive 1 unit of rapid acting insulin.

Example:

1 wheat bagel =	38 grams
2 tbsp. cream cheese =	0 grams
Crystal Light =	0 grams
4 oz. apple =	15 grams
---	---
Total carbs (grams) =	53 grams

Insulin: Carbohydrate ratio = 1:15 (1 unit per 15 grams carbohydrates)

If your meal has 53 grams of carbohydrates, then 53 ÷15 = 3.5 units of rapid acting insulin such as Humalog® or Novolog® (doctors usually advise to round up dosages that end in a 0.5 decimal point or higher, upward to the nearest whole).

Insulin for high blood sugar levels

THE CORRECTION FORMULA

A doctor monitoring a diabetes patient will prescribe a number called the "correction factor" to correct a high blood sugar. It is usually a number such as 20, 25, 30, 50 or 100. When using the correction formula, the student and nurse will subtract 100 (or another number assigned by the doctor) from their current blood sugar level. Then the difference is divided by the correction factor assigned to them.

For example, if the student's pre-meal blood sugar level is 200 and their correction factor is 20, he would take five units of insulin (in addition to the insulin for the carbohydrates eaten if practicing advanced carbohydrate counting) to bring his blood sugar level back down to his target:

$$\frac{\text{Student's blood sugar level} - 100}{\text{Correction Factor}} \qquad 200 - 100 = \frac{100}{20} = 5 \text{ units of insulin}$$

THE SLIDING SCALE FORMULA

Some physicians prefer to prescribe this method to manage a student's high blood sugar level instead of using a correction factor. The sliding scale formula is based on blood sugar ranges.

If your blood sugar level is between:	You will take this many units:
200 – 299	4 units
300 – 399	6 units
Over 400	8 units

For example, if your blood sugar level is 200, you would take four units of rapid acting insulin.

For students that require advanced carbohydrate counting, insulin for high blood sugar levels is given in addition to the required units needed for the total carbohydrates at meals. Corrections to high blood sugar levels should be performed no more than every four hours unless otherwise directed in the Diabetes Management Plan.

Note: Before any medications are administered, be certain that the required Medication Authorization Form with required signature is on file stating the type of medication, dosage and time it is to be given (according to school policy). Be sure to document on the clinic record and student medication record, information concerning precipitating factors and/or complications, medications administered and reaction.

Insulin pumps in a school setting

Continuous Subcutaneous Insulin Infusion (CSII) also known as Insulin Pump Therapy is an alternative method of insulin delivery. The goal of insulin pump therapy is to mimic what normally happens physiologically in the body. The pump, a microcomputer, is about the size and weight of a pager and uses batteries. It is worn outside the body. It holds a reservoir of insulin inside the pump and is programmed to deliver the insulin through a small plastic catheter or cannula. The cannula is inserted into the subcutaneous fat and stays in place for two to three days.

How the pump works

The pump uses only rapid acting insulin. Insulin pumps combine a continuous basal rate of insulin with insulin boluses given at meals, snacks and at times of increased blood sugar levels.

Basal insulin – Basal insulin is a continual dose of insulin that the body requires. The basal rate is given 24 hours a day and is programmed as units per hour. Basal rates are programmed by the child's doctor, parent or even the student himself depending on his age. The basal rate also can be changed temporarily for alterations in schedule, activity, illness or food.

Bolus Insulin – The pancreas releases insulin when higher blood sugar levels are sensed such as after meals or during times of illness. An insulin pump mimics this release when the user programs a bolus dose at meals, snacks or other times that insulin may be needed. Each child wearing an insulin pump should have a plan that determines how much insulin he should take for the amount of food that is being eaten, high blood sugar and planning for exercise. Most pumps, now called "smart pumps," allow the insulin to carbohydrate ratios and correction formulas to be pre-programmed into them.

Teenagers using an insulin pump should be well educated in its use and about diabetes. Younger children with a pump will require more assistance.

Troubleshooting the insulin pump

The following companies make or sell insulin pumps in the United States:

- Animas® Corporation 1-877-767-7373
- Medtronic MiniMed Paradigm® 1-800-826-2099
- OmniPod® (Insulet) 1-800-591-3455
- Roche ACCU-CHEK® Spirit (formerly Disetronic) 1-800-688-4578

The child's parents should instruct the school staff on programming the pump and what to do if any alarms should occur. If the parent cannot be reached at the time a problem arises or a trained staff member is not available, school staff can call the 800 number on the back of the pump designated as the "24-Hour Pump HelpLine." This number directs the caller to trained professionals who can answer any questions about the pump. A student can rapidly deteriorate if a pump malfunctions. There should be no delay in dealing with this situation.

Every student wearing an insulin pump at school should have a supplement to their Diabetes Management Plan that addresses the management of the Insulin Pump (see Diabetes Management Plan at the end of this section).

Stress Management

Stress, good or bad, may increase blood sugar levels. Other factors that increase blood sugar levels are growth, hormones and illness. Sometimes there is no identifiable reason for a high blood sugar level. It is important to refrain from showing a negative reaction to a high blood sugar level.

Complications and Treatment

Of utmost importance to school personnel is the ability to recognize the two most serious emergencies for diabetic children: low blood sugar level (insulin reaction or hypoglycemia) and high blood sugar level with moderate to large ketones (diabetic ketoacidosis). It is necessary to distinguish between the two because each condition requires completely different, but immediate actions. Always treat for low blood sugar levels if unable to distinguish between the two. The target blood sugar level is individualized; children generally are treated when the blood sugar level is below 70 or 80 or if they are symptomatic.

Treatment of high and low blood sugar levels is addressed in the student's Diabetes Management Plan. See also the Hypoglycemia and Hyperglycemia chart at the end of this Diabetes section.

Educational Considerations

Communicating with parents through an annual conference at the beginning of the school year is usually necessary to formulate or review the student's Diabetes Management Plan. This plan should include:

- Meal plan, snacks, eating lunch at an appropriate time with enough time to finish eating
- Current medications/formulas for dosing, assistance as needed/appropriate for age
- Blood sugar level monitoring schedule
- Access to water and bathroom privileges as needed
- Exercise management
- Stress management (testing accommodations, etc.)
- Participating fully in all school and extracurricular activities, planning for field trips
- Accommodations related to absences for medical visits and illness
- Emergency care plan that includes:
  - recognizing symptoms and treatment of low blood sugars, including the administration of glucagon if authorized
  - recognizing symptoms and treatment of high blood sugars
  - checking for ketones when the blood sugar level is over 300 or if the student is sick
  - ensuring insulin and medication supplies and supplies to treat low blood sugars including glucagon is on hand in case of an emergency evacuation.

Ongoing dialogue is needed as changes occur in lunch schedules or PE activity/schedules. Ideally, all school personnel (including the bus driver) involved with the student should receive diabetes education annually from the school nurse.

Other matters that can benefit from education and awareness

Parties

Notify parents ahead of time in order for them to decide if the child may eat the same food or if an alternative should be provided.

Field Trips

Trips may change meal times, which can affect blood sugar levels. Notify parents of changes so they can decide if an additional snack is needed and determine the timing of that snack.

Psychological Issues

School personnel's awareness of the possible impact of diabetes on personality development is essential. Children with diabetes should be perceived as normal and fully able to participate in all school activities. Both factors are critical for developing and maintaining self-esteem and peer acceptance. At the elementary level, at student and parent request, classmates may be oriented to diabetes and reassured that diabetes is not contagious.

At the middle and high school levels, teenagers are sometimes less comfortable disclosing a chronic disease for fear of being perceived as being different than their peers.

Manipulation

When a student's frequent requests for food or bathroom trips are questioned, blood sugar testing will usually resolve the issue. High blood sugar levels will increase the frequency of urination. They may need to urinate several times in an hour.

School Protocols

Refer to individual school protocols for the administration of medication and standard precautions. Remember that syringes and lancets for blood sugar testing require proper disposal in an approved sharps container. Gloves should be worn when assisting a child with blood sugar or ketone monitoring.

Resources

American Diabetes Association – Georgia Affiliate, Inc.

404-320-7100

diabetes.org

Children with Diabetes – Diabetes at School

childrenwithdiabetes.com/d_0q_000.htm

Children with Diabetes: a resource guide for families and schools – New York State Department of Health

health.state.ny.us/publications/0944.pdf

Diabetes Association of Atlanta

diabetesatlanta.org

Diabetes Care Tasks at School: What Key Personnel Need to Know

diabetes.org/living-with-diabetes/parents-and-kids/diabetes-care-at-school/school-staff-trainings/diabetes-care-tasks.html

Diabetes Center – Children's Healthcare of Atlanta (See Diabetes Education Handbook)

choa.org/Childrens-Hospital-Services/Diabetes/Diabetes-Resources

Dial Program, Diabetes Information Action Line

1-800-DIABETES

Georgia Affiliate Juvenile Diabetes Research Foundation

jdrfgeorgia.org

Helping the Student with Diabetes Succeed: A Guide for School Personnel; A Joint Program of the National Institutes of Health and the Centers for Disease Control and Prevention, September 2010

ndep.nih.gov/media/NDEP61_SchoolGuide_4c_508.pdf

Juvenile Diabetes Research Foundation International

jdrf.org

Managing Diabetes at School 2006 – Vermont Department of Health
healthvermont.gov/prevent/diabetes/school_diabetes.aspx

PADRE Foundation (Pediatric Adolescent Diabetes Research Education)
padrefoundation.org

School Advisory Toolkit
typeonenation.org/resources/type-1-toolkits

Publications

Countdown, quarterly magazine
1-800-JDF-CURE (Subscription rates subject to change)

Diabetes Forecast, monthly magazine
1-800-DIABETES (Subscription rates subject to change)

Pumper in the School. Fredrickson, Linda, RN, MA, CDE, Graff, Marilyn R., RN, BSN, CDE. Sylmar, Calif.: MiniMed Inc, 2000.

Taking Diabetes to School. Gosselin, Kim. St. Louis, Mo.: Jayjo Books, 2nd ed., 1998. ISBN: 1891383000 (A book to read to classmates).

The Complete Guide to Carb Counting. Warshaw, Hope S. and Kulkami, Karmen. New York: McGraw Hill Professional Publishing, 2001; ISBN: 1580400469.

Camp Information
Camp Kudzu
campkudzu.org

SCHOOL SUPPLY BOX

It is recommended that a diabetes supply/emergency kit be brought to school and maintained weekly by family:

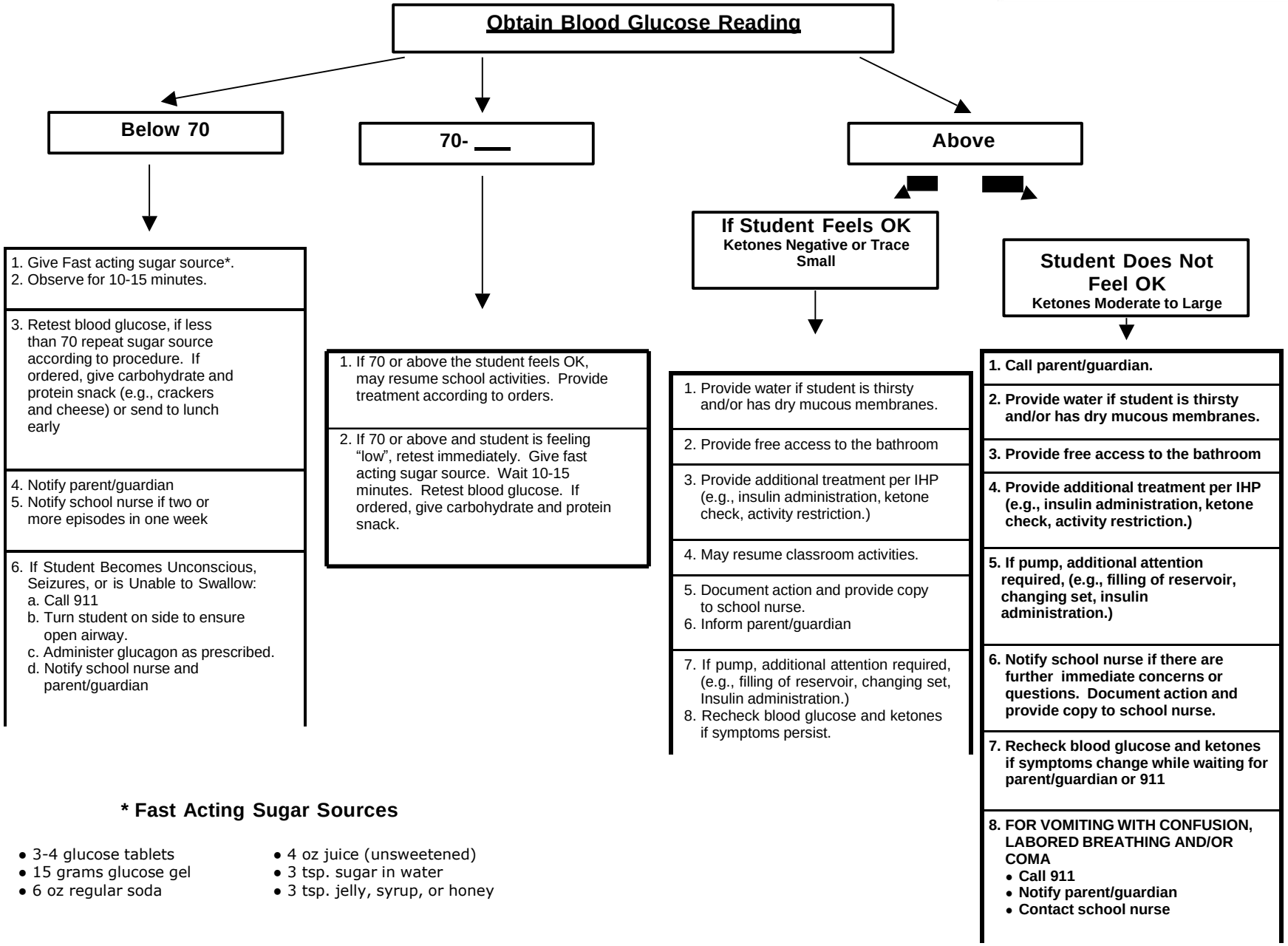
- Insulin, syringes and alcohol swabs
- Blood glucose monitor, test strips, lancet device and lancets
- Ketone strips
- Other medication taken on a regular basis
- Fast acting and slow acting carbohydrate foods for treatment of low blood sugar (non-perishable emergency snacks)
- Glucose tablets
- Glucose gel in case of a minor emergency
- Glucagon Kit (If school will allow someone to be trained on the use of glucagon. Some schools will only allow a RN to administer glucagon.) Be sure to include directions for use and dose.
- Logbook
- List of emergency contact numbers
- _____
- _____
- _____
- _____
- _____

**Communicate with your school nurse weekly. Supplies may need to be restocked. Remember to run controls on your blood sugar meter periodically and to check for expiration dates on supplies including insulin, ketone strips and Glucagon Kit.

Diabetes Checklist for School Nurses

- Arrange meeting between nurse, parent(s)/guardian and student, if appropriate.
- Discuss parent expectations of diabetes care while at school.
- Discuss school's policies, nurse staffing, expectations of parents.
- Determine equipment and supplies needed (including hypoglycemia treatment supplies, ketone sticks, sharps container, blood sugar meter and strips) and where supplies will be kept (hypoglycemia supplies may be kept in multiple locations for easy access).
- Discuss plans for communication of daily levels/issues.
- Have parents sign release of information form and other forms as needed/obtain school care plan from healthcare provider.
- Review school day schedule and assess student's level of independence.
- Identify potential issues requiring accommodations.
- Clarify specifics of treatment plan.
- Arrange meeting with appropriate educational team members.
- Provide education and training as necessary for other staff members.
- Provide classroom education if requested by parent or child.
- Possible accommodation issues:
  - blood sugar monitoring: when, where, who, what to do with results
  - recognition and management of low blood sugar levels (including someone to accompany student if symptomatic)
  - recognition and management of high blood sugar levels
  - insulin injections: who, where, when and how to communicate with parents
  - meals and snacks: timing, monitoring, carb counting, menu selection, special occasions (parties, field trips)
  - access to drinking water/ bathroom privileges
  - transportation issues
  - after school activities, field trips, etc.
  - plan for school absences/ make-up work.
- Review the Diabetes Management Plan at least annually or when changes occur. Revise as needed.
- _____
- _____
- _____
- _____
- _____

H.A.N.D.S.SM
HELPING ADMINISTER TO THE NEEDS OF THE STUDENT WITH DIABETES IN SCHOOL



*** Fast Acting Sugar Sources**

- 3-4 glucose tablets
- 15 grams glucose gel
- 6 oz regular soda
- 4 oz juice (unsweetened)
- 3 tsp. sugar in water
- 3 tsp. jelly, syrup, or honey

Adapted with permission from National Association of School Nurses, 2011

PROCEDURE FOR BLOOD GLUCOSE MONITORING

Equipment and Supplies	• Alcohol prep pad (optional) • Finger lancing device • Blood glucose meter • Blood testing strips for specific meter • Tissue or cotton balls • Gloves • Sharps container

Essential Steps	Key Points & Precautions
1. Wash hands and area to be tested with soap and water. Put on gloves. Student's hands must be washed as well. This is sufficient for prepping the site; however, alcohol may be used if soap and water are not available. (The site selected must be dry before pricking.)	Alcohol may cause toughening of the skin or burning sensation. If moisture (water or alcohol) remains on the skin it may alter test results.
2. Place glucose test strip into meter according to manufacturer's instructions. Verify correct code for strip.	
3. Prepare lancing device according to manufacturer's instructions.	
4. Select a site. If using finger, use the sides of fingertips. Hang the arm below the level of the heart for 30 seconds to increase blood flow.	The tips and pads of the fingertips are more sensitive. The sides of the fingers should be used. Other sites can be used such as the forearm if approved by manufacturer, but should not be used if suspected hypoglycemia.
5. Puncture the site with the lancing device. Gently squeeze the finger so that blood can be absorbed into test strip with wicking motion.	
6. Place blood on test strip and complete instructions according to manufacturer's instructions.	
7. Dispose of test strip and tissue or cotton ball in lined wastebasket. Dispose of lancet in Sharps container.	Compress lanced area with tissue or cotton ball until bleeding stops.
8. Remove and dispose of gloves, wash hands.	
9. Record results per school policy.	Refer to student's IHP for management of blood glucose results.

Adapted with permission from National Association of School Nurses, 2011

Diabetes Checklist for Teachers

- Participate in the healthcare planning meeting and training.
- Understand basic information about diabetes:
  - signs and symptoms of low and high blood sugar levels
  - how to treat low and high blood sugar levels
  - food and snack requirements and routines/importance of timing
  - daily blood sugar level monitoring
  - respect for privacy
  - safety procedures
  - communication with school nurse, parents and other students
- _____
- _____
- _____
- _____
- _____

Hypoglycemia

Causes
Too much insulin
Not enough food
Increased physical activity
Late or skipped meals (if on NPH, Novolog 70/30 or Humalolg 75/25)

Do not leave student alone
Do not allow the student to return to class until blood sugar is greater than 70/80.
Notify parents of low blood sugar.

Symptoms	
Sweating	Slurred speech
Shaky	Pale
Headache	Clammy skin
Hunger	Confusion
Irritable	Blurry vision
Weakness or Fatigue, Sleepy	Change in behavior
Anxious	Fast heartbeat
Numb lip/tongue	Dizzy
Poor coordination	Poor concentration

Severe Symptoms - Call 911
Unconscious
Unable to swallow
Combative
Seizure

Treatment - Check blood sugar level
Treat if blood sugar is below 70/80 or symptoms of low blood sugar are present as outlined in students' Diabetes Management Plan.
If the student does not have a plan or supplies and the student is having symptoms – TREAT AS OUTLINED BELOW
If student is able to swallow, give 15 grams of fast-acting carbohydrates such as 3-4 glucose tablets, 4 oz. fruit juice or regular (not diet) soda, or 3 packets (teaspoons) of sugar. If unable to take glucose tablets, juice, soda, or sugar, treat with 15 grams of glucose gel by placing small amounts of glucose gel into the student's mouth, allowing the mucous membranes to absorb the sugar, as quickly as possible, until all 15 grams have been given.
Recheck blood sugar in 10-15 minutes. If blood sugar level is not greater than 70/80, give another 15 grams of fast-acting carbohydrates. Then recheck blood sugar in 10-15 minutes. Repeat this three times. Notify the parent and/or doctor if it does not resolve after three attempts. Continue to treat with 15 grams of fast-acting carbohydrates and recheck blood sugar every 10-15 minutes until the parent/doctor returns the call.
Be prepared to give glucagon* and call 911 if student is not responsive, seizing or if their condition deteriorates.

Once the blood sugar is above 70/80
If the student is on intermediate acting insulin (ex: Novolog 70/30 or Humalog 75/25), after the above treatment follow with a snack like cheese and crackers or half of a sandwich.
If the student takes rapid acting insulin (Novolog or Humalog) at meals and snacks and they will not be having a meal or snack within the next hour, follow the treatment for a low blood sugar with a small snack (15 grams of slow-acting carbohydrates such as crackers and peanut butter or half a sandwich).
If student is taking insulin using an insulin pump, follow Diabetes Management Plan for specific instructions on managing the pump.

* Glucagon Emergency Kit
If a severe low occurs (loss of consciousness, seizures or inability to safely eat or drink), Glucagon** should be administered if authorized by the Diabetes Management Plan.
A glucagon injection may be given for severe low blood sugars (unconsciousness, unresponsiveness, seizures or the inability to safely eat or drink). Refer to package insert and the Diabetes Management Plan for use and dose.
**Glucagon is a naturally occurring hormone made in the pancreas. It raises blood sugar levels by stimulating the liver to release stored glucose.

Hyperglycemia

Causes
Not enough insulin
Missed doses
Too much food (carbohydrates)
Infection, fever, illness
Stress
Growth and/or hormonal changes
Spoiled or expired insulin (most insulin expires a month after opening)

Do not leave student alone
Extra insulin may be needed.
Follow instructions on Diabetes Management Plan.
When blood sugar level is high, students may need more frequent bathroom breaks and free access to water or sugar free fluids (if fully conscious and not vomiting).

Symptoms	
Emotional stress	Poor Concentration
Blurry vision	Dry skin
Thirst	Face flushed
Dry mouth	Nausea
Frequent urination	Lethargic
Hunger	Sweet and fruity breath odor
Drowsiness / Sleepy	

Severe Symptoms – Call 911
Labored breathing
Confusion
Decreased consciousness - monitor airway

Treatment - Check blood sugar level
If blood sugar is greater than 300, check for ketones:
• If ketones are trace to small, encourage the student to drink water and recheck in 3-4 hours.
• If ketones are moderate to large, call the parent as the student needs medical attention. – Call the doctor if parent cannot be reached.
• If any ketones are present, students should refrain from any physical activity
• Notify the parent if hyperglycemia does not respond to treatment as outlined in Diabetes Management Plan.

If student is taking insulin using an insulin pump, follow Diabetes Management Plan carefully.
One should always suspect that the pump/tubing may not be working correctly:
• Check site and have student change site, tubing and reservoir using new vial of insulin if there is any leaking, redness, tenderness or the cannula is dislodged.
• Check for ketones if blood sugar level is over 250.
IF NO ketones or ketones are TRACE to SMALL:
• Bolus with pump ONE TIME per school plan.
• Recheck blood sugar level in one hour; if blood sugars have not decreased, give a second bolus by INJECTION of FAST-ACTING INSULIN using a SYRINGE per Diabetes Management Plan.
• Change the site, tubing and reservoir of the pump using a new vial of insulin to refill the reservoir.
IF ketones are MODERATE to LARGE:
• Call the parent.
• Give a bolus by INJECTION of FAST ACTING INSULIN using a syringe per Diabetes Management Plan.
• Change the site, tubing and reservoir of the pump using a new vial of insulin to refill the reservoir.
• Offer sugar-free liquids every 30 minutes until parent arrives.

HYPOGLYCEMIA FACT SHEET

A. Hypoglycemia is a potential medical emergency at school.

B. Hypoglycemia means the student's blood glucose is below normal. The exact blood glucose number, and when and how to treat a student's low blood glucose will be in the student's Emergency Care Plan (ECP) and/or Individualized Healthcare Plan (IHP), and explained to you by the school nurse.

C. Causes of hypoglycemia include:
- Getting too much insulin
- Not eating enough food
- Meals or snacks that are missed, off schedule or delayed
- Increased amounts of exercising without eating extra food
- Illnesses that causes a lack of appetite or vomiting
- Taking certain medications
- Drinking alcohol, which may be a concern with adolescents

D. Signs of hypoglycemia will depend on the student and how low the blood glucose is. The school nurse will explain signs unique to each student. In general, signs of hypoglycemia include:
- None at all – this can happen with a student who has become used to having episodes of low blood glucose. A reading from a blood glucose monitor may be the only indication that the student has hypoglycemia.
- Headache
- Sweating
- Shaking
- Change in behavior – including irritability, confusion, slurred speech, combativeness, uncooperativeness
- Decreased ability to concentrate and do school work
- Seizures
- Passing out

E. Treatment of hypoglycemia will be outlined on the student's ECP and/or IHP and explained by the school nurse. In general, plan on:
- Taking prompt action
- Allowing the student to eat foods that provide quick sugar such as fruit juice, sugared soda, or candy. The food options and exact amount will be outlined in the student's ECP and/or IHP and explained by the school nurse.
- Allowing the student to use a blood sugar monitor to test his/her blood.

F. Never allow a student to walk alone to the health office check if you suspect hypoglycemia!

G. With severe hypoglycemia the student may become unconscious or have seizures. This is an emergency medical situation.
- Call 911.
- If a student is unconscious, never give them something to eat or drink.
- Give Glucagon, if ordered on the Diabetes Medical Management Plan (DMMP) and you have been trained.
- If a student is having a seizure, protect them from injury & keep them on their side.
- Follow instructions previously given by the school nurse on what to do next.

H. Prevention is key. Allow the student with diabetes to follow his/her diabetes management plan at school as described by the school nurse.

I. Other: _____

Adapted with permission from National Association of School Nurses, 2011

Eczema

Eczema is a form of dermatitis or inflammation of the upper layer of the skin called epidermis. The term eczema is applied to a range of persistent skin conditions which include dryness, recurring skin rashes, itching, redness, skin swelling, flaking, blistering, cracking, oozing or bleeding.

One type of eczema, atopic dermatitis, is a chronic, inflammatory skin condition that begins in early childhood due to a skin barrier defect. Atopic dermatitis affects about 10-15 percent of the population and is becoming more common for reasons that are not well understood. It affects up to 20 percent of children worldwide. Children with atopic dermatitis often have a family or personal history of asthma and hay fever. Atopic dermatitis is not contagious to others, but it is often runs in families. However, the psychological impact of this disease is significant, especially feelings of embarrassment.

Itch is the main clinical feature of eczema and can cause sleep disturbance and stress for the student and their family. Sleep disruption is common (80 percent), and 60 percent report the condition affecting their daily activities. Although there is no cure, most students can expect to gain good control of their eczema through proper management with support from their parent/ caregiver, schools and community.

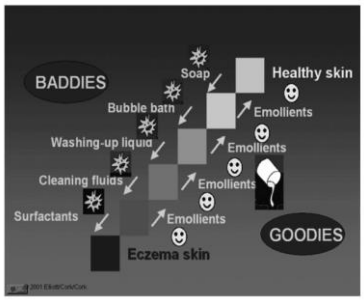
Types of Eczema	Symptoms
Atopic eczema or atopic dermatitis	Hereditary component; particularly noticeable on the face, scalp, neck, inside of elbows, behind knees, flexural area of the arms and buttocks, and starts before the age of two.
Contact dermatitis	Allergy resulting from a direct reaction to nickel or poison ivy or other topical agents.
Seborrheic dermatitis	Causes dry or greasy scaling of the scalp (dandruff or cradle cap), eyebrows, inside of ears, behind the ears, sides of nose, mid-chest, axilla or suprapubic region.
Dyshidrotic hand/foot eczema	Only occurs on the palms, soles, sides of fingers or toes; tiny bumps or vesicles appear on the affected areas; this type of eczema is extremely itchy.
Nummular eczema	Characterized by round spots that are dry, scaly, red, flaking and sometimes cracking, oozing, or bleeding; can often be confused with fungal infections.
Eczema herpeticum	Herpes infection of the skin in children with eczema.
Perioral dermatitis	This skin condition is common and is really an acne/rosacea type eruption. It responds well to both topical and systemic antibiotics. Topical steroids are not an effective treatment because rash returns often worse than before when the topical steroid is discontinued.

Diagnosis of Eczema

The diagnosis of eczema/atopic dermatitis is largely done on the basis of history and physical examination. To specifically diagnose a rash as atopic dermatitis, at least three major features and three minor features should be present. (See chart below):

Major Features
Itching (that can be severe at times)
Chronic and recurring (repeatedly occurring symptoms)
Typical distribution of the atopic dermatitis rash: • Infants and young children – scalp, face (chin and cheeks) and extensor surfaces of extremities • Older children and adults – flexor surface of elbow and knee (inside creases), neck, wrist and ankles
Past/Family history of atopic diseases like asthma, rhinitis (hay fever), etc.
Minor Features
Dryness of skin
Thickening of palm skin with increase in skin lines
Small and pointed rough bumps
Elevated serum IgE (Immunoglobulin E) levels
Facial pallor (around the mouth)
Food intolerance often wheat, eggs, peanuts
Impaired immunity (trouble fighting infection)
Eyes: cataracts, cone-shaped cornea (keratoconus), prominent skin folds below the eyes (Morgan Dennie lines)

Prevention of Eczema



Eczema outbreaks can usually be minimized with some simple precautions. The following suggestions may help to reduce the severity and frequency of flare-ups:

- Moisturize frequently (emollients such as petrolatum are best). Avoid scented lotions.
- Avoid sudden changes in temperature or humidity.
- Avoid sweating or overheating.
- Reduce stress.
- Avoid scratchy materials (e.g., wool or synthetics, just use cotton).
- Avoid harsh soaps, detergents and solvents.
- Avoid environmental factors that trigger allergies (e.g., pollens, molds, mites and animal dander).
- Be aware of any foods that may cause an outbreak and avoid those foods.

Eczema and Skin Cleansers

Recommendations in choosing soap generally include:

- Avoid harsh detergents or drying soaps
  - Use Cetaphil® or CeraVe™ or Dove®.
- Patch test your soap choice, by using it only on a small area until you are sure of its results.
- Use non-soap based cleanser – Cetaphil®.
- Instructions for using soap:
  - Use soap sparingly.
  - Avoid using washcloths, sponges or loofahs, or anything that will abrade the skin.
  - Use soap only on areas where it is necessary – intertriginous areas.
  - Soap up only at the very end of the bath.
  - Use a fragrance-free barrier-type moisturizer such as petroleum jelly before drying off—other moisturizers include Aquaphor®, Eucerin®, CeraVe™, Cetaphil®, Aveeno®, Cutemol®
  - Use care when selecting lotion, soap or perfumes to avoid possible allergens.

Treatment

Treatment focuses on reducing inflammation and associated skin abnormalities such as itch, dryness, heat, redness and secondary infection. Secondary infection can present as broken, bleeding or oozing skin. Parents and patients should be educated about the chronic nature of the disease and the need for continued adherence to proper skin care. There is no cure for atopic dermatitis but often the condition improves with age.

Treatment	
Bathing and Moisturizers	Reasonable recommendation for bathing is once daily with warm water for approximately 5-10 minutes; cleansers should be mild; immediately after bathing and before the skin is completely dry, patients/parents should apply a moisturizer liberally; ointments are superior to creams and lotions, but they are greasy and therefore poorly tolerated; creams are effective and better tolerated than ointments; lotions are the least effective.
Antihistamines	Pruritus (itch) that is refractory to moisturizers and conservative treatment can be treated with antihistamines. The sedating agents such as hydroxyzine and diphenhydramine are more effective in controlling pruritus than the newer non-sedating histamines—Claritin®, Clarinex®, XYZAL®, Zyrtec®.
Antibiotics	Antibiotics should be used to treat secondary bacterial infections. If skin infections are not treated, the eczema will not improve.
Corticosteroids	Systemic corticosteroids should be avoided and only sparingly used in patients with severe treatment-resistant disease. Topical corticosteroids are effective in patients with eczema, but therapy with these agents should not replace the frequent use of moisturizers. Local side effects of topical steroids include skin atrophy (thinning), striae (stretch marks), telangiectasias, hypopigmentation, rosacea, perioral dermatitis and acne. Systemic side effects from topical steroids include adrenal suppression, cataracts, glaucoma and growth retardation in children. The greatest penetration occurs with topical steroid use in the groin and face application on the palms and soles.
Immunomodulators	Topical immunomodulators like Elidel® and Protopic® can be very effective in treating eczema and atopic dermatitis and do not have the side effects of topical steroids. The US Food and Drug Administration has issued a public health advisory about the possible risk of lymph node or skin cancer from use of these products, but many professional medical organizations disagree with the FDA's black box warning because the FDA used data from monkeys force-fed with immunomodulators and extremely large doses.

Management at School

The difficulties faced by children with eczema at school are often underestimated. Problems include time away from school, impaired performance because of disturbed sleep at night, social restrictions, teasing and bullying. Eczema can also cause practical problems relating to handwashing, writing, physical education and swimming. Some children may need to bring milder soaps to wash hands (avoiding harsh antibacterial soaps) and apply emollients and topical medications while at school. Other children may require additional treatment with dressings or bandages. Application of these dressings should be done at home, but school staff should be aware and support children, helping them to overcome feelings of embarrassment. Children with severe eczema may be regarded as having special educational needs if the condition affects their education.

Students with eczema may present with behaviors and characteristics that impact their education and social well-being. Students may benefit from assistance and support with additional issues. These may include:

- fatigue
- poor concentration
- body image
- self-esteem
- social connectedness
- attendance.

Communication

School nurses play a key role in communicating between the child, the family and the school and in educating school staff about eczema and its effects.

The school, health professionals, family and student should work together to ensure comfort with the provision of information to school and peers, as well as discuss other related health concerns such as dietary requirements and allergies if relevant. Parents should take the time to fully explain their child's eczema problem to administrators and classroom teachers. Eczema is not just a rash, and symptoms should be taken seriously by educators. Establish a key contact person with whom the family and student can communicate with regard to eczema and school issues such as the school nurse and/or clinic aide.

Stress or Anxiety

Stress or anxiety can cause flare-ups in children with eczema. Schools are encouraged to explore support mechanisms available to students with a chronic health condition, as required. There should be a key contact person who can monitor, explore and assist with stress-related issues. School-related stress can be a major source of anxiety for students, from fears of other students' comments about the rash or the scabbing that goes with it, to dealing with the general discomfort of the condition. Parents and educators should work together to reduce a student's stress and to ease any concerns that could contribute to flare-ups.

Environment

- Sit on a chair rather than the carpet.
- Children should wear 100 percent cotton clothing and loose cotton clothes where possible.
- Put a cotton cloth or towel over plastic chairs before sitting.

Medications and Other Related Medical Issues

- Lack of moisture is a major symptom of eczema. Be sure the student has constant access to his or her emollients for immediate relief of itchy, dry skin that can cause bouts of scratching and interfere with concentration. Pump action dispensers for emollients are easier, more hygienic and less "messy" for use in a classroom.

- Child should have predetermined spaces for moisturizing, cool compressing and changing clothes if necessary. Arrange for children with eczema to have somewhere private to apply emollients and for young children to receive help to apply emollients.
- Children should have access to their soap substitute at all times.
- Children should avoid use of alcohol-based hand sanitizer gels and sprays.
- Monitor attendance. Students who are unable to attend school due to eczema should seek medical attention.
- If required, notice should be distributed requiring parents/guardians to notify the school of measles and chickenpox on school letterhead.
- As with all students, discuss medication needs with student/parent/guardian and use as directed. Be aware that some types of sunscreens may act as a trigger.
  - Discuss a discreet signal/sign to encourage student to apply cool compress or moisturizer to minimize itch. Students can find it extremely difficult to refrain from itching, so adopting strategies that help to distract children from scratching would be beneficial.
  - Develop IHP and update at least once at the beginning of each school year or more frequently as needed.

Education for staff & students on eczema

Each year, the school nurse, teacher, bus drivers and before/after school care providers should be given updates on the condition of a child with eczema. These updates should include current triggers, new allergies and current medications and dosages Students and families may benefit from discussions on the educational, social and future implications of school attendance. Class education about eczema in consultation with the student may assist with possible adverse reactions from peers.

The National Eczema Society provides information packs for schools at
eczema.org/eczema-at-school

Exercise

Negotiate maximum participation in physical activities with consideration of eczema; students may need to apply moisturizer before and after swimming. Involvement in extracurricular activities is important, keeping in mind that changes in temperature can aggravate eczema. Be aware of the problems caused by temperature changes in PE lessons and allow either long-sleeved shirt or being excused in extremes of temperature.

Other Accommodations

- Allow students to have a drink bottle on desk.
- Remind students not to sit near a heater or in direct sunlight; keep cool, avoiding radiators and sunny windows.
- Ensure access to wet towels/wipes to apply directly to affected skin.
- Keep the student active to divert their attention from the itch.
- Consider requiring short rest breaks to assist with issues of concentration and fatigue that may result from disrupted sleep patterns.
- Use non-irritant gloves to protect hands during Art, Pottery and Food Technology activities. Students may benefit from wearing gloves when working or playing with various mediums such as paint, glue or sand. If a child has been playing in sand, ensure sand is washed off gently and not left under clothing such as socks.
- Allow the child to watch, rather than handle chemicals, in science class.

Headaches

Headaches in children are common and can be divided into two categories - primary and secondary. Primary headaches occur without any underlying health problem and include tension-type, migraine (with or without aura) and cluster headaches.

Secondary headaches result from another condition or cause, including:

- Concussion
- Brain tumor
- Blood vessel problems
- Edication side effects
- Infections such as strep throat, sinusitis and meningitis
- Hypoglycemia
- Caffeine dependence
- Visual impairment (refractive error)
- High blood pressure.

A sudden, severe headache, or a headache accompanied by stiff neck, fever and/or rash, should be evaluated immediately.

Medical attention to address the cause of headaches is important if they are frequent, severe or accompanied by symptoms such as fever, nausea, vomiting, neck pain, light or sound sensitivity, auras or warnings, or if there is a family history of headaches. A pattern of headaches that occur early in the morning and then improve as the day goes on is particularly worrisome and requires prompt attention. In the case of early morning headaches, the cause for concern is a tumor. Other issues may also cause AM headaches, but generally not when right at the time of awakening in the morning.

Headaches secondary to hypoglycemia are fairly easily recognized by timing in relation to food intake (or lack thereof) and response to food (juice is usually used). Specifically, these might present in the AM if breakfast was skipped or later in the day if lunch was skipped. They are always associated with other symptoms such as dizziness, sweating, confusion and – if severe – loss of consciousness.

Disability from headaches can be significant, causing absenteeism and lost learning opportunities while the student is feeling pain. Headaches can also manifest when there is undiagnosed vision impairment. Vision screening should always be considered when recurrent headaches are occurring and can easily help to identify a refraction error. Caffeine dependence is becoming a problem in older children and teens because of energy drinks.

Finally, post-concussion headaches, as part of post-concussion syndrome, have become more common with increasing participation in contact sports. Post-concussion syndrome can cause significant decrease in school performance. Controlled return to normal classroom work, as well as a controlled return to normal physical activity, is necessary for the child who has suffered a concussion.

Most children with recurrent headache have migraines. Migraines are estimated to occur in four to five percent of children, often beginning before age 10. Before puberty, boys and girls are affected equally. After puberty, girls with migraines outnumber boys 3:1. The cause of migraine is considered to be genetic. However, these headaches are often triggered by changes in the environment such as bright lights, changing weather patterns, allergies, certain foods or strong odors.

Some children with migraines will experience an aura before the headache starts, such as visual loss or a sensation of flashing lights. These headaches are usually described as throbbing, may be felt in the frontal area or unilaterally, and often are accompanied by intolerance for light and noise as well as nausea and sometimes vomiting. Stress is probably the strongest trigger factor for migraine headaches.

Tension-type headaches can occur anywhere on the head, and are usually bilateral and constant.

Treatment

The frequency and severity of migraine may be decreased by adequate sleep, balanced meals at regular times, and avoidance of identified triggers and stressful situations. Hydration is very important with avoidance of sugar and caffeine-containing beverages. Ibuprofen at 10-15mg/kg body weight (maximum 600mg) is the recommended pain medication for children with headache. Several additional types of medication may be ordered by the child's healthcare provider to be used either prophylactically or at the onset of a headache.

The school nurse can help a student and family by keeping track of headaches that occur at school (frequency, precipitating factors, timing, medications and their effects) and reporting this data back to parents. The nurse can also educate teachers and help the child identify early symptoms so that medication may be taken as soon as possible for optimum effectiveness. An adequate rest period (30-60 minutes) in a quiet environment, if combined with very early use of prescribed medication, may enable the child to return to classes for the rest of the day.

Use of a pain scale (Wong-Baker FACES Pain Rating Scale, Chapter 2) is helpful to the nurse, both to assess the child and to educate the child in self-care skills. Children may also benefit from being taught how and when to use relaxation techniques. Finally, any child with a headache should have his/her blood pressure taken.

Educational Considerations

- Develop IHP/504/IEP as needed.
- Provide any needed accommodations in physical education and/or school schedule.
- Provide for proper administration of all prescribed treatments, medications.
- Provide staff education for needed educational support during school absences.

Resources

Headaches in Children – American Council for Headache Education
achenet.org/resources/headaches_in_children

Headaches in Kids, What Parents Can Do to Help – American Council for Headache Education
achenet.org/resources/headaches_in_kids_what_parents_can_do_to_help

Kids Help – American Council for Headache Education
achenet.org/news/Kids_Help

School Instruction Form – American Council for Headache Education achenet.org/assets/1/7/School_Nurse_Instruction_Form.pdf

HIV/AIDS

Acquired immunodeficiency syndrome (AIDS) is caused by the Human Immunodeficiency Virus (HIV). Most young children with HIV have contracted the disease during birth or through contact with infected blood or blood products. Although HIV has been isolated in saliva and tears, transmission by exposure to these sources has not been documented. None of the pediatric AIDS cases in the United States have been transmitted in the school, day care or foster care setting; and indirect casual person-to-person contact poses no risk for viral transmission. There are also no medical or legal reasons to restrict a child who is infected with HIV or has a parent infected with HIV from attending school.

Protecting an HIV-positive child's confidentiality is extremely important, and written parental permission should be required before sharing any health information. Clinic personnel, required under HIPAA regulations, should not discuss any child's HIV-status or test results to any other person. Georgia statutory law (O.C.G.A. 24-9-47) defines AIDS Confidential Information (ACI) and makes the confidentiality requirements for the disclosure of ACI more stringent than for other medical conditions. Therefore it does not require parents to disclose their child's HIV status to the school, in order to protect the confidentiality of the child. However, sometimes parents will decide to disclose the child's HIV status to the school system in order for the appropriate personnel to respond should the child fall ill while on school property.

A patient's written consent (or a parent or guardian in the case of a minor) is required to disclose ACI unless the disclosure is otherwise authorized or required by law. According to state law, any person or legal entity intentionally or knowingly disclosing ACI in violation of the law will be guilty of a criminal offense and subject to criminal penalties and civil liability. Unintentional disclosure due to gross negligence or wanton and willful misconduct is also a criminal offense subject to criminal penalties and civil liability (O.C.G.A. 24-9-47).

Go to the following web sites for more information:

Summary of Georgia HIV and STD Laws

hiveis.com/Forms/GeorgiaHIVandSTDLaws.pdf

Georgia Code (search: Georgia Code: 24-9-47)

lexis-nexis.com/hottopics/gacode/default.asp

Children with HIV infection should not receive live virus vaccinations, depending on the severity of their immunodeficiency. Eligibility should be determined by the child's primary HIV physician. Those with severely compromised immune systems should not receive live virus vaccinations and should be excused from regulations requiring them. Any student, including an HIV-infected child, who has contracted a potentially serious contagious disease, should not be allowed to attend school without clearance from the public health department or private physician.

The treatment of HIV infection requires several different daily medications. If there is any question regarding the patient's medications, then the primary HIV physician should be contacted. A resource for these medications can be found at aidsinfo.nih.gov/drugs.

Standard precautions should be followed with HIV-positive children just as with any other child. The key elements include:

- Hand hygiene proper handling and disposal of sharps
- Cleaning and disinfecting patient equipment and environment to prevent transmission of infectious agents,personal protection equipment (gloves, gowns, masks, goggles, etc.) when handling infectious fluids (i.e. blood or body fluids.

Educational Considerations

- Administer medications/treatments as prescribed.
- Adjust attendance policy, adjust schedule or shorten day, if needed.
- Provide rest periods, if needed.
- Adapt physical education curriculum.
- Develop IHP/504/IEP and emergency plan.
- Know child's primary care physician, and who to contact if there is an emergency during school hours.
- Arrange for home tutoring, homebound teacher, if needed.
- Provide staff training on confidentiality, peer education per family request.

The section in this chapter on Childhood Cancers and Transplants has additional information on the immunosuppressed child, which is also applicable to the child being treated for HIV/AIDS.

Resources

AIDS Info
aidsinfo.nih.gov

Guidelines for the Prevention and Treatment of Opportunistic Infections among HIV-Exposed and HIV-Infected Children
aidsinfo.nih.gov/contentfiles/OI_Guidelines_Pediatrics.pdf

H.E.R.O for Children
heroforchildren.org

HIV among Youth
cdc.gov/hiv/risk/age/youth/index.html

HIV – Georgia Department of Public Health
dph.georgia.gov/hiv-prevention-program

HIV/AIDS – Opportunistic infections and other conditions
womenshealth.gov/hiv-aids/opportunistic-infections-and-other-conditions

Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection
aidsinfo.nih.gov/contentfiles/PediatricGuidelines.pdf

Parenting a child with HIV
womenshealth.gov/hiv-aids/living-with-hiv-aids/parenting-a-child-with-hiv.html

Camp Information Camp High Five
heroforchildren.org/camphighfive.php

Seizure Disorders

A seizure is an involuntary sudden change in sensation, behavior, muscle activity or level of consciousness, caused by a disruption of normal electrical activity in the brain. Seizures may be caused by medical conditions such as high fever, central nervous system infections, poisoning, hypoglycemia, electrolyte imbalance, head injury and structural brain lesion. Epilepsy is a condition of the brain characterized by a susceptibility to recurrent seizures. Someone is considered to have epilepsy if they have had more than two unprovoked seizures.

Seizure Recognition

Teachers and school nurses may be the first to detect possible seizure activity. Commonly seen signs of possible seizure activity include: brief staring spells (5-10 sec.) when the child is unresponsive; periods of confusion; head dropping; sudden loss of muscle tone; episodes of rapid blinking or eyes rolling upwards; rhythmic twitching of the mouth or face; aimless, dazed behavior including walking around or repetitive behavior; involuntary stiffening and/or jerking of arm or leg. A pattern of behaviors such as these should be reported to parents.

Important things to observe and document about a seizure:

- Precipitating events
- Student's behavior prior to seizure
- Type of seizure and duration
- Description and duration of post-seizure sleep or drowsiness.

Groups of Seizures/Description

Group 1 - Generalized Seizures; Absence Seizures, Tonic Clonic Seizures (affects both sides of the brain)
Absence seizures (petit mal)

Characterized by:

- A staring spell, lasting a few seconds
- Momentary loss of awareness, interrupting ongoing activity
- Movements of face/arms
- Return to full awareness after episode

Generalized tonic-clonic seizures (grand mal)

May include some or all of the following:

- Body stiffens and/or jerks
- May cry out
- Becomes unconscious or unresponsive
- Loses bowel/bladder control
- Usually lasts one to two minutes
- Shallow breathing and turning blue around lips or mouth
- Confused, sleepy or belligerent after the seizure
- Grinding motion of teeth or jaw

Group 2 – Focal Seizures; (affects one area of the brain) Simple Focal Seizure, Complex Focal Seizure, Secondary Generalized Seizures

Simple focal seizures

The student may:

- Remain conscious, but may not be able to control body movements
- Have distorted senses of sight, smell, hearing, touch
- Be confused and frightened afterwards

Complex focal seizures

The student may:

- Exhibit automatic behaviors in which consciousness is clouded, lasts one to two minutes
- Get up and walk around, as if sleepwalking
- Be unresponsive to spoken direction, or respond inappropriately
- Be fearful
- Exhibit repetitive behaviors
- Be confused and have no memory of the event afterwards

Treatment

Almost all seizures are self-limited events, and the abnormal activity will abate with time, usually in five minutes. In some instances, the administration of medication per rectum, intranasally, intramuscularly or intravenously is necessary to stop the seizure activity.

Emergency medications may be used for children who have prolonged or cluster seizures. One medication is called Diastat®, rectal Valium®, which is ordered now for many children who have prolonged or cluster seizures. See Diastat® in Chapter 3. More information on this drug can be found at: diastat.com. An additional medication being used is Intranasal or IN Versed. See teaching sheet in Chapter 3, page 24 for information regarding the use of this medication.

The seizure disorder, epilepsy, can be partially or completely controlled with the use of anticonvulsant medications in most individuals. These medications must be taken on a routine basis each day. Some children may also be on a special Ketogenic Diet, which would require accommodations from school nutrition services.

Another treatment being used for some children involves vagal nerve stimulation (VNS, Vagal Nerve Stimulator) by an electrical pulse generator that is surgically implanted (most often under the skin on the chest). Vagus nerve stimulation uses regular pulses of electrical energy to prevent or interrupt the electrical disturbances in the brain of the child with epilepsy. In these children, a magnet the child wears can be used to deliver extra stimulation when the child senses a seizure coming on (an aura). For some, the magnet can be used when a seizure occurs to shorten or lessen the severity, stop the seizure, or reduce recovery time.

Management at School

Follow Seizure Action Plan for each individual child

ABSENCE SEIZURE:

- Repeat key parts of the class that may have been missed.
- Note and report to parents if seizures are increasing in frequency.

GENERALIZED TONIC-CLONIC SEIZURES:

- Note the time when it starts and ends.
- Remain calm and remove other students from the area if possible.
- Stay with student until seizure ends.
- Ease the student to the floor, cushioning the head.
- Remove dangerous objects from the area.
- Do not restrain the child or put anything into the mouth.
- Loosen clothing, remove eyeglasses.
- Turn the student on his side to allow fluids to escape out the side of the mouth and to keep the airway clear (choking hazard may not only be vomit, but sometimes a build-up of excess saliva can cause a child to choke.).
- Maintain open airway.
- Ensure school nurse has rescue medication readily available to avoid any delay in administration if indicated.
- Give Diastat® or other rescue medication as ordered if seizure is prolonged.
- Provide a change of clothes if incontinence occurs.
- Allow student to rest quietly after seizure stops.
- Notify parent.

SIMPLE FOCAL SEIZURE:

- Comfort and reassure after seizure.
- Maintain student's safety

COMPLEX FOCAL SEIZURE:

- Ignore automatic behaviors.
- Speak calmly and gently return child to his seat if able.
- Do not force a child to do anything because they may act out and could hurt themselves or others.
- Keep the child in the classroom to provide for safety.
- Reorient the child if confused after the seizure.

When to Call 911

- If there is no past history of seizures
- If the seizure lasts more than five minutes, unless the student's typical seizure is longer as noted in the seizure action plan
- If consciousness does not return after seizure has stopped
- As designated by student's healthcare provider
- If the child turns blue or vomits
- If seizures occur in clusters (back-to-back seizures)
- If pregnant or has diabetes
- If seizure is a different type than is noted in the seizure action plan.

Educational Considerations

- Develop IHP/504/IEP and emergency plans (seizure action plan).
- Communicate with parents about seizures.
- Monitor breathing during and after seizure.
- Provide proper and timely administration of medications.
- Provide in-service education for staff.
- Anticipate need for recovery time after a seizure, provide place to rest.
- Plan for academic make-up work during school absences.
- Observe for consistent triggers as identified by parent or physician.
- May need modified PE schedule/activities, although most students can participate without restrictions.
- Encourage acceptance of diversity and individual differences in the classroom.• Provide education for classmates with parent and student permission, so that they understand and can support their friend.
  Key points you may want to cover:
  – Explain what happened to the child and what the condition is called.
  – It is not contagious.
  – Medication can help control seizures.
  – What they can do during and after a seizure to help their classmate.

Resources

American Epilepsy Society
aesnet.org

Education of Kids with Epilepsy
epilepsy.com/info/family_kids_education

Epilepsy Foundation of America
epilepsyfoundation.org

Epilepsy Foundation of Georgia
epilepsyga.org

Epilepsy Foundation – Spanish language Web site
fundacionparalaepilepsia.org

Kids Health (type “seizures” in search box)
Kidshealth.com

Merck (type “seizures” in search box)
merck.com

Sickle Cell Disease

Sickle cell disease is a group of inherited red cell disorders. Normal red blood cells are round like doughnuts, and they move through small blood vessels in the body to deliver oxygen. Sickle red blood cells become hard, sticky and crescent or sickle-shaped. When these hard and sticky sickle-shaped cells pass through the blood vessels, they clog the flow and break apart. This process results in pain, organ damage, low blood count or anemia, and many other probles. Sickle cell disorders occur in all racial and ethnic groups, but are most common in people of African, Mediterranean, Indian and Middle Eastern heritage. In the United States, these disorders are commonly observed in African Americans and Hispanics from the Caribbean, Central America and parts of South America.

In sickle cell disease, hemoglobin (the substance that carries oxygen and gives blood its red color) is abnormal and polymerizes, causing cells to assume a crescent or sickle shape. There are three common types of sickle cell disease in the U.S.—Hemoglobin SS or sickle cell anemia, Hemoglobin SC disease and Hemoglobin S-Beta thalassemia. All 50 States screen all newborns for sickle cell disease. The confirmatory test for the disease is a simple blood test called the hemoglobin electrophoresis.

Complications from sickle cell disease include:

- Episodes of severe, sometimes excruciating pain that can occur in any part of the body
- Acute chest syndrome (like pneumonia)
- Stroke
- Anemia and fatigue
- Delayed growth and pubertal development
- Decreased resistance to bacterial infections (due to abnormal splenic functional)
- Bone damage (avascular necrosis of femur or humerus)
- Eye damage (retinopathy)
- Kidney damage and proteinuria
- Gallstones
- Priapism, a painful and sustained erection of the penis, that lasts for hours or days
- Neurocognitive defects, secondary to “silent strokes”
- Depression, secondary to recurrent pain and other symptoms

* The severity of SCD is highly variable among individuals. Some patients have more frequent and severe complications than others. It is important to appreciate that some children with SCD also have asthma which, if poorly controlled, can increase the risk of SCD complications

Signs and symptoms requiring emergency treatment include:

- Fever 101º or greater, regardless of whether other signs of illness are present
- Severe pain not relieved by rest and oral pain medications
- Neurological – signs including severe headache, weakness on one side, facial asymmetry, difficulty swallowing, slurred speech or seizure
- Extreme pallor and fatigue due to an acute worsening of anemia from splenic or liver sequestration—when blood becomes blocked and pools in these organs, or aplastic crises in the bone marrow
- Significant respiratory symptoms such as severe cough, difficulty breathing, chest pain with or without fever.

Sickle Cell Pain Crises

Acute episodes of severe pain can be precipitated by cold temperatures, decreased oxygen saturation (due to sleep apnea, asthma), acidosis, dehydration, physical or emotional stress, infection, pregnancy and menses.

The most common symptoms of sickle cell crises and other conditions requiring medical attention are:

- Sudden onset of acute, severe abdominal pain
- Sudden, acute, severe onset of joint or bone pain
- Fever (do not give acetaminophen/ibuprofen for fever but give for pain)
- Unusual headache
- Chest pain, breathing difficulty
- Abdominal swelling
- Sudden weakness or loss of feeling
- Sudden vision changes
- Priapism.

Treatment

Treatment of symptoms as soon they occur is crucial. Pain management should be aggressive and given quickly. Lortab (or other opiod) and Motrin® may be alternated as often as every three hours, and stronger pain medications, including opioids, are often needed and prescribed. Infections are treated aggressively with antibiotics after blood cultures are obtained. Packed Red Blood Cell (pRBC) transfusions are often necessary to treat different complications from the disease. Newer treatments include hydroxyurea, which increases fetal hemoglobin and decreases symptoms and complications in some patients. Bone marrow transplants are available for patients who meet the criteria and are the only cure for sickle cell disease.

Management at School

Adequate fluids are essential to help prevent sickling of the red cells. Students should be allowed and encouraged to carry water bottles at all times and drink plenty of fluids. Patients with sickle cell disease do not concentrate their urine normally, and frequent bathroom breaks are necessary. Anemia can cause extreme fatigue, and students' schedules may have to be adjusted. These students have difficulty fighting certain infections, so report school outbreaks to parents. Students may also be on prophylactic antibiotics. Many students with SCD can participate in PE, but should avoid overexertion or becoming chilled or overheated. Information about the student's treatment, medications and any activity limitations should be provided and updated annually by the child's physician. All students with SCD should have a 504 plan that is shared with teachers, staff, bus drivers and other appropriate personnel. Some may require an IEP.

Report crisis-like symptoms to the school nurse and parents. If any of these symptoms occur, have the child lie down or make him comfortable, and notify a parent or guardian immediately. Know your student, his capabilities and limits. Believe what he or she tells you about pain. Use a pain scale (Wong-Baker FACES Pain Rating Scale, Chapter 2). Parents are an excellent source of knowledge about their children, and should be consulted whenever questions arise about the plan or treatment. Also remember that not all pain is associated with sickle cell disease. These students can have fractures, appendicitis and other illnesses as well. Do NOT use ice with a suspected orthopedic injury because exposure to cold can precipitate pain. Students should always be encouraged to get plenty of rest and eat well.

Resources

Georgia Comprehensive Sickle Cell Center dwb.unl.edu/Teacher/NSF/C10/C10Links/
emory.edu/PEDS/SICKLE/serv01.htm

Medline Plus web site
nlm.nih.gov/medlineplus/sicklecellanemia.html

Sickle Cell – current research (in search bar, type sickle cell)
clinicaltrials.gov

National Coordinating and Evaluation Center – Sickle Cell Disease and Newborn Screening Program
sicklecelldisease.net

Sickle Cell Disease Association of America
sicklecelldisease.org

Sickle Cell Foundation of Georgia
sicklecellga.org

Sickle Cell Kids
sicklecellkids.org

A Counseling Handbook for Sickle Cell and Other Hemoglobinopathies
vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/sickleCell/publications.htm

What is Sickle Cell Disease? – National Institutes of Health
nhlbi.nih.gov/health/health-topics/topics/sca

Camp Information

Camp New Hope
sicklecellga.org

Child Abuse,

Suicide Prevention,

&

Hospital/Homebound Services

The Richmond County Board of Education

Policy **Descriptor Code: JGI**
Child Abuse or Neglect

Richmond County Schools

Policy JGI: Child Abuse or Neglect

All employees of the Board of Education, as well as persons who attend to a child pursuant to their duties as a volunteer for the School System, who suspect that a child is being or has been abused, shall report that abuse immediately, but in no case later than 24 hours from the time there is reasonable cause to believe a child has been abused, in accordance with Georgia law and the protocol for handling child abuse cases for Richmond County, Georgia.

Under no circumstances shall the principal or designee to whom report of child abuse has been made exercise any control, restraint, modification or make other change to the information provided by a mandated reporter, although the reporter may be consulted prior to the making of a report and may provide any additional, relevant and necessary information when making the report.

NOTE: Please refer to the Administrative Procedures for the details of how to report suspected child abuse and for access to the forms for reporting.

Richmond County Schools

Date Adopted: 9/11/2008
Last Revised: 10/20/2015

Memorandum

TO: School Personnel

SUBJECT: Procedure for Reporting Suspected Child Abuse/Neglect

Georgia Law requires all persons who suspect child abuse/neglect to report it to the proper authority which is the Department of Family and Children Services. As the law relates to school institutions, it requires the observer to report it directly to DF ACS **and** specified school personnel (See Form Attached). Any person or official required to report a suspected case who knowingly and willfully fails to do so shall be guilty of a misdemeanor and upon conviction thereof shall be punished for a misdemeanor. The procedure is as follows:

The staff member suspecting child abuse/neglect is responsible for reporting suspected child abuse to DFACS and to the building administrator. An option to this reporting method is that the report to DFACS is made by the employee in the presence of the administrator**.**

1. Report (immediately) the suspected child abuse/**neglect (see Attachment #1)(new form & phone number) to**
   a. the principal or his/her designee
   b. an intake worker at the Department of Family and Children Services

   Note: If the principal or his/her designee is not available, the report should be made to Public Safety and DFACS intake worker.

2. Complete the report form (See Attachment #2) and send to designated personnel. (The individual making the report needs to describe specifically the injuries seen. The severity of the injury is very important in setting the priority response time).

3. Request that the nurse or counselor assist in making the report if you cannot reach an intake worker. This step is not required if any administrator is available to assist.

4. Expect a follow-up from personnel at DFACS - a letter will be received noting that an investigation is/is not underway.

   NOTE: The reporting person will know the results only if there is follow-up treatment which will involve the school. Otherwise, he/she will know only that DF AC is addressing the problem. In terms of the DFACS worker making contact, it should be noted that there is a priority list (see Attachment #3).

5. The observer is bound by law to report any instances of suspected child abuse to DFACS. Notifying the principal does not eliminate that legal expectation.

(Forms are available at RCBOE site under Staff Resources section, *"Frequently Used Forms")*

RICHMOND COUNTY BOARD OF EDUCATION

GEORGIA CHILD PROTECTIVE SERVICES MANDATED REPORTER FORM

The reporter is the RCBOE mandated reporter. Mandated reporters are individuals who work or volunteer in agencies or organizations that serve children and families. Georgia Code O.C.G.A.§ 19-7-5 requires mandated reporters to contact the Division of Family and Children Services (DFCS) if they have reasonable cause to believe that a child known to them is suspected of being abused or neglected. Calls should be made to 1-855-422-4453. Completing this form and routing it to appropriate parties is required but is not acceptable as the first report to Georgia Child Protective Services.	REFERRAL DOCUMENTATION Reported to: 1-855-422-4453 Time: Date: Name of Call Manager receiving report: Signature of Reporter:

Georgia Child Protective Services Mandated Reporter Form

A report can be made by calling **1-855-422-4453**, 24 hours a day, 7 days a week, 365 days per year. A phone agent will respond to your call quickly and gather necessary information that an intake specialist will need to assess the child's safety.

Mandated Reporters also have the choice of three options for submitting this completed form electronically.

Option One: E-mail to cpsintake@dhr.state.ga.us. You will receive an auto-reply stating that the CPS report has been received. You will receive an automatic reply indicating your report has been received. You will also receive a return phone call within 2 hours to acknowledge your report and collect any additional information needed. This return phone call satisfies the legal requirement to speak with a DHS employee. Please include on the report a number where you can be reached.

Option Two: Fax to 229-317-9663. You will receive an automatic reply indicating your report has been received. You will also receive a return phone call within 2 hours to acknowledge your report and collect any additional information needed. This return phone call satisfies the legal requirement to speak with a DHS employee. Please include on the report a number where you can be reached.

Please note that you may be called for additional information regarding this report.

Specific Concern What are your specific concerns about the child(ren)?

Provide a detailed description of your specific concern.

Has something happened to the child? ☐ Yes ☐ No

If so, what happened?

When and where did it occur and who was involved?

Was an object used and if so, what type of object?

How serious is the harm to the child?

RICHMOND COUNTY BOARD OF EDUCATION

GEORGIA CHILD PROTECTIVE SERVICES MANDATED REPORTER FORM

Date: _____ Time: _____ County where child resides: _____

Location of child at time of report: _____

Reporter's Name, Title, Telephone, & email address: _____

Reporter's Organization and Organization address: _____

Primary Caretaker of Child: _____

Address of Primary Caretaker: _____

Reporter's relationship to Child: _____

Additional person (and contact information) who can be contacted if you, the reporter, are not available and additional information is needed: _____

If you are the designated reporter for your agency (i.e. school counselor, law enforcement dispatch…), please indicate the primary staff-person in your organization who has firsthand knowledge of the suspected child maltreatment and/or knows the child and family. DFCS's ability to speak directly with those having firsthand knowledge of the suspected child maltreatment and/or knows the child and family is critical for assessment of short and long term safety and well-being of the alleged victim child.

Name, Contact Information and Best Time to Reach Staff-person with firsthand knowledge of child/family: _____

Family Name/Who has custody of child(ren): _____

Mother's Name: _____ RACE: _____ DOB: _____ SSN: _____

Mother's Residence: _____

Mother's Employment: _____

Mother's Telephone Number: _____ Marital Status: _____

Father's Name: _____ RACE: _____ DOB: _____ SSN: _____

Father's Residence: _____

Father's Employment: _____

Father's Telephone Number: _____ Marital Status: _____

Language: _____ ALT Contact Info: _____

If a school reporter, please indicate all Emergency Contact Information on file with the school and date this information was obtained from family: _____

RICHMOND COUNTY BOARD OF EDUCATION

GEORGIA CHILD PROTECTIVE SERVICES MANDATED REPORTER FORM

CHILDREN:

Child's Name	Victim	Sex	Race	DOB	SSN	Grade Level

OTHER HOUSEHOLD MEMBERS:

Name	RELATIONSHIP To Primary Caretaker	LANGUAGE	MARITAL STATUS	Race	DOB	SSN

OTHER ADULTS OF SIGNIFICANCE NOT RESIDING IN HOME:

Name	RELATIONSHIP To Primary Caretaker	LANGUAGE	MARITAL STATUS	Race	DOB	SSN

Would you like to be notified if an investigation is completed and whether abuse is substantiated or unsubstantiated?
Please indicate Yes ☐ *or No* ☐

Reporter: _____ Date: _____ School: _____

THE REPORTER MUST GIVE A PHOTO COPY OF THIS COMPLETE PACKET (PAGES 1-3) TO THE PRINCIPAL.

PRINCIPALS, PLEASE SEND A PHOTO COPY OF THIS COMPLETED REFERRAL TO THE SUPERINTENDENT AND TO L. O. FLETCHER, 3529 WALTON WAY EXT., AUGUSTA, GEORGIA 30909 (BY MAIL OR INTEROFFICE/PONY MAIL ONLY).

Rev. 8/2014

Looking Out for Georgia's Youth:
EDUCATION CAN MAKE A DIFFERENCE

INTRODUCTION

After attending the **Looking Out for Georgia's Youth: Education Can Make a Difference** training and reading this packet, you should be better able to:

- Understand how the mandated reporting laws affect you
- Define four types of abuse and related indicators
- Describe the process for responding to a disclosure of child abuse
- Follow the basic procedure for reporting suspected of child abuse
- Identify protective factors and strategies for preventing child abuse

DID YOU KNOW?

Nationally in 2010, reports from education personnel and law enforcement made up the largest percentages of alleged child abuse reports, at 16.4 % and 16.7% respectively.

MANDATED REPORTERS

Section 19-7-5 of the Official Code of Georgia Annotated, relating to reporting of child abuse, designated several categories of individuals as **mandated reporters,** who "having reasonable cause to believe that a child has been abused shall report or cause reports of that abuse to be made." **All child service organization personnel are mandated reporters.**

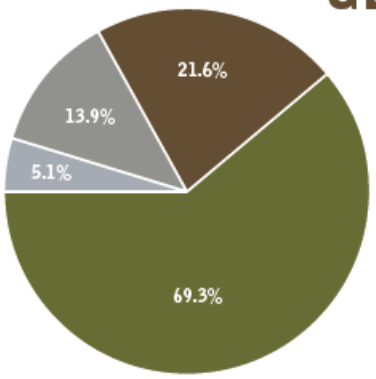
(The complete section of the Georgia Code is on file at your school)

Child service organization personnel' means persons employed by or volunteering at a business or an organization, whether public, private, for profit, not for profit, or voluntary, that provides care, treatment, education, training, supervision, coaching, counseling, recreational programs, or shelter to children.

- O.C.G.A. 19-7-5(b)(5)

A report of alleged child abuse is made in Georgia every 14 minutes.*
*38,578 reports in FFY 2010

OVERVIEW OF CHILD ABUSE IN GEORGIA*



VICTIMS OF CHILD ABUSE (REPORTED)

- Neglect - 69.3%
- Emotional /- Psychological - 21.6%
- Physical Abuse - 13.9%
- Sexual Abuse - 5.1%

NEGLECT IS ABUSE?

Not only are there more reports of neglect and more substantiated cases of neglect than all the other types of abuse combined, but 430 of child fatalities in the U. S. were attributed to neglect alone.

* FFY 2010

Physical Abuse

The non-accidental physical injury of a child. Physical abuse is the most visible and widely recognized form of child abuse.

INDICATORS

- Has unexplained burns, bites, bruises, broken bones, or black eyes
- Has fading bruises or other marks noticeable after an absence from school
- Seems frightened of the parents and protests or cries when it is time to go home
- Shrinks at the approach of adults
- Reports injury by a parent or another adult caregiver

In Georgia, Corporal Punishment is legal. Abuse is not.

Corporal punishment is any physical punishment of a child to inflict pain as a deterrent to wrongdoing. It may produce transitory pain and potential bruising. If pain and bruising are not excessive or unduly severe and result only in short-term discomfort, this is not considered maltreatment.

-Georgia DFCS

2

Neglect

The failure of a parent, guardian, or other caregiver to provide for a child's basic needs.

Neglect may be:

- The failure of a parent, guardian, or other caregiver to provide for a child's basic needs, including safety from harm or danger (failure to protect).
- Physical (e.g., failure to provide necessary food or shelter, or lack of appropriate supervision this also includes the failure to protect a child from harm/danger.)
- Medical (e.g., failure to provide necessary medical or mental health treatment)
- Educational (e.g. failure to educate a child or attend to special education needs)
- Emotional (e.g., inattention to a child's emotional needs, failure to provide psychological care, or permitting the child to use alcohol or other drugs)

INDICATORS

- Is frequently absent from school
- Begs or steals food or money
- Lacks needed medical or dental care, immunizations, or glasses
- Is consistently dirty and has severe body odor
- Lacks sufficient clothing for the weather
- Abuses alcohol or drugs
- States that there is no one at home to provide care

Child Protective Services guidelines for supervision:

- Children eight years or younger should not be left alone;
- Children between the ages of nine years and twelve years, based on level of maturity, may be left alone for brief (less than two hours) periods of time; and,
- Children thirteen years and older, who are at an adequate level of maturity, may be left alone and may perform the role of babysitter, as authorized by the parent, for up to twelve hours.

These guidelines assume that the child's age is equivalent with his or her developmental level. A child's maturity should ALWAYS factor into how much supervision is needed.

3

Sexual Abuse

The exploitation of a child for the sexual gratification of an adult or older child. Sexual abuse is most commonly perpetrated by an individual known to the victim, rarely is the offender a stranger. One-third of all sexual abuse is perpetrated by another child.

Sexual abuse includes touching offenses: fondling, sodomy, rape; and non-touching offenses: child prostitution, indecent exposure and exhibitionism, utilizing the internet as a vehicle for exploitation.

INDICATORS

- Has difficulty walking or sitting
- Suddenly refuses to change for gym or to participate in physical activities
- Reports nightmares or bedwetting
- Experiences a sudden change in appetite
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
- Becomes pregnant or contracts a sexually transmitted disease
- Runs away
- Reports sexual abuse by a parent or another adult caregiver

Up to 50 percent of those who sexually abuse children are under the age of 18.

(Hunter, J.A., Figueredo, A., Malamuth, N.M., & Becker, J.V. (2003). Juvenile sex offenders: Toward the Development of a typology. Sexual Abuse: A Journal of Research and Treatment, (2003) Volume 15, No. 1).

Commercial Sexual Exploitation Of Children

The buying, selling or trading of sex acts with a child

If you suspect a child is a victim of commercial sexual exploitation, please contact the Georgia Care Connection Office at 404-602-0068.

Calling the GCCO links the family to supportive services but does not fulfill mandatory reporting of child sexual exploitation as required by Senate Bill 69.

INDICATORS

- Branding or tattooing: victims branded by their pimp with tattoos that include a male name or initials, street name, gang or money symbols; these are often found on legs, neck, chest, hands or arms (this is one of the ways that pimps maintain physical and psychological control over emotionally vulnerable girls)
- An older boyfriend or male friend or relative
- Withdrawn and uncommunicative
- Possession of large amounts of money (girls turn money over to the pimp)
- Poor personal hygiene and/or inappropriate dress
- Runaway or lack of adult supervision/support

An estimated 300 girls are commercially exploited in Georgia every month (and we are still learning how to track the boys). Atlanta has been identified by the FBI as one of the 14 cities with the highest incidence of commercial sexual exploitation of children. However, victims of exploitation come from all over the state and 45% of those referred to Georgia Care Connection lived outside of Fulton and DeKalb counties.

Emotional Abuse

A pattern of behavior that impairs a child's emotional development or sense of self-worth.

It frequently occurs as verbal abuse, but can also include the following: rejection, terrorizing, shameful forms of punishment, withholding physical and emotional contact; developmentally inappropriate expectations.

INDICATORS

- Shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity, or aggression
- Inappropriately adult(parenting other children, for example) or inappropriately infantile (frequently rocking or head-banging, for example)
- Is delayed in physical or emotional development
- Has attempted suicide
- Reports a lack of attachment to the parent

Suicide

Many of the indicators of abuse are common to multiple categories of abuse. Indicators like running away, school problems, aggression, depression, anxiety, withdrawal, excessive worries, substance abuse, self injury, and suicidal thoughts or actions could be a response to any type of abuse. Deciding why a child needs help is less important than acting on your concern that a child is in harm's way.

If the child you are concerned about has attempted suicide in the past or your concern is about the danger that the child represents to him or herself, you may want to contact the Suicide Prevention Lifeline 1-800-273-TALK (8255) to learn more. Some of the warning signs that someone is at high risk include:

- Talking about wanting to die or kill oneself
- Looking for a way to kill oneself, such as searching online or buying a gun
- Talking about feeling hopeless or having a reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

EXPLANATION

Many children believe something very negative will happen if they break the secret of abuse. The child may have been threatened by the offender to ensure his or her silence. Let the child know that there are some secrets that you just can't keep. Assure the child that your job is to protect the child and keep him/her safe. Let the child know you will keep it as confidential as possible but that you are required by law to make a report.

What to do When a Child Discloses

1. **Find a private place to talk with the child**

2. **Reassure the child**
   "I believe you."
   "I am glad you told me."
   "It is not your fault this happened."
   "(Sexual) abuse is wrong."

3. **Listen openly and calmly.**
   Try to keep your own emotions and nonverbal cues neutral. Don't comment on the child's situation as being "good" or "bad." Let the child tell his or her own story.

4. **Write down the facts and words as the child has stated them.**
   Leave out your own assumptions and value judgments.

5. **Report the disclosure to the designated reporter in your school/ system/agency or your local child protection agency or law enforcement entity.**

6. **Respect the child's need for confidentiality...**
   ...by not discussing the abuse with anyone other than those required by school/agency policy and the law.

7

If a child does make a disclosure, *don't* try to get all the details. Listen attentively and ask him/her if he/she wants to say anything else. Believe in the child and be supportive. If she or he chooses to say nothing more, then proceed to notify DFCS or your designated reporter. Also, write down the actual words used in the disclosure and your interaction with the child. This first statement made spontaneously has forensic significance to the investigators and the exact words can be important.

Above all, MINIMIZE the number of questions you ask the child and avoid the use of leading questions (questions that suggest an answer).

MAKING A REPORT

In Georgia, you may fulfill the mandate by reporting to a **designated reporter**. However, there may be situations when you feel more comfortable making a report directly to DFCS.

During regular business hours (8 a.m. to 5 p.m.), you should call the DFCS office in the county in which the child lives. You can look that up online at **http://dfcs.dhs.georgia.gov/complete-list-all-county-offices** or contact **Georgia's Child Protective Services office** at (404) 657-3400.

Between 5 p.m. and 8 a.m, Monday through Friday and on weekends, holidays, and furlough days, you can call **1-855-GA CHILD (1-855-422-4453)**. This number is staffed 24 hours a day.

When You Suspect a Child is Being Maltreated

- Report your concerns to the designated reporter in your school or to a supervisor
- Follow up with your designated reporter to assure that a report is made to child protective services
- Remember, to make a report or cause a report to be made, mandated reporters only need to have "reasonable suspicions," not direct evidence
- School officials do have the authority to photograph injuries

To Whom Do You Report?

An oral report must be made within 24 hours by telephone or in person to the DFCS office providing protective services in the county in which the child lives.

Your program, agency or facility may have an internal child maltreatment reporting protocol. Know this protocol. It is strongly recommended that each staff person involved in the reporting process receive confirmation when a report is made. When unable to reach DFCS, a report must be made to local law enforcement or district attorney in the county in which the child lives. If the child is in immediate danger, call 911. Follow-up with your local DFCS as soon as possible to make an official report to their office.

Rights of the Mandated Reporter

Mandated reporters who report in "good faith" are protected by law, even if the report is not substantiated.

- ***Anonymity or confidentiality.***
  All reports are confidential, and the reporter may remain anonymous. It is, however, most helpful to the child if the reporter provides his or her contact information. It is also impossible to prove that you fulfilled the mandate to report if you do so anonymously.

- ***Knowledge of the outcome only of a report.***
  Mandated reporters who provide their name at the time of filing the child maltreatment report may request information from DFCS on the outcome of a report. Legally DFCS cannot share any information other than the outcome. Mandated reporters are supposed to receive a letter of acknowledgment, acceptance for investigation or screen-out of the case. If you have reported before and not received a letter, you may want to follow-up to get that documentation.

What are the Penalties for NOT Reporting?

Any person or official required by Georgia law to report suspected cases of child maltreatment and who knowingly and willfully fails to do so shall be guilty of a misdemeanor.

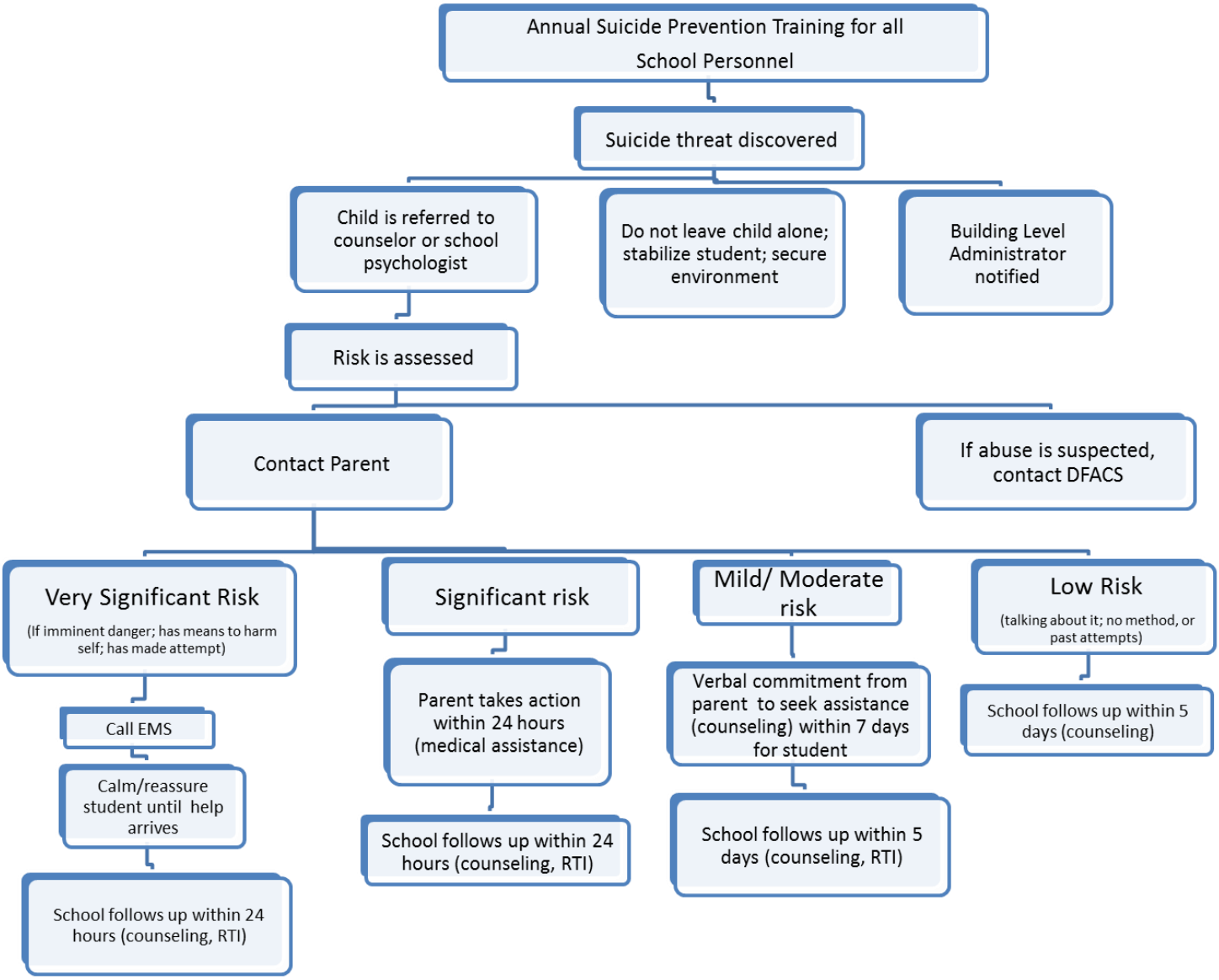
THE ROLE OF CHILD PROTECTIVE SERVICES

The Division of Family and Children Services (DFCS) provides a number of services to communities in Georgia. Child Protective Services (CPS) is a term for those services related to child abuse and neglect, but you may hear DFCS and CPS used interchangeably.

- Interview the child and parents/caregivers
- Arrange for child's medical examination, if necessary
- Assess parents/caregivers' abilities to care for/protect the child
- Provide support for services to parents/caregivers
- Request immediate temporary custody of child from judge in juvenile court when abuse/ neglect is substantiated
- Petition court for permanent custody when parents/ guardians (when given support) fail to demonstrate ability or willingness to care for the child

Suicide Prevention Prototcol

School Nurses play an important role in the prevention of suicide. Richmond County has a protocol (below) for intervening when a student is in crisis. Please see the RCSS Crisis Intervention Manual for more detailed information on suicide prevention and crisis response.



Eligibility Criteria

1. The student must be enrolled in the public school system in which he or she is requesting this service. Private or home school students are NOT eligible for HHB services from a Georgia public school.

2. For a student to receive hospital or homebound instruction, a licensed physician or psychiatrist currently treating the student must declare the diagnosis and that the student is able to participate in and benefit from an instructional program. Students with other disabilities and other handicapping conditions also must meet the eligibility requirements.

3. The student must have a medical and/or psychiatric condition that is documented by a licensed physician. Only a psychiatrist can submit a medical request form for an emotional or psychiatric disorder. The psychiatric condition presented must be listed in the latest edition of the *Diagnostic and Statistical Manual* (DSM)**.** The referring licensed physician and/or licensed psychiatrist must be the treating physician or psychiatrist for the medical and/or psychiatric condition for which the student is requesting HHB services. Examples include the following:
    - A student with leukemia may not request HHB services with a medical statement from a pediatrician. A statement from the oncologist currently treating the student is required.
    - A student with paranoid delusions may not request HHB services with a medical statement from a psychologist or pediatrician. The medical request must be from the licensed psychiatrist currently treating the student.

4. The student must be anticipated to be absent from school for a minimum of ten consecutive school days per year (or the equivalent on a modified calendar) or the student has a chronic health condition causing him/her to be absent for intermittent periods of time anticipated to exceed ten school days during the school year.

5. If the school is on an approved block schedule, then the ten day minimum requirement is reduced to five consecutive or five intermittent days during the school year

6. Students approved for intermittent HHB services must be absent for three consecutive school days on each occurrence before HHB services will be provided.*

7. Students who have been declared emancipated by a court or are 18 years of age or older are eligible to sign the *Hospital/Homebound (HHB) Services Request Form and the Compliant Authorization for Exchange of Health and Education Information* (The Health Insurance Portability and Accountability Act - HIPAA).

8. The referring physician or psychiatrist must certify that the student can receive instruction without endangering the health and safety of the instructor or other students with whom the instructor may come contact. Students who have any form of influenza or other airborne contagious diseases will not be provided services until the licensed physician certifies that the student is no longer infectious. Students out of school because of communicable diseases are eligible for HHB services for a length of time as determined by Educational Services Plan (ESP) provided that they satisfy the other eligibility requirements.

9. Students out of school because of expulsion or suspension are not eligible.

10. Students with absences due to pregnancy, related medical conditions, services or treatment; childbirth; and recovery therefrom are eligible for HHB services for a length of time as determined by the ESP, provided that they satisfy the eligibility requirements.

11. The local education agency (LEA) may require the parent, guardian, emancipated minor, or student 18 years of age or older to sign the HIPAA form relating to the reason for the request for HHB services. If the LEA requires the HIPAA form, it must be submitted before services can be provided.

***Note:** Chronic illnesses that require ongoing intermittent absences may require students missing many days, but possibly not three consecutive days. Such cases will be evaluated on an individual basis.

DELIVERY MODELS

There are three models of Hospital/Homebound instruction offered in Richmond County.

TEMPORARY, INTERMITTENT AND LONG-TERM HOSPITAL/HOMEBOUND SERVICES

Temporary Services

HHB instruction and other services for eligible students who have a medically diagnosed physical or psychiatric condition, which confines the student to home or hospital and restricts activities ***for nine weeks or less, but for a minimum of ten consecutive school days*** or equivalent on a modified calendar or a minimum of five consecutive days on a high school block schedule. An example of a student who might receive temporary services is one who breaks a limb and cannot bear weight, having to remain at home to prevent further injury.

Intermittent Services

In certain cases, it is deemed by the physician that a student may attend school for either part of a day or may miss school on an intermittent basis due to a chronic condition from which they may suffer. In cases such as these, the physician will indicate the attendance parameters for the students based on the illness or injury of the student. ***Students receiving intermittent services must be absent a minimum of three consecutive days before HHB services will be provided, unless the student has a chronic illness requiring ongoing intermittent services, in which case the days may not be consecutive.***

A student receiving ongoing intermittent services (ex. dialysis or chemotherapy patient) will receive an adjusted rate of services based on the number of hours the student is able to attend school. This schedule of services will be evaluated by the Student Services Director and Hospital/Homebound Coordinator and communicated to the school contact person.

Schedule for Students Needing Ongoing Intermittent HHB Services Due to a Chronic Illness

Days Absent	Hours of Service
2	1
3	1.5
4	2
5	3

Note: This scale is only to be used for students who have been diagnosed with a chronic illness warranting ongoing intermittent services (ex. dialysis, chemotherapy, etc.) All other students receiving intermittent services must be absent 3 consecutive days to receive services.

Long-Term Services

HHB instruction and other services for eligible students who have a medically diagnosed chronic health condition which may cause the student to be absent from school for more than nine consecutive weeks per year or equivalent on a modified calendar.

APPLICATION PROCESS

1. The parent/guardian, emancipated minor or student 18 years of age or older should contact the school's HHB contact to discuss HHB services and to obtain an application for these services.

2. The parent/guardian, emancipated minor, or student 18 years of age or older should read and sign a document to certify his or her understanding of the HHB policies, procedures and application process

3. The parent/guardian, emancipated minor or student 18 years of age should be provided a Medical Form and a HIPAA form by the school HHB contact or Coordinator of HHB services.

4. The Parent/guardian, emancipated minor or student 18 years of age or older will have the student's physician or psychiatrist treating the student for the medical condition to complete the medical information section on the Medical Form, including a description of the physical condition, any medical implications for instruction, and the anticipated duration of services. All mental health related diagnoses must be found in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.

5. The completed Medical Form and HIPAA form will be returned to the Coordinator of HHB services. The application will be reviewed to ensure that the student meets the minimal eligibility requirements.

6. Within five days of receiving the completed medical form, it will be determined by the Hospital Homebound Coordinator whether or not a student meets eligibility requirements, the school HHB contact will be notified and the person requesting services will be contacted by the school to set up an Educational Services Plan Meeting. The school personnel will assign a hospital/homebound teacher to the case. The ESP meeting should be held as quickly as possible to assure continuity of instruction for the HHB student. A telephone conference call or other electronic communication may be considered a meeting.

6. The school team or IEP team will develop an Educational Service Plan (ESP) for each designated HHB student. This plan must address: (1)*the disabling condition, (2)anticipated length of absence, (3)accommodations and modifications recommended by the licensed physician or licensed psychiatrist, (4)instructional delivery method, (5)place of instruction, (6)adult parent designee if the student is under 18 years of age, (7)team members participating, and (8)strategies for the student's reentry to school upon his or her return*. The plan does not need to be lengthy, but it must give all parties enough information to adequately serve the student's needs.

7. The ESP meeting can be face-to-face, electronic or by telephone. However signatures of all parties involved should be secured to indicate understanding and agreement by all.

8. Students eligible for services under the Individuals with Disabilities Education Act shall be served by appropriately certified personnel. The IEP committee shall convene to review the IEP for any necessary changes and to recommend hospital/homebound instruction.

9. Three(3) hours of instruction per week must be provided to comply with the Georgia State Board of Education Rule 160-4-2-.31 Hospital/Homebound (HHB) Services and meet attendance requirements.

10. The school shall identify the appropriate course load for the student during the approved period of HHB instruction. It is noted that *HHB instruction is not structured to supplant the regular school day* and may, therefore limit the number and type of classes offered.

11. If hospital/homebound instruction should be necessary beyond the date indicated on the original referral form, the parent will submit a request for an **extension of services, and additional documentation from the physician may be required.** Additionally, students requiring long-term or ongoing services may be required to submit updated medical information.

12. Parents/guardians of students, emancipated minors, or students 18 years of age or older who are hospitalized must follow the application process in order for the LEA to provide HHB services in the hospital setting.

13. A contractual agreement between the LEA and hospital that stipulates the services to be provided shall be entered into prior to the hospital providing HHB services.

ATTENDANCE CREDIT

1. The student shall be counted present for the entire week when he or she is provided instruction on an individual basis or as part of a group by the HHB teacher for a minimum of three hours per week. Note: ***The HHB code ("H") should be used to record attendance which is not the FTE code used for a student being "present***".

2. A student shall be counted absent for the week when the HHB teacher's visit is cancelled by the parent/guardian, emancipated minor or student 18 years of age or older. The LEA may, at its discretion, reschedule the cancelled session. Once the schedule is completed, the student is counted in accordance with the Georgia State Board of Education Rule 160-5-1-.10 Student Attendance.

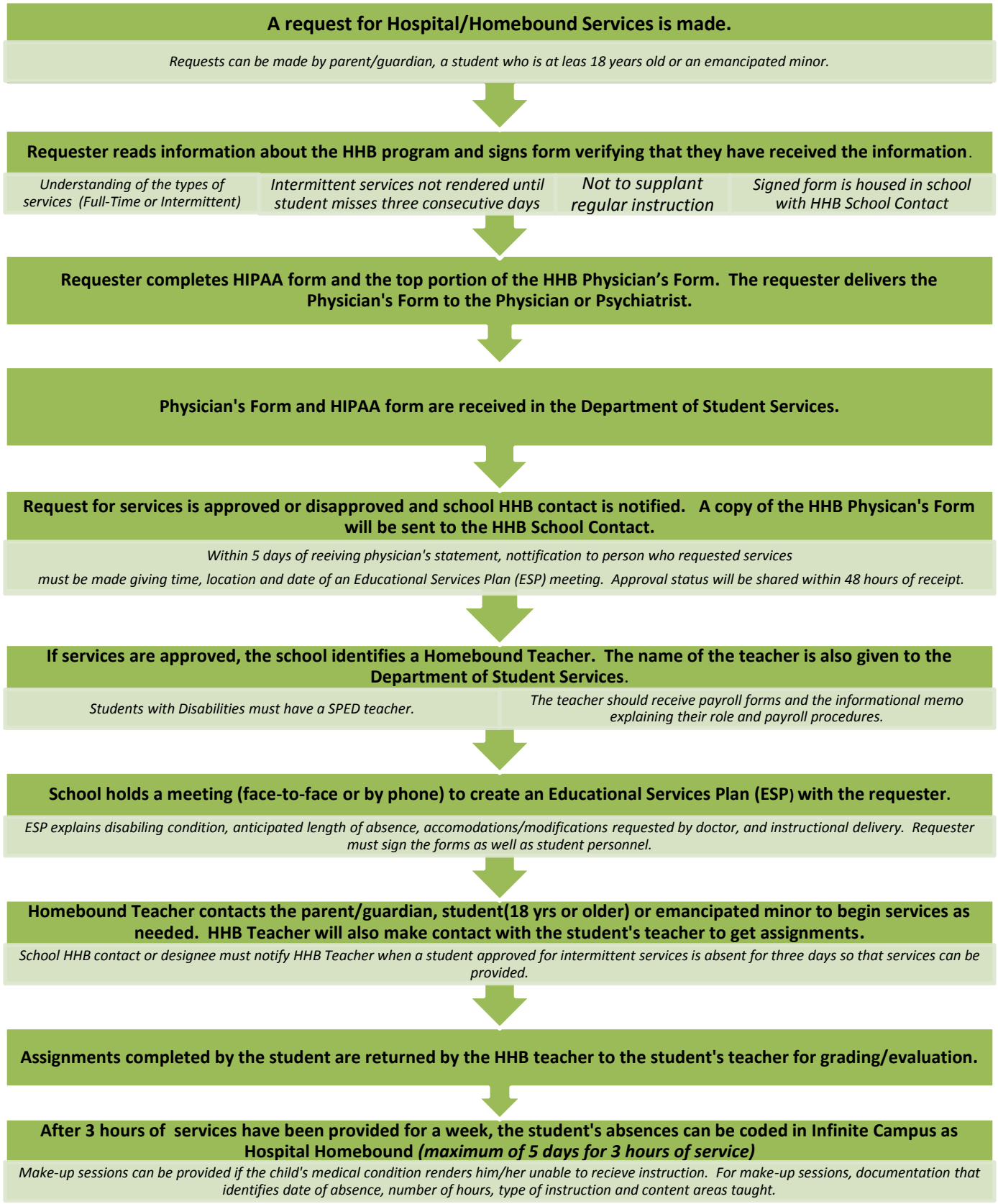
3. If the student is unable to receive HHB instruction during the school week due to his or her medical condition, the school may, at the school's discretion, schedule a make-up session. Once the session is completed, the student is counted in accordance with the Georgia State Board of Education Rule 160-5-1-.10 Student Attendance.

4. Make-up sessions must have documentation that identifies the date of the absence that is being made-up, the number of hours of instruction, the type of instruction provided, and the content area(s) taught.

5. The health care facility providing approved HHB services to a student confined in the facility must submit verification of the number of instructional hours the student received to the appropriate HHB contact at the LEA for the student to be counted present during this time.

6. Each student with whom the hospital/homebound instructor works is enrolled on the regular or special education classroom teacher's roll. The student's absence from the classroom is legitimate and should be understood and accepted by the school. Children who have never been enrolled in a public school must be enrolled if the system is to serve the student and receive attendance credit. These children should be enrolled in the school they would normally attend. After HHB instruction is provided, the student is marked present ("H".) Please note that attendance credit will only be given to students who are active participants in the Hospital/Homebound program. Repeated cancelled instructional appointments will result in a revocation of attendance credit.

Diagram of the Hospital/Homebound Services Process



LIST OF NURSES

2017– 2018
School Nurses' Assignments

Carla Buchanan	Deer Chase
	Diamond Lakes
Connie Butler	Freedom Park
Joann Carter	Josey
	Wilkinson Gardens
Toni Corkrin	Langford
	ILMC
Jenna Daniels (P/T)	Lake Forest Hills
Dontressa Elam	Jenkins White
	Monte Sano
Iris Fordham	Bayvale
	Copeland
Claudina Jones	Hephzibah High
	Hephzibah Elementary
Sharon Garn	Westside
	Merry
Erica Hodge	Hephzibah Middle
	McBean
Mary Knight	Craig-Houghton
	AR Johnson
LaVold Howard	C. T. Walker
	Davidson
Carolyn Jones	Goshen
Colleen Young	Jamestown/Morgan Road
Janet Johnson	Warren Road
	Laney
Regina Mutcherson	Meadowbrook/Alternative

Susie Jones (P/T)	Murphey
Regina Jones	Blythe/Terrace Manor
Gwendolyn Dorsey	Lamar-Milledge
	Sand Hills/PLC
Phyllis McGahee (P/T)	Technical Career Magnet
Latasha McKie	Glenn Hills High
	Glenn Hills Elementary
Deresia Jackson	A.D. Hains
	Rollins
Geraldine Owens	Spirit Creek Middle
	Willis Foreman
Ms. Evans (Sub)	Gracewood
	Tobacco Road
Katherine Riley	Hornsby Elem/Middle
Viola Manigo-Smart	Pine Hill Middle
	Windsor Spring
Jeanette Stokely	Garrett
	Tutt Middle
Arnita Thomas	Barton Chapel
	Glenn Hills Middle
Barbara Washington	ARC
Hattie Williams	Butler
	Southside
Tina Wisniewski	Sue Reynolds
Beverly Jeffers	Cross Creek
	RPM
Annette Pollard	BOE

School Nurse Pairing List: 2017-2018

- Erica Hodge and Dedrius Wright
- Farhana Qazi and Carla Buchanan
- Latasha McKie and Arnita Thomas
- Connie Butler and Tina Wisniewski
- Lavold Howard and Dontressa Elam
- Sharon Garn and Jeanette Stokely
- Beverly Jeffers and Colleen Young
- Deresia Jackson and Regina Mutcherson
- Geraldine Owens and Viola Manigo-Smart
- Barbara Washington and Gwendolyn *Dorsey*
- Janet Johnson and Jenna Daniels
- Iris Fordham and Toni Corkrin
- Regina Jones and Phyllis Mcgahee
- Hattie Williams and Carolyn Jones
- Joann Carter and Susie Jones
- Mary Knight and Katherine Riley

Subs:
Ella Evans
Valerie Lawton

LETTERS
&
FORMS

County Board of Education of Richmond County

Memorandum

Dear Parents:

Your Child, _____, seems to show signs of a skin infection called impetigo. This is a contagious rash that can spread from one child to another with close bodily contact. It is very important that you begin treatment immediately. Most impetigo can be cleared up if you:

1. Scrub the crust off with soap and water.

2. Clean three times a day with hydrogen peroxide.

3. Apply an antibiotic such as Bacitracin or Neosporin which can be purchased at the pharmacy without a physician's prescription.

Any obvious open sores must be covered with a dressing while the child is in school. You may consult your physician if you have any questions. If your child continues to show the rash with no improvement or it gets worse, we will be required to exclude your child from school until treatment is initiated by a physician. Please contact your school nurse at_____ if you have questions or concerns.

Guidance #126 (New 9-06)

Dear Parents:

During 1985, Bill Number S. B. 165 which addresses Scoliosis Screening and parent consent was passed by our state legislature. This bill eliminates the requirement that parents give prior approval for public school children to be screened for scoliosis. This bill does, however, mandate that advance notice of the screening be given to parents and that children be exempt from such screening if parents object.

If your child's spine is suspected of curvature, you will be notified and asked to take the child to your family physician, pediatrician, or an orthopedist for further evaluation.

SPINAL SCREENING PROCEDURE

(Forward Bending Test for Scoliosis and Kyphosis)

Types of Suspected Abnormalities:

1. Elevate Shoulder, Scapula

2. Curve in Spinous Process Alignment

3. Increased Distance between Arm and Truuk

4. Less Prominent Hip (Iliac Crest)

5. Asymmetry of Thorax Back (from front and back view)

6. Accentuated Spine Hump (from lateral view)

The screening date for your child's school is

_____

For those parents who agree to the screening, no further action is required by you. If, on the other had, you do not wish to have your child screened for scoliosis, indicate this below and return the form to the school. Thank you for your cooperation in this effort to detect scoliosis.

_____No, I do not approve the screening of my child for scoliosis.

Parent: _____ Date: _____

Student: _____ Homeroom Teacher_____

School:_____

Guidance #68 (REV.8/00)

County Board of Education of Richmond County

Memorandum

Dear Parents:

Upon inspection, your child _____ seems to show evidence of Conjunctivitis (Pink Eye). This is a contagious disease and can be spread from child to child. It is necessary that your child be excluded from school until treatment has begun. He/she may return to school the next day if he/she brings a note from the physician indicating that treatment has begun.

Guidance #83 (Rev. 9-06)

Head Lice Notification Letter to Parents

Date: _____

Dear Parent/Guardian,

We believe your child has head lice. This means either live adult lice or nits (eggs) were seen in your child's hair. Head lice are very common in school children, even when the hair is clean. They do not carry any disease. However, head lice can spread easily from child to child, and they should be treated at once so they do not spread.

We are also sending some information for families that you should read. The letter tells you about head lice and how they are treated. Talk to your child's healthcare provider, your pharmacist or the Health Department for the most up-to-date advice on treatment for your child.

Your child must be kept at home until he or she is treated so lice do not spread to classmates. This process should only take one or two days. School clinic or office personnel will check your child when he or she returns to school to make sure lice and nits have been removed. If you have any other questions about head lice, please call your child's healthcare provider or the health department.

_____ _____

Signature of Principal/ School Nurse/Clinic Personnel Phone #

Head Lice Notification to Parent/Guardian

SPANISH

Fecha (Date)_____

Estimados padres / apoderado o guardián legal (Dear Parent or Guardian),

Se cree que su niño tiene piojos en la cabeza. Cuando hay evidencia de piojos se pueden notar piojos adultos o huevos de piojos en la cabeza. Los episodios de piojos en la cabeza son muy comunes en los niños de edad escolar. Los piojos en la cabeza no contienen ninguna enfermedad y su presencia no indica la falta de higiene del niño. Sin embargo, los piojos se pueden pasar muy fácilmente de un niño a otro y necesitan ser tratados inmediatamente para evitar que se contagien a otros niños en la escuela.

Le adjuntamos una hoja de información para las familias la cual deben leer cuidadosamente. Esta carta describe los consejos para el tratamiento e información general sobre los piojos en la cabeza. También recomendamos que usted consulte con el proveedor de cuidados de salud de su niño, con su farmaceuta o con el Departamento de Salud para obtener información más corriente y recomendaciones para el tratamiento de su niño.

Ya que hay el riesgo de que los piojos se pasen a otros niños, le pedimos que su niño se quede en casa hasta que haya recibido tratamiento. La clínica de la escuela o el personal de la escuela revisará a su niño cuando regrese a la escuela para asegurarse que los piojos y sus huevos hayan sido destruidos. Si tiene alguna pregunta, por favor llame a la escuela y hable con alguien de la oficina o clínica.

_____

Firma del Rector (Signature of Principal)/Enfemera/Personal de enfermería

_____

Teléfono #

County Board of Education of Richmond County

Memorandum

Dear Parents:

Your child was refused admission to school for the following reason:

_____ Proof of ***head lice*** treatment not provided

_____ Evidence of head lice found on re-examination

Unless your child is satisfactorily treated and provides evidence of treatment (refer to previous letter), he/she will not be readmitted to school. This action is necessary to prevent exposure to other children. Such absences are illegal under State Compulsory Attendance Laws and the matter will be referred to the School Social Worker if the child has not returned to school satisfactorily treated in three days.

Please refer to the attached letter for recommendations regarding treatment of the child and disinfection of the home environment.

Please call the school at _____ to arrange a conference to discuss the options available to you at this time.

County Board of Education of Richmond County

Memorandum

Dear Parents:

Your child,_____shows signs of a rash or infection that will need to be seen by a physician before we can allow him/her to return to school. Please make immediate arrangements for your child to be seen. He/she may retum.to school with a note from your physician

Please contact the school nurse at _____regarding any questions or concerns.

County Board of Education of Richmond County

Memorandum

Dear Parents:

Your child,_____, seems to show signs of a scalp infection called Ringworm of the Scalp or Tinea Capitis. This is a contagious fungus that can spread from one child to another with close bodily contact. Because this exists, your child must be excluded from school until he/she is seen by a physician.

When he/she returns to school he/she must have documentation of the treatment method by the physician. Please provide the school with the physician's treatment plan. The school nurse will review the treatment plan when your child returns to school. Please contact the school nurse at_____if you have questions or concerns.

Name of School

Health Screening Report to Parents

Student's Name:_____ Grade:_____ Date:_____

School:_____ Phone:_____Teacher:_____

School's Report to Parents	*Physician's Report to School*
VISION _____ Within normal limi1s _____ Screening indicates a need for an eye specialist examination.	Diagnosis: Treatment FIU Plan: Recommendations: Physician's signature & title below
HEARING _____ Within normal limi1s _____ Screening indicates a need for medical/ audiological assessment	Diagnosis: Treatment FIU Plan: Recommendations: Physician's signature & title below
DENTAL _____ Within normal limi1s _____ Screening indicates a need for a dental examination and more frequent brushing and flossing.	Diagnosis: Treatment F/U Plan: Recommendations: Physician's signature & title below
BACK _____ Wrthin normal limi1s _____ Screening indicates a need for further assessment by physician.	Diagnosis: Treatment F/U Plan: Recommendations: Physician's signature & title below

County Board of Education of Richmond County

Memorandum

Health Services-Nursing

Dear Parents:

Your child, _____ bumped his/her head today. We have applied ice packs and after resting, he/she appears to be all right. We are sending this notice because we want parents to know of any possible head injuries. If your child become excessively drowsy or sleepy has pupils of unequal size, double vision, dizziness, trouble speaking, should start vomiting or complaining of a headache or other symptoms during the next 24-72 hours, immediately notify your doctor. If you are unable to reach your doctor, call the emergency room.

Signature_____

Title._____

School_____

Phone._____

GUIDANCE #84 (NEW 7-02)

Name:_____ Psychologist_____ Date:_____

School:_____ Grade:_____ Age:_____ Sex:_____

(LEFT) AUDIO (RIGHT)

	500	1000	2000	3000	4000		500	1000	2000	3000	4000	
0												0
10												10
20												20
25-----												-----25
30												30
40												40
50												50
60												60
70												70
80												80
90												90
	500	1000	2000	3000	4000		500	1000	2000	3000	4000	

VISION

NEAR POINT

(without glasses)	(with glasses)
LEFT 20/_____	20/
RIGHT 20/_____	20/_____
BOTH 20/_____	20/_____

FAR POINT

(without glasses)	(with glasses)
LEFT 20/_____	20/_____
RIGHT 20/_____	20/_____
BOTH 20/_____	20/_____

COLOR BLIND:_____

FLASH CARDS:_____

COMMENTS:

VERTICAL.IMBALANCE:_____

LATERAL IMBALANCE:_____

APPROVED BY:_____

PSYCHOLOGICAL SERVICES #26 (REV. 12-03)

Parent/Guardian Notice of
Vision Screening Referral

Date_____ School_____

To the Parent/Guardian of_____:

Your child did not pass the vision screening which was recently completed at school. It is recommended that he/she have an eye examination to see if there is a vision problem, which might need professional attention.

You may take your child, at your own expense, to a private eyecare specialist. **If you have Medicaid or Peachcare, it will pay for one eye exam and one pair of eyeglasses per year**. Please take the attached green medical report with you and give it to the eye specialist to complete. The form should be returned to your child's school.

Contact your School Nurse/Health Care Worker at your child's school or the School Social Worker to discuss other options or if you have questions.

Thank you for your cooperation.

Sincerely,

attachment

Parent/Guardian Notice of
Hearing Screening Referral

Date_____ School_____

To the Parent/Guardian of_____:

Your child did not pass the hearing screening which was recently completed at school. It is recommended that he/she have a complete hearing test to see if there is a hearing problem, which might need medical attention.

You may take your child, at your own expense, to a private ear specialist who has a licensed audiologist on staff. Please take the attached pink medical report with you and give it to the audiologist to complete and return it to your child's school.

Thank you for your cooperation. Please call if you have questions.

Sincerely,

Attachment

School Nurse Supply Request Form

Nurse:				**Date:**	
School(s)					
ITEM		**QUANTITY**			
		On Hand	Requested		
1	Adhesive Tape Yz"			Roll(s)	
2	Adhesive Tape **1"**			Roll(s)	
3	Alcohol			Bottle(s)	16 oz.
4	Alcohol Preps			Box	200 Per Box
5	Applicators			Pack(s)	10 Per Box
6	Band Aids ***Junior***			Boxes	100 Per Box
7	Band Aids ***Regular***			Boxes	100 Per Box
8	Band Aids ***Extra Large***			Boxes	100 Per Box
9	Blood Pressure Kit			Single	1 Per box
10	Cotton Balls			Bag(s)	50+ Per Bab
11	CPR Jv!icro Shields				Single Use - Disposable
12	Gauze Sponge (Non Sterile) ***4"X4"***			Bag(s)	200 Per Bag
13	Gloves ***Small***			Box	100 Per Box
14	Gloves ***Medium***			Box	100 Per Box
15	Gloves ***Large***			Box	100 Per Box
16	Kling			Bag(s)	
17	Ledger (Clinic, Contagious and Lice)				
18	Lice Shampoo			Bottle(s)	
19	Medicine Cups			Sleeve(s)	100 Per Sleeve
20	Penlights			Pack(s)	6 Per Pack
21	Petroleum Jelly			Tube(s)	4oz
22	Pillow Covers			Pack(s)	10 Per Pack
23	Safety Pins			Package(s)	90 Count Assorted
24	Sharps Container/Lid				
25	Stethoscope				
26	Table Paper			Roll(s)	
27	Thermometers ***Digital***			1 Per Box	
28	Thermometer Covers ***Digital***			Boxes	100 Sheaths Per Box
29	Tongue Depressors			Pack(s)	75-80 Per Pack
30	Triangular Bandage			Package(s)	**1** Set Per Package
31	Zip Lock Bags ***6 1/2 x 3 1/4***			Box(s)	50 Per Box
32	Zip Lock Bags ***7X8***			Box(s)	40 Per Box
Nurse Signature:					
Date:					

Parental Notice of Medication Refill Needed

Date_____,

Dear Parent/Guardian,

Your child,_____, has a one-week supply of medication

_____left at school. If he/she is to continue taking this medication, please bring us a new supply within the week. Please remember if the dose changes, we will need a new Medication Authorization form as well. Please call if you have any questions.

Sincerely,

_____
Your school nurse

MEDICATION and/or FOOD ALLERGIES ADMINISTRATION DAILY LOG

(To Be Completed For Each Medication)

Name of Student _____ **Grade** _____

Name of School _____ **School Year** _____

Name and Dosage of Medication _____

Time(s) Given at School _____

Oral _____ Inhaler _____ Eye Drops _____ Ointment _____

Medication Allergies _____ Food Allergies _____

Directions: Document time of administration and initials of person administering medication

	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
Aug																															
Sep																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
Apr																															
May																															
Jun																															

Initials and Signature of Persons Administering Medication:

1. _____ _____
2. _____ _____
3. _____ _____

CODES

(X) Absent

(N) No Medication Given

(O) No School (holiday, weekend, snow)

{Use Reverse side for reporting significant information (e.g. observations of medication's effectiveness, adverse reactions, reason for omission, etc.}

ADMINISTRATION OF MEDICATIONS

Child's Name:_____ Homeroom:_____

Address:_____

Allergies: Food_____ Medicine_____

Name of Medication:_____

Purpose of Medication:_____

Physicians requirement for dosage and method of administration:

_____

_____

_____

What to do in case of side effects:_____

_____

Termination date for administering medication:_____

_____ _____
Date Physician Signature

_____ _____
Date ·Parent Signature****

_____ _____
Date Student Signature
Approved by:

_____ _____
School Name Date

***Parental signature permits medication administration as well as contact with the prescribing physician if there are medication questions.

STUDENT ACCIDENT REPORT

IN THE EVENT OF AN ACCIDENT RESULTING IN INJURY TO *ANY PARTY, SUCH ACCIDENT OCCURRING ON BOARD OF EDUCATION PROPERTY, PLEASE COMPLETE THIS REPORT. FILE WHITE COPY WITH SCHOOL NURSE AND YELLOW COPY* TO *THE DIRECTOR OF MAINTENANCE WITHIN* 3 *WORKING DAYS.*

NAME OF INJURED PERSON _____

HOME ADDRESS _____

LOCATION OF ACCIDENT _____

TIME AND DATE OF ACCIDENT _____

NATURE OF INJURY _____

_____

DID INJURED PERSON RECEIVE MEDICAL TREATMENT? YES — NO — —

NAME OF DOCTOR _____

NAME OF HOSPTIAL _____

NARRATIVE ACCOUNT OF HOW ACCIDENT HAPPENED _____

_____

_____

IF THERE WERE WITNESSES TO THE ACCIDENT, LIST NAMES BELOW:

_____ _____

_____ _____

_____ _____

DATE OF THIS REPORT _____
NAME OF SCHOOL OR DEPARTMENT _____

REPORTED BY _____

WHITE COPY – SCHOOL NURSE

YELLOW COPY – DIRECTOR OF MAINTENANCE

RCSS #1004 (Rev. 8-99)

AFFIDAVIT OF RELIGIOUS OBJECTION TO IMMUNIZATION

_____personally appeared before the undersigned notary public and swore or affirmed as follows:

1. I am the parent or legal guardian of _____(name of minor child).
2. I understand that the Georgia Department of Public Health requires children to obtain the following vaccinations before being admitted to a childcare facility or school: diphtheria; haemophilus influenzae type B (not required on or after the fifth birthday); hepatitis A; hepatitis B; measles; meningitis; mumps; pertussis (whooping cough); pneumococcal (not required on or after the fifth birthday); poliomyelitis; rubella (German measles); tetanus; and varicella (chickenpox).
3. I understand that the Georgia Department of Public Health has determined that these vaccinations are necessary to prevent the spread of dangerous diseases among the children and people of this State; that the required vaccinations are safe; that a child who does not receive these vaccinations is at risk of contracting those diseases; and that a child who does not receive those vaccinations is at risk of spreading those diseases to me, to other children in the childcare facility or school, and to other persons.
4. I sincerely affirm that vaccination is contrary to my religious beliefs, and that my objections to vaccination are not based solely on grounds of personal philosophy or inconvenience.
5. I understand that, notwithstanding my religious objections, my child may be excluded from childcare facilities or schools during an epidemic or threatened epidemic of any disease preventable by a vaccination required by the Georgia Department of Public Health, and that my child may be required to receive a vaccination in the event that such a disease is in epidemic stages.

This ____ day of _____, 20____.

_____ _____

Parent or Legal Guardian (Printed) Parent or Legal Guardian (Signature)

_____

Name of Child/Student (Printed)

Sworn and subscribed before me this__ day of _____, 20____.

_____

Notary Public
My commission expires _____

Georgia Department of Public Health

DPH Form 2208 [5.2015]

Dear: _____

All students attending a Richmond County Public School are required to have adequate immunizations. Students entering a *Richmond County Public School are required to have at least three doses of Diphtheria* ***(inflammation of the mucous)****, Pertussis* ***(whooping cough)****, Tetanus* ***(a serious bacterial infection)*** *and Poliomyelitis* ***(polio)****, the last dose of each administered on or after the child's fourth birthday, and at least two doses of Measles and Mumps and one dose of Rubella (MMR) vaccine administered on or after the child's first* ***birthday***. **In addition, documentation of having had chicken pox or two Varicella (chicken pox) vaccines must be presented.**

Beginning with the school year 2007-2008, if your child is under five (5) years of age, he/she must have protection against the pneumococcal (***pneumonia***) disease. He/she will need the Pneumococcal Conjugate Vaccine (PCV). The number of doses needed will depend on the child's age. In addition, if your child is currently enrolled in a four (4) year old pre-k program, he/she may need to obtain the 2nd dose of varicella and mumps vaccine and will need to submit documentation of meeting the new requirements on the Georgia Certificate of Immunization (Form #3231) upon entry into five (5) year old kindergarten.

Effective with the school year 2000-2001, for entrance into any Georgia Public School, all students must have completed the Hepatitis B Vaccine Series (***inflammation of the liver***). For entrance into the sixth grade, or at its equivalent age, each child must show proof of one additional dose of MMR vaccine, for a total of two MMR vaccines administered on or after the child's first birthday and at least thirty days apart. Also, required are a Dental, Hearing and Vision certificate for students entering pre-kindergarten, kindergarten, first grade or a Georgia Public School for the first time and a birth certificate for pre-kindergarten, kindergarten and first grade students entering school for the first time.

Effective with the school year 2014, students entering 7th & 8th grade born on or after January 1, 2002 are required to receive one dose of TDAP ***(TETANUS, DIPHTERIA, PERTUSSIS Vaccine)*** **and MENINGOCOCCAL CONJUGATE** ***(meningitis)*** vaccine. This will also affect any new entrant to a Georgia School for the first time in Grades 8th through 12th.

The Certificates of immunization, dental, hearing and vision may be obtained at the Richmond county Health Department. Information about the centers, addresses, phone numbers and hours of immunization clinics may be obtained by calling 706-721-5800. These certificates may also be obtained from Fort Gordon or a private physician.

The birth certificates can be obtained from the Health Department in the area where your child was born. Any parent who cannot obtain a birth certificate from the local Department of Health (for a child born in Georgia) should do the following: Send the child's full name, date and place of birth, father's full name and mother's full maiden name along with a U. S. Postal money order for $25.00 (fee required for the search and one certified copy) to:

GA Dept. of Public Health Vital Records
2600 Skyland Dr. NE
Atlanta, GA 30319-3640

Certificates for foreign born students may be obtained by writing to:
Authentication Officer
Department of State
Washington, DC 20025

A review of your child's record reveals that he/she does not have the certificate(s) indicated below. Please have the certificate(s) turned in by the dates indicated so your son/daughter will continue to have the best education possible.

1.__ A Certificate of Immunization (Form #3231 due in 30 calendar days) will be due on or before _____.

2.__Documentation of having had chicken pox or the Varicella (chicken pox) vaccine due in 30 calendar days will be due on or before _____.

3.__ADental, Hearing and Vision Certificate (Form #3300 due in 30 calendar days) will be due on or before _____.

4.__A Birth Certificate (due in 45 calendar days) will be due on or before _____.

I fully understand that I must present to the school officials the certificate(s) checked by the date indicated. I further realize that my child will be withdrawn from school if he/she does not have the certificate(s) on file by the date indicated.

Name of Student	Signature of School Official	Date

Signature of Parent	Date

Student services #58 (Rev 7-2015

Scabies Notification Letter to Parents

Date _____

Dear Parent/Guardian:

Based on observation in the class and clinic, your child _____ was found to have symptoms characteristic of scabies. This is not a diagnosis, and you should follow up with your child's health care provider or the health department.

Scabies is a skin condition caused by a tiny mite that burrows under the skin and causes intense itching, especially at night. The areas most commonly affected are the hands and wrists, but other areas may be affected as well. Other family members should be checked as well if there is any rash or itching present.

Scabies is not serious and is easily treated. However, it is contagious and easily spread through bodily contact. For this reason, your child needs to be examined so that treatment can be started as soon as possible. It is usually treated with a prescription lotion. After the treatment, your child's clothing and bedding used in the last three to four days should be washed and dried or dry-cleaned. Follow your health care provider's instructions carefully.

Before your child returns to school, you will need a note from your child's health care provider (either that no treatment is necessary, or that treatment has been started). If you have further questions concerning the detection and treatment of scabies, please contact your child's health care provider or the health department.

Thank you for your cooperation in this matter.

_____ _____

Signature of Principal/ School Nurse/Clinic Personnel Phone #

Scabies Notification Letter to Parents (Spanish)

Fecha (Date) _____

Estimado Padre/Madre:

Después de observar a su niño (child's name) _____ en la clase y clínica, hemos encontrado que tiene síntomas característicos de la sarna. Este no es un diagnóstico, por consiguiente, usted necesita hablar con el proveedor de cuidados de la salud de su niño o con su departamento de salud.

La sarna es una condición de la piel causada por ácaros muy pequeños que se meten bajo la piel y causan mucha comezón especialmente en la noche. Las manos y las muñecas son las áreas del cuerpo más comúnmente afectadas, pero otras áreas también pueden ser afectadas. Otros miembros de la familia también deben ser revisados si tienen cualquier tipo de sarpullido o comezón.

La sarna no es seria y se puede tratar fácilmente. Sin embargo, la sarna es contagiosa y se puede pasar fácilmente de una persona a otra por el contacto físico. Por esta razón, su niño necesita ser examinado para que el tratamiento empiece lo más pronto posible. La sarna es usualmente tratada con una loción recetada. Después del tratamiento, toda la ropa del niño, sus sábanas y sobrecamas que haya usado en los pasados 3 a 4 días debe ser lavada y secada o lavada en seco. Siga cuidadosamente las instrucciones de su proveedor de cuidado de la salud.

Antes de que su niño regrese a la escuela, usted necesitará una nota del proveedor de cuidados de salud de su niño (indicando que no se necesita el tratamiento o que se ha empezado el tratamiento). Si usted tiene preguntas adicionales acerca de la forma de detectar o tratar la sarna, por favor comuníquese con el proveedor de cuidados de la salud de su niño o con el departamento de salud.

Gracias por su cooperación.

_____ _____

Firma del Rector (Signature of Principal) Personal de enfermería(Signature of School Nurse)

LETTER TO PARENTS OF STUDENTS WITH BED BUGS

Date:_____

Dear Parent or Legal Guardian,

Today, a bed bug was found on your child or in your child's belongings. While this does not necessarily mean that the bed bug was brought to school by your child, it is important to your child's health and to the school community that you inspect your home for signs of bed bugs. Below you will find information about bed bugs and an identification guide to help you with your inspection. Once you have inspected your home, please fill out the form on the back of this letter and return it to the school office by_____

Sincerely,

Principal

Helpful Ways to Eliminate Bed Bugs in the Home

1. Remove any clutter from your home. Highly cluttered homes and bedrooms provide be bugs with numerous places to hide.
2. Use a vacuum to clean away any debris. It makes it easier to determine if the bed bugs are dead or alive. Make sure that the infested vacuum bag is thrown away outside of the building.
3. Put infested clothing in a hot dryer to kill bed bugs and their eggs. Heat can also be used to kill bed bugs in furniture and carpeting by using a steamer.
4. Cover your mattresses/boxsprings with encasements. Encasements are intended to seal your mattress/boxspring so that no bed bugs can infest your mattress, and any bed bugs currently infesting your mattress can never bite through or escape from the encasement. (It is important that the mattress encasements you purchase have a zipper that will close completely.)

Basic Facts.About Bed Bugs

1. Adult bed bugs are about 3/16- inch long and reddisl1-brown, with oval, flattened bodies. They can be mistaken for ticks or cockroaches. Immature bedbugs are smaller and lighter in color.
2. Bed bugs do not fly, but can move rapidly over floors, walls, ceilings and other surfaces.
3. Unlike head lice, they do not live on people. However, they can hitchhike in backpacks, clothing, luggage, books, etc.
4. Bed bugs are active mainly at night. During the day, they hide close to where people sleep.
5. A common concern with bed bugs is whether they transmit disease. Although they can harbor pathogens, transmission to humans is considered unlikely.

Parent Acknowledgment Form

I have been informed that a bed bug was found on my child at school. I understand that I must take action to prevent the spread of bed bugs to the school community. I have read and understood the educational materials provided to me regarding bed bugs, and have:

1. carefully checked my family and home for signs of bed bug infestation myself.

2. hired a pest management professional to check my family and home for signs of bed bug infestation. Name of Pest Control Company:_____

3. After completing a careful inspection, I certify that to the best of my knowledge:

_____ I or a pest management professional found signs of bed bugs in my home, and I will take the following actions to eliminate this infestation:

or

_____ I or a pest management professional did not find signs of bed bugs in my home at this time. If I find evidence of bed bugs in the future, I will notify the school immediately and take action to address the infestation.

I understand that bed bugs can be spread to other homes if they are brought to school in backpacks, clothing, and other belongings. I understand that if bed bugs are repeatedly found on my child, that the school may take additional actions to protect the school community from bed bugs.

Signature_____ Date_____

Pest Management Professional's Signature:

_____Date_____

-Letter to parents in student's classroom
Please Place On School Letterhead-

Date

Dear Parent or Guardian:

This letter is to inform you that we recently found a bed bug in your child's classroom. While bed bugs are a nuisance and can cause discomfort, they are not known to spread disease. They are usually active at night and feed on human blood. The bite does not hurt at first, but it may become swollen and itch, much like a mosquito bite. Watch for clusters of bites, usually in a line, on exposed areas of the body. If you have concerns for you or your child, please contact your health care provider.

We feel we have identified the source of the bed bugs and have treated the classroom to eliminate them. At this time, we feel we have corrected the problem. However, we will continue to monitor the classroom and school.

Please feel free to call the school at _____ if you have any questions or concerns. Thank you for your continued support of the Richmond County School System and _____ School.

Sincerely,

Principal

Department of Student Services
864 Broad Street, Room 103
Augusta, Georgia 30901-4295
706-826-1129 ~ Fax: 706-826-4626

DEBBIE ALEXANDER, Ed. D.
Associate Superintendent of Curriculum

ANGELA D. PRINGLE, Ed.D.
Superintendent

ED SANDERSON, Ph. D.
Director of Student Services

Date

Dear Parent/Guardian,

There has been a case of hand, foot and mouth disease within your child's school and your child may have been exposed.

What is hand, foot and mouth disease? This is a disease caused by a group of viruses which usually affects young children. It causes blisters on hands and feet, and mouth ulcers inside the cheeks and on the tongue. They may also have a sore throat and high temperature. These symptoms last for 7–10 days.

Is it dangerous? No. All make a full recovery.

Is it the same as foot and mouth disease in cows? No. A completely different virus causes foot and mouth disease in cows

How is it spread? The virus is spread by coughs and sneezes, and is also found in the feces of infected children. Some children infected with the virus do not have symptoms but can still pass it to others.

Is there any treatment? There is no specific treatment for hand, foot and mouth disease – it is usually a mild and self-limiting illness. If a child feels unwell paracetamol may help. Antibiotics and creams or ointments for the blisters are not effective. Children recover just as quickly without them

What is the incubation period? Symptoms start 3-5 days after exposure to the virus.

How long are children infectious? Children who are ill are infectious. Also they may carry the virus in their feces for many weeks after they have recovered and so can continue to pass on infection.

How long should children stay away from school? Children who are unwell should be kept out of school until they are feeling better. After 24 hours without fever, and if the child feels well enough to participate, he/she should be able to return to school.

How can spread be prevented? Since the virus is found in feces, careful attention must always be paid to hand washing after using the toilet.

Can you catch it more than once? Yes, but children who are ill during an outbreak at school or nursery are unlikely to get it again during the same outbreak.

Thank you for giving this your attention. Your child's doctor will be able to answer any further questions that you might have about hand, foot and mouth disease.

Sincerely,

When can my child return to school?

Patient and Family Education

This teaching sheet contains general information only. Talk with your child's doctor or a member of your child's healthcare team about specific care of your child.

Is your child too sick for childcare or school?

It is often hard to decide early in the morning if your child is too sick to go to his childcare center or school. It can be hard to tell if minor symptoms will get better or worse during the day.

Use these guidelines to help you decide when to keep your child home. **Check with your child's school for more specific guidelines.**

Illness	Contagious?	Symptoms	When to return to childcare or school
Chickenpox	Yes – spread by direct contact with fluid inside blisters or with droplets from mouth or nose	• Fever • Red, itchy rash on body – changes from bumps to blisters to scabs	• Talk with your child's doctor about treatment for your child. • Keep your child home until all the bumps have scabs and no new bumps appear for 2 days. • Tell the school and playmate's parents if your child gets chickenpox. • Children who have not yet had chickenpox should receive a shot (vaccine) to protect them from the disease.
Colds	Yes	• Runny nose • Scratchy throat • Cough **NOTE:** These symptoms may also be caused by allergies.	• Your child may go to childcare with minor cold symptoms. • If symptoms are worse than you might expect with a common cold, call your child's doctor. Call **right away** if your child is not acting normally, has a fever or has any trouble breathing.
Fever	Depends on cause	Temperature over 100.3°F	Keep your child home until there is no fever without using medicines for 24 hours.
Flu	Yes - spread by contact with droplets from eyes, mouth or nose	• Fever • Chills • Cold symptoms • Body aches • Sometimes vomiting and diarrhea	Keep your child home until there is no fever without using medicines for 24 hours and symptoms subside. This is usually for 5 to 7 days. **NOTE:** Children with chronic health problems should have a flu shot each year.

In case of an urgent concern or emergency, call 911 or go to the nearest emergency department right away.

Illness	Contagious?	Symptoms	When to return to childcare or school
Impetigo	Yes – spread by direct contact or by droplets from mouth or nose	Red, oozing, blister-like rash on body or face	Keep your child home until his doctor says it is OK to return to school.
Middle ear infections	No	• Ear pain • Fever	Your child may attend school if comfort level allows.
MRSA	Yes – spread from person to person by hand contact	• Swelling • Drainage • Fever	• Give antibiotics if advised by your child's doctor. • Your child may return to school once treatment is started. • For open sores, keep covered until no more drainage. • No close contact sports until all sites are healed.
Pinkeye	Yes – spread by a germ or virus	• Watery eyes • Itchy eyes • Redness in whites of eyes • Puffy eyelids • Drainage from eyes **NOTE:** These symptoms may also be caused by allergies.	• Treat your child's pinkeye as advised by his doctor. This may include antibiotics. • Your child may return to school once treatment begins.
Ringworm	Yes – spread by direct contact. Ringworm can affect the skin or scalp.	• Skin – pink, raised patches and mild itching • Scalp – flaky or crusty patches, and hair loss	• Treat your child's skin or scalp as advised by his doctor. • For skin - keep patches covered with a bandage. • For scalp - teach your child not to share hats, brushes, combs, clothing or linens. • Your child may return to school once treatment is started.
Scabies and lice	Yes – spread by direct contact. Scabies affects the skin; lice affect the scalp.	• Itching • Scratching	• Treat your child's skin or scalp right away as advised by his doctor. • For scabies - keep your child home until after treatment is started. • For lice - keep your child home until all live lice are gone. Check your child's head for lice for 7 to 10 days. Re-treat, as needed. • Teach your child not to share hats, brushes, combs, clothing or linens.

In case of an urgent concern or emergency, call 911 or go to the nearest emergency department right away.

Illness	Contagious?	Symptoms	When to return to childcare or school
Strep throat or scarlet fever	Yes – spread by contact with droplets from mouth or nose	• Sore throat • Fever • Headache • Stomach ache	• Take your child to the doctor if he has these symptoms. • Keep your child home until he is free of fever and on antibiotics for 24 hours.
Vomiting or diarrhea	Depends on cause	• Vomits more than once • Loose, runny stools	• Keep your child home until there is no fever without using medicines for 24 hours and symptoms subside. • For vomiting – also, keep your child home until he has not vomited for at least 24 hours. • For diarrhea – also, keep your child home until he has not had diarrhea for at least 24 hours. This includes children who wear diapers. • If diarrhea or vomiting occur often or occur with a fever, rash or general weakness, call your child's doctor.

In case of an urgent concern or emergency, call 911 or go to the nearest emergency department right away.

