Section B.

School Entry & Maintenance

I. Foundations of School Nursing

II. Documentation

III. School Entry

   a. Immunization
   b. Tuberculosis
   c. Physical examination
   d. Lead

IV. Screenings

   a. Vision
   b. Hearing
   c. Postural & Gait

V. Medications

   a. Prescriptions
   b. OTC
   c. Field trips

The information in Section B provides guidelines on some fundamentals of school nursing practice in Delaware. A quality documentation system assures easy input and access of information, continuity of care, transfer of records confidentially, and accuracy. School enrollment health requirements also support the health and well being of the student by providing a current and accurate assessment. Both documentation and data collection help to assure that each student's individual needs are considered when planning for full school participation and academic success. Regulations must be followed as specifically written, but additional protocols and policies may be needed in order to assure safe practice within an individual school setting or for an individual student. For example, the regulation on field trips provides structure for allowing teacher assistance with self-medication; however, in some cases the best management may be to have a school nurse accompany the student.

I. Foundations of School Nursing

School Nurse Responsibilities*

The school nurse should have the physical, mental, social, emotional and ethical capabilities, as well as the professional nursing and other educational preparation, to adequately perform in the following areas:

1. The school nurse provides health care to the school community.
   - *To assume responsibility for the care of the sick and injured in keeping with school policy.*
2. The school nurse provides leadership for the provision of health services.
   - *To maintain adequate and up-to-date health records.*
   - *To evaluate the nursing aspects of the school health program.*
3. The school nurse provides screening and referral for health conditions.
   - *To appraise and identify the health needs of students through school screenings such as vision, hearing, postural/gait, tuberculin testing and physical examinations.*
   - *To encourage the correction of remedial conditions by working with parents/guardians, teachers and community agencies.*
4. The school nurse promotes a healthy school environment.
   - *To work with administrators, teachers, and other school personnel to modify the school environment and curriculum for children with health concerns.*
   - *To recommend changes in the school environment to reduce health and safety hazards.*
5. The school nurse promotes health.
   - *To provide health counseling to students, parents/guardians and school personnel, keeping in mind the limitations as well as abilities.*
   - *To present health education, both informally and formally, as requested.*
6. The school nurse serves in a leadership role for health policies and programs.
   - *To serve as a resource person to the school and the community on health education including, but not limited to, physical, emotional, personal and social, and consumer health and safety.*
   - *To review and evaluate own job performance and professional development.*
7. The school nurse serves as a liaison between school personnel, family, community, and health care providers.
   - *To serve as liaison between the healthcare community and the schools.*

The nurse is a member of the school's professional staff and contributes to the total educational program.

* The seven major roles are identified within the Issue Brief of the National Association of School Nurses, *School Health Nursing Services Role in Health Care, Role of the School Nurse* (2002).

Suggested Schedule for the School Nurse

August – October

Prior to the first student day:

1. Set up health room with medical supplies and equipment.
2. Review Standard Precautions with staff.
3. Organize Student Health Records in a manner that allows easy access; i.e., arrange by homeroom, grade level, or alphabetical order. (Get current pupil roster from school office.)
4. Review health records to identify students with special health concerns or those needing immunizations, tuberculosis screening, physical exams or lead testing. Communicate with appropriate school personnel regarding student health conditions and any needed school modification.

During the first week of school:

5. Carry out responsibilities related to staff and/or volunteer tuberculosis screening as directed by district.
6. Obtain Emergency Data Cards on all students; maintain in nurse's office for easy access.
7. Organize medication and treatment administration.
8. Obtain health records for students transferring into school; if it is believed no record will be forthcoming, obtain data and start entering student health information into electronic medical record system. Forward health records for students transferring out of schools.

After the start of the school year:

9. Update student's electronic health records with information obtained from Student Health History Update.
10. Send copies of School Immunization Form or computer printout of new school enterers' immunizations to the Division of Public Health Immunization Program.
11. If your school participates in a Dental Clinic, identify students eligible for dental clinic services, process parental permission slips, schedule visits to clinic, and arrange for transportation of students (if available).
12. Prepare schedule and begin screening programs. Postural/gait screening should be completed prior to December 15 of each year and reported to the District Coordinator or Lead School Nurse. Hearing and vision screening should be completed by January 15.
13. Continue contacts with parent/guardian of students needing a physical examination, tuberculin screening, immunizations or lead testing.
14. Inform teachers assigned to health instruction of resources and materials available through your office or state and local agencies.
15. Inform parents regarding scheduled, mandated screenings.
16. Train educational staff on Assistance with Medications for Field Trips. Remind staff to provide adequate notice to the nurse of upcoming off-site events so that nursing coverage can be arranged PRN.

January – April

1. Order supplies and equipment for next school year.
2. Assist with kindergarten registration as directed by district.

May – June

1. Complete all documentation related to the District/Charter Summary of School Health Services (see Section B, page 26).
2. Prepare health records for transfer to feeder school or state archives.
3. Follow up on referrals.

Ongoing Responsibilities – September through June

1. Check and re-supply medical supplies in nurse's office.
2. Continue with screening, recording, and follow-up with parent/guardian and school staff.
3. Continue to serve as a resource person for health education in classrooms.
4. Continue conferences with teachers to keep nurse and teachers abreast of any health concerns that may surface.
5. Check absentee lists for clues leading to epidemics. The school nurse is <u>not</u> an attendance officer or clerk, but should utilize expertise in working with absences related to illness.
6. Continue record review, update and follow-up as needed.
7. Continue to follow up with parent/guardian who fail to respond to referrals.
8. Prepare and monitor individual healthcare plans and individual emergency care plans for students with special needs.
9. Continue to assess records of new enterers.
10. Organize/facilitate athletic physical examinations as requested /directed.
11. Participate in IEPs and multi-disciplinary meetings PRN.
12. Provide instruction to school personnel who will be responsible for assisting with medication on field trips.
13. Provide/arrange pertinent inservice programs for staff.

Confidentiality of School Health Information

Confidentiality of student health information is governed by local, state and federal legislation. The school nurse must carefully assess every situation before sharing any student information on a "need to know" basis.

Federal statutes and regulations have jurisdiction over privacy in school records: the Family Educational Rights and Privacy Act (FERPA), the Individuals with Disabilities Education Act (IDEA), and Section 504 of the Americans with Disabilities Act (ADA). Department of Education *Regulation #252, Required Educational Records and Transfer and Maintenance of Educational Records* delineates school responsibilities related to student records. Additionally, Department of Education *Regulation #925, Children with Disabilities* provides guidelines. It should be noted that the Health Insurance Portability of Accountability Act (HIPPA) regulates the sharing and transfer of medical data in medical settings, while FERPA governs educational records including student health data. *Regulation #251, Family Educational Rights & Privacy Act* (FERPA) delineates Delaware School responsibilities.

The school nurse is bound by the Code of Ethics of the National Association of School Nurses to respect confidentiality. Licensure as a registered nurse carries that same obligation and accountability.

It is highly recommended that the school nurse become familiar with confidentiality regulations as outlined in FERPA, IDEA, Section 504 of the ADA and state law. An additional resource is *Guidelines for Protecting Confidential Student Health Information* written by the National Task Force on Confidential Student Health Information, a project of the American School Health Association in collaboration with the National Association of School Nurses and the National Association of School Nurse Consultants.

II. Documentation

811 School Health Record Keeping Requirements

1.0 Definitions

"**Delaware School Health Record Form**" means a form containing documentation of an student's health information, which includes but is not limited to identifying information, health history, immunizations, results of mandated testing and screenings, medical diagnoses, long term medications and referrals.

"**Emergency Treatment Card**" means a card containing general school emergency procedures for the care of a student who becomes sick or injured at school. The card contains the following information: the student's name, birth date, school district, school, grade, home room or teacher, home address, home telephone, the name, place of employment and work telephone of the parent, guardian or Relative Caregiver; two other names, addresses and phone numbers of individuals who can be contacted at times when the parent, guardian or Relative caregiver cannot be reached; the name and telephone number of the family physician and family dentist; any medical conditions or allergies the student has; and the student's medical insurance.

2.0 Emergency Treatment Card

2.1 An Emergency Treatment Card for each public school student shall be on file in the office of the school nurse.

2.1.1 The information on the Emergency Treatment Card shall be shared only on a need to know basis as related to the education and health needs of the student and consistent with state and federal laws.

2.1.2 The parent, guardian or Relative Caregiver or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a) shall sign the Emergency Treatment Card to assure they understand the purpose of the form and acknowledge the accuracy of the information.

3.0 Delaware School Health Record Form

3.1 The Delaware School Health Record Form shall be current and shall be part of the student's health record within the Cumulative Record File (14 **DE Admin. Code** 252) which accompanies the student when he or she moves to another school.

3.2. The Delaware School Health Record Form shall be maintained for the duration of the student's schooling and the school nurse shall use the Student Health History Update Form to keep health records current.

The Delaware School Health Record Form shall remain in the nurse's file during the student's attendance in school.

3.2.1 The Delaware School Health Record Form may be maintained in hard copy or within an electronic documentation program and transferred electronically. Beginning with the 2008-2009 school year, all Delaware School Health Records Forms shall be in an electronic format.

NON REGULATORY NOTE: also see 14 **DE Admin. Code** 251 and 252 and the Delaware Public Archives Document Delaware School Districts General Records Retention Schedule.

4.0 Other Required Documentation

4.1 The school nurse shall document any nursing care provided including the school name, a three point date, the person's (student, staff or visitor) first and last name, the time of arrival and departure, the presenting complaint, the nurse's assessment intervention and the outcome, the disposition of the situation, the parent or other contact, if appropriate, and the nurse's complete signature or initials.

4.1.1 The school nurse shall document the care given at the time of a school based accident by completing the Student Accident Report Form if the student missed more than one half day because of the accident or if the school nurse has referred the student for a medical evaluation regardless of whether the parent, guardian or Relative Caregiver or student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a) followed through on that request.

5.0 Submission of Records

5.1 All local school districts and charter schools shall submit the Summary of School Health Services Form, to the Delaware Department of Education by August 31st of each year. The form shall include all of the school health services provided in all schools during the fiscal year including summer programs.

DELAWARE EMERGENCY TREATMENT DATA CARD

Student's Name ______________________________ Birth Date __________ School District__________________
Last Name First Name M.I.

School_____________________________ Grade________ Homeroom or Teacher______________ Bus No.____

Home Address__________________________________ Development___________________ Home Phone____

Resides with___________________________________ Relationship___________________________________

Mother/Guardian's Name__________________________________ Father/Guardian's Name__________________

Mother's Place of Employment_________________________________ Phone_____________________ Ext.____

Father's Place of Employment__________________________________ Phone_____________________ Ext.____

Pager number___________________________________ Cellular number_____________________

If parents/guardians cannot be reached, call:

1. ____ _______________
Name Address Phone

2. ____ _______________
Name Address Phone

Family Physician_________________ Phone____________ Family Dentist_______________ Phone____________

Indicate student's serious medical conditions____

Student is allergic to: ( ) Penicillin ( ) Aspirin ( ) Other______________________________

Medical Insurance: Medicaid No.______________________________ Other:______________________________
Certificate No. Group No. Type

This information may be shared only on a "need to know" basis with school personnel and emergency medical staff.

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SCHOOL EMERGENCY PROCEDURES

Your schools have adopted the following procedures in caring for a student when he/she becomes sick or injured at school:

In case of a life-threatening emergency, the school will call 911 and then follow the steps below. In case of other emergencies and/or need of medical or hospital care:

1. The school will call the home. If there is no answer,
2. The school will call the father's, mother's or guardian's place of employment. If there is no answer,
3. The school will call the other telephone number(s) listed and the physician.
4. If none of the above answer, the school will call an ambulance, if necessary, to transport the student to a local medical facility.
5. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility.
6. The school will continue to call the parents, guardians, or physician until one is reached.

If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for moving and medically treating this student. I also hereby consent to any treatment, surgery, diagnostic procedures or the administration of anesthesia which may be carried out based on the medical judgment of the attending physician.

Parent/Guardian Signature____ Date___________________________

SCHOOL HEALTH RECORD – STATE OF DELAWARE

Medical Card

The Medical Card consists of the following:

- Student ID
- Student Name
- Gender, Grade
- Birth Date
- Status
- Counselor
- Medical Alerts
- Growth Exam
- Hearing Exam
- Physical Exam
- Posture/Gait Exam
- Vision Exam
- Other Screenings and Record Reviews
- Issued Medicine
- Office Visits
- Immunizations
- Referrals

STATE OF DELAWARE

INDIVIDUAL HEALTH SERVICES LOG

District/School: _____

School Nurse: _____ _____

(printed name / signature / initials) (printed name / signature / initials)

Date	In/Out	Reason (Use Code)	Intervention (Use Code)	Office Visit Detail Include Referral	Disposition	Rx/Tx	Initials

Medical Alerts: _____ Birth Date: _____ Student: _____

STATE OF DELAWARE

CHILDREN'S SERVICES COST RECOVERY PROJECT LOG
EPSDT Nursing Service Description by Medicaid Reporting Number

Date: ____/_____/_____ District/School:_____

School Nurse:_____
Signature(s) Required (Initial below if more than one nurse)

EPSDT Reporting Number	Time In	Time Out	Student Name

Document #229

	Children's Services Cost Recovery Project (CSCRP) **EPSDT Nursing Service Description by Medicaid Reporting Number** **Nursing Service Description: Treatment**
1	Care of the Sick
2	Wound Care – First Aid
3	Wound Care – Ongoing
4	Collateral Contacts for Updating Medical Information: Community Agencies, Doctors, Staff, Family
5	Medications – Administration & Monitoring
6	Physician Prescribed Medical Treatments
7	Nursing Evaluation
8	Diabetic Care – Monitoring and/or Medication Administration
9	Cast Care
10	Personal Care, which is Medically Necessary and Requires Nurse Intervention
11	Naso-gastric Feedings – Bolus/Drip
12	Gastrostomy Feedings – Bolus/Drip
13	Change of Gastrostomy Tube
14	Catheterization
15	Feeding of Children with Oral Motor Deficits Speech Pathology/Occupational Therapy
16	Suctioning
17	Tracheal Suctioning
18	Tracheal Care – Decanulation
19	Tracheal Ventilation – Ambu Bag
20	Oxygen Administration
21	Nebulizing/Humidifying
22	Postural Drainage
23	Chest Percussion
24	Special Diet Consideration: Modification & Monitoring
N/A	Child was Medicaid Recipient, But Non-EPSDT Service or Nurse Judged Service not Medically Necessary

Number	**Nursing Service Description: Assessment**
A1	EPSDT Partial Assessment: Health Education
A2	EPSDT Partial Assessment: Immunization
A3	EPSDT Assessment: Hearing
A4	EPSDT Assessment: Vision
A5	EPSDT Partial Assessment: Developmental/Orthopedic
A6	EPSDT Assessment: Dental

Number	**Nursing Service Description: Counseling Therapy**
C1	Individual Counseling Treatment
C2	Group Counseling Treatment
C3	Family Counseling Treatment
C4	Individual Counseling Co-Treatment
C5	Group Counseling Co-Treatment
C6	Family Counseling Co-Treatment
C7	Case Consultation

NURSING CARE

Admission Care ADMINCARE – *facilitating entry of student into school (health needs)*
Airway Management AIRMGT–*facilitation of patency of air passages*
Airway Suctioning AIRSUC–*removal of airway secretions by inserting a suction catheter into the patient's oral airway &/or trachea*
Allergy Management ALLERGY–*identification, treatment, & prevention of allergic responses to food, medications, insect bites, contrast material, blood, & other substances*
Artificial Airway Management ARTAIR–*maintenance of endotrachial/tracheostomy tubes & prevention of complications associated with their use*
Aspiration Precautions ASPIR–*prevention/minimization of risk factors in the patient at risk for aspiration*
Asthma Management ASTHMA–*identification, treatment and prevention of reactions to inflammation/constriction of the airway passages*
Bleeding Reduction: Nasal NOSEBL– *Limitation of blood loss from the nasal cavity*
Bleeding Reduction: Wound BLEED–*limitation of the blood loss from a wound that may be a result of trauma, incisions, or placement of a tube or catheter*
Bowel Management BWL–*establishment & maintenance of a regular pattern of bowel elimination*
Cast Care: Maintenance CAST–*care of a cast after the drying period*
Chest Physiotherapy CHEST–*assisting the patient to move airway secretions from peripheral airways to more central airways for expectoration &/or suctioning*
Contact Lens Care EYECL – *prevention of eye injury & lens damage by proper use of contact lenses*
Diarrhea Management DIARR–*prevention & alleviation of diarrhea*
Emergency Care (illness) ERILL–*providing life-saving measures in life-threatening situations caused by illness*
Emergency Care (injury) ERINJ–*providing life-saving measures in life-threatening situations caused by injury*
Enteral Tube Feeding TUBEFEED–*delivering nutrients & water through a gastrointestinal tube*
Feeding FEED – *feeding of patient with oral motor deficits*
Fever Treatment FVR–*management of a patient with hyperpyrexia caused by nonenvironmental factors*
First Aid FA – *providing initial care for non wound type of injury*
First AidFA–*providing initial care for a minor injury*
Health Care Information Exchange (illness) INFOILL–*providing patient care information to other health professionals related to illness*
Health Care Information Exchange (injury) INFOINJ–*providing patient care information to other health professionals related to injury*
Heat/Cold Application (injury) HTCLD–*stimulation of the skin & underlying tissues with heat or cold for the purpose of decreasing pain, muscle spasms, or inflammation*
Heat Exposure Treatment HEATX–*management of patient overcome by heat due to excessive environmental heat exposure*
Hemorrhage Control HMRR–*reduction or elimination of rapid & excessive blood loss*
High-Risk Pregnancy Care PREG–*identification & management of a high-risk pregnancy to promote healthy outcomes for mother & baby*
Hyperglycemia Management HYPERG–*preventing & treating above-normal blood glucose levels*
Hypoglycemia Management HYPOG–*preventing & treating low blood glucose levels*
Immunization Management IZMGT – *monitoring immunization status and facilitating access to immunization*
Medication Administration MEDADM–*preparing, giving, & evaluating the effectiveness of prescription & nonprescription drugs*
Medication Management MEDMGT–*facilitation of safe/effective use of prescription & over-the-counter drugs*
Multidisciplinary Care Conference (illness) CONFILL–*planning & evaluating patient care with health professionals from other disciplines*
Multidisciplinary Care Conference (injury) CONFINJ–*planning & evaluating patient care with health professionals from other disciplines*
Nausea Management NAUSEA – *prevention and alleviation of nausea*
Neurologic Monitoring NEURO–*collection & analysis of patient data to prevent or minimize neurological complications*
Non-Nursing Intervention NONNURSE – *providing service not requiring nursing skills/expertise*
Nursing Assessment, No Intervention NASS – *providing assessment requiring professional nursing knowledge and skills without related intervention*
Nursing Intervention NURSE – *intervention requiring professional nursing knowledge and skills (not available on current list)*
Nutrition Management NUTMGT – *assisting with providing a balanced dietary intake of foods and fluids*
Nutrition, Special Diet SPDIET–*modification & monitoring of special diet*
Ostomy Care OSTO– *maintenance of elimination through a stoma & care of surrounding tissue*
Pain Management PAIN–*alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient*
Positioning POSI–*deliberative placement of the patient or a body part to promote physiological &/or psychological well-being*
Referral Management REFMGT – *arrangement for services by another healthcare provider or agency*
Respiratory Monitoring RESP–*collection & analysis of patient data to ensure airway patency & adequate gas exchange*
Rest REST – *providing environment & supervision to facilitate rest/sleep <u>after</u> nursing evaluation*
Resuscitation RESUS–*administering emergency measures to sustain life*
Seizure Management SZR–*care of a patient during a seizure & the postictal state*
Self-Care Assistance, Nursing SELFNUR–*assisting another to perform activities of daily living*
Self-Care Assistance, Non-Nursing SELFNON–*assisting another to perform activities of daily living*
Skin Care SKIN–*application of topical substances or manipulation of devices to promote skin integrity & minimize skin breakdown*
Surveillance SURV - *purposeful/ongoing acquisition, interpretation, & synthesis of patient data for clinical decision making*
Surveillance: Skin SKINSRV–*collection/analysis of patient data to maintain skin & mucous membrane integrity*
Telephone Consultation TC–*for purpose of updating medical information*
Treatment Administration TXADM–*preparing, giving, & evaluating the effectiveness of prescribed treatments*
Treatment Management TXMGT–*facilitation of safe & effective prescribed treatments*

Tube Care TUBECARE–*management of a patient with an external drainage device exiting the body*
Tube Care, Gastrointestinal TUBECAREGI–*management of a patient with a gastrointestinal tube*
Urinary Catheterization CATH–*insertion of a catheter into the bladder for temporary or permanent drainage of urine*
Vital Signs Monitoring VS–*collection/analysis of cardiovascular, respiratory, & body temperature data to determine/prevent complications*
Wound Care (Ongoing) WOUNDON–*prevention of wound complications & promotion of wound healing*

COUNSELING

Abuse Protection Support: Child ABUSE – *identification of high-risk, dependent child relationships & actions to prevent possible or further infliction of physical, sexual, or emotional harm or neglect of basic necessities of life*
Counseling (individual) COUNSEL – *use of an interactive helping process focusing on the needs, problems, or feelings of the patient & significant others to enhance or support coping, problem-solving, & interpersonal relationships*
Counseling (group) COUNSELG – *use of an interactive helping process focusing on the needs, problems, or feelings of the group & significant others to enhance or support coping, problem-solving, & interpersonal relationships*

HEALTH EDUCATION

Anticipatory Guidance (individual) AGUIDE – *preparation of patient for an anticipated developmental &/or situational crisis*
Anticipatory Guidance (group) AGUIDEG – *preparation of a group of patients for an anticipated developmental &/or situational crisis*
Body Mechanics Promotion (individual) BODY – *facilitating a patient in the use of posture & movement in daily activities to prevent fatigue & musculoskeletal strain or injury*
Body Mechanics Promotion (group) BODYG – *facilitating a group of patients in the use of posture & movement in daily activities to prevent fatigue & musculoskeletal strain or injury*
Exercise Promotion (individual) EXER – *facilitation of a patient in regular physical exercise to maintain or advance to a higher level of fitness & health*
Exercise Promotion (group) EXERG – *facilitation of a group of patients in regular physical exercise to maintain or advance to a higher level of fitness & health*
Health Education (individual) HLTHED – *developing & providing individual instruction & learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups, or communities*
Health Education (group) HLTHEDG – *developing & providing group instruction & learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups, or communities*
Smoking Cessation Assistance (individual) SMOKE – *helping the patient to stop smoking through an individual process*
Smoking Cessation Assistance (group) SMOKEG – *helping the patient to stop smoking in a group process*
Substance Use Prevention (individual) SUBAB – *prevention of an alcoholic or drug use life-style through an individual process*
Substance Use Prevention (group) SUBABG – *prevention of an alcoholic or drug use life-style through a group process*
Weight Management WGTMGT – *facilitating maintenance of optimal body weight & percent body fat*

HEALTH PROMOTION/PROTECTION

Environmental Management ENVMGT – *manipulation of the patient's surroundings for therapeutic benefit, sensory appeal & psychological well-being*
Health System Guidance HGUIDE – *facilitating a patient's location & use of appropriate health services*
Infection Protection INFPRO – *prevention & early detection of infection in a patient at risk*
Prevention Care PREVCAR – *prevention of medical condition for an individual at high risk for developing them*
Progressive Muscle Relaxation MURELX – *facilitating the tensing & releasing of successive muscle groups while attending to the resulting differences in sensation*
Seizure Precautions SZRPRE – *prevention or minimization of potential injuries sustained by a patient with a known seizure disorder*
Suicide Prevention PRESUI – *reducing risk of self-inflicted harm with intent to end life*
Surveillance: Safety SAFE – *purposeful & ongoing collection & analysis of information about the patient & the environment for use in promoting & maintaining patient safety*
Sustenance Support SUST – *helping a needy individual/family to locate food, clothing, or shelter*

SCREENING

Health Screening: BMI SCREENBMI – *monitoring growth and detecting abnormalities through height and weight measurement*
Health Screening: Blood Pressure SCREENBP – *detecting possible hypertension through BP measurement*
Health Screening: Dental SCREENDEN – *detecting possible dental abnormalities through a dental exam of the mouth using a dental instrument*
Health Screening: Developmental SCREENDEV – *detecting possible developmental or orthopedic deviations through history & screening*
Health Screening: Hearing SCREENH – *detecting possible hearing deviations through screening measures*
Health Screening: Immunization SCREENI – *determining immunization status & compliance by means of history, examination, & other procedures*
Health Screening: Other SCREENOT – *detecting abnormalities/deviations through the use of standardized screening methods*
Health Screening: Pediculosis SCREENPEDIC– *detecting the presence of lice or nits through examination*
Health Screening: Postural/Gait SCREENPG – *detecting possible postural or gait deviations through screening measures*
Health Screening: Tuberculosis SCREENTB – *detecting possible exposure to TB through the use of a health risk assessment questionnaire*
Health Screening: Vision SCREENV – *detecting possible vision deviations through screening measures*

NIC links to CSCRP

Nursing Intervention - #1 – Care of the Sick

Airway Management – *facilitation of patency of air passages*
Allergy Management – *identification, treatment, and prevention of allergic responses to food, medications, insect bites, contrast material, blood, or other substances*
Aspiration Precautions – *prevention or minimization of risk factors in the patient at risk for aspiration*
Asthma Management – *personal actions to reverse inflammatory condition resulting in bronchial constriction of the airways*
Body Mechanics Promotion (individual) – *facilitating the use of posture and movement in daily activities to prevent fatigue and musculoskeletal strain or injury*
Bowel Management – *establishment and maintenance of a regular pattern of bowel elimination*
Diarrhea Management – *prevention and alleviation of diarrhea*
Emergency Care (illness) – *providing life-saving measures in life-threatening situations*
Fever Treatment – *management of a patient with hyperpyrexia caused by non-environmental factors*
Heat Exposure Treatment – *management of patient overcome by heat due to excessive environmental heat exposure*
Pain Management – *alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient*
Resuscitation – *administering emergency measures to sustain life*
Seizure Management – *care of a patient during a seizure and the postictal state*

Nursing Intervention - #2 – Wound Care – First Aid

Bleeding Reduction: Nasal – *limitation of the amount of blood loss from the nasal cavity*
Bleeding Reduction: Wound – *limitation of the blood loss from a wound that may be a result of trauma, incisions, or placement of a tube or catheter*
Emergency Care (injury) – *providing life-saving measures in life-threatening situations*
First Aid – *providing initial care of a minor injury*
Heat/Cold Application – *stimulation of the skin and underlying tissues with heat or cold for the purpose of decreasing pain, muscle spasms, or inflammation*
Hemorrhage Control – *reduction or elimination of rapid and excessive blood loss*

Nursing Intervention - #3 – Wound Care – Ongoing

Ostomy Care – *maintenance of elimination through a stoma and care of surrounding tissue*
Wound Care (Ongoing) – *prevention of wound complications and promotion of wound healing*

Nursing Intervention - #4 – Collateral Contacts for Updating Medical Information: Community Agencies, Doctors, Staff, Family

4-1 Health Care Information Exchange (illness) – *providing patient care information to health professionals in other agencies*
4-2 Health Care Information Exchange (injury) – *providing patient care information to health professionals in other agencies*
4-1 Multidisciplinary Care Conference (illness) – planning *and evaluating patient care with health professionals from other disciplines*
4-2 Multidisciplinary Care Conference (injury) – planning *and evaluating patient care with health professionals from other disciplines*
4-1 Telephone Consultation – *for purpose of updating medical information*

Nursing Intervention - #5 – Medications – Administration & Monitoring

Medication Administration – *preparing, giving, and evaluating the effectiveness of prescription and nonprescription drugs*
Medication Management – *facilitation of safe and effective use of prescription and over-the-counter drugs*

Nursing Intervention - #6 – Prescribed Treatments

Treatment Administration – *preparing, giving, and evaluating the effectiveness of prescribed treatments (DE)*
Treatment Management – *facilitation of safe and effective prescribed treatments (DE)*

Nursing Intervention - #7 – Nursing Evaluation
Health Screening: Blood Pressure - *detecting possible hypertension through blood measurement*
7-7 Health Screening: BMI – *detecting possible abnormalities through height and weight calculations of BMI*
7-7 Health Screening: Other – *detecting abnormalities and/or deviations through the use of standardized screening methods*
Health Screening: Pediculosis – *detecting the presence of lice or nits through examination*
Health Screening: Tuberculosis - *detecting possible exposure to tuberculosis through the use of a health risk assessment questionnaire*
High-Risk Pregnancy Care – *identification and management of a high-risk pregnancy to promote healthy outcomes for mother and baby*
Neurologic Monitoring – *collection and analysis of patient data to prevent or minimize neurological complications*
Nursing Intervention – *intervention requiring professional nursing knowledge and skills (not available on current list)*
Respiratory Monitoring – *collection and analysis of patient data to ensure airway patency and adequate gas exchange*
Rest – *providing environment and supervision to facilitate rest/sleep after nursing evaluation*
Skin Surveillance – *collection and analysis of patient data to maintain skin and mucous membrane integrity*
Surveillance – *purposeful and ongoing acquisition, interpretation, and synthesis of patient data for clinical decision making*
Vital Signs Monitoring – *collection and analysis of cardiovascular, respiratory, and body temperature data to determine and prevent complications*

Nursing Intervention - #8 – Diabetic Care – Monitoring &/or Medication Administration
Hyperglycemia Management – *preventing and treating above-normal blood glucose levels*
Hypoglycemia Management – *preventing and treating low blood glucose levels*

Nursing Intervention - #9 – Cast Care
Cast Care: Maintenance – *care of a cast after the drying period*

Nursing Intervention - #10 – Personal Care, which is Medically Necessary and Requires Nurse Intervention
Positioning – *deliberative placement of the patient or a body part to promote physiological and/or psychological well-being*
Progressive Muscle Relaxation – *facilitating the tensing and releasing of successive muscle groups while attending to the resulting differences in sensation*
Self-Care Assistance, Nursing – *assisting another to perform activities of daily living*
Skin Care – *application of topical substances or manipulation of devices to promote skin integrity and minimize skin breakdown*
Tube Care – *management of a patient with an external drainage device exiting the body*

Nursing Intervention - #11 – Naso-gastric Feedings – Bolus/Drip

Nursing Intervention - #12 – Gastrostomy Feedings – Bolus/Drip
Enteral Tube Feeding – *delivering nutrients and water through a gastrointestinal tube*

Nursing Intervention - #13 – Change of Gastrostomy Tube
Tube Care, Gastrointestinal – *management of a patient with a gastrointestinal tube*

Nursing Intervention - #14 – Catheterization

Urinary Catheterization – *insertion of a catheter into the bladder for temporary or permanent drainage of urine*

Nursing Intervention - #15 – Feeding

Feeding – *feeding of patient with oral motor deficits (DE)*

Nursing Intervention - #16 – Suctioning

Airway Suctioning – *removal of airway secretions by inserting a suction catheter into the patient's oral airway and/or trachea*

Nursing Intervention - #17 – Tracheal Suctioning

Nursing Intervention - #18 – Tracheal Care - decannulation

Artificial Airway Management – *maintenance of endotrachial and tracheostomy tubes and prevention of complications associated with their use*

Nursing Intervention - #19 – Tracheal Ventilation – Ambu Bag

Nursing Intervention - #20 – Oxygen Administration

Nebulizing/Humidifying - #21

Nursing Intervention - #22 – Postural Drainage

Chest Physiotherapy – assisting the patient to move airway secretions from peripheral airways to more central airways for expectoration and/or suctioning

Nursing Intervention - #23 – Chest Percussion

Nursing Intervention - #24 – Special Diet Consideration: Modification & Monitoring

Nutrition, special diet – *modification and monitoring of special diet*

Nursing Intervention – C1 – Individual Counseling Treatment

Counseling (individual) – *use of an interactive helping process focusing on the needs k problems, or feeling of the patient and significant others to enhance or support coping, problem-solving, and interpersonal relationships*

Exercise Promotion (individual) – *facilitation of regular physical exercise to maintain or advance to a higher level of fitness and health*

Nursing Intervention – C2 – Group Counseling Treatment

Counseling (group) – *use of an interactive helping process focusing on the needs k problems, or feeling of the patient and significant others to enhance or support coping, problem-solving, and interpersonal relationships*

Exercise Promotion (group) – *facilitation of regular physical exercise to maintain or advance to a higher level of fitness and health*

Nursing Intervention - #A1 – Health Education

Health Education (individual) – *developing and providing instruction and learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups, or communities*

Smoking Cessation Assistance (individual) – *helping another to stop smoking*

Substance Use Prevention (individual) – *prevention of an alcoholic or drug use life-style*

Weight Management – *facilitating maintenance of optimal body weight and percent body fat*

Nursing Intervention - #A2 – Immunization

Health Screening: Immunization – *determining immunization status and compliance by means of history, examination, and other procedures (DE)*

Nursing Intervention - #A3 – Hearing

Health Screening: Hearing – *detecting possible hearing deviations through screening measures (DE)*

Nursing Intervention - #A4 – Vision

Health Screening - Vision – *detecting possible vision deviations through screening measures (DE)*

Nursing Intervention - #A5 – Developmental/Orthopedic

Health Screening: Developmental – *detecting possible developmental or orthopedic deviations through history and screening (DE)*

Health Screening: Postural/Gait – *detecting possible postural or gait deviations through screening measures*

Nursing Intervention - #A6 – Dental

Health Screening: **Dental** – *detecting possible dental abnormalities through a dental exam of the mouth using a dental instrument (DE)*

Nursing Intervention - No link to Medicaid

Abuse Protection Support: Child – *identification of high-risk, dependent child relationships and actions to prevent possible or further infliction of physical, sexual, or emotional harm or neglect of basic necessities of life*

Admission Care – *facilitating entry of student into school (health needs)*

Anticipatory Guidance (individual) – *preparation of patient for an anticipated developmental and/or situational crisis*

Anticipatory Guidance (group) – *preparation of patient for an anticipated developmental and/or situational crisis*

Body Mechanics Promotion (group) – *facilitating the use of posture and movement in daily activities to prevent fatigue and musculoskeletal strain or injury*

Environmental Management – *manipulation of the patient's surroundings for therapeutic benefit*

Health Education (group) – *developing and providing instruction and learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups, or communities*

Health System Guidance – *facilitating a patient's location and use of appropriate health services*

Infection Protection – *prevention and early detection of infection in a patient at risk*

Non-Nursing Intervention – *providing service not requiring nursing skills and/or expertise (not available on current list)*

Referral Arrangement - *arrangement for services by another healthcare provider or agency*

Self-Care Assistance, Non-Nursing – *assisting another to perform activities of daily living (DE)*

Seizure Precautions – *prevention or minimization of potential injuries sustained by a patient with a known seizure disorder*

Smoking Cessation Assistance (group) – *helping another to stop smoking*

Substance Use Prevention (group) – *prevention of an alcoholic or drug use life-style*

Suicide Prevention – *reducing risk of self-inflicted harm with intent to end life*

Surveillance: Safety – *purposeful and ongoing collection and analysis of information about the patient and the environment for use in promoting and maintaining patient safety*

Sustenance Support – *helping a needy individual/family to locate food, clothing, or shelter*

Approved Nursing Documentation Abbreviations

eSchool documentation codes are included in Appendix

A		BUE	both upper extremities
$\overline{a}$	before	butt	buttocks
@	at		
abd	abdomen	**C**	
abdt	abduction	$\overline{c}$	with
abr	abrasion	Ca	carcinoma
a.c.	before meals	cal	calorie
add	adduction	cap	capsule
adeq	adequate	cath	catheter
ADL	activities of daily living	CBC	complete blood count
ad lib	freely, as directed	cc	cubic centimeters
admin	administration	C.D.	communicable disease
adv	advise	CHN	Community Health Nurse
AFO	ankle foot orthosis	circ	circulation
a.m.	before noon, morning	CMV	cytomegalovirus
amb	ambulate	c/o	complained of
amt	amount	COA	children of alcoholics
ans	answer	comm	communication
ant	anterior	conf	conference
AP	apical pulse	cont	continued
approx	approximately	couns	counselor
appt	appointment	C.P.	cerebral palsy
AROM	active range of motion	C.P.E.	complete physical exam
ASAP	as soon as possible	CPR	Cardiopulmonary resuscitation
ASHD	anteriosclerotic heart disease	C.R.	classroom
ASOM	acute serous otitus media	CV	cardiovascular
asst	assistance		
aud	auditory	**D**	
Ax temp	axillary temperature	DAT	diet as tolerated
		d.c.	discontinue
B		demo	demonstrate
band	Band-Aid	D/I	dry and intact
B.C. pills	birth control pills	diam	diameter
BG	Blood Glucose	dig	digoxin
BID	twice daily	dip	distal interphalangeal
bilat	bilateral	disch	discharge
BIW	twice weekly	discomf	discomfort
BLE	both lower extremities	Dr.	doctor
BM	bowel movement	drng	drainage
BP	blood pressure	drsg	dressing
BR	bathroom	dsd	dry sterile dressing
brkfst	breakfast	dx	diagnosis
BS	breath sounds	dx'd	diagnosed
B.T.	bowel tones		

E	
ea	each
EEG	electroencephalogram
e.g.	for example
EI	early intervention
EKG	electrocardiogram
enc	encourage
EPSDT	Early and Periodic Screening and Diagnostic and Treatment Program
equip	equipment
ER	emergency room
etiol	etiology
eval	evaluation
exer	exercise
ext	exterior
ext rot	external rotation
F	
FBS	fasting blood sugar
fe	female
FHX	family history
flex	flexion
fr	from
freq	frequency
FROM	full range of motion
ft	foot
FU	follow up
FWB	full weight bearing
fx	fracture
G	
gd	good
G&D	growth and development
GI	gastrointestinal
gm	gram
gr	grain
gtts	drops
GU	genitourinary
H	
H20	water
H202	hydrogen peroxide
HA	headache
HC	health card
HCP	health care provider
hct	hematocrit
hgb	hemoglobin
HL	head lice
HOH	hard of hearing
hosp	hospital
hr	hour
HR	health room
h.s.	at bedtime
ht	height
HTN	hypertension
HV	home visit
hx	history
I	
IEP	individualized educational program
IM	intramuscular
immed	immediate
immu	immunization
incl	include
incont	incontinent
indiv	individual
info	information
inj	injection
int	internal
int rot	internal rotation
intro	introduction
irreg	irregular
irrig	irrigation
IV	intravenous
J-K	
jt	joint
K+	potassium
Kg	kilograms
L	
l	liter
lab	laboratory
lang	language
lat	lateral
lb.	pound

LB	low back
LBP	low back pain
LD	learning disabled
LE	lower extremity
lg	large
liq.	liquid
LLCI	lower left central incisor
LLL	left lower lobe
LLQ	left lower quadrant
LMP	last menstrual period
LOC	level of consciousness
LRCI	lower right central incisor
LTG	long term goal
LUL	left upper lobe
LUQ	left upper quadrant
M	
MD	doctor
MDT	multidisciplinary team
med	medication
mg	milligram
MI	myocardial infarct
mid	middle
min	minute
mm	millimeter
mo	month
MP	menstrual period
MS	multiple sclerosis
musc	muscle
MWB	minimum weight bearing
N	
Na+	sodium
NANDA	North American Nursing Diagnosis Association
NaCI	sodium chloride
NAD	no apparent distress
NaHCO3	sodium bicarbonate
NCP	nursing care plan
nec	necessary
neg	negative
noc	at night
norm	normal
NPH	type of insulin
npo	nothing by mouth
NS	normal saline
nsg	nursing
NTG	nitroglycerin
nutr	nutrition
N/V	nausea and vomiting
NWB	non weight bearing
O	
O	none
obj	object
obs	observe
occ	occasionally
o.d.	right eye
OHI	other health impaired
OK	okay
OPC	out-patient clinic
OPV	oral polio vaccine
o.s.	left eye
OT	occupational therapy
OTC	over the counter
o.u.	both eyes
oz	ounce
P	
p	after
p	pulse
par	parent
path	pathology
pc	after meals
PC	parent contact
PE	physical exam
P.E.	physical education
PERLA	pupils equal and react to light and accommodation
PMD	private medical doctor
po	by mouth
P.O.	post operative
POMR	problem oriented medical record
pos	positive
post	posterior
PPBS	post prandial blood sugar

PPD	purified protein derivative	RUL	right upper lobe
PPP	pedal pulses palpable	RUOQ	right upper outer quadrant
pres	present	RUQ	right upper quadrant
princ	principal	Rx	prescription
pm	when necessary		
prob	problem	**S**	
prog	prognosis	$\overline{s}$	without
PROM	passive range of motion	satis	satisfactory
PRO-TIME	prothrombin time	SBC	school based clinic
pt	patient	sch	school
PT	physical therapy	sched	schedule, scheduled
P/U	pick up, picked up	scr	screen, screening
PWB	partial weight bearing	SED	seriously emotionally disturbed
		sero-sang	sero-sanguineous
Q		shldr	shoulder
q	every	sl	slight
qd	every day	sm	small
qh	every hour	SOAPIE	Subjective, objective, assessment (nursing diagnosis), plan, intervention, evaluation
QID	four times a day		
qmo	every month		
qod	every other day	sob	shortness of breath
qow	every other week	SOM	serous otitis media
ques	question	sp	speech
		s/s	signs and symptoms
R		S/T	sore throat
RA	rheumatoid arthritis	stat	at once
rec	recommend	subq	subcutaneous
ref	refer, referred, referral	superf	superficial
reg	regular	supp	suppository
req	request	SV	school visit
resp	respiration	SW	social worker
RLL	right lower lobe	Sx	symptoms
RLQ	right lower quadrant		
RN	Registered Nurse	**T**	
R/O	rule out	tab	tablet
ROM	range of motion	TB	Tuberculosis
rpt	repeat, repeats, repeated	TBI	traumatic brain injury
R&R	rate and rhythm	TBRF	Tuberculosis Risk Assessment Form
RR	respiratory rate	tbsp	tablespoon (15cc.)
RSW	right side weakness	tc	telephone call
R/T	related to	temp	temperature
RTC	return to class		
rtn	return	TID	three time a day
RTO	return to office	TM	tympanic membrane
		TMR	trainable mentally retarded

TPR	temperature, pulse, respiration
tr	trace
trach	tracheostomy
transc	transcribe, transcribed
tsp	teaspoon (5 cc.)
tx	treatment
U	
UA	urinalysis
U.A.P.	unlicensed assistive personnel
U.I.	unit of insulin
ULCI	upper left central incisor
URCI	upper right central incisor
URI	upper respiratory infection
UTC	unable to contact
UTI	urinary tract infection
V	
VA	Veterans Administration
vag	vaginal
vasc	vascularity
vis	visual
vocab	vocabulary
VS	vital signs
W	
WBC	white blood count
wc	wheelchair
w&d	warm & dry
W/D	withdraw, withdrawn
wk	week
wnd	wound
WNL	within normal limits
wt	weight
X-Y-Z	
y.o.	year old

≃	Approximately
Δ	Change
√	Check
↓	Decrease
=	Equals
>	Greater than
↑	Increase
→	Leading or progressing to
<	Less than
-	Minus
#	Number
¶	Paragraph
/	Per
%	Percent
+	Plus
?	Questions
↗	Unstable

Abbreviations developed from Quality Nursing Interventions in the School Setting (J. Hootman, 1996, NASN), used with permission, and Delaware school nurses' input.

STUDENT ACCIDENT REPORT FORM

This form, or a similar one preferred by the district, is to be completed on each injury which occurs in the school building, on the school grounds, while the student is on his/her way to or from school activities that result in one-half or more day's absence from school or requires a doctor's attention or both. This form can be created electronically with eSchool. Submit all completed reports to the designated office in school district. It is recommended that a duplicate copy of this report be prepared for the school's file. The nurse may be asked by the district/charter to fill out additional medical insurance paperwork.

1. NAME_____ AGE_____ SEX: M_____ F_____

2. DISTRICT_____ SCHOOL_____ GRADE OR CLASSIFICATION_____

3. TIME Accident Occurred: Hour_____a.m. or p.m. Date_____ DATE Accident Reported_____

4. NATURE OF ACCIDENT. Check all appropriate areas. (To be completed by nurse or other designated personnel.)

Nature of Injury		Part of Body Injured (Indicate L or R for left or right when applicable)			
___ Abrasion	__ Dental	__ Ankle	____ Face	____ Knee	____ Shoulder
___ Bite	__ Dislocation	__ Arm	____ Finger	____ Leg	____ Stomach
___ Bruise	__ Foreign body in eye	__ Back	____ Foot	____ Lip	____ Tooth
___ Burn	__ Laceration	__ Chest	____ Hand	____ Mouth	____ Wrist
___Chemical Burn	__ Puncture	__ Collar Bone	____ Head	____ Neck	____ Other
___ Concussion	__ Sprain/Strain	__ Elbow	____ Hip	____ Nose	
___ Cut	__ Other (specify)	__ Eye		____ Scalp	
	_____				

5. Subjective Data_____

_____

_____

_____

Objective Data_____

_____

_____

_____

_____ Date of last tetanus shot_____

Assessment_____

Intervention_____

_____

_____

_____

CONTINUE TO NEXT PAGE

STUDENT ACCIDENT REPORT FORM - continued

6. How did accident happen? What was student doing? Where was student? List specifically any unsafe act(s) and/or unsafe condition(s). Specify any tool, machine or equipment involved.

_____

_____

_____

_____

7. What action(s) was taken and by whom?

First aid treatment	_____	By whom?	(Enter name)_____
Sent to school nurse	_____	By whom?	(Enter name)_____
Sent home	_____	By whom?	(Enter name)_____
Sent to physician	_____	By whom?	(Enter name)_____
Sent to hospital	_____	By whom?	(Enter name)_____

8. Was parent/guardian or anyone notified? Yes_ No_____

   When: Date_____ Time_____ How_____

9. Please complete below:

Location		Activities		Area	
Athletic Field	____	Apparatus	____	Building	____
Auditorium	____	Ball Playing	____	Grounds	____
Cafeteria	____	Baseball	____	Interscholastic	____
Classroom	____	Basketball	____	Intramural	____
Corridor	____	Field Hockey	____	Physical Education	____
Dressing Room	____	Football	____	Shops	____
Gymnasium	____	Free Play	____	Labs	____
Home Economics	____	Gymnastics	____		
Laboratories	____	Running	____	**To and From School**	
Lockers	____	Soccer	____	Bicycle	____
School Grounds	____	Softball	____	Motor Veh Passenger	____
School Shops	____	Swimming	____	Motor Veh Bicycle	____
Science	____	Track and Field	____	Motor Veh Pedes.	____
Showers/Dressing Room	____	Volleyball	____	School Bus	____
Stairs Inside	____	Wrestling	____	Streets and Walks	____
Stairs and Walks Outside	____	Other	____	Other	____
Toilet Rooms	____				
Voc and Indus. Arts	____				

10. Total number of school days lost _____ (To be recorded when student returns to school)

11. Student is covered by Student Accident Insurance Yes_____ No_____

12. Person in charge when accident occurred (Signature)_____

_____ _____

Nurse Principal

DISTRICT/CHARTER SUMMARY OF SCHOOL HEALTH SERVICES

The District/Charter Summary is often referred to as the "Annual Summary" or the "District Summary". It reports Health Services provided in public schools. The document must be submitted annually to the Department of Education (DOE).

Regulation 811: School Health Record Keeping Requirements
Submission of Records

5.1 All local school districts and charter schools shall submit the Summary of School Health Services Form, to the Delaware Department of Education by August 31st of each year. The form shall include all of the school health services provided in all schools during the fiscal year including summer programs.

Data for this report is derived from documentation of health services provided by the school nurses. The Annual Summary form was changed in 2006 to reflect the fields represented within electronic student medical records used in Delaware public schools. Since that time, DOE has assisted in creating the reports by pulling data from eSchool Plus* (the statewide pupil accountability system that includes medical data). Each August, DOE Technology staff creates an initial Annual Summary for each district and charter. If the district/charter has more than one school, both individual school data and district summative data are created. These summaries are sent to the district/charter for review. When electronic documentation and the new Annual Summary were first introduced, school nurses made significant changes to the drafts as the school nurses were not documenting all activities into the electronic record. Today, the only changes to the report should be the inclusion of information on staff volunteer screenings as these are not included in eSchool. All other information is pulled from eSchool Plus.

* FY11 Two districts (Colonial & Red Clay) use a different medical software program; however, the codes are standardized. DOE Technology does not create an initial Summary for these districts.

School Year____

Due Date: _____

Return to :
Linda C. Wolfe, RN
Health Services

Justification:

The State Board shall prescribe rules and regulations governing the protection of health, physical welfare and physical inspection of public school children in the State. 14 Del Code 122(b)(2)

School or School District:

I. Clients	Students	Staff	Visitors	Total	% Total Stud Population	% Total Staff Population
B. Nurse Office Visits (minutes out of class)						
1. < 15 min.						
2. 16 - 30 min.						
3. 31 - 45 min.						
4. 46 - 60min.						
5. 60 - 120 min.						
6.> 120 min.						
7. Average time						
8. Total Visits (B1 - B6)						
C. Disposition: % after nurse intervention						
1. Returned to class/activity						
2. Sent to school staff (ex. principal, counselor)						
3. Sent to Wellness Center						
4. Sent home (nurse directed)						
5. Went home (parent directed)						
6. Exclusion for communicable disease						
7. Sent for immediate evaluation/treatment						
8. 911						
9. Not Seen						
10. Other						
D. Contacts/Communication/Notification re: client						
1. Parents/Guardian						
2. School						
3. Community						
II. Nursing Care: Assessment & Intervention	**Students**	**Staff**	**Visitors**	**Total**	**Outcome (Resolution/ Improvement)**	
A. Functional: *Care to promote basic health needs*						
1. Activity/Exercise					n/a FY09	
2. Comfort/Rest					n/a FY09	
3. Growth & Development/Nutrition					n/a FY09	
4. Self-Care					n/a FY09	
B. Physiological: *Care to promote optimal biophysical health*						
1. Physical Health & Well-Being						
a. Special Nursing Procedures					n/a FY09	
b. First Aid/ Emergency Care					n/a FY09	
c. Body Systems Support (ex. cardiac, resp., tissue)					n/a FY09	
2. Pharmacological						
a. Medications						
b. Treatments						

c. Unduplicated Students receiving Rx/Tx						
C. Psychosocial: *Care to promote optimal emotional health and social functioning*						
1. Coping/Emotional Support					n/a FY09	
2. Communication/Relationships					n/a FY09	
3. Knowledge					n/a FY09	
4. Behavior/Self-perception					n/a FY09	
D. Environment: Care *to protect and promote health and safety*						
1. Health Care System					n/a FY09	
2. Risk Management					n/a FY09	
3. Individual Emergency Plan						
4. Individualized Healthcare Plan						
5. IEP/504 Plan						
E. Nursing Assessments/Interventions *unclassified*						
F. Non-Nursing Interventions						
G. TOTAL Interventions						
	Total	Referred	Completed Referral	% Completed		
H. Office Visits						
III. Health Screening	Total Screened	Referred	Completed Referral	% Completed	Number Required*	# Required Screened
A. Required (Students)						
1. Hearing						
2. Immunization						
3. Postural/Gait						
4. Normal Exam						
5. Athletic Exam (DIAA)						
6. TB Questionnaire/Reading						
7. Vision						
8. Total Number of Required Screenings						
B. Non-Required (Students)						
1. Blood Pressure						
2. BMI						
3. Dental						
4. Developmental						
5. Pediculosis						
6. Record Review						
7. Other						
8. Total Number of Non-Required Screenings						
C. Total Student Screenings						
D. Staff						
1. BP						
2. TB Questionnaire/Reading						
3. Other						
4. Total Number						
E. Total Screenings (III. C + III. D.4)						

*Reg. 815.2.1.1 Each public school student in kindergarten and in grades 2,4, 7 and grades 9 or 10 shall receive a vision and a hearing screening by January 15th of each school year.

Date: _____ Signature _____

INTERAGENCY CONSENT TO RELEASE INFORMATION

Sharing information helps agencies provide better services to me/my child and/or my family. Only those agencies listed below that are planning or giving services to me or my child may receive information.

When relevant, shared information will include:

* my/child's full name
* social security number
* telephone number
* birthdate
* address
* names of parents/brothers/sisters/spouse
* items specified below

I understand that this form is **not** used to release information about drug and alcohol treatment.

I, _____, also allow all of the listed agencies to share the following information about my child/me, _____ (birthdate _____).

Please specify: INFORMATION THAT MAY BE SHARED

Please specify: AGENCIES THAT MAY SEND/RECEIVE INFORMATION
(Include Originating Agency Name)

AGREEMENT TO RELEASE

This permission is good for one year after I sign it.

I agree to the interagency sharing of information. I can take away my permission at any time. I can also change it at any time unless the information has already been released.

Print Name: _____

Signature: _____

Date: _____

Please check all that apply:
Parent [ ] Guardian [ ] Legal Adult (18 years) [ ] Minor 12-18, required below *[ ] Custodian [ ]

*A minor must specifically consent to the release of HIV [ ], STD [ ], and pregnancy information [ ].
Signature of minor: _____ Date _____

ORGANIZATION'S AFFIRMATION

As the participating organization's representative, I affirm that I have reviewed this form and its use with the consenting person and that to the best of my knowledge he/she understands.

Witness _____ Date _____

Agency _____

TRANSLATOR'S STATEMENT

I have orally translated/read/signed the above into _____ (language). To the best of my knowledge, I believe the consenting person understands the nature and use of this form.

Translator's Signature _____ Date _____

……..
Revocation Statement

I, _____ (consenting person), take away the consent I gave to _____ (originating organization) on _____ (date). I understand that _____ (originating organization) will notify any participating organization to which information has been sent or from which information has been received.

Signature _____ Date _____

Witness _____ Date _____

Agency _____ Revocation letter attached (Yes/No) _____

- The Interagency Consent to Release Information Form is based on the Interagency Confidentiality Agreement for Accessibility in Data Sharing between Participating Organizations: Department of Health & Social Services (DHSS), Department of Services for Children, Youth and their Families (DSCYF), Department of Education (DOE), Department of Correction (DOC), Department of Labor (DOL) and local school districts. This document has been approved by the Attorney General's Office. This form may not be altered in any manner without written authorization from the State of Delaware Interagency Confidentiality Committee. This form may be photocopied for use by the participating organizations.

The State of Delaware does not discriminate or deny services on the basis of race, religion, color, national origin, sex, disability and/or age.

III. School Entry

804 Immunizations

1.0 Definition

"**School Enterer**" means any child between birth and twenty (20) years inclusive entering or being admitted to a Delaware school district for the first time, including but not limited to, foreign exchange students, immigrants, students from other states and territories and children entering from nonpublic schools.

10 DE Reg. 1807 (06/01/07)

2.0 Minimum Immunizations Required for All School Enterers

2.1 All School Enterers shall have immunizations given up to four days prior to the minimum interval or age and shall include:

2.1.1 Four or more doses of diphtheria, tetanus, pertussis (DTaP, DTP, or other approved vaccine) or a combination of these vaccines. A booster dose of Td or Tdap (adult) is recommended by the Division of Public Health for all students at age 11 or five years after the last DTaP, DTP or DT dose was administered whichever is later. Notwithstanding this requirement:

2.1.1.1 A child who received a fourth dose prior to his or her fourth birthday shall have a fifth dose;

2.1.1.2 A child who received the first dose of Td (adult) at or after age seven may meet this requirement with only three doses of Td or Tdap (adult).

2.1.2 Three or more doses of inactivated polio virus (IPV), oral polio vaccine (OPV), or a combination of these vaccines with the following exception: a child who received a third dose prior to the fourth birthday shall have a fourth dose.

2.1.3 Two doses of measles, mumps and rubella (MMR) vaccine. The first dose should be administered on or after the age of 12 months. The second dose should be administered after the fourth birthday. Individual combination vaccines of measles, mumps, rubella (MMR) may be used to meet this requirement.

2.1.3.1 Disease histories for measles, rubella and mumps shall not be accepted unless serologically confirmed.

2.1.4 Three doses of Hepatitis B vaccine.

2.1.4.1 For children 11 to 15 years old age, two doses of a vaccine approved by the Center for Disease Control (CDC) may be used.

2.1.4.2 Titers are not acceptable in lieu of completing the vaccine series and a disease history for Hepatitis B shall not be accepted unless serologically confirmed.

2.1.5 Varicella vaccine is required beginning in the 2003-2004 school year with kindergarten. One grade shall be added each year thereafter so that by the 2015-2016 school year all children in grades kindergarten through 12 shall have received the vaccination. Beginning in the 2008-2009 school year new enterers into the affected grades shall be required to have two doses of the Varicella vaccine. The first dose shall be administered on or after the age of twelve (12) months and the second at kindergarten entry into a Delaware public school. A written disease history, provided by the health care provider, parent, legal guardian, Relative Caregiver or School Enterer who has reached the statutory age of majority (18), 14 **Del.C.** §131(a)(9), will be accepted in lieu of the Varicella vaccination. Beginning in the 2008-2009 school year, a disease history for the Varicella vaccination must be verified by a health care provider to be exempted from the vaccination.

2.2 Children who enter school prior to age four (4) shall follow current Delaware Division of Public Health recommendations.

10 DE Reg. 1807 (06/01/07)

11 DE Reg. 666 (11/01/07)

3.0 Certification of Immunization

3.1 The parent, legal guardian, Relative Caregiver or a School Enterer who has reached the statutory age of majority (18), 14 **Del.C.** §131(a)(9), shall present a certificate specifying the month, day, and year that the immunizations were administered by a licensed health care practitioner.

3.2 According to 14 **Del.C.** §131, a principal or person in charge of a school shall not permit a child to enter into school without acceptable evidence of immunization. The parent, legal guardian, Relative Caregiver or a School Enterer who has reached the statutory age of majority (18), 14 **Del.C.** §131(a)(9), shall be notified of this requirement in writing. Within 14 calendar days after notification, evidence must be presented to the school that the basic series of immunizations has been initiated or has been completed.

3.3 A school enterer may be conditionally admitted to a Delaware school district by presenting a statement from a licensed health care practitioner who specifies that the School Enterer has received at least:

3.3.1 One dose of DTaP, or DTP, or DT; and

3.3.2 One dose of IPV or OPV; and

3.3.3 One dose of measles, mumps and rubella (MMR) vaccine; and

3.3.4 The first dose of the Hepatitis B series; and

3.3.5 One dose of Varicella vaccine as per 2.5.

3.4 14 **DE Admin. Code** 901 Education of Homeless Children and Youth 6.0 states that "School districts shall ensure that policies concerning immunization, guardianship and birth certificates do not create barriers to the school enrollment of homeless children and youth". To that end, school districts shall as stated in 14 **DE Admin. Code** "assist homeless children and youth in meeting the immunization requirements".

3.5 If the school enterer fails to complete the series of required immunizations the parent, legal guardian, Relative Caregiver or a school enterer who has reached the statutory age of majority (18), 14 **Del.C.** §131(a)(9), shall be notified that the School Enterer will be excluded according to 14 **Del.C.** §131. 10 DE Reg. 1807 (06/01/07)

4.0 Lost or Destroyed Immunization Record

When a student's immunization record has been lost or destroyed by the medical provider who administered the vaccine, the parent, legal guardian, Relative Caregiver or a school enterer who has reached the statutory age of majority (18), 14 **Del.C.** §131(a)(9),shall sign a written statement to this effect and must obtain at least one dose of each of the immunizations as identified in 3.3. Evidence that the vaccines were administered shall be presented to the superintendent or his or her designee. 10 DE Reg. 18707 (06/01/07)

5.0 Exemption from Immunization

5.1 Exemption from this requirement may be granted in accordance with 14 **Del.C.** §131 which permits approved medical and notarized religious exemptions.

5.2 Alternative dosages or immunization schedules may be accepted with the written approval of the Delaware Division of Public Health. 10 DE Reg. 1807 (06/01/07)

6.0 Verification of School Records

The Delaware Division of Public Health shall have the right to audit and verify school immunization records to determine compliance with the law.

1 DE Reg. 1808 (05/01/98)
4 DE Reg. 1515 (03/01/01)
5 DE Reg. 2295 (06/01/02)
10 DE Reg. 1807 (06/01/07)

7.0 Documentation

7.1 School nurses shall record and maintain documentation of each student's immunization status.

7.2 Each student's immunization record shall be included in the Delaware Immunization Registry.

1 DE Reg. 1808 (05/01/98)
4 DE Reg. 1515 (03/01/01)
5 DE Reg. 2295 (06/01/02)
10 DE Reg. 1807 (06/01/07)

Approved Immunization Alternative Doses and/or Schedules

5.2	Alternative dosages or immunization schedules may be accepted with the written approval of the Delaware Division of Public Health.

The following have been reviewed by the Division of Public Health:

1. Children, who are immunosuppressed, should follow the recommendations of their physician regarding immunization.
2. Children with as allergy to the vaccine should be exempt.
3. Titers in lieu of completion of the Hep B series are not acceptable (12/1/00).
4. In lieu of two MMRs, the child can receive two measles, one rubella and one mumps (5/19/04).
5. A second MMR given prior to the fourth birthday is accepted, although not recommended as standard protocol, if:
   - the first dose was not earlier than the first birthday and
   - there is a minimal 28-day interval between doses (5/19/04 & 10/14/10).
4. DT vaccine (in lieu of DTaP) is applicable only to children who react to the Pertussis component of DTaP (2/15/2007).
5. If a child receives one dose of Varicella and later develops the disease, a second dose is not required. A verified disease history is required. (12/28/07)
6. DPH follows the CDC "catch-up" schedule for students who are behind in vaccinations (1/22/08).
7. An exemption from the Varicella requirement is allowed based upon a physician's note reporting a protective level based upon a Varicella Zoster IgG (2/19/08).
8. The final dose in the IPV series should be administered $\geq$ 4 years regardless of the number of previous doses (3/25/10).
9. In situations where records are lost and serology has been done, ask the physician to write and sign an official letter indicating that in his/her capacity as the physician responsible for the patient, his/her medical opinion is that the child is fully protected and that additional immunization is not required. This will form the basis of a medical exemption to be held in the child's file. If the physician is uncomfortable committing themselves, then you will assume the child is not immunized and start from scratch. If you have record of some shots, these should be taken as #1, #2, etc.

• SAMPLE LETTER

(Regarding School Entry)

Dear Parent/Guardian:

According to Delaware laws and Department of Education regulations, all children entering school for the first time are required to have proof on file of the following:

Immunizations[1]
- 5 or more doses of DTaP, DTP or TD vaccine (unless 4th dose was given after the 4th birthday)
- 4 doses of IPV or OPV (unless the 3rd dose was given after the 4th birthday)
- 2 doses of measles, mumps and rubella vaccine (first dose after the age of 12 months, second dose after the 4th birthday)
- 3 doses of Hepatitis B vaccine
- 2 doses of Varicella or a written disease history by a licensed healthcare provider **(10/11 School Year:** New enterers to Grades K-7; **11/12 School Year:** New enterers to Grades K-8; **12/13 School Year:** New enterers to Grades K-9, etc.)

Physical[2]
- Current, within the two years prior to entry into school

Tuberculosis (TB)[3]
- Results from either a TB Risk Assessment or a Tuberculosis Test (Mantoux or Quantiferon TB Gold Test) administered within the past 12 months

Lead blood test[4]
- Documentation for children entering kindergarten or pre-school program

Please provide the school nurse with the necessary information. We appreciate your cooperation in complying with the law.

Sincerely,

(Superintendent or Principal)

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[1] Delaware Code, Title 14, Section 131
[2] Department of Education Regulation 804
[3] Department of Education Regulation 805
[4] Delaware Code, Title 16, Chapter 26

S A M P L E

(School/School District Name)

VARICELLA (Chickenpox) IMMUNITY STATEMENT

Name:_____ Birthdate:_____
Please Print

Check one of the following boxes regarding Varicella (Chickenpox) Immunity:

☐ Varicella Vaccine Date Given:_____

☐ Varicella Lab Evidence Date:_____

☐ Varicella Disease Age of child when he/she had Chickenpox:_____

Name:_____
Licensed healthcare provider

Signature:_____ Date:_____

AFFIDAVIT REQUIRED PER 14 DEL. CODE SEC. 131

AFFIDAVIT OF RELIGIOUS BELIEF
STATE OF DELAWARE
……. COUNTY

1. (I) (We) (am) (are) the (parent[s]) (legal guardian[s]) of ……..
Name of Child

2. (I) (We) hereby (swear) (affirm) that (I) (we) subscribe to a belief in a relation to a Supreme Being involving duties superior to those arising from any human relation.

3. (I) (We) further (swear) (affirm) that our belief is sincere and meaningful and occupies a place in (my) (our) life parallel to that filled by the orthodox belief in God.

4. This belief is not a political, sociological or philosophical view of a merely personal moral code.

5. This belief causes (me) (us) to request an exemption from the mandatory school vaccination program for _____.
Name of Child

_____
Signature of Parent(s) or Legal Guardian(s)

SWORN TO AND SUBSCRIBED before me, a registered Notary Public, this _____ day of _____, 2_____.

_____(Seal)

Notary Public
My commission expires:

_____

Instructions for Completing School Immunization Records

1. *If a computer is not used for immunization records, initiate a School Immunization Record form on each new enterer in Grades K-12 that upon review has immunization information that is different than data in the State Immunization Registry. If a computer is used, print a copy and mail to Immunization Program.*
2. *Enter the appropriate "School Information" and "Student Information."*
3. *Enter the dates of documented immunizations in the area entitled "Immunizations."*
4. *Retain one copy of the Immunization Record for pupil's record folder. Mail one copy to Immunization Program.*
5. *Obtain additional forms from the Immunization Registry. If you call them, they will send stamped envelopes. Immunization Program Main #: (302) 744-1060 Fax#: (302) 739-2555 Toll Free #: 1-800-282-8672 State Mail: Thomas Collins Building, Suite #4 SLC-D620P U.S.Mail: 417 Federal Street, Dover DE 19901.*
6. *Access Delaware's Immunization Registry at http://vacattack.dhss.delaware.gov.*

Delaware Division of Public Health
School Immunization Record

Mail To: Immunization Program, HMPC
Jesse Cooper Bldg. D320A, Dover DE 19901

1. School Information

School Code:	School:

2. Student Information

Date of Birth:	Student Name:
Sex: oMale oFemale	Last First Mi
Race: oAlaskan Native oAmerican Indian oAfrican American oCaucasian oHispanic oPacific Island/Asian oUnknown oOther	Student Address: Address City State Zip

3. Immunizations – Shaded Vaccines Required

DTP/Hib 1 / /	**DTP/Hib 2** / /	**DTP/Hib 3** / /	**DTP/ Hib 4** / /	**DTaP/Hib 4** / /
DTP/DTaP 1 / /	**DTP/DTaP 2** / /	**DTP/DTaP 3** / /	**DTP/DTaP 4** / /	**DTP/DTaP 5** / /
DT/Td 1 / /	**DT/Td 2** / /	**DT/Td 3** / /	**DT/Td 4** / /	**DT/Td 5** / /
OPV/IPV 1 / /	**OPV/IPV 2** / /	**OPV/IPV 3** / /	**OPV/IPV 4** / /	**OPV/IPV 5** / /
MMR 1 / /	**MMR 2** / /	**HepB 1** / /	**HepB 2** / /	**HepB 3** / /
Hib 1 / /	**Hib 2** / /	**Hib 3** / /	**Hib 4** / /	
Hep B 1 (2 dose Version Only) / /	**Hep B 2 (2 dose Version Only)** / /	**Hep B/Hib 1** / /	**Hep B/Hib 2** / /	**Hep B/Hib 3** / /
Varicella 1 / /	**Varicella 2** / /	**Lyme Vax 1** / /	**Lyme Vax 2** / /	**Lyme Vax 3** / /
Pneumococcal Conjugate 1 / /	**Pneumococcal Conjugate 2** / /	**Pneumococcal Conjugate 3** / /	**Pneumococcal Conjugate 4** / /	
Pneumococcal Polysaccharide1 / /	**Pneumococcal Polysaccharide 2** / /	**Hep A 1** / /	**Hep A 2** / /	
Influenza 1 / /	**Influenza 2** / /	**Other:** / /	Other: / /	

CH- 125 New 12/00
DOC. # 35-05-20/00/12/06

CDC RECOMMENDED CHILDHOOD AND ADOLESCENT IMMUNIZATION SCHEDULE

http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm
(Site also includes catch-up schedules)

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2010

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼ Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB			HepB						
Rotavirus[2]			RV	RV	RV[2]						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP	see footnote[3]	DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	Hib[4]	Hib					
Pneumococcal[5]			PCV	PCV	PCV	PCV				PPSV	
Inactivated Poliovirus[6]			IPV	IPV	IPV						IPV
Influenza[7]					Influenza (Yearly)						
Measles, Mumps, Rubella[8]						MMR		see footnote[8]			MMR
Varicella[9]						Varicella		see footnote[9]			Varicella
Hepatitis A[10]						HepA (2 doses)				HepA Series	
Meningococcal[11]										MCV	

Range of recommended ages for all children except certain high-risk groups

Range of recommended ages for certain high-risk groups

This schedule includes recommendations in effect as of December 15, 2009. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: **http://www.cdc.gov/vaccines/pubs/acip-list.htm**. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at **http://www.vaers.hhs.gov** or by telephone, **800-822-7967.**

Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2010

For those who fall behind or start late, see the schedule below and the catch-up schedule

Vaccine ▼ Age ►	7–10 years	11–12 years	13–18 years
Tetanus, Diphtheria, Pertussis[1]		Tdap	Tdap
Human Papillomavirus[2]	see footnote 2	HPV (3 doses)	HPV series
Meningococcal[3]	MCV	MCV	MCV
Influenza[4]	Influenza (Yearly)		
Pneumococcal[5]	PPSV		
Hepatitis A[6]	HepA Series		
Hepatitis B[7]	Hep B Series		
Inactivated Poliovirus[8]	IPV Series		
Measles, Mumps, Rubella[9]	MMR Series		
Varicella[10]	Varicella Series		

Range of recommended ages for all children except certain high-risk groups

Range of recommended ages for catch-up immunization

Range of recommended ages for certain high-risk groups

This schedule includes recommendations in effect as of December 15, 2009. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations: **http://www.cdc.gov/vaccines/pubs/acip-list.htm**. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS) at **http://www.vaers.hhs.gov** or by telephone, **800-822-7967.**

805 The School Health Tuberculosis (TB) Control Program

1.0 Definitions

"New School Enterer" means any child between the ages of one year and twenty one (21) years entering or being admitted to a Delaware public school for the first time, including but not limited to, foreign exchange students, immigrants, students from other states and territories, and children entering from nonpublic schools. For purposes of this regulation, "new school enterer" shall also include any child who is re-enrolled in a Delaware public school following travel or residency of one month in a location or facility identified by the Delaware Division of Public Health as an area at risk for tuberculosis exposure.

"School Staff and Extended Services Personnel" means all persons hired as full or part time employees in a public school. This includes, but is not limited to teachers, administrators, substitutes, contract employees, bus drivers and student teachers whether compensated or not.

"Tuberculosis Risk Assessment" means a formal assessment by a healthcare professional to determine possible tuberculosis exposure through the use of a health history or questionnaire.

"Tuberculosis Test" means a Mantoux skin test, Quantiferon Gold blood test, or other test approved by the Delaware Division of Public Health.

"Verification" means a documented evaluation of the individual's disease status.

"Volunteers" mean those persons who give their time to help others for no monetary reward and who share the same air space with public school students and staff on a regularly scheduled basis.

13 DE Reg. 1205 (03/01/10)

2.0 School Staff and Extended Services Personnel

2.1 School Staff and Extended Services personnel shall provide the Tuberculosis Test results from a test administered within the past 12 months during the first 15 working days of employment.

2.1.1 Tuberculosis Test requirements may be waived for public school staff and extended services personnel who present a notarized statement that tuberculosis testing is against their religious beliefs. In such cases, the individual shall complete the Delaware Department of Education TB Health Questionnaire for School Employees or provide, within two (2) weeks, verification from a licensed health care provider or the Division of Public Health that the individual does not pose a threat of transmitting tuberculosis to students or other staff.

2.1.1.1 If a school staff member or extended services person, who has submitted a waiver because of religious beliefs, answers affirmatively to any of the questions in the Delaware Department of Education TB Health Questionnaire for School Employees he/she shall provide, within two (2) weeks, verification from a licensed health care provider or the Division of Public Health that the individual does not pose a threat of transmitting tuberculosis to students or other staff.

2.1.2 School Staff and Extended Services Personnel need not be retested if they move, within Delaware, from district to district, district to charter school, charter school to district, or charter school to charter school within a five year period; however, a copy of the result of the latest Tuberculosis Test shall be provided to the new district or charter school within sixty (60) days.

2.2 Every fifth year, by October 15th, all public school staff and extended services personnel shall complete the Delaware Department of Education TB Health Questionnaire for School Employees or, within two (2) weeks, provide Tuberculosis Test results administered within the last twelve (12) months.

2.2.1 If a school staff member or extended services staff member answers affirmatively to any of the questions in the *Delaware Department of Education TB Health Questionnaire for School Employees* he/she shall provide, within two (2) weeks, verification from a licensed health care provider or the Division of Public Health that the individual does not pose a threat of transmitting tuberculosis to students or other staff.

2.3 All documentation related to the School Health Tuberculosis (TB) Control Program shall be retained in the same manner as other confidential personnel medical information.

13 DE Reg. 1205 (03/01/10)

3.0 Volunteers

3.1 Volunteers shall complete the *Delaware Department of Education's TB Health Questionnaire for Volunteers in Public Schools* prior to their assignment and every fifth year thereafter.

3.1.1 If the volunteer answers affirmatively to any of the questions, he/she shall provide, within two (2) weeks, verification from a licensed health care provider or the Division of Public Health that the individual does not pose a threat of transmitting tuberculosis to the students or staff.

3.2 Each public school nurse shall collect and monitor all documentation related to the volunteer's School Health Tuberculosis (TB) Control Program and store them in the school nurse's office in a confidential manner.

13 DE Reg. 1205 (03/01/10)

4.0 New School Enterers

4.1 New school enterers shall provide tuberculosis screening results from either a Tuberculosis Test or the results of a Tuberculosis Risk Assessment administered within the past 12 months prior to school entry.

4.1.1 If the new school enterer is in compliance with the other school entry health requirements, a school nurse who is trained in the use of the *Delaware Department of Education TB Risk Assessment Questionnaire for Students* may administer the questionnaire to the student's parent(s), guardian(s) or Relative Caregiver or to a new school enterer who has reached the statutory age of majority (18).

4.1.1.1 If a student's parent(s), guardian(s) or Relative Caregiver or a student 18 years or older answers affirmatively to any of the questions, he/she shall, within two (2) weeks, provide proof of tuberculosis testing results or provide verification from a licensed health care provider or the Division of Public Health that the student does not pose a threat of transmitting tuberculosis to staff or other students.

4.2 School nurses shall record and maintain documentation relative to the School Health Tuberculosis (TB) Control Program.

13 DE Reg. 1205 (03/01/10)

5.0 Tuberculosis Status Verification and Follow up

5.1 Tuberculosis Status shall be determined through the use of a Tuberculosis Risk Assessment, Tuberculosis Test or other testing, which may include x-ray or sputum culture. Individuals who either refuse the Tuberculosis Test or have positive reactions to the same, or give positive responses to a tuberculosis risk assessment shall provide verification from a licensed health care provider or the Division of Public Health that the individual does not pose a threat of transmitting tuberculosis to staff or other students.

5.1.1 Verification shall include Mantoux results recorded in millimeters (if test was administered), or other Tuberculosis Test results, current disease status (i.e. contagious or noncontagious), current treatment (or completion of preventative treatment for tuberculosis) and date when the individual may return to his/her school assignment without posing a risk to the school setting.

5.1.2 Verification from a health care provider or Division of Public Health shall be required only once if treatment was completed successfully.

5.1.3 Updated information regarding disease status and treatment shall be provided to the public

school by October 15 every fifth year if treatment was previously contraindicated, incomplete or unknown.

5.1.4 Persons with a positive Tuberculosis Test, without active disease, who do not receive prophylactic treatment shall be excluded from school in the event of showing any signs or symptoms of active, infectious disease as described by the Division of Public Health.

5.2 In the event an individual shows any signs or symptoms of active tuberculosis infection, he/she shall be excluded from school until all required medical verification is received by the school. During the specified verification and follow-up an asymptomatic individual, as described by the Division of Public Health, may remain in school until testing and evaluations are completed, but no longer than six (6) weeks.

1 DE Reg. 1971 (6/1/98)
3 DE Reg. 440 (9/1/99)
8 DE Reg. 1134 (2/1/05)
13 DE Reg. 1205 (03/01/10)

Non regulatory note: See 14 DE Admin. Code 930 Supportive Instruction (Homebound)

Employee Name:_____ **Date:**_____

Employee Signature:_____

Delaware Department of Education[1]
CONFIDENTIAL TUBERCULOSIS (TB) Health Questionnaire for School Employees

The Delaware Department of Education Regulation 805[2] requires all school employees to provide Tuberculosis (TB) Test results during the first 15 days of employment. Every 5th year, by October 15, all[3] personnel shall complete the TB Health Questionnaire for School Employees as a routine follow-up screening. This document shall be retained in the same manner as other confidential personnel medical information.

Please consider the following questions and indicate one response in the box below:

1. In the past five years, have you lived or been in close contact with anyone who had active, infectious TB disease?
2. Do you currently have any of the following symptoms which are unexplained and which have lasted at least three weeks?
   Cough
   Fever
   Night sweats
   Weight loss
3. Have you ever had a positive HIV test?
4. In the past five years, have you ever used illegal intravenous drugs?
5. In the past five years, have you been incarcerated?
6. In the past five years, have you been homeless?
7. Refer to the list, provided by The Delaware Division of Public Health, which is based on World Health Organization data.
   - In the past five years, have you stayed/lived in one of these countries for 1 month or longer?
   - In the past five years, have you lived or been in close contact with someone who stayed/lived in one of these countries for 1 month or longer?

Can you answer "yes" to any of the above questions? ( ) Yes ( ) No

If you checked YES, you are required (within 2 weeks) to provide verification from a licensed health care provider or the Division of Public Health that there is no communicable threat.

If you have any questions about your risk of infection, please speak with your healthcare provider or contact the Delaware Division of Public Health TB Elimination Program at 302-741-2923.

[1] Developed in collaboration with the Delaware Division of Public Health, 2/2005, with revisions 7/2010.
[2] Regulation 805, The School Health Tuberculosis (TB) Control Program, can be accessed at http://www.state.de.us/research/AdminCode/title14/800
[3] Anyone with a previous positive Tuberculosis Test shall provide updated information regarding disease status and treatment to the public school by October 15 every fifth year if treatment was previously contraindicated, incomplete or unknown.

Delaware Department of Education[1]
Student Tuberculosis (TB) Risk Assessment Questionnaire

Prior to use of this form, the school nurse must review the student's health records and assure that the student is compliant with the requirement for a current physical (within past 2 years) and up-to-date immunizations. The questionnaire must be administered by the school nurse to the parent/guardian in person or by phone and signed by the parent who answered the questions.

Name:_____
Last First MI

Date of Birth: ____/_____/____ Date Form Completed ___/___/___

1. Has your child had any contact with anyone with an active infectious TB disease?
2. Was any household member, including your child, born in or has he/she traveled to areas where TB is common (refer to the list, provided by the Delaware Division of Health, which is based on World Health Organization data).
3. Does your child have regular (i.e., daily) contact with adults at high risk for TB (i.e., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?
4. Does your child have any health conditions or take medications that might affect his/her immune system?

Any "yes" response is considered a positive risk factor and is an indication for administering a Mantoux tuberculin skin test or a TB blood test, such as The Quantiferon TB Gold Test, to the child.

This child has been screened by his/her school nurse for risk of exposure to tuberculosis. Based upon the results of the TB Risk Assessment Questionnaire the child,

____**does not** require a Tuberculosis Test

____**does** require a Tuberculosis Test

TB testing and documentation must be completed and given to the school nurse by ____/_____/____ (date) or your child will be excluded from school.

School Nurse comments:_____

_____

_____

School Nurse (signature) _____

I give permission for the school nurse and my child's primary care physician _____ (name of physician) to share information relating to this form.

Parent/Guardian (signature) _____

[1] Student questionnaire was developed in collaboration with the Delaware Division of Public Health, 8/2004, with revisions 7/2010. Regulation 805, The School Health Tuberculosis (TB) Control Program, can be accessed at http://www.state.de.us/research/AdminCode/title14/800

Name (Printed):_____ **Date**_____

Name (Signature):_____

DELAWARE DEPARTMENT OF EDUCATION[1]
CONFIDENTIAL HEALTH QUESTIONNAIRE FOR VOLUNTEERS[2]

All school employees are required to have a Tuberculosis (TB) Test[3]. The purpose of this requirement is to safeguard school-aged children from exposure to TB in the school setting. In the same way, this questionnaire is designed to identify volunteers who MAY have been exposed to TB and thus need further screening. A school designee will collect and monitor the Health Questionnaire, which will be stored in the School Nurse's office in a confidential manner.

Please consider the following questions:

1. Have you ever lived or been in close contact with anyone who had active, infectious TB disease?
2. Have you ever had a positive HIV test?
3. Have you ever used illegal intravenous drugs?
4. Have you ever been incarcerated?
5. Have you ever been homeless?
6. Do you currently have any of the following symptoms which are unexplained and which have lasted at least three weeks?
   - Cough
   - Fever
   - Night sweats
   - Weight loss
7. Refer to the list on the following page, provided by the Delaware Division of Public Health, which is based on World Health Organization data.
   - Were you born in one of these countries?
   - Have you ever stayed/lived in one of these countries for 1 month or longer?
   - Have you ever lived or been in close contact with someone who stayed/lived in one of these countries for 1 month or longer?

Can you answer "yes" to any of the above questions? **( ) Yes** **( ) No**
If you checked yes, you are required to have a TB Test (Mantoux or Quantiferon TB Gold Test) **test prior to your assignment as a volunteer.**

Have you ever had a positive skin test for tuberculosis? ( ) Yes ( ) No
If you checked yes, you are required to provide documentation related to current disease status prior to your assignment as a volunteer.

These requirements are for the safety of our school and for your personal health. Screening for tuberculosis is recommended by health professionals for any individual who is at risk. Routine screening, using a Mantoux tuberculin skin test or a TB blood test, such as the Quantiferon TB Gold Test, can detect if a person has been exposed to tuberculosis. Such early identification is of great benefit in reducing the effects of disease.

If you have any questions about your risk of infection, please speak with your healthcare provider or plan to discuss it at your next examination. For additional information, you can contact the Delaware Division of Public Health TB Nurse Consultants at 302-744-1050.

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[1] Developed in collaboration with The Delaware Division of Public Health, with revisions 9/2010.
[2] Upon completion by the volunteer, the form should be given to the School Nurse. For more information, contact the School Nurse or your primary healthcare provider.
[3] Regulation 805, The School Health Tuberculosis (TB) Control Program can be accessed at http://regulations.delaware.gov/AdminCode/title14/800/805.

Current as of 9/20/2010
WHO | Online Tuberculosis Database | Powered by the Global Health Atlas

Global Tuberculosis Database

Communicable Diseases -> Tuberculosis (as of 24 March 2009) Estimated TB prevalence (MDG indicator 23)
TB prevalence, all forms (per 100 000 population per year)
Total Periodicity: Year, Applied Time Period: from 2007 to 2007) **The number after the country is the number of TB patients per 100K of the populace.**

Countries in color represent those with TB rates of 20/100K or more. CDC Immigration requires people coming to the US from these countries to be tested for TB.

Afghanistan	238
Albania	22
Algeria	56
American Samoa	5
Andorra	19
Angola	294
Anguilla	34
Antigua and Barbuda	9
Argentina	35
Armenia	81
Australia	6
Austria	10
Azerbaijan	86
Bahamas	51
Bahrain	60
Bangladesh	387
Barbados	3
Belarus	69
Belgium	9
Belize	46
Benin	135
Bermuda	6
Bhutan	363
Bolivia	198
Bosnia and Herzegovina	55
Botswana	622
Brazil	60

British Virgin Islands	16
Brunei Darussalam	65
Bulgaria	41
Burkina Faso	403
Burundi	647
Cambodia	664
Cameroon	195
Canada	4
Cape Verde	280
Cayman Islands	5
Central African Republic	425
Chad	497
Chile	12
China	194
Colombia	43
Comoros	83
Congo	485
Cook Islands	31
Costa Rica	11
Croatia	54
Cuba	7
Cyprus	6
Czech Republic	9
Côte d'Ivoire	582
Democratic People's Republic of Korea	441
Democratic Republic of the Congo	666
Denmark	6

Djibouti	1,104
Dominica	19
Dominican Republic	82
Egypt	27
El Salvador	48
Ecuador	140
Equatorial Guinea	469
Eritrea	134
Estonia	39
Ethiopia	579
Fiji	30
Finland	5
France	11
French Polynesia	32
Gabon	379
Gambia	404
Georgia	83
Germany	5
Ghana	353
Greece	16
Grenada	6
Guam	36
Guatemala	87
Guinea	448
Guinea-Bissau	276
Guyana	136
Haiti	366
Honduras	71
Hungary	19
Iceland	3
India	283
Indonesia	244
Iran (Islamic Republic of)	27
Iraq	79
Ireland	11
Israel	6
Italy	6
Jamaica	7
Japan	28
Jordan	9
Kazakhstan	139

Kenya	319
Kiribati	423
Kuwait	25
Kyrgyzstan	134
Lao People's Democratic Republic	289
Latvia	55
Lebanon	23
Lesotho	568
Liberia	398
Libyan Arab Jamahiriya	17
Lithuania	69
Luxembourg	9
Madagascar	417
Malawi	305
Malaysia	121
Maldives	48
Mali	599
Malta	5
Mauritania	559
Mexico	23
Micronesia (Federated States of)	100
Monaco	2
Mongolia	234
Montserrat	8
Morocco	80
Mozambique	504
Myanmar	162
Namibia	532
Nauru	33
Nepal	240
Netherlands	6
Netherlands Antilles	15
New Caledonia	25
New Zealand	7
Nicaragua	56
Niger	292
Nigeria	521
Niue	0
Northern Mariana Islands	72
Norway	4
Oman	14

Pakistan	223
Palau	71
Panama	45
Papua New Guinea	430
Paraguay	73
Peru	136
Philippines	500
Poland	28
Portugal	23
Puerto Rico	5
Qatar	81
Republic of Korea	126
Republic of Moldova	151
Romania	128
Russian Federation	115
Rwanda	590
Saint Kitts and Nevis	12
Saint Lucia	18
Saint Vincent and the Grenadines	39
Samoa	25
San Marino	5
Sao Tome and Principe	240
Saudi Arabia	65
Senegal	468
Seychelles	55
Sierra Leone	941
Singapore	27
Slovakia	20
Slovenia	15
Solomon Islands	180
Somalia	352
South Africa	692
Spain	23
Sri Lanka	79
Sudan	402
Suriname	155
Swaziland	812
Sweden	5
Switzerland	5
Syrian Arab Republic	27

Tajikistan	322
Thailand	192
The former Yugoslav Republic of Macedonia	33
Timor-Leste	378
Togo	750
Tokelau	0
Tonga	28
Trinidad and Tobago	15
Tunisia	28
Turkey	34
Turkmenistan	75
Turks and Caicos Islands	17
Tuvalu	203
Uganda	426
Ukraine	102
United Arab Emirates	24
United Kingdom of Great Britain and Northern Ireland	12
United Republic of Tanzania	337
United States Virgin Islands	16
United States of America	3
Uruguay	23
Uzbekistan	140
Vanuatu	102
Venezuela	39
Viet Nam	220
Wallis and Futuna Islands	25
West Bank and Gaza Strip	31
Yemen	130
Zambia	387
Zimbabwe	714

Affidavit of Religious Belief
S A M P L E

STATE OF DELAWARE

_____ COUNTY

1. (I) (We) (am) (are) the (parent[s]) (legal guardian[s]) (Relative Caregiver[s]) of

_____
Name of Child

1. (I) (We) hereby (swear) (affirm) that (I) (we) subscribe to a belief in a relation to a Supreme Being involving duties superior to those arising from any human relation.

2. (I) (We) further (swear) (affirm) that our belief is sincere and meaningful and occupies a place in (my) (our) life parallel to that filled by the orthodox belief in God.

3. This belief is not a political, sociological or philosophical view of a merely personal moral code.

4. This belief causes (me) (us) to request an exemption from the mandatory Tuberculosis Test for _____.
Name of Child

_____
Signature of Parent(s) or Guardian(s)

SWORN TO AND SUSCRIBED before me, a registered Notary Public, this _____ day of _____, 20____.

_____(Seal)
Notary Public

My commission expires:

_____

TB Resources for School Nurses

Provided by Division of Public Health (DPH)

DPH TB Nurse Consultant:
Jeannie Rodman, RN
Collins Bldg., Dover (302) 744-1050

DPH TB Clinics:

- Kent Co. (Williams SCC) 857-5130
- Sussex Co. (Georgetown SCC) 856-5119
- New Castle Co. (Hudson SCC) 283-7588

1. The School Nurses Handbook on TB
   http://www.umdnj.edu/globaltb/downloads/products/nursehb.pdf

2. DOE Regulations for TB
   http://regulations.delaware.gov/AdminCode/title14/800/805.pdf

3. Guidelines for reading the Mantoux Skin Test
   http://www.umdnj.edu/globaltb/downloads/products/Mantoux_Appendices/tbmantouxapp04.pdf

4. Form for Recording Skin Test Results
   http://www.umdnj.edu/globaltb/downloads/products/Mantoux_Appendices/tbmantouxapp05.pdf

5. Guidelines for Developing an in-school DOT Program
   https://sntc.medicine.ufl.edu/ProductDownload.aspx?ProductId=7

6. TB at a Glance – small booklet gives excellent overview of TB
   http://www.heartlandntbc.org/click_counter.asp?u_link=tb_at_a_glance.pdf&p=47

7. Fact sheet for new blood test, Quantiferon Gold TB
   http://www.cdc.gov/tb/publications/factsheets/testing/QFT.pdf

8. Centers for Disease Control & Prevention/TB for guidelines, data, etc.
   www.cdc.gov/tb

Interpreting (Classifying) the Mantoux Tuberculin Skin Test (TST) Provided by Division of Public Health (DPH)

Classification of TST Reactions

Whether a reaction to the Mantoux tuberculin skin test is classified as positive depends on the size of induration and the person's risk factors for TB. Only persons with risk factors for TB should be tested; since TB is rare in the U.S., a positive TST in the US-born populace with no risk factors would be more likely to be a false-positive result than a true positive, and likely be due to exposure to non-Tb mycobacteria.

≥ 5 mm of induration is considered a positive reaction in:

- HIV-infected persons
- Close contacts of a person with infectious TB
- Persons who have chest x-ray findings consistent with prior TB
- Organ transplant recipients
- Persons who are immunosuppressed for other reasons (e.g., taking the equivalent of ≥15 mg/day of prednisone for 1 month or more, use of Tnf-alpha inhibitors (i.e. Remicade)

≥ 10 mm of induration is considered a positive reaction in:

- Recent immigrants (within last 5 years) from a high-prevalence country (20/100K or more)
- Injection drug users (with unknown or HIV negative status)
- Residents or employees of high-risk congregate settings (for example, nursing homes or correctional facilities)
- Mycobacteriology laboratory personnel
- Children <4 years of age, or children or adolescents exposed to adults at high risk
- People with other high-risk conditions such as diabetes

≥ 15 mm of induration is considered a positive reaction in:

- **Persons with no known risk factors for TB**

815 Physical Examinations and Screening

1.0 Physical Examinations

1.1 All public school students shall have a physical examination that has been administered by a licensed medical physician, nurse practitioner or physician's assistant. The physical examination shall have been done within the two years prior to entry into school. Within fourteen calendar days after notification of the requirement for a physical examination, new enterers shall have received a physical examination or shall have a documented appointment with a licensed health care provider for a physical examination.

1.1.1 The requirement for the physical examination may be waived for students whose parent, guardian or Relative Caregiver, or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a) presents a written declaration acknowledged before a notary public, that because of individual religious beliefs, they reject the concept of physical examinations.

1.1.2 The school nurse shall record all findings on the Delaware School Health Record Form (see 14 **DE Admin. Code** 811) and maintain the original copy in the child's medical file.

NON REGULATORY NOTE: See 14 **DE Admin. Code** 1008.3 and 14 **DE Admin. Code** 1009.3 for physical examination requirements associated with participation in sports.

2.0 Screening

2.1 Vision and Hearing Screening

2.1.1 Each public school student in kindergarten and in grades 2, 4, 7 and grades 9 or 10 shall receive a vision and a hearing screening by January 15th of each school year.

2.1.1.1 In addition to the screening requirements in 2.1.1, screening shall also be provided to new enterers, students referred by a teacher or an administrator, and students considered for special education.

2.1.1.1.1 Driver education students shall have a vision screening within a year prior to their in car driving hours.

2.1.2 The school nurse shall record the results on the Delaware School Health Record Form and shall notify the parent, guardian or Relative Caregiver or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a) if the student has a suspected problem.

2.2 Postural and Gait Screening

2.2.1 Each public school student in grades 5 through 9 shall receive a postural and gait screening by December 15th.

2.2.2 The school nurse shall record the findings on the Delaware School Health Record Form (see 14 **DE Admin. Code** 811) and shall notify the parents, guardian or Relative Caregiver, or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 1434a) if a suspected deviation has been detected.

2.2.2.1 If a suspected deviation is detected, the school nurse shall refer the student for further evaluation through an on site follow up evaluation or a referral to the student's health care provider.

2.3 Lead Screening

2.3.1 Children who enter school at kindergarten or at age 5 or prior, shall be required to provide documentation of lead screening as per 16 **Del.C.** Ch. 26.

2.3.1.1 For children enrolling in kindergarten, documentation of lead screening shall be provided within sixty (60) calendar days of the date of enrollment. Failure to provide the required documentation shall result in the child's exclusion from school until the documentation is provided.

2.3.1.2 Exemption from this requirement may be granted for religious exemptions, per 16 **Del.C.** §2603.

2.3.1.3 The Childhood Lead Poisoning Prevention Act, 16 **Del.C.,** Ch. 26, requires all health care providers to order lead screening for children at or around the age of 12 months of age.

2.3.2 The school nurse shall document the lead screening on the Delaware School Health Record form. See 14 **DE Admin. Code** 811.

DELAWARE SCHOOL PHYSICAL EXAMINATION FORM

To be completed by licensed medical physician, nurse practitioner or physician's assistant.

Name:_____ **Sex:**_____ **DOB:**_____

Date:_____ **Examiner:**_____

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

[ ] ADD/ADHD	**[ ] Body Piercing/Tattoo**	**[ ] Emotional**	**[ ] Physical Disability**
[ ] Allergies	**[ ] Bone/Spine**	**[ ] Hearing**	**[ ] Seizures**
[ ] Asthma	**[ ] Bowel/Bladder**	**[ ] Heart**	**[ ] Speech**
[ ] Behavior	**[ ] Chicken Pox**	**[ ] Infections**	**[ ] Surgery**
[ ] Blood Disorder	**[ ] Diabetes**	**[ ] Kidney**	**[ ] Vision**

[ ] OTHER _____

Comments:_____

_____

Height: _____ **Weight:** _____ **BMI:** _____ **BP:**_____ **Pulse:**_____

Vision: **Right**_____ **Left**_____

Hearing: **Right**_____ **Left**_____

Lead Screening: **Date Completed**_____ **Results**_____

Hematocrit/Hemoglobin: **Date Completed**_____ **Results**_____

TB Risk Assessment: Date Completed_____ **Results**_____

Tuberculin Skin Test (in lieu of TB Risk Assessment OR as follow-up)

PPD (Mantoux): Date Placed_____ **Date Read**_____ **Results (in mm)**_____

or Quantiferon TB Gold Test: Date _____ **Results** _____

3. Immunizations – *Shaded Vaccines Required*

DTP/Hib 1 / /	**DTP/Hib 2** / /	**DTP/Hib 3** / /	**DTP/ Hib 4** / /	**DTaP/Hib 4** / /
DTP/DTaP 1 / /	**DTP/DTaP 2** / /	**DTP/DTaP 3** / /	**DTP/DTaP 4** / /	**DTP/DTaP 5** / /
DT/Td 1 / /	**DT/Td 2** / /	**DT/Td 3** / /	**DT/Td 4** / /	**DT/Td 5** / /
OPV/IPV 1 / /	**OPV/IPV 2** / /	**OPV/IPV 3** / /	**OPV/IPV 4** / /	**OPV/IPV 5** / /
MMR 1 / /	**MMR 2** / /	**HepB 1** / /	**HepB 2** / /	**HepB 3** / /
Hib 1 / /	**Hib 2** / /	**Hib 3** / /	**Hib 4** / /	
Hep B 1 (2 dose Version Only) / /	**Hep B 2 (2 dose Version Only)** / /	**Hep B/Hib 1** / /	**Hep B/Hib 2** / /	**Hep B/Hib 3** / /
Varicella 1 / /	**Varicella 2** / /	**Lyme Vax 1** / /	**Lyme Vax 2** / /	**Lyme Vax 3** / /
Pneumococcal Conjugate 1 / /	**Pneumococcal Conjugate 2** / /	**Pneumococcal Conjugate 3** / /	**Pneumococcal Conjugate 4** / /	
Pneumococcal Polysaccharide1 / /	**Pneumococcal Polysaccharide 2** / /	**Hep A 1** / /	**Hep A 2** / /	
Influenza 1 / /	**Influenza 2** / /	**Other:** / /	Other: / /	

CHILD'S NAME_____

PHYSICAL EXAMINATION	Check (✓) NORMAL	ABNORMAL	COMMENTS
General Appearance			
Head/Scalp			
Eyes			
Ears			
Nose/Throat			
Mouth/Teeth/Gums			
Heart			
Chest/Lungs			
Skin			
Abdomen/Hernia			
Genitalia			
Neurological			
Developmental			
Musculoskeletal			
Nutrition			

Health Concerns or Special Needs Identified:_____

_____

_____

FOR CHRONIC CONDITIONS:
Please attach care plan, protocols, and/or emergency care plan.
Children with life-threatening conditions need an emergency care plan in place.

Recommendations or Referrals:_____

_____

Current Medication/Treatments:_____

Examiner's Signature:_____ **Date:**_____

Printed Name_____ **Phone Number:**_____

Address:_____

DELAWARE INTERSCHOLASTIC ATHLETIC ASSOCIATION

Parents/Guardian: The DIAA pre-participation physical evaluation and consent form is a five page document. Pages one, two and four require your signature while page five is a reference for you to keep. This physical evaluation must be completed after May 1 of the current year playing sports and runs through June 30 of the following year.

Athlete: _____ Phone: _____ School: _____

Age:_____ Gender: _____ Date of Birth: _____ Grade: _____

Parent/Guardian Name: (Please Print) _____

PARENT/GUARDIAN CONSENTS

_____ Has my permission to participate in all interscholastic
(Name of Athlete) sports **not checked below**.

If you check any sport in this box it means the athlete <u>will not</u> be permitted to participate in that sport.

Collision		Contact		Non-Contact	
__ football	_ ice hockey	__ volleyball	___ softball	__ cross country	___tennis
__ soccer	_ boys' lacrosse	__ field hockey	___ baseball	__ swimming	___golf
__ wrestling		__ basketball	___ girls lacrosse	__ track	___crew
		__ squash		__ cheerleading	

1. My permission extends to all interscholastic activities whether conducted on or off school premises. I have read and discussed page 5, which is the list of items that protect against the loss of athletic eligibility, with said participant and I will retain that page for my reference. I have also discussed with him/her and we understand that physical injury, including paralysis, coma or death can occur as a result of participation in interscholastic athletics. I waive any claim for injury or damage incurred by said participant while participating in the activities <u>not checked above</u>.
   Parent Signature: _____ **Date**: _____

2. To enable DIAA and its full and associate member schools to determine whether herein named student is eligible to participate in interscholastic athletics, I hereby consent to the release of any and all portions of school record files, beginning with the sixth grade, of the herein named student, including but not limited to, birth and age records, name and residence of student's parent(s), guardian(s) or Relative Care Giver, residence of student, health records, academic work completed, grades received and attendance records.
   Parent Signature: _____ **Date**: _____

3. I further consent to DIAA's and its full and associate member schools use of the herein named student's name, likeness, and athletically related information in reports of interscholastic practices, scrimmages or contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.
   Parent Signature: _____ **Date**: _____

4. By this signature, I hereby consent to allow the physician(s) and other health care providers(s) selected by myself or the schools to perform a pre-participation examination on my child and to provide treatment for any injury received while participating in or training for athletics for his/her school. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation, with coaches, medical staff, Delaware Interscholastic Athletic Association, and other school personnel as deemed necessary. Such information may be used for injury surveillance purposes.
   Parent Signature: _____ **Date**: _____

DIAA Preparticipation Physical Evaluation **HISTORY FORM**

DATE OF EXAM_____

Name_____ Sex_____ Age_____ Date of birth_____

Grade_____ School_____ Sport(s)_____

Address_____ Phone_____

Personal physician_____

In case of emergency, contact

Name_____ Relationship_____ Phone (H)_____ (W)_____

Explain "**YES**" answers below.
Circle questions you don't know the answers to.

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5.	Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6.	Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8.	Does your heart race or skip beats during exercise?	☐	☐
9.	Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10.	Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
11.	Has anyone in your family died for no apparent reason?	☐	☐
12.	Does anyone in your family have a heart problem?	☐	☐
13.	Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14.	Does anyone in your family have Marfan syndrome?	☐	☐
15.	Have you ever spent the night in a hospital?	☐	☐
16.	Have you ever had surgery?	☐	☐
17.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/toes

20.	Have you ever had a stress fracture?	☐	☐
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22.	Do you regularly use a brace or assistive device?	☐	☐
23.	Has a doctor ever told you that you have asthma or allergies?	☐	☐
24.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25.	Is there anyone in your family who has asthma?	☐	☐
26.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30.	Have you had a herpes skin infection?	☐	☐
31.	Have you ever had a head injury or concussion?	☐	☐
32.	Have you been hit in the head and been confused or lost your memory?	☐	☐
33.	Have you ever had a seizure?	☐	☐
34.	Do you have headaches with exercise?	☐	☐
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39.	Have you had any problems with your eyes or vision?	☐	☐
40.	Do you wear glasses or contact lenses?	☐	☐
41.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42.	Are you happy with your weight?	☐	☐
43.	Are you trying to gain or lose weight?	☐	☐
44.	Has anyone recommended you change your weight or eating habits?	☐	☐
45.	Do you limit or carefully control what you eat?	☐	☐
46.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐

FEMALES ONLY

47. Have you ever had a menstrual period? ☐ ☐
48. How old were you when you had your first menstrual period?___
49. How many periods have you had in the last 12 months?_____

Explain "Yes" answers here:_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete_____ Signature of parent/guardian_____ Date_____

DIAA PRE-PARTICIPATION PHYSICAL EVALUATION

Name_____ Date of Birth_____
Height_____ Weight_____ %Body fat (optional)_____ Pulse_____ BP___/___(___/___)
Vision R 20/___ L20/___ Corrected: Y N Pupils: Equal____ Unequal____ Risk behaviors discussed: Y N
(diet, weight, driving, drugs, alcohol, sexuality, safety, stress)

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary(males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only +Having 3rd party present is recommended for the genitourinary exam

Notes:

Please choose one of the following four (4) options:

___1. Cleared without restriction
___2. Cleared, with recommendations for further evaluation or treatment for:
_____
___3. **Not Cleared, but needs additional evaluation by (whom):*_____
___4. Not Cleared for either ___All sports ___Certain sports:_____
Reason:_____

Please note any necessary equipment, medications, or restrictions for cleared athlete to play or practice:

By this signature, I hereby state that I have performed a pre-participation examination in accordance with DIAA standards (current edition of Physician and Sports Medicine's Pre-participation Physical Evaluation) and certify that the above clearance and attached PPE is accurate, complete and compliant to such standards. I also agree that I have documented and signed any playing restrictions on the High School Athlete Medical Card (pg 4).

HealthCare Provider's Signature:_____ Date:_____
Printed Name:_____ Title:_____ Phone:_____

**If Option 3 checked then Referred Physician needs to complete below:*
____ Cleared- no restriction _____Cleared with the following restrictions:_____
____ Not Cleared for ___All sports ___Certain sports:_____
Referred Physician Signature:_____Print:_____ Date:_____

SCHOOL ATHLETE MEDICAL CARD

(Parent/Guardian: please print and complete Sections 1, 2 & 3)

Section 1: **CONTACT/PERSONAL INFORMATION**

NAME:_____ SPORT:_____ SS#:_____
AGE:____GRADE:____ BIRTH DATE:_____ GUARDIAN NAME:_____
ADDRESS:_____
PHONE: (H)_____ (W)_____ (C)_____ (P)_____

Other authorized person to contact in case of emergency:
NAME:_____ PHONE(s):_____
NAME:_____ PHONE(s):_____

Preference of Physician (and permission to contact if needed):
NAME:_____ PHONE:_____
HOSPITAL PREFERENCE:_____ INSURANCE:_____
POLICY #:_____ GROUP:_____ PHONE:_____

Section 2: **MEDICAL INFORMATION**

MEDICAL ILLNESSES:_____
LAST TETANUS (mo/yr):_____ ALLERGIES:_____
MEDICATIONS:_____
(any medications that may be taken during competition require a physician's note)
PREVIOUS HEAD/NECK/BACK INJURY:_____
PREVIOUS HEAT-RELATED PROBLEMS:_____
PREVIOUS SIGNIFICANT INJURIES:_____
ANY OTHER IMPORTANT MEDICAL INFORMATION:_____

Section 3: **Consent for Athletic Conditioning, Training and Health Care Procedures**

I hereby give consent for my child to participate in the school's athletic conditioning and training program, and to receive any necessary healthcare treatment including first aid, diagnostic procedures, and medical treatment, that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract by the school, or the opposing team's school. The healthcare providers have my permission to release my child's medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency I give permission for my child to be transported to receive necessary treatment. I understand that Delaware Interscholastic Athletic Association or its associates may request information regarding the athlete's health status, and I hereby give my permission for the release of this information as long as the information does not personally identify my child.

Parent/Guardian Signature:_____ **Date:**_____
Athlete's Signature:_____ **Date**:_____

Section 4: **Clearance for Participation**

__ Cleared without restrictions **__ Cleared with the following restrictions:**

Health Care Provider's Signature:_____ **MD/DO, PA,NP** **Date**:_____

For office use only: *This card is valid from May 1, 20_____ through June 30, 20_____*
Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school athletic director's or athletic trainer's office. A copy should be kept in the sports' athletic kits. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.
Name of School: _____ ***Name of ATC:*** _____

Protect Your Athletic Eligibility

YOU ARE NOT ELIGIBLE:

1. If you attend a high school and become 19 years of age before June 15. (Reg. 1009.2.1.1)
2. If you attend a junior high/middle school that terminates in the 8th grade and become 15 years of age before June 15. (Reg. 1008.2.1.1.1)

*3. If you are not legally enrolled at the school which you represent. (Reg. 1008.2.3.1 and Reg. 1009.2.3.1)

4. If you are not residing with your custodial parent(s), court appointed legal guardian(s), Relative Caregiver, or are a student 18 years of age or older and living in the attendance zone of the school you attend unless you are participating in the Delaware School Choice Program, attend a private school or are a boarding school student. **IF YOUR CUSTODIAL PARENT(S), LEGAL GUARDIAN(S) OR RELATIVE CAREGIVER(S) RELOCATES TO A DIFFERENT ATTENDANCE ZONE, YOU MUST NOTIFY YOUR ATHLETIC DIRECTOR IMMEDIATELY.** (Reg. 1008.2.2.1 and Reg. 1009.2.2.1)

*5. If you were absent unexcused or absent due to illness or injury; have been suspended (in-school or out-of-school); or have been assigned to homebound instruction or an alternative school for disciplinary reasons. (Reg. 1008.2.3.4 and 1008.2.3.5 Reg. 1009.2.3.5 and 1009.2.3.6)

6. If you failed to complete the preceding semester for reasons other than personal illness or injury. (Reg. 1008.2.3.6; Reg. 1009.2.3.7)

*7. If you do not pursue a regular course of study and pass at least five credits per marking period (equivalent of four credits in junior high/middle school), two credits of which must be in the areas of Mathematics, Science, English, or Social Studies. **IF YOU ARE A SENIOR, YOU MUST PASS ALL COURSES WHICH SATISFY AN UNMET GRADUATION REQUIREMENT.** (Reg. 1008.2.6.; Reg. 1009.2.6.1)

8. If you transferred and have not been in regular attendance at your receiving school for at least 90 school days unless the transfer was the result of a change in residence by you and your custodial parent(s) or court appointed legal guardian(s) from the attendance zone of the sending school to the attendance zone of the receiving school or you transferred after the end of the previous academic year and completed registration at your receiving school before the first student day of the current academic year. (Reg. 1008.2.4 and Reg. 1009.2.4)

9. If you participated in the Delaware School Choice Program during the previous academic year and transferred to your "home school" for the current academic year without completing your two-year commitment or receiving a release from the sending school. (Reg. 1008.2.3.3; Reg. 1009.2.3.4)

10. If you participated in the Delaware School Choice Program during the previous academic year and transferred to another "choice school" for the current academic year unless you are playing a sport not sponsored by the sending school. (Reg. 1008.2.4.6.1; Reg. 1009.2.4.7.1)

11. If you reached the age of majority (18), occupied a residence in a different attendance zone than your custodial parent(s) or court appointed legal guardian(s), and have not been in regular attendance at your receiving school for at least 90 school days unless you are participating in the Delaware School Choice Program and your application was properly submitted prior to your change of residence. (Reg. 1009.2.2.1.7)

12. If you attend a high school and more than four years has elapsed since you first entered 9th grade, or more than five years has elapsed since you just entered 8th grade in schools with 8th grade eligibility for high school sports. (Reg. 1009.2.7.1 and 2.7.2.1)

13. I**f you attend a junior high/middle school in which only grades 7-8 are permitted to participate in interscholastic athletics and more than two years has elapsed since you first entered 7th grade. (Reg. 1008.2.7.1)**

14. I**f you attend a junior high/middle school in which grades 6-8 are permitted to participate in interscholastic athletics and more than three years has elapsed since you first entered 6th grade. (Reg. 1008.2.7.2)**

15. If you have played on or against a professional team or have accepted cash or a cash equivalent (savings bond, certificate of deposit, etc.); a merchandise item(s) with an aggregate retail value of more than $150; a merchandise discount; a reduction or waiver of fees; a gift certificate or other valuable consideration for athletic participation. (Reg. 1009.2.5.1.4 and 2.5.1.5)

16. If you have used your athletic status to promote a commercial product or service in an advertisement or personal appearance. (Reg. 1009.2.5.1.7)

17. If you have not received a physical examination from a licensed physician (M.D. or D.O.), a certified nurse practitioner or a certified physician's assistant on or after **May 1** and written consent from your custodial parent(s) or court appointed legal guardian(s) to participate in interscholastic athletics is not on file in the school office. (Reg. 1009.3.1.1.1 and Reg. 1008.3.1.1)

18. If you participate in an all-star game not approved by DIAA before you graduate from high school. (Reg. 1009.5.4)

19. If you are a foreign exchange student not participating in a two-semester program listed by the Council on Standards for International Educational Travel (CSIET). (Reg. 1009.2.8.1.2)

20. If you are an international student not in compliance with all DIAA regulations including Reg. 1009.2.2 residency requirements. (Reg. 1009.2.8.2)

***IF YOU ARE NOT IN COMPLIANCE WITH THESE REQUIREMENTS, YOU MAY NOT PRACTICE, SCRIMMAGE OR PLAY IN A GAME.**

NOTE: Consult with your coach, athletic director, or principal for information concerning additional eligibility requirements.

STUDENT HEALTH HISTORY UPDATE

This information will be shared on a need to know basis with staff, administration and emergency medical staff in the case of an emergency unless you notify us otherwise.

*Date*_____ *Parent/Guardian's Signature*_____

*Student*_____ *DOB:*_____ *Grade*____ *Teacher*_____

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

1. [ ] ADD/ADHD [ ] Allergies [ ] Asthma [ ] Behavior [ ] Blood Disorder [ ] Body Piercing/Tattoo [ ] Bone/Spine [ ] Bowel/Bladder [ ] Chicken Pox [ ] Diabetes [ ] Emotional [ ] Hearing [ ] Heart [ ] Infections [ ] Kidney [ ] Physical Disability [ ] Seizures [ ] Speech [ ] Surgery [ ] Vision
   [ ] OTHER_____
   Comments:_____
   _____
2. Does your child have allergies to medicine, food, latex or insect bites?
   NO [ ] YES [ ] To What_____ What happens_____
   Treatment_____
3. Has your child had any illnesses since school ended in June?
   NO [ ] YES [ ] Type of illness, with date(s)_____
4. Has your child had surgery since school ended in June?
   NO [ ] YES [ ] Type of surgery, with date(s)_____
5. Has your child received any immunizations since school ended in June?
   NO [ ] YES [ ] List immunizations, with dates_____
6. Is your child being treated or evaluated for any health conditions?
   NO [ ] YES [ ] List condition_____
7. Is your child on any medication or treatment?
   NO [ ] YES [ ] Name of medication and/or treatment_____
   Does your child need medicine during school hours?
   NO [ ] YES [ ] ****If yes, please contact the school nurse to make arrangements.***
8. Has your child ever been examined by an eye doctor?
   NO [ ] YES [ ] Date of last exam_____
   NO [ ] YES [ ] Glasses Prescribed
   If your child wears glasses or contact lenses, when was the prescription last changed_____
9. Has your child had any emotional upsets (recent move, death, separation, divorce) since school ended in June?
   NO [ ] YES [ ] List_____
10. What is the name of your child's dentist? _____
    What is the date of his/her last dental exam? _____
11. What is the name of your child's primary healthcare provider? _____
    What is the date of his/her last physical exam? _____

Thank you.

Lead Screening Program

Current Program

The Childhood Lead Poisoning Prevention Act requires all healthcare providers to order screening for children at or around 12 months of age. "Child care facilities, public and private nursery schools, preschools and kindergartens shall require screening for lead poisoning for admission or continued enrollment."

Schools are responsible for informing parents of this mandate at the time of registration for PreK or Kindergarten. Documentation that a blood lead test was completed must be on file in the Student Health Record. Results of the test are not required although encouraged. Schools should work with families of children with known high blood levels to assure follow-up and appropriate treatment. Families failing to provide documentation should be notified early in the school year. Children without documentation will be excluded from school after 60 days of the date of enrollment.

History

In 1995, legislation was passed requiring lead exposure. Its goal is the foundation of today's program: to assure all Delaware children have reduced exposure to lead and receive early identification.

In 2001, the Division of Public Health reported that 1.4% of Delaware children screened had levels above 10 microgram. The national average at that time was 4.4%. With Delaware's mandated blood lead testing for school entry at PreK or Kindergarten, the number of children tested in Delaware continues to rise as the number of children with elevated blood levels continues to decline.

Overview of Lead Poisoning

Lead has existed since antiquity and occurs naturally in the environment. Egyptians used lead in mascara and the United States later used it in paint, plumbing and gasoline. Paint containing lead was banned in the late 1970's; however, the military continued to use it. Lead poisoning is a silent disease with subtle, if any, signs and symptoms, but very damaging because it affects soft tissues of the body (ex. brain, kidneys, bone, etc.) and can be passed through the placenta to a fetus. Lead poisoning effects concentration and the ability of children to learn. High blood levels have been associated to lower IQs. Lead poisoning can be obtained by inhalation or water, but the most common mode is hand-to-mouth. More than 80% of houses built prior to 1950-55 have lead even if well maintained.

While lead poisoning is more likely to occur in early childhood, older children and adults can also be exposed and affected. In 2005 the CDC issued *Recommendations for Lead Poisoning in Newly Arrived Refugee Children*. The report noted: "Although blood lead levels (BLLs) in children aged 1 to 5 years are decreasing in the United States, the prevalence of elevated BLLs among newly resettled refugee children is substantially higher than children born in the United States." The complete *Recommendations for Lead Poisoning in Newly Arrived Refugee Children*

are available online at www.cdc.gov/nceh/lead. In Delaware, Medicaid will cover testing costs for newly arrived refugee children. Possible exposure, signs and symptoms include:

Exposure:
Breathing air or dust with lead

- Dust from lead-based paint
- Work-site where lead paint is used
- Certain hobbies (stained glass, home renovation, removing lead paint, making lead fishing weights, etc.)

Ingesting contaminated food/water
Non-western cosmetics
Health-care products, not produced in the U.S., with lead
Folk remedies with lead
Improperly glazed pottery, ceramic dishes or leaded-crystal glassware
Lead piping for plumbing

Signs/Symptoms associated with lead poisoning:
Poor concentration
Anemia
Weakness in fingers, wrists or ankles
Decreased reaction time
Mental retardation
Decreased physical growth

Resources

www.cdc.gov/lead

www.cdc.gov/nceh/lead

Affidavit of Religious Belief
S A M P L E

The Childhood Lead Poisoning Prevention Act states *"for every child born on or after March 1, 1995, and who has reached the age of 12 months, child care facilities and public and private nursery schools, preschools and kindergartens shall require screening for lead poisoning for admission or continued enrollment; except in the case of enrollment in kindergarten, such testing may be done within 60 calendar days of the date of enrollment. A statement shall be provided from the child's primary health care provider that the child has been screened for lead poisoning or in lieu thereof a certificate signed by the parent or guardian stating that the screening is contrary to that person's religious beliefs."* The following Affidavit is provided as a template, but another form can be used.

STATE OF DELAWARE

_____ COUNTY

1. (I) (We) (am) (are) the (parent[s]) (legal guardian[s]) (Relative Caregiver[s]) of

_____.
Name of Child

5. (I) (We) hereby (swear) (affirm) that (I) (we) subscribe to a belief in a relation to a Supreme Being involving duties superior to those arising from any human relation.

6. (I) (We) further (swear) (affirm) that our belief is sincere and meaningful and occupies a place in (my) (our) life parallel to that filled by the orthodox belief in God.

7. This belief is not a political, sociological or philosophical view of a merely personal moral code.

8. This belief causes (me) (us) to request an exemption from the lead screening for

_____.
Name of Child

_____
Signature of Parent(s) or Guardian(s)

SWORN TO AND SUSCRIBED before me, a registered Notary Public, this _____ day of _____, 20____.

_____(Seal)
Notary Public
My commission expires:_____

IV. Screening

815 Physical Examinations and Screening

1.0 Physical Examinations

1.1 All public school students shall have a physical examination that has been administered by a licensed medical physician, nurse practitioner or physician's assistant. The physical examination shall have been done within the two years prior to entry into school. Within fourteen calendar days after notification of the requirement for a physical examination, new enterers shall have received a physical examination or shall have a documented appointment with a licensed health care provider for a physical examination.

1.1.1 The requirement for the physical examination may be waived for students whose parent, guardian or Relative Caregiver, or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a) presents a written declaration acknowledged before a notary public, that because of individual religious beliefs, they reject the concept of physical examinations.

1.1.2 The school nurse shall record all findings on the Delaware School Health Record Form (see 14 **DE Admin. Code** 811) and maintain the original copy in the child's medical file.

NON REGULATORY NOTE: See 14 **DE Admin. Code** 1008.3 and 14 **DE Admin. Code** 1009.3 for physical examination requirements associated with participation in sports.

2.0 Screening

2.1 Vision and Hearing Screening

2.1.1 Each public school student in kindergarten and in grades 2, 4, 7 and grades 9 or 10 shall receive a vision and a hearing screening by January 15th of each school year.

2.1.1.1 In addition to the screening requirements in 2.1.1, screening shall also be provided to new enterers, students referred by a teacher or an administrator, and students considered for special education.

2.1.1.1.1 Driver education students shall have a vision screening within a year prior to their in car driving hours.

2.1.2 The school nurse shall record the results on the Delaware School Health Record Form and shall notify the parent, guardian or Relative Caregiver or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a) if the student has a suspected problem.

2.2 Postural and Gait Screening

2.2.1 Each public school student in grades 5 through 9 shall receive a postural and gait screening by December 15th.

2.2.2 The school nurse shall record the findings on the Delaware School Health Record Form (see 14 **DE Admin. Code** 811) and shall notify the parents, guardian or Relative Caregiver, or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a) if a suspected deviation has been detected.

2.2.2.1 If a suspected deviation is detected, the school nurse shall refer the student for further evaluation through an on site follow up evaluation or a referral to the student's health care provider.

2.3 Lead Screening

2.3.1 Children who enter school at kindergarten or at age 5 or prior, shall be required to provide documentation of lead screening as per 16 **Del.C.** Ch. 26.

2.3.1.1 For children enrolling in kindergarten, documentation of lead screening shall be provided within sixty (60) calendar days of the date of enrollment. Failure to provide the required documentation shall result in the child's exclusion from school until the documentation is provided.

2.3.1.2 Exemption from this requirement may be granted for religious exemptions, per 16 **Del.C.** §2603.

2.3.1.3 The Childhood Lead Poisoning Prevention Act, 16 **Del.C.,** Ch. 26, requires all health care providers to order lead screening for children at or around the age of 12 months of age.

2.3.2 The school nurse shall document the lead screening on the Delaware School Health Record form form. See 14 **DE Admin. Code** 811.

Vision Screening Procedures

The American Optometric Association identifies six vision skills that are needed in school: visual acuity (near and far), eye focusing, eye tracking, eye teaming, eye-hand coordination, and visual perception (http://www.aoa.org/x9451.xml#1). The primary goal of school vision screening is early identification and referral of children with visual abnormalities which can interrupt educational, physical and emotional growth.

I. Preparation
   A. Obtain class rosters to use as a worksheet and to record results of screening, if results are not directly entered in a computer program.
   B. Notify parents (school newsletter, note, other), students and faculty of upcoming screening.
   C. Schedule screenings to assure completion by January 15.
   D. Review equipment and manufacturer's directions.

II. External Exam

During vision screening the school nurse has the opportunity to observe for other signs/symptoms which could indicate conditions that should be referred for further evaluation.

- Alignment of the eyes, symmetry
- Red or swollen eyelids
- Drainage from the eyes or abnormal conjunctiva
- Pruitis
- Red, pink, bluish-tone or yellow-stained sclera
- Cloudy or hazy appearance of lens or cornea
- Pupil size
- Drooping eyelids

III. History

Teachers and others working with children can assist with early identification of visual problems. The following should be reported to the nurse for further evaluation and referral.

- Frequent eye rubbing, blinking or tearing
- Squinting
- Headaches
- Tilting head or covering one eye
- Moving to the board or holding book close to face
- Short attention span
- Dislike of or difficulty with reading
- Reporting blurred or double vision

IV. Acuity

If corrective lenses are usually worn by the student, all testing should be done with the glasses in place.

   A. Non Instrument (appropriate for Grade Pre-K-adult)
      1. <u>Equipment Needed</u>
         a. Lighted chart (Snellen, Good Lite, Instaline, NOTV) or graduated cards (ex. Lighthouse, Blackbird)
         b. Plastic occluder
         c. Plus lens: +2.25 and +1.75 lens
         d. Near Vision Card
         e. Quiet room at least 20 feet in length (or 10 feet if using 10-foot chart) with adequate lighting
            (1) Illumination of chart, evenly diffused over chart without glare
            (2) General illumination not less than 1/5 of chart illumination and nothing in the field of vision brighter than the chart
      2. <u>Recommended Procedures</u>

a. Distance Vision Acuity (appropriate screening tool for Grades Pre-K through adult)
   (1) Place the child at a mark exactly 20 feet or 10 feet, depending upon the chart used, from the chart with the eye level at the 20/20 or 10/10 line. If standing, the heels should be on the 20 or 10-foot mark. If seated, the back legs of the chair should be on the mark.
   (2) Children with prescriptive glasses for distance should be tested wearing the glasses.
   (3) Prior to screening review the symbols or letters with the child to ascertain the child's ability to recognize and communicate the symbol.
   (4) Teach the child to use the occluder to cover one eye while keeping both eyes open during test.
   (5) Expose one symbol or letter at a time.
   (6) Test the right eye first, then the left, then both eyes.
   (7) Begin with the 30 or 40-foot line and proceed to include the 20-foot line. With children suspected of low vision, begin with the 200-foot line.
   (8) Move rhythmically from one symbol to another at a pace that is comfortable to the child. Reading the majority (i.e., more than half) of the symbols on a line is considered passing.
   (9) Observe for thrusting head forward, tilting head, eyes watering, frowning or scowling, closing one eye during the test of both eyes together, and excessive blinking.
   (10) Stop when the child fails a line and record last line read correctly. Record visual acuity in order given for the right eye, left eye, for both eyes. Numerator equals distance from the chart; denominator represents the line read (20/60 means 20 feet distance over 60-foot line.)
   (11) A second screening is recommended on all children who fail prior to referral.

b. Near Vision – using plus lens or chart
   (1) Plus lens (testing hyperopia)
      (a) Place the plus lens glasses on the child. Use small framed (+2.25) glasses for preschool through second grade and larger framed (+1.75) glasses for third grade and up.
      (b) As before, show the symbol at 20 feet or 10 feet and ask the child to read the 20-foot or 10-foot line.
      (c) If a child is able to read with either eye the 20/20 or 10/10 line through a plus lens, he/she fails.
   (2) Chart
      (a) Review the symbols or letters on the chart with the child and ascertain the child's ability to recognize and communicate the symbol.
      (b) Hold/place the child's head at the distance directed by manufacturer (typically 13" or 16").
      (c) Occlude each eye, alternately, to screen individually and then test binocular vision.
      (d) Stop when the child fails a line and record last line read correctly.

3. Screening Failure Criteria
   a. Grades Pre-K and Kindergarten:
      (1) Children with vision 20/50, or
      (2) Repeated screening of 20/40 with other visual concerns or learning problems; visual complaints.
   b. Grade 1 and above:
      (1) Children with vision 20/40 or less, or
      (2) Screening of 20/30 with other visual concerns or learning problems; visual complaints.

c. Unequal screening acuity between eyes of more than one line.
d. Ability to read the 20/20 or the 10/10 line with either eye through the plus lens.

B. Instrument (recommended for children in Grades 3 and up)
1. Equipment Needed
a. Stereoscopic Instrument (ex. Titmus)
b. Quiet room with adequate lighting as recommended by manufacturer
2. Recommended Procedures
a. Distance and Near Vision
(1) Follow instructions outlined by maker of instrument to test each eye.
(2) Assure the child's head is correctly placed up against machine.
3. Screening failure criteria (See A.3. above)

V. Muscle Tests
A. Non Instrument (appropriate screening tool for Grade K-adult)
1. Equipment Needed
a. Occluder
b. Test object: something handheld that the child can focus on (ex: sticker on finger, pencil puppet, pen light)
2. Recommended Procedures
a. Cover/uncover tests (near and far)
(1) Hold the test object about 14 inches from the child and instruct him/her to look at the object. Talk to him/her and ask questions about the object so he/she won't stare but will actually look at it.
(2) Cover the right eye with the occluder. Observe the left eye for movement. Cover the right eye again and observe for movement of the right eye.
(3) Repeat technique for left eye.
(4) Repeat as many times as it takes to be sure of the result. The occluder should be moved quickly without touching the child's face.
(5) Repeat the procedure using a test object at 10 or 20-feet away.
b. Tracking
(1) Hold test object approximately 16" from patient's eye.
(2) Move object to all four quadrants in "H" pattern.
(3) Move object towards nose.
(4) Observe for stramisbus, nystagmus, diplopia, convergence, and smoothness of movement.
c. Screening Failure Criteria
(1) Cover test: If either eye moves in or out to see the object, or is unsteady. Record – (minus) for failing, +(plus) for passing.
(2) Tracking: Signs of difficulty in any area.

B. Instrument (appropriate screening tool for Grade 3-adult)
1. Equipment Needed
a. Stereoscopic Instrument (ex. Titmus)
b. Quiet room with adequate lighting as recommended by manufacturer
2. Follow instructions outlined by maker of instrument to test each eye.
3. Assure the child's head is correctly placed up against machine.

VI. Depth Perception (recommended screening tool for Grade K and for new enterers not previously screened)
A. Non Instrument (appropriate screening for Grade K-adult)
1. Equipment Needed
a. Stereo test
b. Polaroid glasses for depth perception
2. Recommended Procedures
a. Place the special glasses on the child.

b. Hold the picture of the fly sixteen inches away, avoiding reflection on the shiny surface.
c. Have the child try to "pinch" the fly's wings using the thumb and forefinger. (It may aid the preschool age child to show him how to "pinch" before he sees the fly.) If the eyes are functioning properly, the child will see the fly as a solid, three-dimensional object and the fingers will not touch the picture.

3. Screening Failure Criteria – The child fails the test if his fingers touch the picture, meaning that he/she sees it as an ordinary, flat photograph. Record the results, + (plus) for passing, - (minus) for failing.

B. Instrument (appropriate screening tool for Grade 3-adult. Refer to #I.B. for guidelines.)
1. Equipment Needed
a. Stereoscopic Instrument (ex. Titmus)
b. Quiet room with adequate lighting as recommended by manufacturer
2. Recommended procedures
a. Follow instructions outlined by maker of instrument to test each eye.
b. Assure the child's head is correctly placed up against machine.

VII. Color Vision (recommended screening for Grade K and new enterers not previously screened; this screening is only required once)
A. Equipment Needed – Ishihara or Hardy-Rand-Rittler Pseudoisochromatic Plates
B. Recommended Procedures
1. Follow instructions as outlined in the manufacturer's directions.
2. Adequate lighting.
C. Screening Failure Criteria – Any child who cannot discriminate colors.

VIII. Common Mistakes Screeners Make:
A. Not being organized
B. Not knowing how to use the testing equipment
C. Not testing equipment first to make sure it work
D. Failing to check student's health record before vision screening to note whether the child already wears glasses, but doesn't have them with him/her
E. Assuming children know their letters in kindergarten or assuming children know the English words for the letters/symbols
F. Failing to provide privacy
G. Making sure equipment fits correctly
H. Making sure student is properly positioned (ex. Resting forehead on machine, or <u>heels</u> on 20' line)
I. Screening without glasses
J. Assuming child is looking at same line or reading in proper direction you are indicating
K. Thinking that assessment equals intervention
L. Not following up on referrals
M. Not utilizing the services of the Lion's Club for vision/glasses

IX. Follow-Up
A. Record test results on the School Health Record.
B. Referral
1. Students under professional care need not be referred, but should be followed to encourage continuity of appropriate treatment.
2. Notify parent/guardian that child has a suspected visual problem (see "Sample," Section B, page 71). They should be advised to seek further examination from an ophthalmologist or optometrist. If the family cannot afford to have the child seen privately, a referral may be made to the Optometric Clinic in the County Health Unit. Contact the clinic for eligibility.
C. Meeting student's immediate needs
1. Discuss suspected or known deviations with appropriate school personnel.

2. Color deficiency is not correctable, but parent/guardian and students should be made aware of this condition and its implications.

X. Visually Impaired Students

Medical assistance and educational services may be received through the Division for the Visually Impaired, 305 West 8th Street, Wilmington, Delaware 19801 (577-3333).

XI. Resource Information

A. To See of Not to See – Screening the Vision of Children in School (2005). S. Proctor. National Association of School Nurses.

B. School Nursing: A Comprehensive Text (2006). Chapter 20, Health Promotion. J. Selekman, author and editor. National Association of School Nurses.

Vision Referral Letter
S A M P L E

Date_____

Dear Parent/Guardian:

A recent vision screening test at school indicates that_____
(student and grade)
may have some vision difficulty. An eye examination is recommended. Please take this form with you at the time of examination.

_____
(School Nurse)

_____
(School)

REASON FOR REFERRAL

Vision Test Results_____

_____Frequent headaches after reading _____Blinking _____Blurred Vision

_____Squinting _____Watering Eyes

Remarks_____

_____

EYE EXAMINER'S REPORT TO SCHOOL

_____Glasses Prescribed _____Not Prescribed

____To be worn at all times.
____To be worn at all times except during physical education.
____To be worn for driving.
____To be worn in the classroom.
____Preferential Seating

_____Vision to be expected with correction: R 20/ L 20/

_____When should student return for reexamination?_____

We would appreciate any additional information which may be pertinent to this student's school adjustment.

Date_____ _____
Signature of Eye Examiner

NOTE: Please complete and return to the school nurse. Thank you.

School Nurse Address_____

School Nurse Fax_____

Hearing Screening Procedures

The ability to communicate effectively impacts the well-being of a child, in terms of education, physical and social development. Early identification and intervention of hearing loss is critical in supporting speech/language development and full participation in the learning process. Even mild hearing losses may be educationally and medically significant.

I. Preparation
   A. Obtain class rosters to use as a worksheet and to record results of screening, if results are not directly entered in a computer program.
   B. Notify parents (school newsletter, note, other), students and faculty of upcoming screening.
   C. Schedule screenings to assure completion by January 15.
   D. Consider the impact of allergy and cold seasons when scheduling.
   E. Review equipment and manufacturer's directions.
   F. Testing area should be:
      1. Quiet and free from ambient noises such as fans, typewriters, blowers, flushing toilets, ringing phones, band rehearsals, gymnasiums, or playgrounds. Experience has shown that rooms treated with acoustical tile, heavy drapes covering windows, carpeting, and solid core doors help to eliminate extraneous noise.
      2. Of sufficient size to accommodate the evaluator and the student. In some cases it is helpful to have space that permits the seating of 2 to 4 additional students so that they may observe the test procedure.
      3. Supplied with an electrical outlet (110V AC).
   G. Set up a table sufficient in size to accommodate the audiometer and provide the evaluator with ample writing space. Seating for the tester and the student should be of appropriate size.
   H. Assemble necessary forms: class roster for recording results, parent/guardian letter, and referral form.
   I. Children with hearing aids or a medical diagnosis of hearing loss do not require further screening.

II. External Exam
   A. Hearing screening affords the opportunity to observe for the following and make appropriate referrals:
      1. Hair/scalp conditions
      2. Piercings, which may be un-healed or may interfere with alignment of headphones during procedure
      3. Drainage or cerumen from ear

III. Acuity
   A. Equipment needed
      1. Pure tone audiometer, calibrated annually to current ANSI standards.
   B. Recommended procedure
      1. Turn on audiometer. Some manufacturers recommend allowing older machines to warm up for 15-20 minutes. Leave the machine on for the entire screening period.
      2. Always test the audiometer before using it. (Test it on yourself.)
      3. Arrange the chairs so the student cannot view the equipment or the recording sheet.
      4. Give directions to the student on an appropriate response to hearing the tone.
      5. Place earphones on the student's head, being sure to line up the microphone with the student's ear canal. Typically, the red earphone goes on the right ear. It may be

necessary to remove earrings, headbands, hair from behind the ear and glasses to get a snug fit.

6. Screening should be performed only at the following frequencies: 1000, 2000, and 4000 Hertz (Hz).
7. Intensity level of screenings will be 20 decibels (dB) at each frequency. (NOTE: If there appears to be a fair amount of extraneous noise, screening intensity level can be raised to 25 dB for each frequency.) Press the tone for 2-4 seconds. Vary the interval between tones.
8. Only a lightly damp cloth should be used to clean the rubber earphones, unless recommended otherwise by the manufacturer. Do not put liquid on the microphones which are located in the center of each earphone! Alcohol is not recommended as it may dry the material.

NOTE: Some students with significant limitations may be incapable of screening via the traditional audiometric screening as described in this section. For these students, the school may elect to purchase specialized equipment to facilitate a screening. The School Nurse should receive appropriate training in the use of the equipment as a screening tool and follow recommended guidelines for appropriate screening frequencies, decibels, referral criteria, etc.

C. Screening Failure Criteria
   1. Failure to respond at the recommended screening level at any frequency in either ear constitutes failure.
   2. All failures should be re-screened within the same session. This should be accomplished by removing and repositioning the earphones and carefully re-instructing the student.
   3. Any student who fails the initial screening should have a repeat screening done within two (2) weeks.
   4. Any student failing the initial screening and repeat screening will be referred for appropriate follow-up and re-screened the following year.
   5. An otoscopic exam should be done for any student who fails the initial and repeat screenings. Immediate referral is indicated for signs of otitis, cerumen build-up or foreign body.

IV. Common Mistakes Screeners Make:
   A. Not being organized
   B. Failure to check student's health record before screening to note whether already wears hearing aid or has medical diagnosis of hearing loss
   C. Not knowing how to use the testing equipment
   D. Not testing equipment before use
   E. Not using a quiet/private area for screenings
   F. Not making sure equipment fits correctly
   G. Not having child turned away/back to equipment for hearing
   H. Not holding hearing tone for sufficient length of time
   I. Screening at 20dB, 1000, 2000 and 4000 only
   J. Failure to view ear with otoscope following failed hearing screening to rule out cerumen, foreign body, or infections
   K. Not following up on referrals
   L. Thinking that assessment equals intervention

V. Follow-up
   A. Record test results on the School Health Record.

B. Referral
   1. Students under professional care need not be referred, but should be followed to encourage continuity of appropriate treatment.
   2. Notify parent/guardian that the student has failed the hearing screening and may have a hearing loss (see "Sample," Section B, page 75). They should be advised that they might elect to receive a diagnostic audiological and otological (ear examination by an ENT physician) through their family physician, community ENT physician, or the Division of Public Health.

C. Should the parent/guardian elect services through the Division of Public Health:
   1. Contact the family physician to obtain permission to refer student to the clinic. Treatment services are not involved in this referral.
   2. New Castle County: Referrals for Audiologic and Otologic Services should be forwarded to Christiana Care ENT Clinic at the following location: Wilmington hospital, Speech and Hearing Department, 501 West 14th Street, Wilmington, DE 19801 (428-2286).
   3. Kent County: Refer for audiology or A & O services to: Williams State Service Center, Hearing Services, Route 13 and River Road, Dover, DE 19901 (739-5376).
   4. Sussex County: Refer for audiology or A & O services to: Sussex County Health Unit, Hearing Services, 544 South Bedford Street, Georgetown, DE 19947 (856-5213).

D. Discuss suspected or known deviations with the appropriate school personnel.

NOTE: Nurses are urged to follow-up the hearing of students receiving private care within a reasonable period of time or to check with the student or family on what care was given so as to insure adequate follow-up of the suspected hearing loss.

VI. Resource
   A. The Ear & Hearing: A Guide for School Nurses (2004). E. Gregory. National Association of School Nurses.
   B. School Nursing: A Comprehensive Text (2006). Chapter 20, Health Promotion. J. Selekman, author and editor. National Association of School Nurses.

Hearing Referral Letter
S A M P L E

DATE: _____

Dear Parent/Guardian:

Your son/daughter _____recently failed a hearing screening and may have a hearing problem. You may already be aware of this possible problem and are taking steps to correct it. If not, a medical examination is recommended. Please contact me to discuss the suspected problem.

Many hearing losses today may be corrected before they become serious. While some individuals have a temporary hearing loss during a cold or other infection, it is important that the cause of such a temporary loss be determined and treated to protect the individual's future hearing.

_____
Nurse

_____
School

EXAMINING PHYSICIAN

(Please complete and return to the school nurse.)

Name_____ School_____ Grade_____

Diagnosis _

State Treatment Complete_____

_____

Additional Medical Recommendations:

Prognosis: Stationary _____ Will improve _____ Progressive _____ Intermittent _____

Educational Recommendations:

Do you advise any of the following educational recommendations for the student?

Speech reading _____ Auditory Training _____ Use of hearing aid or amplifier _____

Date of Examination:_____ Examiner_____ M.D._____

Date of Return Visit: _____

NOTE: Please complete and return to the school nurse. Thank you.

Address_____

Fax_____

Postural & Gait Screening

I. Preparation
   A. Obtain class roster to use as work sheet and to record results of screening.
   B. Notify parents, students and faculty of upcoming screening. Include information on rationale for screening and procedure.
   C. Males and females should be screened separately. Boys should be dressed in shorts and sleeveless top; girls should wear bathing suit or shorts and sleeveless blouse, tank top, or one that opens in the back. This allows for adequate examination of head, arms, back, legs and feet.
   D. Arrange for a private area for screening of each child.
   E. Make arrangements to complete screenings by December 15. Schedule approximately 30 – 60 seconds per child.

II. Procedure
   A. Examination should be done in this sequence:
      1. Student walks toward examiner, look for:
         a. Symmetry of the body
         b. Abnormality of gait (limp, waddle, feet turn in or out excessively)
      2. With student standing in front of examiner, look for:
         a. Limitation of neck motion
         b. Limitation of arm motion
         c. Shoulder level
         d. Eye level
         e. Pelvic tilt
         f. Short leg
         g. Leg and foot abnormalities interfering with gait/comfort
      3. With student standing sideways to examiner, look for:
         a. Abnormalities of AP posture
      4. With student standing with back to the examiner, look for:
         a. Curvature of the spine or other abnormalities
            (1.) Back straight
            (2.) Back bent in Adams position
      5. Student walks away from examiner and gait is checked again
   B. In addition to the above, look for such things as allergies, suspicious moles, skin conditions, flat feet, and scarring. Refer to primary healthcare provider for further evaluation.
   C. Pain is a cardinal sign for <u>immediate</u> referral.

III. Common Mistakes Screeners Make
   A. Not being organized
   B. Not having a quiet-private area for screenings
   C. Scheduling males/females at the same time
   D. Failing to check student's health record before screening to note if child is followed for an orthopedic condition or is already scheduled for a re-examination in Phase II from a previous year
   E. Letting child wear shoes
   F. During the Adams Bend test:
      1. Overlooking the thoracic area
      2. Not looking directly at lumbar spine

3. Forgetting to assure the student does not lock his/her knees
4. Allowing the child to bend over too fast, or too far, or with only one knee bent

G. Referring a child with a dominant side (shoulder) slightly lower than the other side (This is normal as long as all other aspects of exam are normal.)
H. Failing to alert parents of Phase II
I. Not following up on referrals
J. Thinking that assessment equals intervention

IV. Follow-up – Phase I and Phase II

A. Record findings on the School Health Record. If a suspected deviation is detected, complete one copy of form on the following page for Phase II. Notify the District Coordinator or Lead School Nurse by December 15 of the number of students to be checked in Phase II.
B. The District Coordinator or Lead School Nurse will arrange for Phase II through the Supervisor of Health Services, Department of Education.
C. Notify parent of referral to Phase II (sample letter on page 78).
D. If parent/guardian elects to seek private medical care in lieu of Phase II:
   1. Obtain name of physician and send one copy of the special form with a cover letter
   2. Check with the student or family within a reasonable time on what care was given to insure adequate follow-up
   3. Have parent/guardian sign authorization to release information for private physician, duPont Hospital for children, and Shriners Hospital referrals
E. Discuss suspected or known deviations with appropriate school personnel.
F. After Phase II, notify parent/guardian that a suspected deviation has been detected. They should be advised that they should seek further examination through the family physician, duPont Hospital for Children, or the Shriners Hospital (1-800-281-4050). Note: Some families may have to check with their primary care physician before contacting the duPont Hospital for Children or Shriners Hospital.

V. Resources

A. Postural Screening Guidelines for School Nurses (2004). J. Ryberg. National Association of School Nurses.
B. School Nursing: A Comprehensive Text (2006). Chapter 20, Health Promotion. J. Selekman, author and editor. National Association of School Nurses.

Phase II Referral

STUDENT'S NAME _____ SCHOOL _____

SCHOOL EXAMINER _____ DATE OF REFERRAL _____

1. POSTURE
   a) Poor_____ (unable to correct)

2. WALKS WITH
   a) Limp_____ (unknown cause)
   b) Unusual Gait_____
   c) Feet turned in _____ (problem of tripping)

3. UPPER EXTREMITIES
   a) Abnormalities _____ (contractures or lack of ROM - range of motion)

4. SPINE
   a) Lateral Curvature (Scoliosis) _____ (all curves)
   b) Posterior Curvature (Kyphosis) _____ (cannot correct)
   c) Anterior Curvature in lower spine (Lordosis) _____ (cannot reduce)
   d) Back pain _____

5. LOWER EXTREMITIES
   a) Hip problem _____ (Pain, lack of ROM)
   b) Knee problem _____ (Pain, lack of ROM, unstable knee)
   c) One shorter

6. FEET
   a) Any conditions causing pain, excessive shoe wear and/or other problems
      _____

7. MUSCULATURE
   a) Generalized weakness _____ (overall poor muscle tone, cannot keep up with peers)
   b) Apparent weakness _____ (one or more extremities)

8. REMARKS (Explanation of above, if desired, or any other unlisted abnormalities)

_____

_____

_____

FINAL SCREENING (Phase II)

a) Impression _____

b) Recommendation _____

SIGNATURE (Physical Therapist) _____

Postural & Gait Screening Letter

S A M P L E

DATE: _____

Dear Parent/Guardian:

A recent postural/gait screening test at school indicates that _____ may have a postural or gait irregularity which could affect his/her during these growing years.

The physical therapist will be at this school on _____ to perform Phase II of the postural/gait screening. He/she will examine your child to determine if a referral to the doctor is needed. Please make every attempt to have your child at school on time this day.

After this exam, you will be notified if the physical therapist feels that your child needs to have an additional exam by his/her doctor.

Please call the school nurse with any questions.

_____

School Nurse

_____

Phone

VI. Medications

817 Administration of Medications and Treatments

1.0 Administration of Medications and Treatment

1.1 Medications, in their original container, and treatments may be administered to a public school student by the school nurse when a written request to administer the medication or treatment is on file from the parent, guardian or Relative Caregiver or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a). The school nurse shall check the student health records and history for contra indications and all allergies, especially to the medications, and shall provide immediate medical attention if an allergic reaction is observed or make a referral if symptoms or conditions persist. The school nurse shall also document the student's name, the name of medication and treatment administered, the date and time it was administered and the dosage if medication was administered.

2.0 Licensed Health Care Provider

2.1 Any prescribed medication administered to a student, in addition to the requirements in 1.0, shall be prescribed by a licensed health care provider. Treatment, including specialized health procedures, shall be signed by a licensed health care provider with directions relative to administration or supervision.

3.0 Prescription Medications

3.1 Prescription medication shall be properly labeled with the student's name; the licensed health care provider's name; the name of the medication; the dosage; how and when it is to be administered; the name and phone number of the pharmacy and the current date of the prescription. The medication shall be in a container which meets United States Pharmacopoeia National Formulary standards.

3.2 Medications and dosages administered by the school nurse shall be limited to those recommended by the Federal Drug Administration (FDA), peer review journal that indicates doses or guidelines that are both safe and effective or guidelines that are specified in regional or national guidelines.

3.2.1 The prescription and the medication shall be current and long term prescriptions shall be re authorized at least once a year.

3.2.2 All medications classified as controlled substances shall be counted and reconciled each month by the school nurse and kept under double lock. Such medications should be transported to and from school by an adult.

4.0 Non Prescription Medications

4.1 Non prescription medications may be given by the school nurse after the nurse assesses the complaint and the symptoms to determine if other interventions can be used before medication is administered and if all requirements in 1.0 have been met.

5.0 IEP Team

5.1 For a student who requires significant medical or nursing interventions, the Individual Education Program (IEP) team shall include the school nurse.

6.0 Assistance With Medications on Field Trips

6.1 Definitions

"Assist a Student with Medication" means assisting a student in the self administration of a medication, provided that the medication is in a properly labeled container as hereinafter provided.

Assistance may include holding the medication container for the student, assisting with the opening of the container, and assisting the student in self administering the medication. Lay assistants shall not assist with injections. The one exception is with emergency medications where standard emergency procedures prevail in lifesaving circumstances.

"Field Trip" means any off campus, school sponsored activity.

"Medication" means a drug taken orally, by inhalation, or applied topically, and which is either prescribed for a student by a physician or is an over the counter drug which a parent, guardian or Relative Caregiver has authorized a student to use.

"Paraeducator" mean teaching assistants or aides.

6.2 Teachers, administrators and paraeducator employed by a student's local school district are authorized to assist a student with medication on a field trip subject to the following provisions:

6.2.1 Assistance with medication shall not be provided without the prior written request or consent of a parent, guardian or Relative Caregiver (or the student if 18 years or older, or an unaccompanied homeless youth (as defined by 42 USC 11434a). Said written request or

consent shall contain clear instructions including: the student's name; the name of the medication; the dose; the time of administration; and the method of administration. At least one copy of said written request or consent shall be in the possession of the person assisting a student with medication on a field trip.

6.2.2 The prescribed medication, in addition to the requirements in 1.0, shall be prescribed by a licensed health care provider. The medication shall be properly labeled with the student's name; the licensed health care provider's name; the name of the medication; the dosage; how and when it is to be administered; the name and phone number of the pharmacy and the current date of the prescription. The medication shall be in a container which meets United States Pharmacopoeia National Formulary standards.

6.2.3 A registered nurse employed by the school district in which the student is enrolled shall determine which teachers, administrators and paraeducators are qualified to safely assist a student with medication. In order to be qualified, each such person shall complete a Board of Nursing approved training course developed by the Delaware Department of Education, pursuant to 24 **Del.C.** §1921. Said nurse shall complete instructor training as designated by the Department of Education and shall submit a list of successful staff participants to the Department of Education. No person shall assist a student with medication without written acknowledgment that he/she has completed the course and that he/she understands the same, and will abide by the safe practices and procedures set forth therein.

6.2.4 Each school district shall maintain a record of all students receiving assistance with medication pursuant to this regulation. Said record shall contain the student's name, the name of the medication, the dose, the time of administration, the method of administration, and the name of the person assisting.

6.2.5 Except for a school nurse, no employee of a school district shall be compelled to assist a student with medication. Nothing contained herein shall be interpreted to otherwise relieve a school district of its obligation to staff schools with certified school nurses.

NON REGULATORY NOTE: 14 **DE Admin. Code** 612, *Possession, Use and Distribution of Drugs and Alcohol* addresses student self administration of a prescribed asthmatic quick relief inhaler and student self administration of prescribed autoinjectable epinephrine.

Recommended Procedures to Follow for Medications

- When prescribed or over- the counter medication is administered to a student, the nurse will document medication administration in the student's electronic medical record or Individual Heath Services Log.

- For medication to be administered by the school educational staff on an off campus event, the school nurse will create an individual Field Trip Medication Form for each student and file the form in the student's Health Record. Additional documentation should be made the student's electronic medical record or Individual Heath Services Log.

Recommended Procedures to Follow for Controlled Substances*

- Controlled substance medications should be brought to school by a responsible adult member of the student's family and given to the school nurse in the original container.

- If it creates a hardship for the family to deliver the medication, it is the parent/guardian's responsibility to count the number of pills or capsules sent to the school and to verify this with the school nurse.

- The controlled substance medication is to be counted on arrival by the school nurse in the presence of an adult family member, if possible. In the event that the parent/guardian did not deliver the medication, a copy of this account should be sent to the parent/guardian who should contact the school nurse if there are questions. A copy of the communication sent to the parent/guardian should be kept on file.

- All controlled substances are to be kept under double lock. (The storage cabinet plus locked room should be sufficient.) Only authorized licensed personnel should have access to the area.

- Documentation will show the student's name, time, date of administration and dosage**.

- All controlled substances will be counted and reconciled at least once a month.

- When controlled substances are sent home (end of school year, etc.), the school nurse will give the medication to a responsible family member after a count is verified and signed by both the school nurse and the adult. If it presents a hardship for a family member to pick up the medication, the school nurse will verify numbers with an adult staff person and inform the parent/guardian of the number of pills/capsules that are being sent home.

*Reviewed by the State Board of Education on 10/17/96.
** Change 3/05.

SAMPLE

Parental Request to Have Prescription Medication/Treatment Administered in School

If it is necessary for your child to receive medication during the school day, please do the following:

- Send the medication to school with a responsible individual if you are unable to take it to school.
- Send the medication in the original container properly labeled with correct name, time, dose and date.
- Count the tablets (unless the number of tablets is the exact number on the label) or approximate amount of liquid in the bottle.
- Fill out the following information:

Date _____

Student's Name _____

Medication _____

Dose _____ Time _____

Reason for Medication _____

Allergies to any medications _____

Number of tablets sent _____

Amount of liquid _____

I am aware that the school nurse may have need to contact the prescribing healthcare provider or pharmacist relative to the medication/treatment and I give my permission.

Parent/Guardian Signature _____

Nurse's Signature _____

Number of tablets/amount of liquid received _____

Information on Controlled Substances

General Information - To determine if a drug is a controlled substance, check the PDR (*Physician's Desk Reference*) which will indicate whether or not the drug is controlled and the schedule under which is located.

Some examples are:

Brand Name	**Generic Name**	**Schedule**	**Title I6 Section #**
Opium or Derivative	**Narcotics**		
* Codeine	Codeine	II	4716(b) (1)
Morphine	Morphine	II	4716(b) (1)
Percodan, Tylox	Oxycodone	II	4716(b) (1)
Tussionex, Hycodan	Hydrocodone	III	4718(e) (4)
Opium Tincture	Opium Tincture	III	4718(e) (7)
Paregoric	Camphorated Tincture of Opium	III	4718(e) (7)
Dilaudid	Hydromorphone	II	4716(b) (1)
Barbiturates	**(Non-Narcotic)**		
Fiorinal	Butalbital	III	4718(c) (1)
Phenobarbital	Phenobarbital	IV	4720(b) (11)
Seconal	Secobarbital	II	4716(e) (3)
Nembutal	Pentobarbital	II	4716(e) (4)
Non-Narcotic Stimulants			
Ritalin	Methylphenidate	II	4716(d) (4)
Preludin	Phenmetrazine	II	4716(d) (2)
Tenuate, Tepanil	Diethylpropion	IV	4720(h) (1)
Voranil	Clortermine	III	4718(g)
Sanorex	Mazindol	IV	4720(j)
Didrex	Benzphetamine	III	4718(h)
Pleoine, Prelu-2, Bontril	Phendimetrazine	III	4718(j)
Adipex, Fastin	Phentermine	IV	4720(f)
Non-Narcotic Tranquilizers and Depressants			
Talwin	Pentazocine	IV	4720(g)
Librium	Chlordiazepoxide	IV	4720(b) (12)
Valium	Diazapam	IV	4720(b) (13)
Xanax	Alprazolam	IV	4720(b) (23)

* Various Codeine combinations with non-controlled drugs may be either a schedule III 4718(e) (1) or (2) or Schedule V 4722(b) (1) substance depending on the quantity of Codeine therein. Check your "PDR" or call the Office of Narcotics and Dangerous Drugs (302) 739-4798.

SAMPLE

LETTER TO PARENTS/GUARDIANS ABOUT

NONPRESCRIPTION MEDICATIONS

School nurses may give nonprescription medications with parental permission. The following guidelines need to be followed:

1. The school nurse must assess the child's complaint and symptoms to determine if other measures can be used before medication is given.

2. The school nurse must be notified of any allergies, especially to medication, that your child has.

3. All medications sent to the school must be in the original container. (This is the law.)

4. A record of the medication given will be kept by the school nurse.

5. Nurses must use restraint at all times in the use of nonprescription medicines.

Please contact the school nurse, ____, if you have any questions.
Nurse Name and Phone Number

- -

I have read the above and request ____ to give
Name of Nurse

____ to ____
Name of Nonprescription Drug — Name of Student

on _________________________ for the following reason: ____

____

List known allergies to medicine ____

____

____

____
Signature of Parent or Guardian

____
Date

Medication/Treatment Error Report

A medication or treatment error is the failure to administer a prescribed medication within the appropriate time frame, in the correct dosage, in accordance with accepted practice and/or to the correct student. Appropriate documentation should be entered into the medical record. This form should be maintained in the same manner as Student Accident Report Forms, unless directed otherwise by district/charter administration.

Date of report_____ School_____

Student's name_____ DOB_____ Sex_____ Grade_____

Home address_____

Home telephone_____

Date error occurred_____ Time noted_____

Person administering medication_____

Licensed prescriber (name and address)_____

Reason medication was prescribed_____

Date of order_____ Instructions for administration_____

Medication_____ Dose_____ Route_____ Scheduled time_____

Describe the error and how it occurred (use reverse side if necessary):

Action taken PRN_____

Licensed prescriber notified: Yes □ No □ Date_____ Time_____

Parent/Guardian notified: Yes □ No □ Date_____ Time_____

Other person(s) notified:_____

_____

Yes □ No □ Date_____ Time_____

Outcome: _____

Name (type or print)_____ Signature_____

Title_____ Date_____

Assistance with Medication
Information for School Staff
(For Field Trips Only)*

When assisting with medications, it is expected that assistance will be given in a manner which protects the student from harm. It is expected both from a legal and ethical standpoint that you will not knowingly participate in practices which are outside your legally permissible role or which may endanger the well being of the student.

Medication is given to the right student, at the right time, in the right amount (dose), and by the right route (such as orally, topically, by inhalation). The following information is developed around these FIVE RIGHTS:

- AT THE RIGHT TIME
- THE RIGHT STUDENT
- THE RIGHT MEDICATION
- AT THE RIGHT DOSE
- BY THE RIGHT ROUTE

- **THE RIGHT TIME**
  Routine medications are taken at established times. This helps to insure that the desired levels of medication will be maintained and doses will not be given dangerously close to each other.

  Medications may be given ½ hour before or after the indicated time except for medications to be given with meals. These may be medications which must be given with food.

  Some medications should not be given at the same time or in combination with other medications. If two or more practitioners prescribe medications, the person assisting must check medication compatibility with the nurse, pharmacist, or poison control center.

- **THE RIGHT STUDENT**

  Unlike acute care medical facilities, most schools and other institutions do not require personal identification tags. This presents a problem in assisting with medications as levels of communication and cooperation vary. Even a student may answer to another student's name. Basic rules are:

  a. Never assist with medication unless you know the student.
  b. Use the student's name during the assistance process.
  c. Only deal with one student at a time to prevent other students from interfering with the medication process.
  d. Pre-fill water cups to avoid distractions; **do not ever turn away from the student** during the medication process.

- **THE RIGHT MEDICATION**

  Before leaving on the field trip, check the parent/guardian's permission slip and the prescription bottle to be sure the correct medication was sent. For this reason it would be a good practice to have all medication on the day before the field trip.

  Pill bottles should contain one drug and one drug only. If a prescription is received which appears **strange** and unlike what you remember seeing before, check with the school nurse. It may be another drug company's product, a generic drug or a mistake. **NEVER** mix the contents of an old

* A field trip is an "off-campus, school-sponsored activity."

pill bottle with the contents of a new pill bottle; there may be a change in the brand or dose which will create confusion and error.

Read the prescription label and check against the medication log sheet.

- **THE RIGHT DOSE**

All medications, including over-the-counter (OTC) products, are given in some measured amount. Common measurement terms and their abbreviations for tablets, pills and capsules are milligrams (mg or mgm), grams (GM) and grains (gr). The prescription will indicate how many pills have to be given so you will not need to figure out the number of milligrams. For example, the prescription may read: "Tegretol 200 mg tablets; give two tablets daily." You would give two tablets. The actual milligram dosage is 400 mg daily but you are not asked to compute this, only to comply with the label.

Common measurement terms and their abbreviations for liquids are: ounce (oz), tablespoon (Tbsp.), and teaspoon (tsp.). Some prescriptions may indicate a measurement in milliliters (ml).

5 mls = 1 teaspoon; however, teaspoons can vary in size and should not be used routinely. Liquid medication measuring cups/containers are available and should be used.

Ear and eye liquids are usually measured in drops (gtt or gtts) or droppers full. Droppers should be included in the medication package.

Prescriptions will state the specific amount of medication to be measured out. If confused about a measurement, **DO NOT GIVE** until you have checked with the parent/guardian or school nurse or the pharmacist. Follow the practitioner's orders carefully.

When assisting with medications, you are legally responsible for making sure that you comply with the requirements that medications be in original containers.

- **THE RIGHT ROUTE**

Lay assistants are not to assist with injections. **The one exception is in use of the lifesaving medications, where standard emergency procedures prevail in lifesaving circumstances.** The teacher, guidance counselor or administrator should be informed about the medication instructions.

For your information, the routes appropriate for lay assistance are:

a. oral b. topical c. inhalants

Generally oral, inhalant, and topical medications will be considered for field trip purposes.

a. ORAL: (by mouth)
   Types of oral medications are:
   (1) Tablets: Pressed powders which are usually acted upon in the stomach. You may crush between two spoons and unless otherwise indicated, mix with a small amount of food such as pudding if client has difficulty swallowing. You must make sure he/she swallows everything.
   (2) Capsules/Caplets: Gelatin coated powders or tiny time released beads as in spansules. Caplets are replacing many capsules in over-the-counter products as caplets resist tampering. Caplets have the medication in a very highly compressed form with the outer covering resisting digestion until the intestines are reached. These should not be crushed or mixed with food.
   (3) Enteric Coated Tablets: These have a hard often colored coat on them (similar to the M&M candies). This is to prevent them from releasing the medication too soon in the GI tract and causing irritation. **DO NOT CRUSH.**

(4) Liquids: Pour liquids away from the labeled side to keep the label legible. Two types of oral liquids exist for our purposes: liquids with a short shelf life, and liquids with a long shelf life.

(a) **Short shelf life:** Most prescription antibiotics have a short shelf life and frequently have to be either refrigerated or kept away from heat and out of direct sunlight. They should be used completely and the container discarded. The printed expiration date on these bottles indicates the life of the DRY medication. The pharmacy label gives the date when the mixed solution will expire. **DO NOT USE BEYOND THE PHARMACIST'S LABEL OF EXPIRATION DATE.**

(b) **Long shelf life.** Most OTC liquids have a long shelf life. The label expiration date should be checked periodically to insure freshness.

b. TOPICAL: Medications which are applied to surfaces (skin, eyes, ear canals)

(1) Topical skin/hair medications may be creams, liquids, powders, soaps, shampoos, ointments.

(a) Wear gloves when assisting with topical medications.

(b) Never dip anything (for example a Q-tip) into the medication. Pour (or with a clean spoon) dip out just enough of the medication for one application into a clean container and use from there. Never put unused medication back into its original container.

(c) Ointment in a tube can be squeezed onto a sterile gauze pad or a bandage.

(d) Avoid splashing facial medications into eyes; they can be very irritating.

(e) Do not share tubes of ointment or liquid medications between students to avoid spreading infections.

c. INHALANTS:

(2) Nasal Inhalants: Follow the directions on the package insert exactly. **DO NOT** place the tip of the inhaler deeply into the nose, place the inhaler tip just at the opening of the nose.

(3) Oral Inhalants such as mist asthma inhalants: Follow the directions on the package insert exactly. Be very aware of discard dates on these medications as they **MUST** be discarded and replaced promptly.

QUICK CHECK

Wash your hands before and after assisting a student.

Identify the right student.

Read the parent/guardian's request and medication label.

STOP and obtain guidance if you have any questions.

Follow medication instructions.

Record medication assistance to the student on the medication sheet.

Report observations.

ERRORS

Errors do occur despite training and precautions. For the student's safety, errors should be reported immediately upon discovery. 911, the Poison Control Center, practitioner, parent/guardian or school nurse should be contacted depending upon the nature of the error. All cases of errors reported by the person assisting will be kept on file by the school nurse.

RESPONSES TO MEDICATIONS

For the safety of the student, the <u>first</u> dose of any medication should be given under the supervision of the parent/guardian or school nurse.

a. DESIRED: good response, mission accomplished, the medication bringing desired results
b. NO RESPONSE: medication does not seem to be working
c. ADVERSE REACTIONS: (This is to alert you to potential difficulties, even though no problems have been documented on field trips.)
    (1) ALLERGY: medication causes rashes (sometimes with itching), hives, fatal shock. An allergy can occur several days after a student has been on a medication or from a medication the client has had many times before. **IF THE STUDENT IS HAVING TROUBLE BREATHING, CALL "911"**; otherwise, call the healthcare provider and parent/guardian.
    (2) UNTOWARD REACTION: This means the effect of the medication is the opposite of what is expected and desired. Examples are: giving an antihistamine for a cough but having the student become behaviorally out of control or giving a medication to control nausea but vomiting occurs instead. Treat as you would an illness that develops on a field trip.
    (3) SIDE EFFECTS: These are undesirable but known reactions to the medication. Report observations to the parent/guardian and school nurse.

RESOURCES ON DRUG INFORMATION

It is the responsibility of every individual who assists with medication to review possible side effects of the medication being given. Information on medication side effects should be available as part of the medication log.

For over-the-counter (OTC) medications, the information concerning how to use the medication and how to properly store it is printed on the package or bottle. Also, any pharmacist can provide answers to questions on use and storage.

a. For **prescription medications**, the following resources are available concerning how to use the medication and how to properly store it:
    (1) The container label will give directions for use including whether it should be taken with or without food. If a drug must be refrigerated or has to have special handling, the pharmacist indicates that on the container.
    (2) The pharmacy listed on the container can be called if information is needed concerning use and storage.
    (3) The person's practitioner listed on the container can be contacted for information in accordance with school policy.
b. **Written information references** about medications are available upon request from the following sources:
    (1) The pharmacy: Upon request a package insert from particular medications can be provided. Usually the insert will describe the drug, its intended use, side effects which can occur with use, side effects which warrant immediate medical consultation, warnings about individuals who should not be using the drug, and any special handling or storage directions as appropriate.
    (2) The insert is available for prescription medications. Similar information can be found on the packaging of over-the-counter medications.

MEDICATION STORAGE AND SAFETY

Medication storage and safety indicate a two fold obligation:

a. Medication must be carried in such a manner as to protect it from being accessed by unauthorized persons – a situation which could lead to misuse/abuse. Medications taken on a

field trip should be in the personal possession of the person assisting with the medication and secure from unauthorized use.

b. Medication must be carried in a manner that protects the product from deterioration or container breakage.
   (1) Medications which need refrigeration or storage away from light should be appropriately labeled by the pharmacy and stored accordingly. If medication needs to be refrigerated, it should be carried in a cooler.
   (2) Medications **MUST** be stored in their original containers. Should an adaptation of a container be needed, it **MUST** be obtained from a pharmacist and it must bear the appropriate pharmacy label. This includes over the counter medications. No medication may be stored in a container other than the original container. Only a pharmacist or practitioner can generate a container other than that in which the medication was originally distributed from the manufacturer.

DISPOSAL OF MEDICATION CONTAINERS

Medication containers should be returned to the parent/guardian or the school nurse.

MEDICATION RECORDS

Records pertaining to medication use include: parent/guardian's written permission, the pharmacy label (original container label), and any other records such as a medication log sheet which are required by your school.

The medication log sheet is a record sheet which you initial/sign after each student has received the appropriate medication. (A signature sheet identifying the initials must be included on the sheet.)

The log sheet must show the student's name, name of the medication, dose, route of administration, and time received by the student.
Example: John Doe – ampicillin 250 mg by mouth at 1:00 p.m.
The log should be returned to the school nurse and attached to the regular daily log.
For the reader's information: Controlled substances must be counted and accounted for to conform with federal law, state law, and school policy. Ritalin is a controlled substance.

Errors in recording medication information should be handled according to school policy.

24 Delaware Code Section 1921 (a) (16) allows for assistance in self administering medication during school field trips upon completion of a training course. The law does not guarantee that one will not be held liable, and thereby protected from litigation. There are no such guarantees despite the fact that parents/guardians must sign a statement that they "… fully and completely waive any claim for liability that may exist against any staff member, resulting from the assistance with medication to my child."

SIGN-OFF SHEET

SCHOOL EMPLOYEE "MEDICATION ON FIELD TRIP"* INFORMATION

I received, read, and understand the medication information in the "Assistance with Medication Information for School Staff." I will abide by the safe practices and procedures set forth therein. I am aware that any questions regarding this information or the medication should be discussed with the School Nurse.

Printed Name of School Employee	Signature of School Employee	Date Information Received and Read

Signature of Staff Instructor:** _____

* A field trip is an "off-campus, school-sponsored activity."

** The Staff Instructor is a School Nurse, who has completed the DOE training. Only educational staff, not school nurses, can be trained by this Instructor.

S A M P L E

Parent/Guardian Permission to Assist with Medication to Student on Field Trip

I give permission for _____ to go on _____
(Student's Name) (Specify field trip)

on _____. I understand a staff member will assist my child with
(date)
medication. Information about the medication that needs to be taken by _____
(Student's
_____ is as follows:
Name)

Name of medication_____

Dose (amount to be taken)_____

Time to be taken_____

How it is taken_____

I understand I must send the medication in the original container.

All of the above information is on the label on the container prepared by the pharmacist as prescribed by

_____
(Doctor's Name)

The following are any allergies or health conditions my child has:_____

_____

Date _____ Parent/Guardian Signature _____

Please contact your school nurse _____ if you have any questions.

School _____ District_____

District_____ **SAMPLE**

Field Trip Medication Record*

Trip_____ School_____ Date_____

Student's Name	Medication	Dose Amount Given	Route: By mouth or inhalation, etc.	Time	Assisted by

* To be kept in the school nurse's office.