

VIRGINIA SCHOOL HEALTH GUIDELINES



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Virginia School Health Guidelines

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FOREWORD

We are pleased to present the *Virginia School Health Guidelines*, a resource document for school and public health personnel. It was developed and published under the leadership of the Virginia Department of Health in collaboration with the Virginia Department of Education through a joint venture with the Virginia Institute for Developmental Disabilities and Virginia Commonwealth University, School of Nursing, Community Nursing Organization.

This document is intended to enhance the educational process by providing guidance to and resources for school administrators, school nurses, teachers, and other staff members on the development, implementation, and evaluation of a comprehensive or coordinated approach to school health. It presents up-to-date, practical health information and recommendations for developing local programs and policies related to school health programs. Federal and state laws and regulations, local needs, professional personnel from educational and health care fields, and the availability of resources will influence how this publication can be adapted for local use.

The development of the *Virginia School Health Guidelines* exemplifies the commitment of the Virginia Department of Health and Virginia Department of Education to ensure that all schools in the Commonwealth have a safe and healthy learning environment.

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A resource document of this type cannot be put together without the help and support of many people. Special thanks are extended to the members of the Virginia School Health Guidelines Task Force, who helped—by providing expert advice and adept review—to develop this document. Likewise, the work of the additional expert reviewers is gratefully appreciated.

A final word of thanks must be given to the many other participants in this effort who have not received formal acknowledgment but who provided comments and suggestions that were helpful in the preparation of the *Virginia School Health Guidelines*.

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PREFACE

Purpose

Resource Book. This manual is a resource book that contains basic information, guidelines, and recommendations for establishing and enhancing a school health program. It reflects a growing emphasis on the role of school health in prevention of disease and health promotion and wellness for students. The purpose of this manual is to provide guidelines for local school divisions to develop or strengthen their school health program at the individual, school program, or community level.

These guidelines are intended to:

- ◆ Provide direction for school divisions to develop a school health program at the local level.
- ◆ Increase the awareness of school health issues and strategies that can be used to address these issues.
- ◆ Provide guidelines for primary prevention.
- ◆ Serve as a guide for appropriate practices that relate to school health.
- ◆ Provide a guide for development of local school health policies and programs.
- ◆ Serve as a tool for orienting new school personnel.

Who Should Use This Manual

Intended Audience. The intended audience for this manual is the professional who has responsibility for one or more components of a school health program. The professionals may include, but are not limited to, the following:

- ◆ School health services personnel, such as school nurses, nurse practitioners, physicians, school-based health center staff, and health educators.
- ◆ Administrators, such as superintendents, assistant superintendents, and principals.
- ◆ Teachers.

Although this manual is written for professionals, it may also be used by other persons who are involved in a school health program to increase their understanding of the issues involved in school health. These persons might include:

- ◆ School health aides.

- ◆ Classroom aides.
- ◆ Parents and parent advocates.
- ◆ Students, when appropriate.

What This Manual Includes

A school health program includes the following eight components: (1) parent/community involvement; (2) healthful school environment; (3) health services; (4) health education; (5) physical education; (6) nutrition services; (7) counseling, psychological, and social services; and (8) health promotion for school staff.

This manual directly addresses the three traditional components of a school health program (health services, health education, and healthful school environment) and parent and community involvement.

In addition, this manual indirectly addresses counseling, psychological, and social services; nutrition services; and physical education.

The remaining component of a school health program, health promotion for staff, is not addressed in this manual.

Multiple school health program documents and references are cited throughout this manual.

How to Use This Manual

This manual is organized into six sections, as follows:

1. **School Health Programs:** Provides an overview of school health programs including models, historical development, and planning steps.
2. **Parent and Community Involvement:** Describes ways of involving parents and the community in school health programs through local school health advisory boards and partnerships.
3. **School Health Services:** Provides information on school health services models; facilities; appraisal, preventive, and remedial aspects; and evaluation guidelines.
4. **Health Education:** Provides information about school health education assessment, standards, planning steps, and resources.

5. **Environment:** Provides information on school building and environmental standards, indoor air quality and other environmental concerns, school maintenance and sanitation, disposal of medical waste, school food service, water supply, and lighting.
6. **Appendices:** Includes *Code of Virginia* citations, data collection tools, first aid guidelines, special education terminology definitions, required forms, sample letters, and immunization and infectious disease information.

In each of these sections, there are guidelines for assessing the school health component, guidelines for establishing or enhancing the component, requirements associated with the component as defined by the *Code of Virginia* or federal guidelines, and recommended practice guidelines.

Note: Although these guidelines reflect the most up-to-date information at time of publication, users of the *Virginia School Health Guidelines* are advised to confirm federal, state, and local laws, regulations, and policies when using this manual to plan, implement, and evaluate school health programs.

School Health Programs

Parents have the primary responsibility to assure the health and well-being of their children. Private health care providers and government services are resources to help parents deal with the health needs of their children. Since children spend most of their awake hours in school and since healthy kids make better students, schools can play an important role in helping parents successfully assure the health and well-being of their children.

The Need. For young people today to succeed in school, and ultimately in life, they must learn to read, write, and master mathematics. Perhaps less apparent, however, is the fact that problems can adversely affect not only a young person's health but also *their ability to learn*. More children with special health care needs and chronic illnesses are entering our school daily. Furthermore, schools must deal with students who suffer from substance abuse, communicable diseases, physical and sexual abuse, eating disorders, chronic illnesses, grief and depression, teen pregnancy, sexually transmitted diseases such as HIV and AIDS, and violence. Such physical, mental, and emotional health problems cause students to miss school, lack energy, be distracted, or have significant problems that may impair their and other students' ability to learn as well as the school's ability to provide a safe and stable learning environment.

A school health program should include (1) parent and community involvement; (2) healthful school environment; (3) health services; (4) health education; (5) physical education; (6) nutrition services; (7) counseling, psychological, and social services; and (8) health promotion for staff.

Framework. This manual uses as its overarching framework the importance of parental involvement in its examination of the elements of school health and recommendations for implementing different aspects of a school health program. Users of this manual are likewise encouraged to encompass parent and community involvement as a backdrop in all aspects of their school health program.

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CHAPTER 1

Introduction to School Health Programs

This chapter presents overview information about establishing or enhancing *school health programs*. It also provides some background information on the evolution of school health programs in Virginia. In addition, it provides guidelines on program development.

In This Chapter

Describing the Components of a School Health Program

- ◆ Three-Component Model
- ◆ Eight-Component Model
- ◆ Full-Service Schools Model

Terminology: Comprehensive Versus Coordinated

Reviewing History: Legislative Studies

- ◆ The Health Needs of School-Age Children
- ◆ A Study on Ways to Encourage Local School Divisions to Recognize the Importance of School Nurses and the Feasibility of Establishing Standards for School Health Services
- ◆ Current Health Programs in the Public Schools of Virginia and the Efficacy and Appropriateness of Adopting a Comprehensive Approach to Health Education
- ◆ Report on the Needs of Medically Fragile Students
- ◆ Findings and Recommendations of the Blue Ribbon Commission on School Health

Developing a Program: Infrastructure and Planning Process Steps

- ◆ Infrastructure
- ◆ Planning Process Steps

Establishing Roles of Personnel: Position Descriptions

- ◆ School Nurse: Registered Nurse
- ◆ School Nurse: Licensed Practical Nurse
- ◆ School Nurse Practitioner
- ◆ School Health Supervisor/Coordinator: Registered Nurse
- ◆ Unlicensed Assistive Personnel
- ◆ School Health Volunteer
- ◆ School Health Physician

Delineating Roles and Responsibilities for the Safe Delivery of Specialized Health Care

Describing the Components of a School Health Program

Overview

Definition. There are a variety of definitions of a school health program. The following definition of a comprehensive school health program was established by the Institute of Medicine (IOM) Committee on Comprehensive School Health Programs in Grades K-12.¹

*A comprehensive school health program is an integrated set of planned, sequential, school-affiliated strategies, activities, and services designed to promote the optimal physical, emotional, social, and educational development of students. The program involves and is supportive of families and is determined by the local community, based on community needs, resources, standards, and requirements. It is coordinated by multidisciplinary team and is accountable to the community for program quality and effectiveness.*²

Models. There are a variety of models that have been used to describe the components of a school health program. Three of the most common models are summarized below.³

- ◆ **The Three-Component Model.** Originating in the early 1900s and evolving through the 1980s, the three-component model is considered the traditional model of a school health program, consisting of the following basic components: (1) health education, (2) health services, and (3) a healthful environment.
- ◆ **The Eight-Component Model.** In the 1980s, the three-component model was expanded into an eight-component model—traditionally referred to as a “comprehensive school health program”—consisting of the following components: (1) health education; (2) health services; (3) healthy school

¹ The Committee on School Health in Grades K-12 was convened by the Institute of Medicine in late 1994 to carry out a study of comprehensive school health programs in grades K-12 to examine the structure, function, and potential of these programs. The study findings, conclusions, and recommendations are published in Allensworth, D., Lawson, E., Nicholson, L., and Wyche, J., (1997), *School & Health: Our Nation's Investment*, National Academy Press, Washington, D.C.

² Allensworth, D., Lawson, E., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (p. 2). Washington, D.C.: National Academy Press.

³ Allensworth, *School & Health*, (pp. 3, 59).

environment; (4) physical education; (5) nutrition services; (6) health promotion for school staff; (7) counseling, psychological, and social services; and (8) parent and community involvement.

- ◆ **Full-Service Schools.** In recent years, additional models, definitions, and descriptions have emerged that build on previous models, including the full-service school model. In addition to quality education, a full-service school model involves a one-stop, seamless institution, where the school is the center for providing a wide range of health, mental health, social, and/or family services.

While the most frequently encountered models and definitions of school health programs have much in common, no single model is best. A school health program should be locally tailored—with involvement of all critical stakeholders—to meet each community’s needs, resources, perspectives, and standards.

Recommendation

Essential Elements. While there is no one universally accepted definition and model of a school health program, the following essential elements should be considered in designing a school health program.⁴

- ◆ **Services**, which include *health services* (which depend on the needs and preference of the community and include services for students with disabilities and special health care needs and the traditional first aid, medication administration, and screening services), *counseling, psychological, and social services* (which promote academic success and address the emotional and mental health needs of students), and *nutrition and food services* (which provide nutritious meals, nutrition education, and a nutrition-promoting school environment).
- ◆ **Education**, which includes *health education* (which addresses the physical, mental, emotional, and social dimensions of health), *physical education* (which teaches the knowledge and skills necessary for lifelong physical fitness), and *other curricular areas* (which promote healthful behavior and an awareness of health issues as part of their core instruction).
- ◆ **School Environment**, which includes the *physical environment* (involving proper building design, lighting, ventilation, safety, cleanliness, freedom from environmental hazards that foster infection and handicaps, safe transportation policies, and having emergency plans in place), the *policy and administrative*

⁴ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation’s Investment* (p. 2-3). Washington, D.C.: National Academy Press.

environment (consisting of policies to promote health and reduce stress, and regulations ensuring an environment free from tobacco, drugs, weapons, and violence), the *psychosocial environment* (including a supportive and nurturing atmosphere, a cooperative academic setting, respect for individual differences, and involvement of families), and *health promotion for staff* (in order that staff members can become positive role models and increase their commitment to student health).

- ◆ **Community Participation**, which includes *parent and community involvement* (which consists of involving a wide range of community stakeholders—parents, students, educators, health and social service personnel, insurers, and business and political leaders—to develop and form the structure of the school health program tailored to meet each local community’s needs, resources, perspectives, and standards).

Although the schools are accountable to the community and provide a critical facility within which many agencies can work together to maintain the well-being of students, they cannot be expected to address the student’s serious health and social problems in the school setting without assistance from the community. Families, healthcare workers, the media, religious organizations, community organizations that serve children and adolescents, and young people themselves must also be involved.

Subsections

The following subsections describe key features of the three- and eight-component models for a school health program and the full-service schools model:

- ◆ Three-Component Model
- ◆ Eight-Component Model
- ◆ Full-Service Schools Model

The Three-Component Model

Traditional Model. Originating in the early 1900s and evolving through the 1980s, the three-component model is considered to be the traditional model of a school health program. According to this model, a school health program consists of the following three basic components.⁵

1. Health Instruction
2. Health Services
3. Healthful School Environment

Definitions. The definitions of each component of the traditional school health program model are presented below.

Key Features of a Traditional School Health Program

Component	Definition
Health Instruction	Accomplished through a comprehensive health education curriculum that focuses on increasing student understanding of health principles and modifying health-related risk behaviors.
Health Services	Focuses on prevention and early identification and redemption of student health problems.
Healthful School Environment	Concerned with the physical and psychosocial setting and such issues as safety, nutrition, food services, and a positive learning atmosphere

⁵ Allensworth, D., Lawson, E., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (p. 52). Washington, D.C.: National Academy Press.

The Eight-Component Model

CDC Model. The Centers for Disease Control and Prevention (CDC) eight-component model of a comprehensive school health program consists of the following interactive components.⁶

1. Health Education
2. Physical Education
3. Health Services
4. Nutrition Services
5. Health Promotion for Staff
6. Counseling, Psychological, and Social Services
7. Healthful School Environment
8. Parent and Community Involvement

The following is a summary of CDC's definitions and descriptions of each component of a comprehensive school health program.

Key Features of a Comprehensive School Health Program

Component/Definition	Description
Health Education <i>A planned, sequential, K-12 curriculum that addresses the physical, mental, emotional, and social dimensions of health.</i>	<ul style="list-style-type: none"> ◆ Designed to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors. ◆ Allows students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills, and practices. ◆ Includes a variety of topics, such as personal health, family health, community health, consumer health, environmental health, sexuality education, mental and emotional health, injury prevention and safety, nutrition, prevention and control of disease, and substance use and abuse. ◆ Qualified, trained teachers provide health education.

⁶ Centers for Disease Control and Prevention. (1998). *A Comprehensive School Health Program*[On-line]. Available: <http://www.cdc.gov/nccdphp/dash/cshpdef.htm>.

Key Features of a Comprehensive School Health Program

Component/Definition	Description
<p>Physical Education</p> <p><i>A planned, sequential K-12 curriculum that provides cognitive content and learning experiences in a variety of activity areas.</i></p>	<ul style="list-style-type: none"> ◆ Promotes each student’s optimum physical, mental, emotional, and social development through a variety of planned physical activities. ◆ Promotes activities and sports that all students enjoy and can pursue throughout their lives. ◆ Includes such activities as basic movement skills; physical fitness; rhythms and dance; games; team, dual, and individual sports; tumbling and gymnastics; and aquatics. ◆ Qualified, trained teachers teach physical activity.
<p>Health Services</p> <p><i>Services provided for students to appraise, protect, and promote health.</i></p>	<ul style="list-style-type: none"> ◆ Designed to ensure access or referral to primary health care services or both. ◆ Fosters appropriate use of primary health care services. ◆ Prevents and controls communicable disease and other health problems. ◆ Provides emergency care for illness or injury. ◆ Promotes and provides optimum sanitary conditions for a safe school facility and school environment. ◆ Provides educational and counseling opportunities for promoting and maintaining individual, family, and community health. ◆ Qualified professionals (such as physicians, nurses, dentists, health educators, and other allied health personnel) provide these services.
<p>Nutrition Services</p> <p><i>Access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students.</i></p>	<ul style="list-style-type: none"> ◆ Reflects the U.S. Dietary Guidelines for Americans and other criteria to achieve nutrition integrity. ◆ Offers students a learning laboratory for classroom nutrition and health education. ◆ Serves as a resource for linkages with nutrition-related community services. ◆ Qualified child nutrition professionals provide these services.

Key Features of a Comprehensive School Health Program

Component/Definition	Description
<p>Health Promotion for Staff</p> <p><i>Opportunities for school staff to improve their health status through such activities as health assessments, health education, and health-related fitness activities.</i></p>	<ul style="list-style-type: none"> ◆ Encourages school staff to pursue a healthy lifestyle that contributes to their improved health status, improved morale, and a greater personal commitment to the school's overall comprehensive health program. ◆ Personal commitment often transfers into greater commitment to the health of students and creates positive role modeling. ◆ Improves staff productivity. ◆ Decreases staff absenteeism. ◆ Reduces health insurance costs.
<p>Counseling and Psychological/Social Services</p> <p><i>Services provided to improve students' mental, emotional, and social health.</i></p>	<ul style="list-style-type: none"> ◆ Includes individual and group assessments, interventions, and referrals. ◆ Organizational assessment and consultation skills of counselors and psychologists contribute not only to the health of students but also to the health of the school environment. ◆ Professionals (such as certified school counselors, psychologists, and social workers) provide these services.
<p>Healthful School Environment</p> <p><i>The physical and aesthetic surroundings and the psychosocial climate and culture of the school.</i></p>	<ul style="list-style-type: none"> ◆ Factors that influence the physical environment include the school building and the area surrounding it, any biological or chemical agents that are detrimental to health, and such physical conditions as temperature, noise, and lighting. ◆ Psychological environment includes the physical, emotional, and social conditions that affect the well-being of students and staff.
<p>Parent/Community Involvement</p> <p><i>An integrated school, parent, and community approach for enhancing the health and well-being of students.</i></p>	<ul style="list-style-type: none"> ◆ Builds support for school health program efforts through school health advisory councils, coalitions, and broadly-based constituencies for school health. ◆ Schools should actively solicit parent involvement and engage community resources.

The Full-Service Schools Model

Full Service School Model. A recent model in the evolution of school health programs is the full-service school. Under this model, the charge to the community is to bring into the school a wide range of services, including health, mental health, employment services, child care, parent education, case management, recreation, cultural events, welfare, community policing, and whatever else may fit into the picture based on the needs of the community. The result is a type of “one-stop” system—facilities that can offer a seamless experience for the students, parents, and staff.⁷

Seamless Institution. According to Dryfoos, the ideal full-service school encompasses both quality education and support services, where school and community agency personnel have common and shared goals and participate in joint decision making. The result of this new kind of “seamless” institution is a community-oriented school with joint governance structure that allows maximum responsiveness to the community, as well as accessibility and continuity for those most in need of services.⁸

Quality Education. According to the Institute of Medicine (IOM) Committee on Comprehensive School Health programs in Grades K-12, a full-service school provides a quality education for students, which includes individualized instruction, team teaching, cooperative learning, a healthy school climate, alternative to tracking, parental involvement, and effective discipline. The school and/or community agencies collaborate together to provide comprehensive health education, health promotion, social skills training, and preparation for the world of work.⁹

Support Services. Furthermore, according to the IOM Committee, the continuum of services to be provided by community agencies at the full-service school include health services (e.g., health and dental screening), nutrition counseling and weight management, mental health services (e.g., individual counseling, crisis intervention, and substance abuse treatment and follow-up services), family welfare, and social services (e.g., child care, parent literacy, employment training, legal services, recreational and cultural activities, and basic services for housing, food, and clothing).¹⁰

⁷ Dryfoos, Joy G. (1994). *Full-Service Schools: A Revolution in Health and Social Services for Children, Youth, and Families*. San Francisco, Calif.: Jossey-Bass Publishers.

⁸ Ibid.

⁹ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.) (1997). *Schools & Health: Our National's Investment* (p. 59). Washington, D.C.: National Academy Press.

¹⁰ Ibid.

Idealized Model of the Full-Service School. Exhibit 1 presents a summary of broad categories of services that can be put together to make a full-service school. According to Dryfoos, the components listed are based on existing program experiences and on findings of a study of one hundred successful prevention programs in the separate fields of substance abuse, teen pregnancy, delinquency, and school failure. This model represents the belief that there is no one single program or component that can significantly change the lives of disadvantaged children, youth, and families. Rather, it incorporates a variety of interventions that can result in measurable change.¹¹

Exhibit 1. Full-Service Schools: One-Stop, Collaborative Institutions.

Quality Education Provided by Schools	Support Service Provided by Community Agencies
Effective basic skills	Health screening and services
Individualized instruction	Dental services
Team teaching	Individual counseling
Cooperative learning	Substance abuse treatment
School-based management	Mental health services
Healthy school climate	Nutrition/weight management
Alternatives to tracking	Referral with follow-up
Parent involvement	Basic services: housing, food, clothes
Effective discipline	Recreation, sports, culture
	Mentoring
Provided by Schools or Community Agencies	Family welfare services
Comprehensive health education	Parent education, literacy
Health promotion	Child care
Social skills training	Employment training/jobs
Preparation for the world of work (life planning)	Case management
	Crisis intervention
	Community policing

Source: Adapted from Dryfoos, Joy G. (1994). *Full-Service Schools: A Revolution in Health and Social Services for Children, Youth, and Families* (p.13). San Francisco, Calif.: Jossey-Bass Publishers.

According to Dryfoos, there is no one particular model of school-based services. Throughout the country, a variety of models exist and are referred to by a variety of names, including school-based health clinics, youth service centers, family resource centers, full-service schools, wellness centers, student service centers, and community schools. Although such school-based services offer different services and are referred to by different names, what they all have in common is their location in or near the school.

¹¹ Dryfoos, Joy G. (1994). *Full-Service Schools: A Revolution in Health and Social Services for Children, Youth, and Families*. San Francisco, Calif.: Jossey-Bass Publishers.

Being located in or near a school opens up access to students and their family for all kinds of health and social services. In practice, “full service” is defined by a particular community and school, with an array of services that are needed, feasible to provide in or near the school, and acceptable to the school division and the community.¹²

¹² Dryfoos, Joy G. (1994). *Full-Service Schools: A Revolution in Health and Social Services for Children, Youth, and Families*. San Francisco, Calif.: Jossey-Bass Publishers.

Terminology: Comprehensive Versus Coordinated

Coordinated School Health Program. There has been much discussion over the term “comprehensive” in describing a school health program. A number of organizations have proposed changing the term to “coordinated” school health program. These organizations state that “comprehensive school health programs” have been confused with “comprehensive school health education,” which relates to instruction, and that the term “comprehensive” implies a need for new expanded resources that overburdened school divisions cannot provide. The term “coordinated,” on the other hand, implies consolidating and expanding existing resources, which is more feasible for school divisions.¹³

Comprehensive School Health Program. Persons who favor keeping the term “comprehensive” believe that the change to “coordinated” would undermine the progress made in promoting the concept of a “comprehensive” school health program. They believe that while having consistent terminology is important, more important is the understanding that health must be an integral part of a school program.¹⁴

Institute of Medicine. In late 1994, an Institute of Medicine (IOM) Committee was convened to carry out a study of comprehensive school health in grades K-12. In 1995, the committee published an interim statement that included the following provisional definition of a comprehensive school health program (CSHP):

*A comprehensive school health program is an integrated set of planned, sequential, school-affiliated strategies, activities, and services designed to promote the optimal physical, emotional, social, and educational development of students. The program involves and is supportive of families and is determined by the local community, based on community needs, resources, standards, and requirements. It is coordinated by a multidisciplinary team and is accountable to the community for program quality and effectiveness.*¹⁵

¹³ Marx, E., and Wooley, S.F. (Eds.). (1998). *Health Is Academic: A Guide to Coordinated Health Programs* (pp. xii-xx). New York, N.Y.: Teachers College Press.

¹⁴ Marx, E., and Wooley, S.F. (Eds.). (1998). *Health Is Academic: A Guide to Coordinated Health Programs* (pp. xii-xx). New York, N.Y.: Teachers College Press.

¹⁵ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1995). *Defining a Comprehensive School Health Program: An Interim Statement* (p.2). Washington, D.C.: National Academy Press.

Each term printed in bold is further described and discussed in the IOM interim statement and final report. Below is a brief summary of the terms “comprehensive” and “coordinated,” as defined by the IOM Committee in its final report.

Comprehensive means inclusive, covering completely and broadly, and refers to a broad range of components. It should be emphasized, however, that programs and services actually delivered at the school site may not provide coverage by themselves but are intended to work with and complement the efforts of families, primary sources of health care, and other health and social service resources in the community to produce a continuous and complete system to promote and protect students’ health.¹⁶

Coordinated means brought into combined action to cause separate elements to function in a smooth concerted manner. Coordination implies a formal relationship and blurring of boundaries between coordinating partners, although partners can still retain identity and affiliation to their profession.¹⁷

The IOM Committee concluded in its final report that its original provisional definition of a CSHP was still valid and useful. The committee determined that its definition is flexible, not overly prescriptive, and emphasized what the committee believes are the crucial features of a CSHP—family and community involvement, multiple interventions, integration of program elements, and collaboration across disciplines. The IOM Committee believes that there is no single “best” definition or model for a CSHP but that programs must be tailored to meet each community’s needs, resources, perspectives, and standards.¹⁸

Council of Chief State School Officers (CCSSO) and the Association of State and Territorial Health Officials (ASTHO). The CSSO and the ASTHO commissioned the Academy for Educational Development (AED) to develop messages that chief school officials and state health officials (SHOs) can use to encourage support for comprehensive school health programs. Target audiences for these messages were: (1) administrators, teachers, and other school staff, and (2) parents. Results of the qualitative and quantitative research conducted by the AEO are published in a draft report entitled

¹⁶ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.) (1997). *Schools & Health, Our Nation’s Investment* (p. 60). Washington, D.C: National Academy Press.

¹⁷ Allensworth, *Schools and Health*, p. 62.

¹⁸ Allensworth, *Schools and Health*, p. 62.

*Developing Messages to Support Comprehensive School Health Programs: Results of Primary and Secondary Research.*¹⁹

Although the in-depth interview and focus group findings discussed in the report are qualitative in nature, they provide useful insights for understanding the target audience's thoughts and perceptions. The subsequent survey helped to measure the prevalence of particular sentiments expressed by participants in the qualitative research.

Because the level of awareness of the term “comprehensive school health programs” was unlikely to be high among most of the audience groups, some research questions used such phrases as “school’s approach to health” rather than “comprehensive school health program,” or for that matter, “coordinated school health program.” As anticipated, few participants were familiar with the term “comprehensive school health programs,” although, some school staff, such as the occasional principal or teacher, gave the “correct” definition of a comprehensive school health program.

Readers of this manual are encouraged to review the final report for further information on developing messages—targeted to parents, teachers and administrators—that support the comprehensive or coordinated approach (even if it is not called that) as a foundation of a successful school or a component of strengthening a school, not a complete solution.

Centers for Disease Control and Prevention. The CDC eight-component model of a school health program has been traditionally referred to as a “Comprehensive School Health Program,” consisting of the following interactive components: health education, physical education, health services, nutrition services, health promotion for staff, counseling and psychological services, healthy school environment, and parent/community involvement.²⁰ However, in a recently published handbook, CDC refers to the eight-component model as a “Coordinated School Health Program,” in which the following definition is presented.

Coordinated School Health Program (CSHP). A planned and coordinated school-based program designed to enhance child and adolescent health, which consists of eight components: healthful school environment; health services; health education; physical education; counseling, psychological, and social services;

¹⁹ *Developing Messages to Support Comprehensive School Health Programs: Results of Primary and Secondary Research*, prepared for the Council of Chief State School Officers Association of State and Territorial Health Officials by the Academy for Educational Development, 1255 23rd St., N.W., Washington, D.C. 20037, draft—May 29, 1997.

²⁰ Centers for Disease Control and Prevention. (1998). *A Comprehensive School Health Program*[Online]. Available: <http://www.cdc.gov/nccdphp/dash/cshpdef.htm>.

*nutrition services; family and community involvement; and health promotion for staff.*²¹

The main premise of this definition of a “coordinated school health program” is that a model involving all aspects of educational agencies (both state education agencies [SEAs] and local education agencies [LEAs] and state health agencies [SHAs] and local health agencies [LHAs]) will (1) eliminate program gaps and overlaps, (2) provide more effective programming, and (3) improve the school’s ability to enhance the health of children and adolescents.²²

Virginia’s Blue Ribbon Commission on School Health. In 1994, the Governor of Virginia established the Blue Ribbon Commission on School Health to collaborate in developing, implementing, and evaluating school health programs, in response to Senate Joint Resolution No. 155, which was passed by the 1994 General Assembly. In 1995, the Commission conducted a study on school health programs in Virginia. For the purpose of its study, the Commission described a school health program in terms of the following nine components: (1) health education, (2) health services, (3) healthful school environment, (4) parent/community involvement, (5) counseling, (6) psychological and social services, (7) nutrition services, (8) physical education, and (9) health promotion for staff.²³

Virginia School Health Guidelines. This manual uses the term “school health program.” Readers of this manual are encouraged to develop a definition or model of a school health program that best meets their community’s needs, resources, perspectives, and standards.

The Virginia School Health Guidelines Task Force recommends that a school health program should:

- ◆ Be based on the premise that parents have the primary responsibility to assure the health and well-being of their children.
- ◆ Be supportive and involve families.
- ◆ Be determined by the local community and based on community needs, resources, standards, and requirements.

²¹ Centers for Disease Control and Prevention. (1997). *Coordinated School Health Program Infrastructure Development: Process Evaluation Manual*, (p. XI). Atlanta, Ga.: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

²² Centers for Disease Control and Prevention, *Coordinated School Health Program Infrastructure*, p. 2.

²³ *Findings and Recommendations of the Blue Ribbon Commission on School Health*. (1996). Senate Document No. 29, Commonwealth of Virginia.

- ◆ Be coordinated by a multidisciplinary team.
- ◆ Be accountable to the community for program quality and effectiveness.
- ◆ Include the following components: (1) parent and community involvement; (2) healthful school environment; (3) health services; (4) health education; (5) physical education; (6) nutrition services; (7) counseling, psychological, and social services; and (8) health promotion for staff.

Reviewing History: Legislative Studies

Overview

Historical Perspective. Prior to the mid-1800s, efforts to introduce health into public schools were isolated and sparse. The “modern school health era” began in the mid-1800s²⁴ after the release of the Shattuck report, which recognized the role schools could play in controlling communicable disease with their “captive audience” of children and young people.²⁵

The era of “medical inspection” began at the end of the nineteenth century when “medical visitors” went to schools and examined children thought to be “ailing.”²⁶ The role and advantages of school nurses began to be recognized around the turn of the century after Lillian Wald, in 1902, demonstrated that nurses working in schools could reduce absenteeism due to contagious diseases by 50 percent in a matter of weeks.²⁷ The range of school-linked health services was broad in the early twentieth century, and school-based medical and dental clinics were set up to provide services, especially to indigent students.

World War I marked a turning point in the history of school health programs, with the advent of the war making the problems of poverty more visible.²⁸ New health promotion philosophies and movement began to replace outmoded methods. During the years immediately following World War I, the image of modern school health programs began to emerge. Between 1918 and 1921, almost every state enacted laws related to health education and physical education for school children, and school-based medical inspection and screening continued into the 1930s. A number of school health demonstration projects and studies were carried out between the 1920s and 1940s.

²⁴ Pigg, R.M. (1992). The School Health Program: Historical Perspectives and Future Prospects. In *Principles and Practices of Student Health, Volume Two: School Health.*, H.M. Wallace, K. Patrick, G.S. Parcel, and J.B. Igoe, eds. Oakland, Calif.: Third Party Publishing.

²⁵ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (pp. 33-76). Washington, D.C.: National Academy Press.

²⁶ Means, R.K. (1975). *Historical Perspectives on School Health*. Thorofare, N.J.: Charles B. Stack.

²⁷ Lynch, A. (1977). Evaluating School Health Programs. In *Health Services: The Local Perspective*. A. Levin, ed. New York, N.Y.: Academy of Political Science; *Proceedings of the Academy of Political Science*, 32(3):89-105.

²⁸ Means, R.K. (1975). *Historical Perspectives on School Health*. Thorofare, N.J.: Charles B. Stack.

Although the Great Society programs of the 1960s and 1970s brought an influx of funding for school health, most of these programs focused on disadvantaged and special populations.²⁹ During the 1980s, the role of health and physical education in the curriculum, as well as the perceived importance of school health for mainstream students, came under question. However, since the mid- to late-1980s there has been a renewed focus on the potential for schools to address health and social problems.³⁰

Evolution of Comprehensive School Health Programs in Virginia. The evolution of school health programs in recent years in Virginia can be followed by reviewing recent school health-related legislation and legislative studies. Key state laws related to school health are cited throughout this manual and are contained in Appendix A. In addition, summaries of key school health-related legislative studies are provided in the following five subsections.

Subsections

The next five subsections contain summaries of the following school health-related legislative studies that were conducted in Virginia, including background information and recommendations.

- ◆ *The Health Needs of School-Age Children*, Senate Document No. 22, Commonwealth of Virginia, 1987.
- ◆ *A Study on Ways to Encourage Local School Divisions to Recognize the Importance of School Nurses and the Feasibility of Establishing Standards for School Health Services*, House Document No. 19, Commonwealth of Virginia, 1989.
- ◆ *Current Health Programs in the Public School of Virginia and the Efficacy and Appropriateness of Adopting a Comprehensive Approach to Health Education*, House Document No. 21, Commonwealth of Virginia, 1992.
- ◆ *Report on the Needs of Medically Fragile Students*, Senate Document No. 5, Commonwealth of Virginia, 1995.
- ◆ *Findings and Recommendations of the Blue Ribbon Commission on School Health*, Senate Document No. 29, Commonwealth of Virginia, 1996.

²⁹ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (p. 46). Washington, D.C.: National Academy Press.

³⁰ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (pp. 46-47). Washington, D.C.: National Academy Press.

Copies of Legislative Reports. To obtain a complete copy of any of the above reports, please contact the Virginia General Assembly, Legislative Services, at telephone (804) 786-3591. (Ask for each publication by document number and date of publication; e.g., “Senate Document No. 19, published in 1996.”)

The Health Needs of School-Age Children (Senate Document No. 22, 1987)

Background

In 1986, the Secretary's Task Force on the Health Needs of School-Age Children was assembled as an outgrowth of Senate Joint Resolution No. 76. The resolution requested the Secretary of Human Resources to study the health needs of school-age children. The recommendations are summarized below.

Recommendation

1. The number of school nurses providing school health services should be increased to allow for at least one school nurse in every school or a ratio of one school nurse per 1,000 students.
2. Minimum standards for school health services in Virginia should be developed jointly by the Departments of Education and Health.
3. The Departments of Education and Health should establish a nursing position within the State Department of Education to supervise and coordinate the provision of school health services in the Commonwealth.
4. The Department of Education should mandate family life education curriculum in grades K-12 with an emphasis on promoting parental involvement and the fostering of positive family living skills in all public schools in the Commonwealth.
5. The Departments of Health and Education along with the Virginia Dental Association should work together on a state and local level to coordinate dental care resources and to increase dental screenings and educational programs.
6. A formal memorandum of agreement should be developed between the Secretary of Human Resources and the Secretary of Education to address overlapping concerns related to the health needs and care of school-age children.
7. The Boards of the Departments of Education and Health should establish a formal agreement to meet jointly at a minimum of twice yearly to advise each of the designated agencies on matters pertaining to school health services policy.
8. The Governor's Task Force on indigent care as well as the Secretary of Human Resources should specifically address the special health care needs of the school-age child especially the medically indigent.

9. The Departments of Education, Health, and Mental Health and Mental Retardation should co-sponsor at regular intervals continuing education opportunities for school nursing personnel on a regional basis.
10. The Departments of Health, Education, and Mental Health and Mental Retardation should provide for school personnel continuing education opportunities about the new morbidity facing today's school-age children.
11. Every school division within the state should have a school health advisory body composed of public and private sector representatives to assist with school health policy.
12. An interdisciplinary health care plan for school-age children at the local level should be developed with technical assistance from the State Departments of Education, Health, and Mental Health and Mental Retardation as requested. Such a plan should include a component on methods of financing health care services to school-age children.
13. Each school division within the state should establish formal interagency agreements with appropriate community resources involved in the provision of health care to school-age children. Appropriate community resources may include, but should not be limited to, local health departments, community services boards, social services agencies, institutions of higher education, private sector health professionals, and others.
14. Local school boards should develop, whenever possible, strong relationships with volunteer organizations and the business community for improving the delivery and financing of health care for school-age children.
15. The Virginia Chapter of the American Academy of Pediatrics should encourage its membership to provide a leadership role at the local level in advocating for and providing a coordinated system of health care for school-age children.
16. The Virginia Congress of Parents and Teachers (PTA) and all other parent organizations should vigorously undertake a parent awareness campaign to educate parents about the health needs of school-age children and to increase parental involvement in their children's health.
17. Every school division should establish a cooperative agreement with a health care provider to serve in the capacity of consulting medical director to provide medical care consultation and backup to nursing personnel.
18. Formal, written emergency medical procedures should be developed in every school division within the state.

19. The State Department of Education should direct all school divisions to maintain appropriate documentation on all student injuries as part of a program of comprehensive risk management.
20. The State Department of Education should continue to monitor and insist that all schools comply with state laws pertaining to vision and hearing assessments.
21. The Department of Education should direct all school divisions to provide time in the curriculum for health education. Further, there should be a strong emphasis on health promotion and disease and injury prevention programs.
22. The Department of Education should assist all school divisions with guidance on the physical education curriculum to develop and emphasize individual fitness programs.
23. The Department of Education should encourage all school divisions to establish after-school programs addressing health issues and concerns.

A Study on Ways to Encourage Local School Divisions to Recognize the Importance of School Nurses and the Feasibility of Establishing Standards for School Health Services (House Document No. 19, 1989)

Background

The Department of Education, in cooperation with the Department of Health, was requested by the 1988 General Assembly of Virginia to study ways to encourage local school divisions to recognize the importance of school nurses and the feasibility of establishing standards for health services in the public schools in the Commonwealth (House Joint Resolution Number 33 [HJR 33]). A study committee was established to respond to the task as defined by HJR 33.

Recommendation

1. Qualified school nurses should be required in every school division contingent upon appropriate funding.
2. The goal for nurse/student ratios should conform to the standards set by the National Association of School Nurses, American Nurses Association, and the American School Health Association.
3. School health advisory boards, composed of public and private sector representatives, should be established to enhance community support for school health services and to assist in the development of local school health policy.
4. Minimum standards for school health services in Virginia should be developed jointly by the Departments of Education and Health.
5. A nursing position should be established by the Departments of Education and Health within their respective departments to supervise and coordinate the provision of school health services.
6. School nurses should be involved as members of school teams to facilitate learning by providing care and treatment to students with chronic and handicapping conditions.
7. Students and school personnel should be counseled as a means of reducing the “new morbidities.”

8. A cooperative agreement should be established in every school division with a health care provider to serve in the capacity of consulting medical director to provide medical care, consultation, and backup to nursing personnel.
9. Formal written emergency medical procedures should be developed in every school division within the state.
10. Appropriate documentation on all student injuries should be maintained by all school divisions as part of a program of comprehensive risk management.
11. Continuing education opportunities, especially in the new morbidities, should be co-sponsored by the Departments of Education, Health, Mental Health and Mental Retardation on a regional basis, and at regular intervals for school nursing personnel.
12. Qualifications for school nurses should be developed jointly by the Departments of Education and Health.

Current Health Programs in the Public School of Virginia and the Efficacy and Appropriateness of Adopting a Comprehensive Approach to Health Education (House Document No. 21, 1992)

Background

This study was conducted during the spring and summer of 1991 in response to House Joint Resolution (HJR) 343 (1991 session). The resolution requested that the Department of Education study current health education programs, as well as the efficacy and appropriateness of adopting a comprehensive approach to health education in the public schools. The study was conducted in conjunction with the study required by HJR 437 (1991 session) on HIV/AIDS education.

Recommendation

1. All persons teaching health education in the elementary and middle school grades without a health education endorsement should be encouraged to complete training essential for quality instruction. This training should be a minimum of one undergraduate or graduate course in health education.
2. Minimum standards for school health education curricula and health services should be developed jointly by the Departments of Education and Health, in conjunction with school divisions in Virginia.
3. The Department of Education should design and implement a plan for evaluating the effectiveness of comprehensive school health programs.
4. The Board of Education and the Department of Education should commit to the further development of Comprehensive School Health Programs, addressing all health education and health service needs in a coordinated and comprehensive manner, and to the promotion of the program in the public schools of Virginia. This would include consideration for expanding the Health Standards of Learning to include grades 11 to 12 and developing a K-12 health education curriculum guide using the Health Standards of Learning Objectives as a foundation. To be funded in the 1994-96 biennium.
5. The Department of Education should continue to provide on-going education on timely health topics. This should be accomplished through the Blue Ridge School Health Conference and regional and local conferences.

Report on the Needs of Medically Fragile Students (Senate Document No. 5, 1995)

Background

During its 1993 legislative session, the Virginia General Assembly adopted a senate resolution (SJR 306) requesting that the Department of Education in conjunction with the Department of Health study the needs of medically fragile children in Virginia.

Recommendation

1. Local school divisions should develop policies that address the provision of services to students who are medically fragile to include staff selection and training, roles, and responsibilities.
2. Local school divisions should develop policies to address the emergency medical needs of students, including those who are medically fragile.
3. The local school health advisory board, required by §22.1-275.1 of the Code of Virginia, should take an active role in assisting school divisions in developing policies related to children who are medically fragile.
4. School divisions should provide periodic in-service or opportunities for school staff to attend programs to increase staff awareness and understanding of the general health issues faced by schools and the needs of medically fragile students, specifically.
5. For risk management purposes, school divisions should document the health services provided to any medically fragile or other students.
6. Nursing homes in the Commonwealth that elect to establish pediatric units should be licensed under both Chapter 5 of Title 32.1 of the Code of Virginia and under Chapter 10 of Title 63.1 of the Code.
7. School divisions should review and evaluate their policies and procedures relative to Section 504 of the Rehabilitation Act of 1973.
8. The Department of Education, in conjunction with the Attorney General's Office, should review and evaluate the need for legislation establishing statutory immunity for school personnel performing acts within the scope of their employment while providing health-related services to the medically fragile population.
9. The Department of Education, in collaboration with the Department of Health, should develop and update procedural guidelines.
10. The General Assembly may wish to consider further study, focusing on the needs of families with medically fragile children.

Findings and Recommendations of the Blue Ribbon Commission on School Health (Senate Document No. 29, 1996)

Background

The Blue Ribbon Commission on School Health Study was conducted during 1995 in response to Senate Joint Resolution No. 155, requesting the Governor to establish a Blue Ribbon Commission on School Health to collaborate in developing, implementing, and evaluating school health programs (1994).

Recommendation

1. School superintendents should recognize the importance of school health advisory boards as a means of parent and community involvement and of assisting with the development of school health policies and the evaluation of school health programs.
2. The Department of Education, in collaboration with the Department of Health, should provide periodic training and technical assistance to school health advisory board members and school health administrators to assist them in strengthening the boards' effectiveness in localities.
3. Recommendations Nos. 1-6 and 8 of Senate Document No. 5, "Report on the Needs of Medically Fragile Students (1995)," should be implemented:
 - ◆ School divisions should develop a "health service plan" for each student who is a medically fragile child as defined by Senate Document No. 5 (1995).
 - ◆ Local school divisions should develop policies that address the provision of services to students who are medically fragile, including staff selection and training and roles and responsibilities.
 - ◆ Local school divisions should develop policies to address the emergency medical needs of students, including those who are medically fragile.
 - ◆ The local school health advisory board, required by §22.1-275.1 of the *Code of Virginia*, should take an active role in assisting school divisions in developing policies related to children who are medically fragile.
 - ◆ School divisions should provide periodic in-service education or opportunities for school staff to attend programs to increase staff awareness and understanding of the general health issues faced by schools and the needs of students who are medically fragile.

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- ◆ For risk management purposes, school divisions should document school health services provided to all students, including those who are medically fragile.
 - ◆ School divisions should review and evaluate their policies and procedures relative to Section 504 of the Rehabilitation Act of 1973.
4. Students with special health care needs and chronic illnesses should have their medical care managed at school by a professional nurse in collaboration with the child's parents and primary health care provider.
 5. The Virginia Board of Nursing efforts to address delegation of nursing services in the school setting to unlicensed assistive personnel while ensuring that the professional nurse retains authority for nursing assessment, nursing evaluation, and nursing judgment should be supported.
 6. The Department of Health, in collaboration with the Department of Education, should distribute guidelines to assist qualified personnel in the assessment and ongoing management of students with specialized health care needs in the school setting. Such guidelines should be sent to all public and private schools in the Commonwealth.
 7. School divisions should require that specialized health care procedures be provided by licensed health care professionals or by personnel who have received training from persons qualified to provide such training and are certified or licensed to perform the procedure being taught.
 8. School divisions are encouraged to devote a portion of their professional development resources to assist staff in developing skills and strategies for working with parents and increasing parental involvement in the planning and implementation of school health programs.
 9. School divisions are encouraged to review physical education, grades K-I 2, and determine ways by which the program could be improved.
 10. The Department of Medical Assistance Services' studies on Virginia managed care Medicaid programs—MEDALLION II and OPTIONS—should include the impact of these programs on school health services.
 11. The Department of Medical Assistance Services should study the appropriateness and feasibility of contracting for school health services, including school nursing services, especially in medically underserved areas or health manpower shortage areas.
 12. School divisions, especially those in medically underserved areas, are encouraged to develop public-private contracts (e.g., HMO-Health Maintenance Organization, CHIP-Comprehensive Health Investment Project of Virginia) that include formal reimbursement for school health services (e.g., school nursing services) provided by qualified personnel.

Developing a Program: Infrastructure and Planning Process Steps

Overview

Introduction. As described in *School & Health: Our Nation's Investment*,³¹ the vision of a comprehensive school health program (CSHP) can seem daunting and out of reach. However, this vision may be closer in reality than might be perceived. Many components of the infrastructure that are needed to support CSHPs—the basic underlying framework of policies, financial and human resources, organizational structures, and communication channels that will be needed for program to become established and grow—already exist or are emerging.

Nationally, as reported in *Coordinated School Health Program Infrastructure Development: Process Evaluation Manual*,³² all eight components are represented in state education agencies and are present to some extent in local school districts and agencies and in most schools. They are represented to some degree in state and local health agencies. However, according to CDC, the components are seldom well planned or coordinated within state and local educational agencies or with comparable programs in state or local health agencies.

In Virginia, according to the legislative study *Findings and Recommendations of the Blue Ribbon Commission on School Health*,²⁶ all school divisions offer some portion of a school health program. The Commission found that there is virtually no success difference in school health program components by school type (i.e., elementary, middle, and secondary schools) and regions of the state, with the exception of health promotion for staff. That is, elementary schools did not necessarily report greater success in accomplishing school health services goals than secondary schools. Furthermore, the Commission reported that school respondents rated meeting the goals of each component of a school health program as follows:

- ◆ High success group: health services, healthful school environment, psychological and social services, nutrition services, health promotion for staff, and physical education.
- ◆ Middle success group: school counseling.
- ◆ Low success group: health education and parent/community involvement.

³¹ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (1997). *School & Health: Our Nation's Investment* (p. 237). Washington, D.C.: National Academy Press.

³² Centers for Disease Control and Prevention. (1997). *Coordinated School Health Program Infrastructure Development: Process Evaluation Manual* (p. 2). Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

Subsections

The following two subsections summarize resources available at the national, state, and local levels and the planning process steps that need to be done to build a school health program.

- ◆ Infrastructure
- ◆ Planning Process Steps

Infrastructure

Building the Infrastructure for a School Health Program

National Infrastructure. According to *School & Health: Our Nation's Investment*,³³ there are many federal agencies that have developed programs to improve the health of children and adolescents. These programs can be a source of technical assistance and funding that states and local school districts can use to develop the infrastructure to develop a school health program. Some of these agencies are listed below, including their Internet Web site address (URL).

Federal Programs and Funding Streams for School Health	
Agency/Internet Address	Examples of Programs
CDC, Division of Adolescent and School Health (DASH) http://www.cdc.gov/nccdphp/dash/what.htm	<ul style="list-style-type: none"> ◆ CSHP Infrastructure Demonstration Grants, Adolescent and School Health Initiative ◆ School Health Program Finance Project
U.S. Department of Agriculture http://www.usda.gov/	<ul style="list-style-type: none"> ◆ School Lunch, School Breakfast, Special Milk, and Snack Programs ◆ Nutrition Education and Training Program
U.S. Department of Education http://inet.ed.gov/	<ul style="list-style-type: none"> ◆ Title I of the Elementary and Secondary Education Act (ESEA) ◆ Title IV of ESEA, Safe and Drug-Free Schools ◆ Title XI of ESEA, Coordinated Services Projects Individuals with Disabilities Act (IDEA)
U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA) http://www.hcfa.gov/	<ul style="list-style-type: none"> ◆ Medicaid ◆ Early Periodic Screening and Diagnosis and Treatment (EPSDT) Program ◆ Child Health Insurance Programs
U.S. Department of Health and Human Services: Maternal and Child Health Bureau (MCHB) http://www.mchb.hrsa.gov/index.html	<ul style="list-style-type: none"> ◆ MCH Title V State Block Grants ◆ National Resource Centers ◆ Healthy Schools, Healthy Communities ◆ Community and Migrant Health Centers Initiatives

³³ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (pp. 237, 241-245). Washington, D.C.: National Academy Press.

Furthermore, there are many national organizations that are involved in supporting school health programs. The scope of involvement is presented in the publication *Creating An Agenda for School-Based Health Promotion: A Review of Selected Reports*, published by the Harvard School of Public Health (Lavin et al., 1992). In addition, there are many nonprofit and philanthropic organizations that support school health programs. Some of these organizations are listed below, including their Internet Web site address (URL).

National Organizations Supporting School Health Programs	
Organization/Internet Address	Description
American Academy of Pediatrics (AAP) http://www.aap.org/	The AAP and its member pediatricians dedicate their efforts and resources to the health, safety and well-being of infants, children, adolescents, and young adults.
American Cancer Society, Health for Success http://www.cancer.org/	It is the American Cancer Society's goal to eliminate cancer as a major health problem. The Society has determined that strengthening school health education is the best and most economic way to fight this devastating disease.
American School Health Association (ASHA) http://www.ashaweb.org/	The ASHA promotes comprehensive and coordinated school health programs comprising health services, health education, and a healthful school environment.
Association of State and Territorial Health Officials (ASTHO) http://www.astho.org/index/html	The mission of ASTHO is to formulate and influence sound national health policy and to assist state health departments in the development and implementation of programs and policies to promote health and prevent disease.
National Association of School Nurses (NASN) http://www.vrmedia.com/Nurses/	The mission of the NASN is to advance the practice of school nursing and provide leadership in the delivery of quality health programs to the school community.
National Association of State School Nurse Consultants http://lserver.aea14.k12.ia.us/swp/tadkins/nassnc/nassnc.html	The mission of the NASSNC is to provide a forum for state-level nurse consultants to share information, develop expert consensus on issues, and impact policies related to the practice of school nursing and the health and education of the nation's school children and youth.
Robert Wood Johnson Foundation http://www.rwjf.org/main.html	The Robert Wood Johnson Foundation is the nation's largest philanthropy devoted exclusively to health and health care.
School Health Resource Services (SHRS), Office of School Health University of Colorado Health Sciences Center http://www.uchsc.edu/sn/shrs/	SHRS is a direct way to access the diverse resources needed to implement or improve school health programs and services. SHRS provides technical information, resource materials, and research assistance.

State Infrastructure. As noted in *School & Health: Our Nation’s Investment*,³⁴ the overall task of the state’s leadership should be to integrate education, physical and mental health, and other related programs and services for children and families. An effective approach for anchoring the state infrastructure is to establish an official state interagency coordination council for school health with designated authority and responsibilities, along with an advisory council of representatives from relevant public and private sector agencies, including representatives from managed care and indemnity insurers.

In Virginia, in 1992, the Virginia Maternal and Child Health Council was created to improve the health of the Commonwealth’s mothers and children by promoting and improving programs and service delivery systems related to maternal and child health. When the Council was first convened, a School Health Subcommittee was formed to make recommendations to the Council on school health-related issues. In 1997, the Subcommittee presented a report on school health services to the MCH Council. The report, entitled *Recommendations to the MCH Council: School Health Services*, September 17, 1997, is available on the web at <http://www.vdh.state.va.us/fhs/child/school/publications.htm>.

Many state agencies can provide localities with child health information and technical assistance, which can help communities enhance or establish a school health program. Some of the key agencies are listed below, including their Internet Web site address (URL).

Key Child Health-Related State Agencies

Agency	Description
Virginia Department of Education (DOE) http://www.pen.k12.va.us/	The mission of Virginia’s public education system, first and foremost, is to educate students in the fundamental knowledge and academic subjects that students need to become capable, responsible, and self-reliant citizens. Therefore, the mission of the Board of Education and Superintendent of Public Instruction, in cooperation with local school boards, is to increase student learning and academic achievement.
Virginia Department of Health (VDH) http://www.vdh.state.va.us/	The mission of the VDH is to achieve and maintain optimum personal and community health by emphasizing health promotion, disease prevention, and environmental protection.
Virginia Department of Medical Assistance Services (DMAS) http://www.state.va.us/~dmas/	The DMAS administers the Medicaid program; Indigent Health Care Trust Fund; State and Local Hospital Program; Involuntary Commitment Program; Regular Assisted Living Payments for Residents of Adult Homes; Health Premium Assistance Program for HIV-Positive Individuals; and the Virginia Children’s Medical Security Insurance Plan (CMSIP).

³⁴ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation’s Investment* (pp. 263-264). Washington, D.C.: National Academy Press.

Key Child Health-Related State Agencies

Agency	Description
Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) http://www.dmhmrzas.state.va.us/overview.htm	Central Office provides leadership in the direction and development of public mental health, mental retardation, and substance abuse services which are responsive to client and constituency needs and accountable to statutory requirements and State MHMRSAS Board policies. This leadership involves: obtaining and allocating resources to Community Services Boards (CSBs) and state facilities in an effective and efficient manner; monitoring field operations; providing technical assistance and consultation; human resource development and management; promoting client advocacy; systems planning; regulating and licensing programs; and maintaining relationships with other human resource agencies.
Virginia Department of Social Services (DSS) http://www.dss.state.va.us/	The mission of the Virginia Department of Social Services (VDSS) is to promote self-reliance and the protection of Virginians through community-based services. The Department, with its five state regional offices, supervises and supports the locally operated social services agencies, which administer financial assistance as well as a variety of other programs for children, adults, and families.

Local Infrastructure. A formal organization with broad representation—a coordinating council for school health—should be established in every school district, to anchor the infrastructure at the community or district level.³⁵

In Virginia, such coordinating councils, known as school health advisory boards (SHABs) should exist in all school divisions. SHABs were established by the 1992 General Assembly (*Code of Virginia*, § 22.1-275.1), to assist with the development of health policy in the school division and the evaluation of the status of school health, health education, the school environment, and health services. Please see “Establishing and Enhancing School Health Advisory Boards” in Chapter II for further information on SHABs in Virginia.

School Level. According to *School & Health: Our Nation’s Investment*,³⁶ individual schools should establish a school health committee and appoint a school health coordinator to oversee the school health program. Please see the following section, “Establishing School Health Team: Position Descriptions,” for recommendations on establishing a school health team.

³⁵ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation’s Investment* (p. 264). Washington, D.C.: National Academy Press.

³⁶ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation’s Investment* (p. 265). Washington, D.C.: National Academy Press.

CDC Guidance on Developing the Coordinated School Health Program Infrastructure³⁷

The Centers for Disease Control and Prevention (CDC) handbook *Coordinated School Health Program Infrastructure Development* provides guidance to those responsible for developing coordinated school health program infrastructure at state and local levels.

The CDC handbook is a planning tool for developing organizational supports to build a coordinated school health program and an implementation tool for institutionalizing these supports at the state and local levels. The CDC handbook was designed as a tool for assessing progress toward institutionalizing the Coordinated School Health Program at established intervals. Summarized below are some infrastructure-related terminology contained in the handbook.

CSHP Definition. The Centers for Disease Control and Prevention, Division of Adolescent and School Health (CDC/DASH), defines the Coordinated School Health Program (CSHP) as a planned and coordinated school-based program designed to enhance child and adolescent health. For the CSHP to exist and perform consistently over time, CDC/DASH reports that it must be fully institutionalized within state and local education and health agencies and supported by an infrastructure.

CSHP Infrastructure. The CSHP infrastructure is the basic system on which the larger CSHP program depends for continuance and growth. When fully implemented, the CSHP infrastructure will enable each state and community to establish a collaborative organizational pattern that facilitates community-wide planning, implementation, and evaluation of activities to help schools implement CSHPs that are consistent with community values and needs.

CSHP Infrastructure Supports. The four main units that comprise infrastructure are (1) authorization and funding, (2) personnel and organizational placement, (3) resources, and (4) communication and linkages. Each support can be broken down into multiple subcategories.

CSHP Institutionalization. The CSHP as an integrated, self-sustaining part of health and education agencies that is subject to minimal disruption caused by changes.

Need for CSHP Infrastructure. According to CDC, when CSHP infrastructure is fully institutionalized, school health initiatives with sufficient quality and duration will provide long-term health benefits for children and their families. The CSHP that has a strong infrastructure is able to:

³⁷ Centers for Disease Control and Prevention. (1997). *Coordinated School Health Program Infrastructure Development: Process Evaluation Manual* (p. VI-4). Atlanta, Ga.: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

- ◆ Respond to the changing health priorities routinely faced by policymakers in health and education agencies.
- ◆ Facilitate predictable and coherent organizational change to benefit children and youth.
- ◆ Coordinate independent programs and services provided to children, youth, and families by multiple organizations.
- ◆ Effectively use finite fiscal, technical, and human resources to meet a wide range of health problems affecting children and youth.

Planning Process Steps

Introduction. When developing or enhancing a school health program—whether at the national, state, local, or school level—a planned approach is essential for success. Use of a program planning process can improve a school health program because change may be difficult both on a personal and organizational level. It is critical to set the stage by choosing the appropriate community participants and school health professionals. A team with the appropriate mixture of responsibility, knowledge, and experience can lead the schools in an improvement project that will make a difference for students and staff. The team should define the problem from a national, state, local, or school level perspective as appropriate. Then the team can do an assessment of the problem or need, set goals and objectives, develop an action plan with strategies to be used, implement the plan, and evaluate the results.

The six key steps in a planning process are listed below.

1. Establish the planning team.
2. Assess health problems and service needs.
3. Set goals and objectives.
4. Develop an action plan.
5. Implement the plan.
6. Evaluate effectiveness of the planning process and program.

This sub-section, “Planning Process Steps,” summarizes the steps of a logical planning process, which can be used at the school level for enhancing or establishing a school health program. The information presented can be modified according to what is appropriate at national, state, or local level. (For additional information on building support for a comprehensive or coordinated approach to school health programs, please see Chapter III, “Building Support for School Health Programs.”)

Establish Planning Team

Role Assignment. When developing a school health team, it may be customary to assign roles on the team based on the team members’ responsibilities associated with their existing school health role. For example, the school nurse may be assigned school health services because the school nurse is responsible for school health services as part of the school nurse role. However, there are no clear-cut responsibilities and members may contribute in several areas. While health services may be considered by many to be the domain of the school nurse, every staff member should refer students who exhibit health problems, such as vision and hearing disorders or substance abuse, for early detection

and correction of health problems. In another example, the healthy school environment component is often assigned to administrators. The principal may typically set the tone for the school; however, without the cooperation of all staff, efforts to make the school environmentally safe and aesthetically pleasing may fall short. Using a variety of individuals who each bring specific attributes to a particular plan strengthens the school health improvement team.

Primary Team Members. The following list identifies potential team members and describes attributes they may bring to the team based on their functional responsibility.³⁸ (It is important to remember that each person can bring more attributes than those based on their identified role in school health.)

Features of a School Health Team: Primary Members

Primary Team Member	Attributes
◆ School Administrators	Sets the tone for the school environment and can facilitate implementation of the plan.
◆ School Nurses ◆ Nurse Practitioners ◆ Clinic Aides	Understands student health needs, can link school and community programs, can provide case management for student health needs, and can serve as a health resource for all staff.
◆ Health Educators	Can coordinate supplemental health instruction with the health curriculum and provide access to a variety of health resources.
◆ Physical Educators ◆ Coaches ◆ Trainers	Can coordinate the physical education program with special wellness-related fitness programs, as well as implement special physical activity events.
◆ Food Service Directors ◆ Food Service Managers	Can organize supplemental nutrition education programs.
◆ Guidance Counselors ◆ School Psychologists ◆ Social Workers	Can direct peer instructional programs, small group process, and support groups, as well as teach within the guidance program the generic skills needed to address a variety of health problems.
◆ Worksite Health Promotion Directors	Can organize health promotion activities and coordinate community health promotion resources.
◆ Community Professionals ◆ Physicians ◆ Parents ◆ Community Leaders ◆ SHAB (School Health Advisory Board) Members ◆ Law Enforcement Officials (e.g., Dare Officers, Resource Officers)	Have access to human and material resources and leverage within the community to assure implementation of projects.

³⁸ Allensworth, D., Symons, C., and Olds, R. (1994). *Healthy Students 2000: An Agenda For Continuous Improvement In Schools* (p. 20). Kent, Ohio: American School Health Association.

Additional Team Members. Although the previous list contains the major players who have some responsibility for the school health program, other individuals can facilitate the accomplishment of program goals because of their unique role in the school. The following list identifies individuals who could assist in health programs.³⁹

Features of a School Health Team: Other Members

Additional Team Members	Attributes
<ul style="list-style-type: none"> • Librarians 	Have access to school media resources and can prepare exhibits for students.
<ul style="list-style-type: none"> • Special Education Teachers 	Teach students with disabilities.
<ul style="list-style-type: none"> • Occupational Therapists • Physical Therapists • Speech-Language Pathologists 	Implement IEP requirements.
<ul style="list-style-type: none"> • Work and Family Studies Teachers (Home Economics) • Science Teachers 	Can provide significant health programming within their respective discipline.
<ul style="list-style-type: none"> • English Teachers 	Can assign homework with health themes.
<ul style="list-style-type: none"> • Office Secretaries 	Are aware of available school resources and have contact with students waiting in office for professional staff.
<ul style="list-style-type: none"> • Music Teachers • Art Teachers • Drama Teachers 	Can use a variety of channels to provide health messages. Additionally, any teacher or school staff member who works with students can be valuable in this endeavor.
<ul style="list-style-type: none"> • Students 	Although students routinely have not been placed on committees to improve school health programs, it is appropriate to consider their value. Students have the attention of their peer group, the idealism and energy to complete projects, and the need to engage in meaningful activity. They also can promote behavioral change among students more effectively than adults.
<ul style="list-style-type: none"> • Consultants 	Outside consultants, who are trained health education specialists and understand the theories of individual and organizational change and the process of program implementation, can facilitate institutionalization of an interdisciplinary approach to school health programming. Consultants may be based at the district office, secured from a local university, or hired through a consulting firm.

³⁹ Adapted from Allensworth, D., Symons, C., and Olds, R. (1994). *Healthy Students 2000: An Agenda For Continuous Improvement In Schools* (p.20). Kent, Ohio: American School Health Association.

Health program team members who represent various disciplines foster greater dissemination of information and innovations. The team members can share activities of the team with their respective professional groups and can request assistance from these groups in implementing specific parts of the action plan.

Note: Please see the following section, “Establishing School Health Team: Position Description,” for guidelines for selected school health program personnel.

Assess Health Problems and Service Needs

Data Collection and Interpretation.⁴⁰ Once the team is formed, the next step in developing a school health program is to assess the school community health status and available resources. Assessment involves the regular collection, analysis, and sharing of information about the health conditions, risks, and resources in a community. Assessing the school community is needed to identify (1) trends in illness, injury, high-risk health behaviors, and death, and the factors that may cause these events; and (2) available school health resources and their application, unmet needs, and community perceptions about school health issues. Assessment results are then interpreted, and school community health problems and capabilities are identified.

Assessment Questions. To identify the unique needs of the students in the school division, data are collected to answer such questions as:

- ◆ What are the major health problems?
- ◆ What is the current status of programming that addresses these health problems?
- ◆ What are the gaps in needed programming?
- ◆ What health problems should be addressed first?

Data Collection Methods. Data can be collected from a variety of sources that might include:

- ◆ Students’ knowledge, attitudes, and behaviors about health in general or in any priority area.
- ◆ School health programming in each of the eight-component areas.
- ◆ Community resources.

⁴⁰ Adapted from Washington State Core Governmental Public Health Functions Task Force Members. *Core Public Health Functions* (July 1993). National Association of County Health Officials, Washington, DC.

- ◆ Programming within the school and community that addresses specific priority areas.
- ◆ Epidemiological data (e.g., mortality/morbidity) and social indicator data (e.g., injury reports, school health records, crimes, driving-under-the-influence arrests).
- ◆ Parents.

Data Collection Tools. Some examples of tools that may be used for assessment include:

- ◆ A Model Survey: Healthy Schools Make Sense: Evaluating Your School Health Program (1995), which was developed and published by the Virginia Department of Education and Virginia Department of Health. The survey addresses the components of a comprehensive school health program as defined by CDC.⁴¹
- ◆ Blue Ribbon Commission on School Health Evaluation Survey, which is a modification of the above survey that was developed by the Virginia Department of Education. (See Appendix A.)
- ◆ Youth Risk Behavior Survey (YRBS), which was developed by the Centers for Disease Control and Prevention to assess health-related risk behaviors in youth. The survey focuses on behaviors in six priority areas: (1) physical fitness, (2) nutrition, (3) intentional injuries, (4) unintentional injuries, (5) reproductive health, and (6) substance abuse. Local programmers can compare local students' behavior with the behavior of students at the national or state level.⁴²
- ◆ School Health Education Profile (SHEP), which is a report designed to help state education agencies and local education agencies monitor the status of school health education at the middle/junior high school level in their school divisions. The profile addresses the quantity and quality of school health education provided in schools.⁴³
- ◆ Guidelines for Evaluation of Health Services, which is an evaluation of general school health services, such as school health procedures and cumulative health records and specific school health services, such as nursing and screening programs. (See Chapter III, School Health Services, for more detailed information.)

⁴¹ Contact Fran Meyer, Comprehensive School Health Specialist, Office of Special Education and Student Services, Virginia Department of Education at (804) 225-4543 for more information and a copy of the evaluation tool.

⁴² Ibid.

⁴³ Ibid.

Problem Analysis and Prioritization.⁴⁴ After the information about the health conditions, risks, and resources of the school community is collected, problem analysis should be undertaken by the school health team for each identified problem to clarify the nature of the problem. This analysis can include (1) identification of the origins (i.e., precursors of the problem) and impact (i.e., consequences) of the problem, (2) the point at which interventions (e.g., health services, health education) might be undertaken and the adequacy of existing services, and (c) the community representatives that have an interest in the problem and its solution.

Communities are always faced with the dilemma of addressing a large number of health problems with limited human, financial, and other resources. This necessitates setting priorities among the identified problems in order to decide how to allocate resources to address them. The school team should consider numerous criteria and the perspectives of many individuals when the school health problems are being prioritized. To allow a variety of perspectives and criteria to be fully represented, the school health team should consider using a problem analysis and prioritization framework that encourages consideration of all of them in a balanced, rational way.

Various models or decision frameworks exist for conducting problem analyses and health services needs assessments. The school health team might consider using an already-developed process and substantive experts to facilitate problem analysis and problem prioritization.

Set Goals and Objectives

Goals. After the needs are identified, goals and objectives are specified. Goals are broad statements that identify long-term outcomes the school health program is to achieve.

Objectives. After the goals have been identified, specific objectives are identified that will help facilitate the attainment of the goal. Objectives are the incremental steps that must be accomplished before the goal can be attained. Objectives identify the action to be performed and should be stated in specific, measurable terms. Specific objectives are important because they will become the focus of the evaluation plan that will be developed.

Develop Action Plan

Action Plan. The next step in developing a school health program is developing an action plan. The action plan is a strategy or blueprint for meeting the identified priority needs from the assessment. The action plan answers the question of what can be done to resolve the identified needs or problems. It focuses on analysis of the need, setting

⁴⁴ Adapted from Mary D. Peoples-Sheps, DrPH, Anita Farel, DrPh, and Mary M. Rogers, MSN, DrPH (authors). (1996). *Assessment of Health Status Problems*. Maternal and Child Health Bureau.

priorities for goals and objectives, identifying the strategies to facilitate attainment of the objectives and goals, delineating the specific activities needed to complete each strategy, establishing timelines, and identifying evaluation procedures.

Strategies. The team should formulate specific strategies to achieve each objective. A strategy is a set of activities designed to bring about the desired change. Strategies can take the form of a policy development, formal instruction, informal modeling of behavior, social support, facility modification, direct intervention, or mass media campaigns to change behavior. As the action plan is implemented, attention to the reception and the progress of the program is paramount. In this phase, there is a formative evaluation that provides guidance for program modification. If the plan is not proceeding according to schedule or if unexpected outcomes are discovered, revision and restructuring of the action plan are warranted.

Factors to Consider. When developing the action plan, it is important to consider the following factors:

- ◆ Involve as many people as possible in the planning process. The more people who have ownership of the plan, the more people who will support the plan when it is implemented. Successful school health improvement projects link professionals within the school and integrate school activities with the community.
- ◆ Identify the key stakeholders associated with the identified problem and encourage their involvement.
- ◆ Anticipate potential problems with the plan and develop contingency plans.
- ◆ Ensure that the plan is communicated to everyone who will be affected by it.
- ◆ Determine if the plan is manageable and reasonable.
- ◆ The work of the school health team is enhanced if the community has mounted a similar campaign and if there is a link integrating the programming in the community with what is occurring in the school. Various options are available for school community partnerships, such as community agency professionals and parents working on school health improvement teams, and formal task forces that include coalitions or consortiums. As the organizational unit becomes more formal and complex, the roles and responsibilities of participating individuals and agencies should be clarified.

School Health Advisory Boards. The school health advisory board (SHAB) is an excellent vehicle to assist in the development of the school health program. The SHAB may be the group that can assist in the assessment of the health conditions, risks, and resources in a school community, or may assist persons associated with the school division to plan for an identified school health need. In many situations, the SHAB members are key stakeholders associated with a particular school health need. (Please see

“Establishing and Enhancing School Health Advisory Boards” in Chapter II for more information on SHABs.)

Implement Plan

After being developed, the plan is implemented to effect the identified school health needs. As each school division has unique needs, each school division will develop plans that are specific to their school’s situation. For example, a plan developed to meet the accessibility needs of a small rural school division will not be appropriate for the accessibility needs of a large urban school division. One system may have only 5 students with special needs, while the other has 100 students with special needs.

General Guidelines. General guidelines for implementing the action plan include:

- ◆ Involve the community and community leaders in implementation of the action plan.
- ◆ Communicate the plan to all persons who need to be involved.
- ◆ Identify the appropriate resources at the state level, such as the Virginia Department of Education and the Virginia Department of Health, and at the local level, such as school health advisory boards, school administration, area health professionals, local health departments, and school boards.
- ◆ Build partnerships and develop interdisciplinary collaboration as needed.
- ◆ Obtain a written agreement with all involved agencies and partners so that each person’s/organization’s role is clearly defined in the action plan.

Evaluate Effectiveness

The final component of the planning process is evaluation. The purpose of the evaluation is to appraise the effects of the school health program. Evaluation procedures should be developed during the planning process. Ongoing or formative evaluation guides program implementation. Outcome or summative evaluation determines program effectiveness. Evaluation of the program planning process is conducted to determine if the goals, objectives, strategies, activities, personnel, and time frames chosen were appropriate, attainable, comprehensive, congruent, and acceptable to community standards. Evaluation of the program’s effectiveness focuses on planned and unplanned outcomes and the degree to which established goals were realized.

Basic Steps. The basic steps in the evaluation process are:

1. Develop questions that should be answered to determine whether the program is successful.

2. Identify procedures and persons to answer the questions.
3. Obtain information and data that specifically address the questions asked.
4. Analyze and interpret collected information and data.
5. Use evaluation results to plan for future programs.

Evaluation Questions for Program Planning Process. Examples of questions that may be asked regarding evaluation of the program planning process as presented in the following table.⁴⁵

Evaluation Area	Sample Questions
Goals	<ul style="list-style-type: none"> • Are the chosen goals congruent with needs identified in the assessment? • Are the chosen goals capable of being attained?
Objectives and Outcomes	<ul style="list-style-type: none"> • Are the objectives and outcomes comprehensive? • Are the objectives and outcomes attainable? • Are the objectives and outcomes measurable? • Are the objectives and outcomes congruent with goals and strategies?
Strategies	<ul style="list-style-type: none"> • Are the chosen strategies congruent to the attainment of goals? • Are the chosen strategies comprehensive? • Are the chosen strategies attainable? (Resources available amenable to student developmental levels?) • Are the chosen strategies acceptable to community standards and values?
Activities	<ul style="list-style-type: none"> • Are the activities attainable? (Resources available?) • Are the activities developmentally appropriate? • Are the activities comprehensive? • Are the activities congruent with strategies and goals? • Are the individuals in charge of each activity or strategy competent, well-organized, interesting, and effective?
Time Frame	<ul style="list-style-type: none"> • Is the time frame reasonable?
Outcome of Action Plan	<ul style="list-style-type: none"> • How effective were the specific health promotion strategies that were implemented by the components of the school health program (health services, health instruction, healthful school environment) in changing knowledge? attitudes? behavior? • Have new policies been implemented? • Has health status improved?

⁴⁵ Adapted from Allensworth, D., Symons, C., and Olds, R. (1994). *Healthy Students 2000: An Agenda For Continuous Improvement In Schools*. (p. 33). Kent, Ohio: American School Health Association.

Establishing a School Health Team: Position Descriptions

Authorization

Regulations. Virginia Department of Education (September 1997). *Regulations Establishing Standards for Accrediting Public Schools in Virginia*. Richmond, Va.: Author.

Excerpt: The regulations state that:

Each school shall have contingency plans for emergencies that includes staff certified in Cardiopulmonary Resuscitation, the Heimlich maneuver, and emergency first aid.

Code of Virginia, Section 22.1-274E.

Excerpt:

Each school board shall ensure that, in school buildings with an instructional and administrative staff of ten or more, at least two instructional or administrative employees have current certification in cardiopulmonary resuscitation or have received training, within the last two years, in emergency first aid and cardiopulmonary resuscitation. In school buildings with an instructional and administrative staff of fewer than ten, school boards shall ensure that at least one instructional or administrative employee has current certification in cardiopulmonary resuscitation or has received training, within the last two years, in emergency first aid and cardiopulmonary resuscitation.

Recommendation

Local School Health Team. The basic school health team consists of the parents, primary care physician, school physician or public health medical director, and school nurse. A school nurse practitioner functioning in an expanded role may also be a member of the school health team per school division policy. Ideally, this group will collaborate with administrators, teachers, guidance counselors, occupational therapists, physical therapists, speech-language pathologists, audiologists, social workers, psychologists, educational diagnosticians, food services, dentists, court services, legal services, and child welfare services.

The school health team recognizes that parents or guardians have the basic responsibility for the health of their children. School health services supplement, rather than substitute for, parental care and concern for the health of the student. Parents are to be advised of health problems, encouraged to secure needed medical or dental care, and made aware of various private and public community resources available to them.

Interdisciplinary Team. The intervention of an interdisciplinary team is the ideal method to be used in solving problems of a student with complex medical, social, and emotional needs. The team works in collaboration to develop a comprehensive plan to meet the needs of each student who has problems. The individual disciplines represented on the team will vary according to the needs of the student.

The appropriate lead member of the interdisciplinary team should be based upon the student's primary need. Interdisciplinary team membership may vary among school divisions; smaller school divisions are more likely to have personnel who are assigned multiple roles. The key to the interdisciplinary approach is not so much the specific disciplines represented on the team but the coordinated approach to problem solving and to meeting the needs of each student.

The activities of school health staff may overlap with those of other school personnel. For example, children with social and emotional problems are the concern of school guidance counselors, social workers, psychologists, mental health workers, and special education teachers, as well as of the school physician and school nurse. Collaboration is necessary to prevent duplication of services and to ensure a coordinated approach in meeting the student's health needs. Coordination of interventions by the interdisciplinary team is the ideal method to be used in solving problems of a student with complex medical/social/emotional needs.

For an interdisciplinary team to function cohesively, each member must understand the role of the other members of the team. The following guidelines contain recommended functions and responsibilities of various team members. The information contained under staff personnel is not intended to be a complete position description.

Subsections

Functions and Responsibilities of School Health Program Personnel. The following subsections provide guidelines on the roles of each of the following school health program personnel.⁴⁶

- ◆ School Nurse: Registered Nurse
- ◆ School Nurse: Licensed Practical Nurse
- ◆ School Nurse Practitioner
- ◆ School Health Supervisor/Coordinator: Registered Nurse
- ◆ Unlicensed Assistive Personnel
- ◆ School Health Volunteer
- ◆ School Health Physician

Resource. Committee on School Health, American Academy of Pediatrics. (1987). *School Health: A Guide for Health Professionals*. Elk Grove, Ill.: the Academy.

⁴⁶ Massachusetts Department of Health. (1995). *Comprehensive School Health Manual* (pp. 45-49, 50-59). Boston, Mass.: Author.

School Nurse: Registered Nurse

The following are recommendations for school divisions to consider when developing a position description for a school nurse—Registered Nurse.

Scope of Responsibilities

The Registered Nurse (RN) is responsible for developing, implementing, and managing a school health program for a school population as defined by the school division. Responsibilities include program management, nursing services, collaboration, health education, community health planning, and professional practice.

Supervision Received

The Registered Nurse reports to the school nursing supervisor (if available) and to the chief administrator of the school building. In some cases, the RN reports to the local health department nursing supervisor. School physicians or medical health director may also be available for consultation.

Supervision Given

The Registered Nurse supervises the health aide/technician and others as defined by the position description (e.g., licensed practical nurse, health services secretary, school health volunteer).

Required Qualifications

- ◆ Must have a valid license to practice as a Registered Nurse in the Commonwealth of Virginia.
- ◆ Must maintain current certification in cardio-pulmonary resuscitation and first aid from a recognized provider (e.g., American Heart Association).
- ◆ Must have a minimum of two years of supervised nursing experience in community health or child health prior to entry into school nursing practice.

Recommended Qualifications

- ◆ A baccalaureate degree in nursing or public health nursing from an accredited college or university program in nursing.
- ◆ Work toward (and subsequently maintain) certification in school nursing, community health/public health nursing, family nurse practitioner, or pediatric/school nurse practitioner by a nationally recognized professional nursing organization.

Responsibilities⁴⁷

Program Management. Establishes and manages a school health program consistent with Virginia guidelines, regulations, and statutes governing nursing and school health, and local school division policy.

- ◆ Advises the local school health advisory board (SHAB).
- ◆ Consults with the school physician, school administrators, and others to establish, review, and revise policies, procedures, and specific programs for school health education and services.
- ◆ Works with others to develop a needs assessment and data collection procedures.
- ◆ Ensures the orientation, training, supervision, and evaluation of paraprofessionals, as needed, to comply with the nurse practice act and other relevant statutes and regulations.
- ◆ Organizes and implements state-mandated programs, such as immunization surveillance and screening programs.
- ◆ Promotes positive safety practices both within and outside of school buildings, and ensures that the school has an emergency plan that is communicated to personnel and students.
- ◆ Maintains comprehensive school health records.
- ◆ Collaborates with school administrators and personnel in assessing and improving the social and emotional climate of students and faculty and involves them in maintaining a healthful school environment.

⁴⁷ Adapted from: American Nurses Association. (1983). *American Nurses Association Standards of School Nursing Practice*.

- ◆ Uses population-based data to plan and evaluate the school health program.
- ◆ Prepares regular written reports for school officials and other agencies describing the services provided by the program, numbers of students served, and so forth; interprets school health service needs and the role of the school nurse to the school and community.
- ◆ Carries out communicable disease prevention and infection control based on current guidelines for universal precautions, prevention of bloodborne pathogens exposure and hazardous medical waste disposal.

Nursing Services. Using the nursing process, collaborates with the parent/guardian and student, where appropriate, to develop and implement an individualized health care plan for the student.

- ◆ Collects information about the health and developmental status of the student and his/her family, and significant others, in a systematic and continuous manner, including health and social histories, screening results, physical assessment, emotional status, performance level and health goals, and makes home visits as needed.
- ◆ Develops a nursing diagnosis and care plan with specific goals and interventions delineating school nursing actions specific to student needs and coordinated with the efforts of other providers and school personnel; implements plans in a manner aimed at improving health and educational status.
- ◆ Provides medically prescribed interventions, including medication administration (based on state regulations), and provides care to ill children on a daily basis.
- ◆ Responds to frequently encountered health issues, providing counseling and crisis intervention as required by state and local policy (e.g., adolescent pregnancy, substance abuse, death of a family member, suicide, and child neglect or abuse issues).
- ◆ Assesses student response to nursing actions in order to revise the database, nursing diagnoses, and nursing care plan and to determine the progress made toward goal achievement; documents pertinent information in student records or confidential nursing notes.
- ◆ Provides first aid to injured children and staff, provides everyday care of acutely ill children, and manages children with communicable disease.

Collaboration. Collaborates with other professionals, team members, and community providers in assessing, planning, implementing, and evaluating programs and other school health activities, so as to maximize and coordinate services and prevent duplication.

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- ◆ Establishes a process to identify students at risk for physical and psychosocial problems. Communicates health needs to other school personnel, as appropriate, and establishes a referral system using both internal and community resources.
 - ◆ Participates as a team member—with parental consent, when indicated. Shares information with other team members about children with special health care problems that affect learning and growth; acts as an advocate for the student and family when appropriate; attends special education team meetings.
 - ◆ Includes the student and parent in the team conference whenever possible and appropriate.
 - ◆ Identifies health-related needs for inclusion in the individualized education program (IEP).
 - ◆ Serves as a member of pertinent committees and teams (e.g., crisis intervention team, support groups for grieving students, and so forth).

Health Education. Assists students, families, and groups to achieve optimal levels of wellness through health education and promotion.

- ◆ Identifies need for health education; teaches the basic principles of health promotion and disease prevention to students and staff, using principles of learning and appropriate teaching methods.
- ◆ Encourages students to be health educated people and knowledgeable health consumers.
- ◆ Assumes responsibilities for in-service programs for school personnel for first aid, emergency care procedures, and current health issues.
- ◆ Acts as a resource in health education for school personnel, students, and families.

Community Health Planning. Participates with other members of the community to assess, plan, implement, and evaluate school health services and community services that include the broad continuum of primary, secondary, and tertiary prevention.

- ◆ Uses population-based data.
- ◆ Uses community resources for referral of students with unmet health needs, including the need for a primary care provider.
- ◆ Participates in planning and implementing new services.
- ◆ Interprets school health service needs and the role of the school nurse to the school and community.

- ◆ Works with the media to convey important health information.

Professional Practice. Applies appropriate nursing theory as the basis for decision-making in the school setting while expanding knowledge and skills in response to the student health needs and participating in research.

- ◆ Demonstrates current knowledge in such areas as (1) professional issues in school nursing, (2) school and community health, (3) communicable disease control, (4) growth and development, (5) health assessment, (6) special health conditions—both chronic and acute, (7) injury prevention and emergency care, (8) health counseling, health education and promotion, and (9) current adolescent issues.
- ◆ Assumes responsibility for continuing own education; obtains expert consultation, supervision, and peer review as needed.
- ◆ Collaborates with local schools of nursing to provide student practice in community health, as well as to obtain nursing education resources.

Note: The administrator and school nurse should review and revise the position description at a minimum of every two years based on changing student health needs.

Note: In 1996, the Virginia Department of Health sent the following manual to all Virginia school divisions via the School Nurse Coordinator/Contact Person. School divisions are encouraged to consult the manual when developing orientation programs for new school nurses.

- ◆ Zaiger, Donna Shipley. *School Nursing Practice: An Orientation Manual*. Scarborough, Maine: National Association of School Nurses.

School Nurse: Licensed Practical Nurse

The following are recommendations for school divisions to consider when developing a position description for a school nurse—Licensed Practical Nurse.

Scope of Responsibilities

The Licensed Practical Nurse (LPN) is responsible for implementing a school health program for a school population as defined by the school division under the direction of a licensed health professional. Responsibilities include selected nursing acts and collaboration with licensed health professional to implement school health services.

Supervision Received

The LPN reports to the school nursing supervisor (if available) and to the chief administration of the school building. The LPN receives direction or supervision from a licensed medical practitioner, a registered nurse, or other licensed health professional authorized by regulations of the Virginia Board of Nursing.

Required Qualifications

- ◆ Must have a valid license to practice as a Licensed Practical Nurse.
- ◆ Must have a minimum of two years of supervised nursing experience in community health or child health prior to entry into school nursing practice.
- ◆ Must maintain current certification in cardio-pulmonary resuscitation and first aid from a recognized provider (e.g., American Heart Association).

Responsibilities⁴⁸

Nursing Services. Using the nursing process, collaborates with a supervising licensed health professional, where appropriate, to develop and implement an individualized health care plan for the student with the assistance of the parent/guardian and students.

⁴⁸ Adapted from: American Nurses Association. (1983). *American Nurses Association Standards of School Nursing Practice*.

- ◆ Collects information about the health and developmental status of the student and student's family and significant others, in a systematic and continuous manner, including health and social histories, screening results, physical assessment, emotional status, performance level and health goals; makes home visits as needed.
- ◆ Provides medically prescribed interventions, including medication administration (based on state regulations), and provides care to ill children on a daily basis.
- ◆ Initially responds to frequently encountered health issues and to child neglect or abuse issues (as required by state and local policy), and reports to appropriately trained and licensed health professional so that counseling and crisis intervention can be provided when required (e.g., adolescent pregnancy, substance abuse, death of a family member, suicide).
- ◆ Assesses student response to nursing actions in order to work with supervising licensed health professional to revise the database and individualized care plan and to determine the progress made toward goal achievement; documents pertinent information in student records or confidential nursing notes.
- ◆ Provides first aid to injured children and staff; provides everyday care of acutely ill children, and manages children with communicable disease.

Health Education. Assists students, families, and groups to achieve optimal levels of wellness through health education and promotion.

- ◆ Encourages students to be health educated people and knowledgeable health consumers.
- ◆ Acts as a resource in health education to school personnel, students, and families.

Note: The administrator and school nurse manager should review and revise the position description at a minimum of every two years based on changing student health needs.

School Nurse Practitioner

Overview

The following are recommendations for school divisions to consider when developing a position for a school nurse practitioner—Licensed Nurse Practitioner (LNP).

Scope of Responsibilities

The Licensed Nurse Practitioner's responsibilities vary according to the specific school division. In some school divisions, the LNP is the primary care provider for students who are registered in the school-based health center. In other divisions where there is no school-based health center, the LNP practices in an expanded role for the general student population.

Supervision Received

The Licensed Nurse Practitioner receives clinical consultation from a designated physician. When functioning as part of the school health service team, the LNP receives administrative supervision from the school nurse manager as defined in the specific position description.

Supervision Given

The Licensed Nurse Practitioner functioning as the primary care provider within a school-based health center (SBHC) provides supervision to those licensed and unlicensed persons functioning within the SBHC and as defined by the LNP's position description. If the LNP functions within the general school health program, the LNP likewise is responsible for those licensed and unlicensed personnel as defined by the position description.

Required Qualifications

- ◆ Must have a valid license to practice as a Registered Nurse in the expanded role in Virginia. (Refer to the Virginia Nurse Practice Act for a description of this expanded role.)

- ◆ Must possess a minimum of a baccalaureate in nursing from an accredited nursing program; possess/maintain certification as a School/Pediatric or Family Nurse Practitioner.

Recommended Qualifications

- ◆ Master's degree in primary health care nurse specialist practitioner with emphasis in pediatric, family, or school health.
- ◆ Have a minimum of three years experience in school nursing or a related field.
- ◆ Maintain certification in cardio-pulmonary resuscitation and first aid.
- ◆ Have an identified physician who provides consultation.
- ◆ Assume responsibility for updating knowledge and skill in community health, management, and related fields as new information emerges.
- ◆ Experience and/or education in the areas of school law and school health.
- ◆ Complete ongoing continuing education programs pertinent to the evolving specialty area of school health and school nursing practice, as well as meet the continuing education requirements for licensure in the expanded role in Virginia.

Responsibilities

The Licensed Nurse Practitioner practicing within the school setting is responsible for many of those areas listed in the position description for the school nurse. In addition, the LNP role may include the following responsibilities.

- ◆ Consultation and collaboration with a pediatrician and medical specialist in adolescent medicine or other related field in addressing medical issues presented by the students and in developing practice guidelines.
- ◆ Provision of primary care to students.
- ◆ Management of the health care of students with chronic and acute conditions while providing intervention and/or referral as necessary.
- ◆ Provision of physical examinations to identified students at appropriate intervals, including prior to participation in sports, prior to obtaining work permits, and so forth.

- ◆ Provision of physical examinations to identified school staff according to school board requirements (e.g., school bus driver annual physical exam).
- ◆ Consultation with teachers on health issues and provision of clinical in-service education as needed.

School Health Supervisor/Coordinator: Registered Nurse

Overview

The following are recommendations for school divisions to consider when developing a position description for a school health supervisor/coordinator: registered nurse—School Nursing Supervisor.

Scope of Responsibilities

The School Nursing Supervisor manages the total school nursing program, providing nursing leadership within the school system. The supervisor coordinates the clinical aspects of the school health program, collaborating with other members of the health services and health education team.

Supervision Received

The School Nursing Supervisor reports to the school administrator as defined in her/his position description and collaborates with the designated school physician in developing and implementing the school health service program.

Supervision Given

The School Nursing Supervisor supervises all clinical nursing staff providing services in the school health program, as well as those unlicensed personnel (e.g., health aides as designated in the organizational chart).

Recommended Qualifications

- ◆ Must have a valid license to practice as a Registered Nurse in Virginia.
- ◆ Possess a minimum of a baccalaureate in nursing from an accredited nursing program. (A master's degree in nursing or related field is preferred with an emphasis on nursing, education, or public health.)
- ◆ Have a minimum of three years experience in school nursing or a related field.
- ◆ Experience in personnel management.

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- ◆ Experience in program administration.
 - ◆ Certification by a national organization of school nurses.
 - ◆ Maintain certification in cardio-pulmonary resuscitation; CPR-instructor certification for the supervisor or the supervisor's delegate is recommended.
 - ◆ Assume responsibility for updating knowledge and skill in community health, management, and related fields as new information emerges.
 - ◆ Complete ongoing continuing education programs pertinent to the evolving specialty area of school health and school nursing practice.

Responsibilities

Needs Assessment.

- ◆ Using available demographic, health, and school system data, identifies health needs of the student population.
- ◆ Selects or develops surveys, questionnaires, and other tools for obtaining information.

Planning.

- ◆ Assumes leadership in the establishment of a school health service advisory committee consisting of representation from such groups as school administration, faculty, students, parents, and community providers.
- ◆ Based on needs assessment, develops program goals, objectives, and action steps.
- ◆ Coordinates planning with interdisciplinary colleagues in the comprehensive school health education and health services program.

Implementation.

- ◆ Employs, orients, and assigns qualified personnel to implement the school health program.
- ◆ Implements communication systems that promote participatory management.
- ◆ Participates in the development of an interdisciplinary plan for each building to ensure that students in need of services are identified in a timely manner and appropriate intervention is initiated.
- ◆ Develops and implements written policies and procedures for the clinical services and programs addressing health issues (e.g., immunizations, medication administration,

services for children with special health care needs, school-wide injury prevention programs, and such special programs as groups addressing eating disorders, smoking cessation, and violence prevention).

- ◆ Develops and implements documentation systems at both the individual student level and the programmatic level.
- ◆ Provides clinical consultation to the health education staff, physical educators, and other administrative and teaching staff.
- ◆ Participates in interdisciplinary teams (e.g., crisis team, child abuse team, and so forth) to ensure that integrated systems are in place that address the comprehensive health needs of the student population.
- ◆ Carries out communicable disease prevention and infection control measures based on current guidelines for universal precautions, prevention of bloodborne pathogens exposure, and hazardous medical waste disposal.
- ◆ Ensures that there is an emergency care plan in place that is communicated to all staff and is closely coordinated with community emergency care procedures.
- ◆ Collaborates with other school administrators and teachers, and promotes a physically and psychologically healthy school environment.
- ◆ Promotes positive linkages and referral mechanisms to community providers for a range of services addressing child and adolescent health.
- ◆ Seeks opportunities to interpret the health needs of school-age children and adolescents, the goals of the health service program, and the importance of health education to administrators, school committee members, faculty, families and the general community, through special reports, the media, health fairs, and other special events.
- ◆ Prepares and administers the health services budget; seeks opportunities to apply for outside sources of funding for the school health services program.

Evaluation.

- ◆ Compiles statistical reports as required by the school system and state agencies.
- ◆ Evaluates nursing and other health service staff.
- ◆ Reviews changing trends in health needs and the outcomes of programs to determine need for revision of goals and objectives.

Staff Development.

- ◆ Implements an ongoing continuing education program for staff.
- ◆ Encourages health services staff to participate in pertinent conferences and workshops addressing a range of school health issues.
- ◆ Provides ongoing formal and informal feedback to staff about their progress in achieving the goals of the program, encouraging their continued educational and professional development.

Other.

- ◆ Collaborates with local nursing education institutions (e.g., provides student practice in the school health programs, guest lectures, participates in nursing research), seeks opportunities to give consultation on the specific issues of school-age children and adolescents, and publishes when possible.

Unlicensed Assistive Personnel

Overview

The following are recommendations for school divisions to consider when developing a position description for unlicensed assistive personnel—UAP.

Scope of Responsibilities

Unlicensed Assistive Personnel (UAP) includes nursing assistants, clinic aides, health aides, and so forth. The UAP assists in the school health program as determined by the school nurse (who is a registered nurse). Therefore, the scope of responsibilities will vary according to school health program needs, the capabilities of the UAP, and the availability of the school nurse to provide supervision. When the Registered Nurse determines that certain tasks may be delegated to the UAP, such delegation shall be under the supervision of the Registered Nurse and consistent with the Virginia Board of Nursing regulations.

Minimum Qualifications

- ◆ Possess a high school diploma or its equivalent.
- ◆ Demonstrate sound judgment.
- ◆ Ability to communicate with verbal and written language.
- ◆ Be able to read and write English.
- ◆ Respect and protect the confidentiality of students, staff, families, and so forth.
- ◆ Be willing to accept nursing supervision.
- ◆ Complete training in both cardio-pulmonary resuscitation and a basic first aid program, and maintain the necessary certifications.
- ◆ Demonstrate clerical proficiency.

Recommended Qualifications

- ◆ Post high school education.

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- ◆ Office management skills, such as typing, computer literacy, and filing.
 - ◆ Experience in the care of the school-age child.
 - ◆ Certification as a nursing assistant.

Supervision Received

The UAP receives supervision from the registered nurse appointed under the provisions of Virginia Nurse Practice Act.

Responsibilities

A Registered Nurse assigns responsibilities to the UAP. These responsibilities may include but are not limited to the following activities.

Assisting in health care activities.

- ◆ Assists with vision and hearing screenings and related tasks, such as recording results, sending letters to parents/guardians, and so forth.
- ◆ Weighs and measures students; completes graphs of heights and weights.
- ◆ Assists with preparation for health activities, such as physical examination of students, immunizations, Mantoux testing, and so forth.
- ◆ Administers medications and treatments as delegated by the school nurse, after having received the required training (if provided for in the policy of the local school division or local health department).
- ◆ Reports major health concerns to the supervising school nurse and/or school administrator within appropriate time limits.
- ◆ Provides first aid care to students with minor injuries.
- ◆ Follows guidelines contained in *First Aid Flipchart for School Emergencies*. (See Appendix B.)
- ◆ Reports all illnesses and injuries to the school nurse for professional review, care, and/or follow-up.
- ◆ Contacts parents of ill or injured students.
- ◆ ***Maintains confidentiality on student information.***

- ◆ Maintains a clean, orderly, and attractive health office/clinic.
- ◆ Attends ongoing in-service education programs.

Performing clerical functions.

- ◆ Records health information (e.g., results of various screening tests, immunization information, and so forth).
- ◆ Maintains an up-to-date master file of student health emergency information and so forth.
- ◆ Sends notices to parents, tabulates returns, and follows up on non-respondents.
- ◆ Provides ongoing communication to the school nurse regarding the status of health notices.
- ◆ Distributes information, forms, and so forth, to teachers and administrative staff.
- ◆ Develops computer skills as needed.
- ◆ Initiates and distributes incident and accident reports according to school division policy.

School Health Volunteer

School health volunteers should be selected and function according to local school division policy. Volunteers should not administer medications or perform treatments unless specifically covered by local school board policy. In addition, they should not have access to confidential student records.

Reference. Virginia Department of Education. (1999). *Guidelines for the Management of the Student's Scholastic Record in the Public Schools of Virginia*. Richmond, Va.: Author.

School Health Physician

Overview

In elementary, middle, and high schools in Virginia, the physician might have the following roles in the school health program.

Primary Care Provider. “The most valuable role of the physician as primary care provider in a school program is that of general resource and liaison between the child, the family, and school personnel. By interpreting the health problems of a student for school personnel, the physician helps the staff to modify the student’s program as needed. Conversely, the school helps the primary care provider by providing pertinent information, and by reporting observations about the student’s physical and emotional behavior. In certain circumstances, the school can help the physician manage some aspects of health problems, such as psychosocial disorders, chronic disease, and physical disabilities.”⁴⁹

School Health Physician. The role of the school physician is to serve in the capacity of consulting medical director to provide medical evaluations, consultation, and support to nursing personnel. The duties of the school physician are to provide consultation to the school health program, provide medical evaluations where appropriate, and maintain two-way communication between the school and the student’s primary care physician. The school health physician usually serves as advisor for medical concerns related to medically fragile/unstable students, special education placement, and issues related to Section 504 of the Rehabilitation Act.

The school physician may be employed by a single school division or by a group of school divisions.

Medical Director of the Local Health Department. The role of the medical director of the local health department (Health District Director) is to serve as a consultant and/or advisor to the local school division regarding school health laws, immunization regulations, control of communicable diseases, and enforcement of environmental laws and regulations.

⁴⁹ American Academy of Pediatrics. (1987). *School Health: A Guide for Health Professionals* (p. 9). Grove, Ill.: The Academy.

Recommendation

The following are recommendations for school divisions to consider when developing a contract for a school health physician.

Scope of Responsibilities

The school physician/physician consultant contracts with the local school division to provide medical expertise and consultation in the development and implementation of the school health program. The school nurse may request consultation on individual students or groups of students with specific health issues at any time. The school physician acts as a resource.

Qualifications

- ◆ Must have a valid license to practice medicine in the Commonwealth of Virginia.
- ◆ Knowledgeable about the health needs of children and adolescents.
- ◆ Additional Suggested Qualifications: The school physician/physician consultant should, in addition, be board certified or board eligible in pediatrics or family practice. When the primary student population includes adolescents, the medical consultant or school physician should have education and experience in adolescent medicine.

Responsibilities

The school physician/physician consultant may include the following responsibilities.

Consultation to the school health program.

- ◆ Provides general consultation to school nurse and to the school division on matters relating to the health of the school population.
- ◆ Collaborates with the school nurse in identifying the need for and developing policies and procedures governing school health services for individuals or groups of students, which are then shared with the school health advisory board for adoption.
- ◆ Participates as a member of the school health advisory board.
- ◆ Provides consultation on the development of policies pertinent to the health and safety of the school (e.g., emergency care plan, first aid program, bee sting protocol, HIV/AIDS, environmental safety, athletic safety).

- ◆ Collaborates with the school nurse, school administrators, and other pertinent school personnel, as well as the local health department, to develop and implement a program for immunization against communicable diseases and control of infectious illnesses (e.g., bloodborne illnesses, parasitic diseases, and tuberculosis) and assists in developing policies on exclusion and readmission of students based on the aforementioned conditions.
- ◆ Collaborates with the interdisciplinary comprehensive school health education staff to develop educational programs specific to the current needs of student, faculty, and parent groups on such topics as nutrition, child development, family life, HIV/AIDS prevention, and so forth.
- ◆ Collaborates with the school nurse, teachers, support staff, and parents on specific health issues of individual students as they relate to the school setting, including classroom management of the student with physical or emotional problems.
- ◆ When indicated or requested by the school nurse, communicates with the student's primary physician on medical issues pertinent to the school setting.
- ◆ When indicated or requested by the school nurse, reviews the reports of physical examinations performed by the student's primary care provider.

Physical assessment.

- ◆ Completes the health assessments on such students who do not have this service performed by a primary care provider.
- ◆ Provides the physical examination of students participating in competitive or contact sports, prior to that participation (for students who do not have this service performed by a primary care provider).
- ◆ Examines students referred by the school nurse or other personnel because of health issues identified during screening and/or frequent school absences (if this service is not provided by a primary care provider).
- ◆ Conducts physical examinations on students as needed for special education assessment.

Health education.

- ◆ In collaboration with the comprehensive health education staff, assists in presenting educational programs as needed by faculty, parents, and students.

Coordination with community providers.

- ◆ In collaboration with the school nurse, interprets the needs and responsibilities of the school health program to the school committee, the community, and other health care providers within the community.
- ◆ Collaborates with other medical and public health professionals in prevention programs designed to enhance the health of children and adolescents within the community.

Delineating Roles and Responsibilities for the Safe Delivery of Specialized Health Care

Authorization

Code of Virginia, Sections 22.1-274, School Health Services. The *Code of Virginia* states that each school board may strive to employ, or contract with local health departments for, nursing services consistent with a ratio of at least one nurse (i) per 2,500 students by July 1, 1996; (ii) per 2,000 students by July 1, 1997; (iii) per 1,500 students by July 1, 1998; and (iv) per 1,000 students by July 1, 1999.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-274, A-D.

Code of Virginia, Section 54.1-3000, Definitions. The *Code of Virginia* defines “professional nurse,” “professional nursing,” “practical nurse,” and “practical nursing.”

Excerpt:

Registered Nurse

“Professional nurse,” “registered nurse” or “registered professional nurse” means a person who is licensed under the provisions of this chapter to practice professional nursing as defined in this section. Such a licensee shall be empowered to provide professional services without compensation, to promote health and to teach health to individuals and groups. The abbreviation “R.N.” shall stand for such terms.

“Professional nursing,” “registered nursing” or “registered professional nursing” means the performance for compensation of any nursing acts in the observation, care and counsel of individuals or groups who are ill, injured or experiencing changes in normal health processes or the maintenance of health; in the prevention of illness or disease; in the supervision and teaching of those who are or will be involved in nursing care; in the delegation of selected nursing tasks and procedures to appropriately trained unlicensed persons as determined by the board; or the administration of medications and treatments as prescribed by any person authorized by law to prescribe such medications and treatment. Professional nursing, registered nursing and registered professional nursing require specialized education, judgment, and skill based upon knowledge and

application of principles from the biological, physical, social, behavioral and nursing sciences.

Licensed Practical Nurse

“Practical nurse” or “licensed practical nurse” means a person who is licensed under the provisions of this chapter to practice practical nursing as defined in this section. Such a licensee shall be empowered to provide nursing services without compensation. The abbreviation “L.P.N.” shall stand for such terms.

“Practical nursing” or “licensed practical nursing” means the performance for compensation of selected nursing acts in the care of individuals or groups who are ill, injured, or experiencing changes in normal health processes; in the maintenance of health; in the prevention of illness or disease; or, subject to such regulations as the Board may promulgate, in the teaching of those who are or will be nurse aides. Practical nursing or licensed practical nursing requires knowledge, judgment and skill in nursing procedures gained through prescribed education. Practical nursing or licensed practical nursing is performed under the direction or supervision of a licensed medical practitioner, a professional nurse, registered nurse or registered professional nurse or other licensed health professional authorized by regulations of the Board.

See Appendix A for *Code of Virginia*, § 54.1-3000.

Code of Virginia, Section 54.1-3005, Specific powers and duties of the Board. The *Code of Virginia* confers specific powers and duties to the Board (of Nursing). One specific power/duty involves delegation.

Excerpt:

To promulgate regulations for the delegation of certain nursing tasks and procedures not involving assessment, evaluation or nursing judgment to an appropriately trained unlicensed person by and under the supervision of a registered nurse, who retains responsibility and accountability for such delegation.

See Appendix A for *Code of Virginia*, § 54.1-3005.

Note: At the time of development of this manual, the final regulations had not been promulgated by the Virginia Board of Nursing. Please contact the Board of Nursing at (804) 662-9909 for current information on delegation.

Overview

Role Delineation. Advances in health care technology and procedures have resulted in increased numbers of children with special health care needs in the school setting. The trends toward out-patient and home-based treatments, federal mandates for educating special education students in the regular classroom, plus parental expectations have all reinforced the need for school divisions to clearly define roles and responsibilities in addressing the specialized health care needs of these children.

Delegation. The issue of delegation involves the responsibilities of registered nurses (R.N.s) in delegating patient or client care activities to unlicensed persons.⁵⁰ The American Nurses Association (1992) defines delegation as the transfer of responsibility for the performance of an activity from one individual to another while retaining the accountability for the outcome. The National Council for State Boards of Nursing (1990) defines delegation as transferring to a competent individual authority to perform a selected nursing task in a selected situation.

Note: At the time of development of this manual, the final regulations for delegation had not been promulgated by the Virginia Board of Nursing. The Virginia Board of Nursing will include a definition of delegation in its regulations.

Recommendation

Role Delineation. Specialized health care procedures should be performed by qualified personnel who have received child-specific training as defined by the student's primary health care provider(s) and the student's family. Every student who has a special health care need requiring nursing care, intervention, and/or supervision should have a nursing care plan written by a nurse.

The National Joint Task Force for the Management of Children with Special Health Needs with membership from the American Federation of Teachers, the Council for Exceptional Children, the National Association of School Nurses, and the National Education Association developed the matrix, "Guidelines for the Delineation of Roles and Responsibilities for the Safe Delivery of Specialized Health Care in the Educational Setting."⁵¹ (Please see matrix at the end of this section.) Many of the special health care procedures that some children may need in the educational setting are regulated by professional standards of practice. The matrix delineates the persons qualified to perform

⁵⁰ Schwab, N. and Hass, M. (1995). Delegation and Supervision in School Settings: Standards, Issues, and Guidelines for Practice (Part 1). *Journal of School Nursing*, 11(1), pp. 19-27.

⁵¹ Joint Task Force for the Management of Children with Special Health Care Needs. (May, 1990). *Guidelines for the Delineation of Roles and Responsibilities for the Safe Delivery of Specialized Health Care in the Educational Setting*. Reston, Va.: Author.

specific procedures, who should perform them, and the circumstances under which these persons would be deemed qualified. The term “qualified” assumes that the individual has received appropriate training and has been certified as competent to perform the procedure by a registered nurse or physician. The matrix may be useful to administrators, health care providers, and educators in planning educational programs for staff who provide care for children with special health care needs.

Delegation. In the Commonwealth of Virginia, a registered nurse can delegate certain nursing tasks to an appropriately trained unlicensed person who is under the RN’s supervision. When delegating, the RN retains responsibility and accountability for such delegation. As defined in the *Code of Virginia*, RNs cannot delegate nursing tasks and procedures that involve assessment, evaluation, or nursing judgment. The final regulations, which will be developed by the Board of Nursing, will address the requirements that must be met in order for a task to be delegated.

**GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES
FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING ***

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL ¹	PARA PROFESS SIONALS ²	OTHERS ³
1.0 ACTIVITIES OF DAILY LIVING							
1.1 Toileting/Diapering		A	A	A	A	(A)	A
1.2 Bowel/Bladder Training (Toilet Training)		A	A	(A)	A	S	S
1.3 Dental Hygiene		A	A	A	A	S	S
1.4 Oral Hygiene		A	A	(A)	A	S	S
1.5 Lifting/Positioning		A	A	(A)	A	S	S
1.6 Feeding							
1.6.1 Nutrition Assessment		A	X	X	N	X	X
1.6.2 Oral-Motor Assessment		X	X	X	(SP/TH)	X	X
1.6.3 Oral Feeding		A	A	A	A	(S)	S
1.6.4 Naso-Gastric Feeding	*	(A)	(S)	X	X	(S/HA)	X
1.6.5 Monitoring of Naso-Gastric Feeding		A	S	S	S	S	X
1.6.6 Gastrostomy Feeding	*	(A)	(S)	X	X	(S/HA)	X
1.6.7 Monitoring of Gastrostomy Feeding		A	S	S	S	S	X
1.6.8 Jejunostomy Tube Feeding	*	(A)	(S)	X	X	X	X
1.6.9 Total Parenteral Feeding (Intravenous)	*	(A)	(S)	X	X	X	X
1.6.10 Monitoring of Parenteral Feeding		A	S	S	S	S	X

DEFINITION OF SYMBOLS

- A Qualified to perform task, not in conflict with professional standards
- S Qualified to perform task with RN supervision and inservice education
- EM In emergencies, if properly trained, and if designated professional is not available
- X Should not perform
- 1 Related Services include N, TH, and SP.
- 2 Paraprofessionals include teacher aides, health aides, uncertified teaching personnel.
- 3 Others include secretaries, bus drivers, cafeteria workers, custodians.

* DELINEATION OF RESPONSIBILITIES MUST ADHERE TO EACH STATE NURSE PRACTICE ACT.

GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING *

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL ¹	PARA PROFESSIONALS ¹	OTHERS ³
1.6.11 Naso-Gastric Tube Insertion	*	(A)	(S)	X	X	X	X
1.6.12 Naso-Gastric Tube Removal	*	(A)	(S)	EM	EM	EM/HA	X
1.6.13 Gastrostomy Tube Reinsertion	*	(A)	(S)	X	X	X	X
2.0 CATHETERIZATION							
2.1 Clean Intermittent Catheterization	*	(A)	(S)	X	X	SHA	X
2.2 Sterile Catheterization	*	(A)	(S)	X	X	X	X
2.3 Crede	*	A	S	S	S	(SHA)	S
2.4 External Catheter	*	(A)	(A)	S	S	(SHA)	X
2.5 Care of Indwelling Catheter (Not Irrigation)	*	(A)	(S)	S	S	(SHA)	X
3.0 MEDICAL SUPPORT SYSTEMS							
3.1 Ventricular Peritoneal Shunt							
3.1.1 Pumping	*	(EM)	(EM)	X	X	X	X
3.1.2 Monitoring	*	(A)	S	S	S	S	X
3.2 Mechanical Ventilator							
3.2.1 Monitoring	*	(A)	(S)	EM	EM	SHA	X
3.2.2 Adjustment of Ventilator	*	X	X	X	X	X	X
3.2.3 Equipment Failure	*	(A)	(S)	EM	EM	EM	EM

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DELINEATION OF RESPONSIBILITIES MUST ADHERE TO EACH STATE NURSE PRACTICE ACT.

**GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES
FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING ***

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL	PARA PROFESSIONALS ¹	OTHERS ²
1.6.11 Naso-Gastric Tube Insertion	*	(A)	(S)	X	X	X	X
1.6.12 Naso-Gastric Tube Removal	*	(A)	(S)	EM	EM	EM/HA	X
1.6.13 Gastrostomy Tube Reinsertion	*	(A)	(S)	X	X	X	X
2.0 CATHETERIZATION							
2.1 Clean Intermittent Catheterization	*	(A)	(S)	X	X	SHA	X
2.2 Sterile Catheterization	*	(A)	(S)	X	X	X	X
2.3 Crede	*	A	S	S	S	(SHA)	S
2.4 External Catheter	*	(A)	(A)	S	S	(SHA)	X
2.5 Care of Indwelling Catheter (Not Irrigation)	*	(A)	(S)	S	S	(SHA)	X
3.0 MEDICAL SUPPORT SYSTEMS							
3.1 Ventricular Peritoneal Shunt	*	(EM)	(EM)	X	X	X	X
3.1.1 Pumping	*	(EM)	(EM)	X	X	X	X
3.1.2 Monitoring	*	(A)	S	S	S	S	X
3.2 Mechanical Ventilator	*	(A)	(S)	EM	EM	SHA	X
3.2.1 Monitoring	*	(A)	(S)	EM	EM	SHA	X
3.2.2 Adjustment of Ventilator	*	X	X	X	X	X	X
3.2.3 Equipment Failure	*	(A)	(S)	EM	EM	EM	EM

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DELINEATION OF RESPONSIBILITIES MUST ADHERE TO EACH STATE NURSE PRACTICE ACT.

GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING *

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL ¹	PARA PROFESSIONALS ²	OTHERS ³
3.3 Oxygen							
3.3.1 Intermittent	*	(A)	(S)	EM	EM	EM	X
3.3.2 Continuous (Monitoring)	*	A	S	S	S	S	S
3.4 Hickman/Broviac/IVAC/MED	*	(A)	(S)	X	X	X	X
3.5 Peritoneal Dialysis	*	(A)	(S)	X	X	X	X
3.6 Apnea Monitor	*	A	S	S	S	S/HA	X

4.0 MEDICATIONS

Medications may be given by LPN's and Health Aides only where the Nurse Practice Act of the individual state allows such practice, and under the specific guidelines of that nurse practice act.

4.1 Oral	*	(A)	(S)	X	X	S/HA	X
4.2 Injection	*	(A)	(S)	X	X	X	X
4.3 Epi-Pen Allergy Kit	*	(A)	(S)	EM	EM	EM	EM
4.4 Inhalation	*	(A)	(S)	EM	EM	EM/HA	EM
4.5 Rectal	*	(A)	(S)	X	X	EM/HA	X
4.6 Bladder Installation	*	(A)	(S)	X	X	X	X
4.7 Eye/Ear Drops	*	(A)	(S)	X	X	S/HA	X

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- X Should not perform
- T Related Services include N, TH, and SP.
- N Nutritionist only
- TH Occupational or physical therapist only
- SP Speech/language Pathologist only
- Person who should be designated to perform task
- 2 Paraprofessionals include teacher aides, health aides, uncertified teaching personnel
- 3 Others include secretaries, bus drivers, cafeteria workers, custodians.

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**GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES
FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING ***

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL	PARA PROFESSIONALIST	OTHERS ³
4.8 Topical	*	(A)	(S)	X	X	S/H/A	X
4.9 Per Nasogastric Tube	*	(A)	(S)	X	X	S/H/A	X
4.10 Per Gastrostomy Tube	*	(A)	(S)	X	X	S/H/A	X
4.11 Intravenous	*	(A)	(S)	X	X	X	X
4.12 Spirometer	*	(A)	(S)	X	X	S/H/A	X
5.0 OSTOMIES							
5.1 Ostomy Care	*	(A)	(S)	EM	EM	EM	X
5.2 Ostomy Irrigation	*	(A)	(S)	X	X	X	X
6.0 RESPIRATORY ASSISTANCE							
6.1 Postural Drainage	*	(A)	(S)	S	S	S/H/A	S
6.2 Percussion	*	(A)	(S)	S	TH	S/H/A	S
6.3 Suctioning	*	(A)	(S)	S	S	S/H/A	X
6.3.1 Pharyngeal	*	(A)	(S)	S	S	S/H/A	X
6.3.2 Tracheostomy	*	(A)	(S)	S	S	S/H/A	X
6.4 Tracheostomy Tube Replacement	*	(EM)	(EM)	EM	EM	EM	EM
6.5 Tracheostomy Care (Cleaning)	*	(A)	(S)	X	X	X	X

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D E L I N E A T I O N O F R E S P O N S I B I L I T I E S M U S T A D H E R E T O E A C H S T A T E N U R S E P R A C T I C E A C T .

GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING *

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL	PARA PROFESSIONALS ¹	OTHERS ²
7.0 SCREENINGS							
7.1 Growth		(A)	(S)	S	S	S	X
7.2 Vital Signs		(A)	(S)	X	X	S/HA	X
7.3 Hearing		(A)	(S)	X	(SP)	S/HA	X
7.4 Vision		(A)	(S)	X	X	S/HA	X
7.5 Scoliosis		(A)	(S)	S	TH	S/HA	X
8.0 SPECIMEN COLLECTING/TESTING							
8.1 Blood Glucose	*	(A)	(S)	X	X	S/HA	X
8.2 Urine Glucose	*	(A)	(S)	X	X	S/HA	X
9.0 OTHER HEALTH CARE PROCEDURES							
9.1 Seizure Procedures	*	(A)	(S)	X	X	TH	X
9.2 Soaks	*	(A)	(S)	X	X	X	X
9.3 Dressings, Sterile	*	(A)	(S)	X	X	X	X

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CHAPTER 2

Parent and Community Involvement

This chapter presents guidelines for increasing *parent and community involvement* in schools, an essential component of a school health program. Included within this chapter is information about related codes, policies, and recommendations for engaging a wide range of resources and support to enhance the health and well-being of students.

In This Chapter

- Involving Parents and Community
- Establishing and Enhancing School Health Advisory Boards
- Involving Parent/Teacher Groups
- Developing Partnerships
- Building Support for School Health Programs

Involving Parents and Community

Introduction. Involving parents and the community is essential to a successful school health program. By integrating school, parent, and community in a school health program, the health and well-being of students are enhanced. Examples of parent and community involvement in school health include school health advisory boards (SHABs), such parent teacher organizations as the PTA, and partnerships with organizations within the community. This involvement creates broadly-based constituencies for school health that build support for school health program efforts.

Please refer to “Developing a Program: Planning Process Steps” in Chapter I for detailed information on how to develop a program.

Definitions. Although a universally accepted definition of the term “Parent and Community Involvement” has not been adopted, *Health Is Academic: A Guide to Coordinated School Health Programs* presents the following definition:⁵²

Family and Community Involvement in Schools: Partnerships among schools, families, community groups, and individuals. Designed to share and maximize resource and expertise in addressing the healthy development of children, youth, and their families.

According to the Institute of Medicine (IOM) Committee on Comprehensive School Health Programs in Grades K-12, and as described in Chapter I, a comprehensive school health program (CSHP) “**involves** and is **supportive of families** and is **determined** by the **local community** based on community **needs, resources, standards, and requirements.**”⁵³

Each term printed in bold is further described and discussed in the IOM interim statement and final report. A brief summary of these terms is described below, as defined by the IOM Committee in its final report.⁵⁴

***Involve** means to engage as a participant, to include. **Supportive of families** implies helping, assisting, or advocating, to keep families as a key foundation, with family defined in its broadest context as a unit consisting of one or more children plus parent(s), guardian, or other care provider(s). Involving the family implies that the family has*

⁵² Marx, E., and Wooley, S.F. (1998). *Health Is Academic: A Guide to Coordinated Health Programs* (p. 4). New York, N.Y.: Teachers College Press.

⁵³ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (p. 60). Washington, D.C.: National Academy Press.

⁵⁴ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (p. 61-62). Washington, D.C.: National Academy Press.

knowledge about the CSHP and participates in community deliberations to determine needs and to design program strategies, activities, and services. When properly designed and sensitive to community concerns, CSHPs provide family support by reinforcing community values and providing access to health and social services, both for students and possibly for other family members.

Determine means to come to a decision by investigation, reasoning, or calculation, to settle or decide by choosing among alternatives or possibilities.

The **local community** refers to the wide range of stakeholders—parents, students, educators, health and social services personnel, insurers, business and political leaders, and so forth—at the particular site where the program will be implemented.

Need refers to the lack of something desirable or useful and to conditions requiring relief or remediation. **Resources** refer to the strengths and available sources of relief or recovery upon which the community can draw in meeting identified needs. **Standards and requirements** involve both professional and legal criteria and community ethics, mores, and values.

Recommendation

Beginning the Process. As described in Chapter I, various models for school health programs exist, but most models have essential common elements. There is no one universally accepted “best” formula for establishing a school health program—each community must specifically tailor the program to meet its needs. Active community involvement is the key, and the integration of school programs with other community efforts appears to produce more positive results than a school or community program operating in isolation.⁵⁵

Planning Process. The form and structure of a school health program should be determined through a deliberate planning process by a broad range of stakeholders—those who will be involved in and affected by the program.⁵⁶ Chapter I describes a logical planning process that can be used to develop the program.

⁵⁵ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (p. 76). Washington, D.C.: National Academy Press.

⁵⁶ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (p. 61). Washington, D.C.: National Academy Press.

Subsections

The following subsections describe some of the ways to involve the local community—parents, students, educators, health care and social service providers, insurers, business, policymakers, and so forth—in developing the form and structure of the school health program.

- ◆ Enhancing and Establishing School Health Advisory Boards
- ◆ Involving Parent and Teacher Groups
- ◆ Developing Partnerships

Establishing and Enhancing School Health Advisory Boards

Authorization

Code of Virginia, Section 22.1-275.1, School Health Advisory Board. The *Code of Virginia* requires that each school board shall establish a school health advisory board of no more than twenty members to assist with the development of health policy in the school division and the evaluation of the status of school health, health education, the school environment, and health services.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-275.1.

SUPTS. MEMO. No. 137, June 19, 1992, Subject: School Health Education Advisory Board.

Excerpt:

The 1992 General Assembly amended and reenacted § 22.1-275.1 to require each school division to have a school health advisory board. The advisory board should be organized to advise school divisions about the development and implementation of school health programs, including health instruction, the school environment and health services.

The school health advisory board should be organized to include no more than twenty (20) members, with a broad base of representation including parents, students, health professionals and educators. In addition, the board may be organized to include representatives from community agencies, the local school board, business and industry, child advocacy groups, volunteer health agencies, the school division staff, and institutions of higher education. Each advisory board is required to meet at least semi-annually and to provide an annual report on the status and needs of student health in the school divisions to any relevant school, the school board, the Virginia Department of Health and the Virginia Department of Education.

Overview

History. School health advisory boards began with a Governor’s Task Force on Child Health. To accomplish the goal of Virginia’s students taking full advantage of a “world class education,” the Governor’s Task Force on Child Health recommended that the Secretaries of Education and Health and Human Resources work together to encourage local school divisions to increase the school’s role in improving the health of the children of the Commonwealth so that they are ready to learn and can concentrate on learning while they are in school. To reinforce this effort the 1992 General Assembly amended and reenacted Section 22.1-275.1 of the *Code of Virginia* to require each school division to have in place a school health advisory board (SHAB) by December 1992.

Recommendation

Membership. As described in *A Guide to Establishing and Maintaining School Health Advisory Boards*,⁵⁷ a school health advisory board is an advisory group composed primarily of individuals selected from broad-based segments of the community, including but not limited to parents, students, health professionals, educators, and others. The group acts collectively to provide advice to the school division on aspects of the school health program. The members of a school health advisory board are specifically appointed by the school division to advise the school division.

SHABs may have up to 20 members. Each member should:

- ◆ Be interested and involved in youth-related activities.
- ◆ Have a general understanding or awareness of the community.
- ◆ Have professional abilities to contribute to the SHAB.
- ◆ Be willing to devote time to the SHAB.
- ◆ Be representative of the community’s population.
- ◆ Be respected by the community.

Potential SHAB members should include members from some of the following categories:

- ◆ Parents or parent groups.

⁵⁷ Virginia Department of Education. (1995). *A Guide to Establishing and Maintaining School Health Advisory Boards*. Richmond, Va.: Author.

- ◆ Medical professionals, such as nurses, physicians, dentists, nutritionists, psychologists, speech-language pathologists, vision specialists, and audiologists.
- ◆ Social services agencies.
- ◆ Business/industry.
- ◆ Volunteer health agencies.
- ◆ Churches/synagogues.
- ◆ Hospitals/clinics.
- ◆ Public health agencies.
- ◆ Civic and service organizations.
- ◆ Community service boards.
- ◆ Colleges/universities.
- ◆ Public media.
- ◆ Attorneys and law enforcement officials.
- ◆ School personnel, such as pupil medical director, health supervisor/coordinator, guidance counselor, nutritionist, high school student, principals, teachers, school nurse, custodian bus driver, vision/hearing specialist, and speech therapist.
- ◆ Youth groups.
- ◆ Professional societies.
- ◆ Government officials.

Functions. The SHAB facilitates understanding and cooperation among those interested in developing and improving the local school health program. In addition to their overall purpose of advising school divisions about the development and implementation of school health programs, SHABs perform many other functions. These potential functions should be periodically reviewed by the board and the school system to determine mutually beneficial priorities. If weighting is not provided by the school system, the SHAB may annually decide which functions should receive the most emphasis, or the decision may be made according to the board plans for each major issue, project, or topic. Whatever the priorities, the SHAB meetings and other activities should reflect these

functions. The following is a summary of required and recommended functions of a SHAB.⁵⁸

- ◆ **Health Policy:** Assist with the development of health policy in the school division. (Required by *Code of Virginia*, § 22.1-275.)

Note: Information gathered from assessment activities can be used to assist policy makers in developing policies based on local priorities, needs, and resources. Policy development includes consideration of political, organizational, and community values. Good policy development includes information sharing, citizen participation, compromise, and consensus building.⁵⁹ Please see “Planning Process Steps” in Chapter I for information on assessing the school community health status and available resources.

- ◆ **Evaluation:** Assist with the evaluation of the status of school health, health education, the school environment, and health services. (Required by *Code of Virginia*, § 22.1-275.) Please see “Planning Process Steps” in Chapter I for information on evaluating the effectiveness of a school health program.
- ◆ **Meeting:** Hold meetings at least semi-annually. (Required by *Code of Virginia*, § 22.1-275.)
- ◆ **Student Health Report:** Report on the status and needs of student health in the school division to any relevant school, the school board, the Virginia Department of Health, and the Virginia Department of Education. (Required by *Code of Virginia*, § 22.1-275.)

Note: The Department of Education and Department of Health collaboratively administer the reporting process by administering an annual school health advisory board survey and publishing an annual report of survey findings. The purpose of the annual report is to provide information to state and local policy makers for improving school health programs in the Commonwealth.

For further information about the school health advisory board reporting process and published reports, contact Fran Meyer, Comprehensive School Health Specialist, Office of Special Education and Student Services, Virginia Department of Education, telephone (804) 225-4543.

⁵⁸ Adapted from Virginia Department of Education. (Reprinted November 1995). *A Guide to Establishing and Maintaining School Health Advisory Boards*. Richmond, Va.: Author.

⁵⁹ Adapted from Washington State Core Governmental Public Health Functions Task Force Members. *Core Public Health Functions* (July 1993). Washington, DC.: National Association of County Health Officials.

The 1995 – 96 report, entitled *School Health Advisory Boards: A Report on School Health Advisory Boards in Virginia for School Year 1995 – 96*, published October 1997, is on the web at <http://www.vdh.state.va.us/fhs/child/school/publications.htm>. It is anticipated that future reports will be available at the same web site.

- ◆ **Visibility for School Health:** Provide visibility for school health within the school system and community by communicating to school personnel and community members messages of concern for the health of students and staff.
- ◆ **Parent and Community Involvement:** Promote parent, citizen, and professional involvement in the schools by providing an opportunity for participation by parents in activities and decisions influencing the lives of their children and by serving as a mechanism for involving other community members.
- ◆ **Advocacy for School Health:** Conduct or facilitate activities that bring attention to the relationship between academic achievement and health, including benefits of high-quality school health programs, such as improvement in attendance, decreased tobacco use among students and staff, decreased disciplinary problems, and delayed onset of high-risk behaviors.
- ◆ **Forum for Health Issues:** Provide a positive environment for constructive presentations and reviews of controversial health issues affecting students and school staff that need to have a specific place in the community for discussion, decision-making, and planning.
- ◆ **Recruitment of Community Health Resources:** Coordinate the participation of multiple community individuals and agencies to address a specific need in the school health program.
- ◆ **Facilitate Understanding of Schools and Community Segments:** Provide opportunities for parents and other community members to gain further insight into the life of schools and allow school personnel to learn more about varied backgrounds and views of community segments.

Note: The Virginia Department of Health, Office of Minority Health, is available to provide consultation and technical assistance on improving the health of African-Americans/Blacks, Asian/Pacific Islanders, Native Americans, and Hispanics/Latinos in the Commonwealth through policy development and program analysis.

For further information about minority health, contact Robert L. Bolling, Director, Office of Minority Health, Virginia Department of Health, telephone (804) 786-3561.

- ◆ **Public Relations:** Function as public relations extensions of the school division by informing the community, media, and school personnel about school health program components, goals, objectives, and success.
- ◆ **Facilitate Innovation:** Advocate for the introduction of new or enhanced school health program components by sharing with school personnel special interests or new approaches, providing financial and motivational support for change, and functioning as a sounding board for new approaches.

Resources

For more information on the formation and maintenance of a school health advisory board refer to:

Virginia Department of Education. (1995). *A Guide to Establishing and Maintaining School Health Advisory Boards*. Richmond, Va.: Author.

Involving Parent/Teacher Groups

Overview

Parent and Teacher Groups. Another way to involve the community and parents is through parent and teacher groups, such as the local parent teacher organization (PTO) or local/state chapter of the National Parent Teacher Association (PTA). The PTOs are local organizations with guidelines developed by each local organization. The local PTA chapter is part of the national association and abides by the national association guidelines for Parent Teacher Associations. In Virginia, the state association is called the Virginia Congress of Parents and Teachers. Involving parents and the community through such established organizations as the PTA or local PTO can provide support for a school health program in the form of administrative support, actual personnel to staff the programs, program advocates, and financial support.

National PTA.⁶⁰ Both the mission and objectives of the National PTA are congruent with the concept of a successful school health program. The mission of the National PTA is three-fold:

- ◆ To support and speak on behalf of children and youth in the schools, in the community, and before governmental bodies and other organizations that make decisions affecting children.
- ◆ To assist parents in developing the skills they need to raise and protect their children.
- ◆ To encourage parent and public involvement in the public schools of this nation.

The objectives of the PTA are:

- ◆ To promote the welfare of the children and youth in the home, school, community, and place of worship.
- ◆ To raise the standards of home life.
- ◆ To secure adequate laws for the care and protection of children and youth.
- ◆ To bring into a closer relationship the home and the school so that parents and teachers may cooperate intelligently in the education of children and youth.

⁶⁰ National PTA. (1998, August 7). Our Mission, Objective, and Promise. *Children First Web Site* [Online]. Available: <http://www.pta.org/siteMap.htm>

- ◆ To develop between educators and the general public such united efforts as will secure for all children and youth the highest advantages in physical, mental, social, and spiritual education.

The National PTA ⁶¹ has adopted seven standards for parent/family involvement programs to promote meaningful parent and family participation in schools, to raise awareness regarding the components of an effective program, and to provide guidelines for schools that wish to improve their programs. The following standards reflect the National PTA's commitment to parent involvement in schools: ⁶²

- I. Communicating - Communication between home and school is regular, two-way, and meaningful.
- II. Parenting - Parenting skills are promoted and supported.
- III. Student Learning - Parents play an integral role in assisting student learning.
- IV. Volunteering - Parents are welcome in the school and their support and assistance are sought.
- V. School Decision Making and Advocacy - Parents are full partners in the decisions that affect children and families.
- VI. Collaborating with Community - Community resources are used to strengthen families and student learning.

Recommendation

Ideas for Parent Involvement in a School Health Program. The Health Committee of the Virginia Congress of Parents and Teachers developed the following list of potential ways that parents might be involved in some of the components of a school health program.

1. Health Services
 - ◆ Parents with training in universal precautions can be volunteers for school-based health services.
 - ◆ Parents can drive/walk students to appointments.

⁶¹ National PTA. (1997, August 8). *PTA Guide to the National Standards for Parent/Family Involvement Programs* [On-line]. Available: <http://www.pta.org/programs/stnrdgd.htm>

⁶² Ibid.

- ◆ Parents can assist staff members with non-confidential paperwork.
- ◆ A school nurse (with assistance from the local PTA) can plan and conduct many types of training sessions for parents, including first-aid, disease prevention and control, and injury prevention.

2. Health Education

- ◆ Parents can talk with the school administration about mailing the school board's newsletter to parents.
- ◆ Parents can volunteer to have a regular column on student and family health in the newsletter.
- ◆ Parents can ask teachers to require their students to share articles on health with their parents. (This may meet the challenge of possible parent illiteracy.)
- ◆ Parents can hold parent education workshops for other parents. In doing so, parents should be included in the planning and implementation of the workshops.
- ◆ Parents can help provide incentives to encourage attendance at the workshops (e.g., providing transportation to the workshops, child-care during the workshops, and food/refreshments for the participants).
- ◆ Parents can help with publicizing the events (e.g., school newsletters, PTA newsletters, menus, phone tree, television, radio, through homeroom/health classes, use of case workers).

3. Physical Education

- ◆ Parents (through the local PTA) can help sponsor awards for participation in sports that also encourage academic excellence (for males and females). Parents may want to sponsor "most improved" awards.
- ◆ Parents can work with the school's physical education department to plan and/or implement field days and "athletic" festivals, class/grade/school dance performances, or events.
- ◆ Parents can volunteer with the school's athletic department to work at track meets and swim (or other) classes.

4. School Nutrition Services

- ◆ Parents can work with the school personnel to establish a parent-student school nutrition committee (or subcommittee to the local school health advisory board) to help the nutrition services staff promote good nutrition practices.

-
- ◆ Parents can work with the school administration to invite other parents to eat at school with their children at least twice a year.
 - ◆ Parents could help the school establish a “lunch buddy” program where parents (or other professionals, community members, or other role models) could eat lunch on a regular basis (once or twice a month) with assigned students. These role models may give support and encouragement to students on a one-on-one basis.

5. Counseling and Psychological Services

- ◆ In most cases, parents should be involved in any counseling and psychological services provided their own children (unless it is determined that it is not in the best interest of the student).
- ◆ Parents may assist school staff members in non-confidential paper work.
- ◆ Parents may drive/walk students to appointments.
- ◆ Parents and school staff members may collaborate to plan and implement training sessions for other parents.

6. Healthy School Environment

- ◆ The local PTA, or other parent group, can work with the school administration to conduct an evaluation of the school environment (grounds, ventilation, handicap accesses, crosswalks, safety features, and so forth).
- ◆ Parents can develop a school-sponsored project to improve some aspect of the school’s environment. However, local PTAs are discouraged from raising large sums of money for such projects. An alternative is to develop a business-PTA partnership to fund the project and/or arrange for volunteer labor. Parents can work with the local school board to fund projects to improve the school grounds and facilities. It is also important to be aware of tax laws related to these projects.

7. Staff Wellness Programs

- ◆ Parents can work with school personnel to establish school staff wellness programs.
- ◆ Parents can volunteer to assist in sponsoring staff health screenings.
- ◆ Parents can work with a school committee to plan and implement parent/staff/student wellness nights.
- ◆ Parents can sponsor incentives for on going parent/staff “health improvement” programs (e.g., smoking cessation, weight control, exercise programs, and so forth).

Developing Partnerships

Overview

Introduction. Many local school divisions do not have the resources to provide the type of school health program that the community needs. The school health program team should look outside the school division to meet these needs. These outside avenues may include the development of a partnership with other community organizations.

Potential Partnerships. Potential partnerships that the school division might explore include nonprofit agencies, corporations, or managed care organizations. Examples of partnerships are summarized below.

- ◆ **Nonprofit Agency.** A partnership could be developed with a nonprofit agency, such as the American Cancer Society (ACS). ACS has a strong school health division that has many volunteers and educational programs which include printed materials, videos, posters, and handouts. If a school division has a need for education on the ills of tobacco or how to reduce risk factors in elementary school children, then ACS could help with that need.
- ◆ **Corporate.** A corporate partnership could be developed with a large corporation with large numbers of employees who have children in a school division. The corporation may be willing to fund specific project or provide the expertise and staff for a school health program.
- ◆ **Health Maintenance Organization.** A school division entering into a partnership with health maintenance organization to manage a school-based health center is an example of a partnership with a managed care organization.
- ◆ **Local Small Business.** Employees of a small company could read to students.
- ◆ **Local Civic Organizations.** A senior citizen group could team with students to be “lunch buddies.”
- ◆ **Individuals.** Parents with medical backgrounds (e.g., nurses) could volunteer to assist with screening programs.

Recommendation

Guidelines for Developing New Partnerships. The following guidelines are key concepts when developing a new partnership.

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- ◆ **Involve All Key Players** - Involve all persons who have a stake in the proposed program to include organizational representatives, influential people in the community, and children and families who will be affected by the program.
 - ◆ **Choose a Realistic Strategy** - Choose a strategy that reflects the level of commitment by all partners. The potential partner may not be ready for a true collaborative relationship but would rather commit to a cooperative relationship. For example, a local health department may be able to provide nurses two days a week to assist with immunizations for a school health program. This level of commitment could be used to build trust and a sense of accomplishment that could lead to a more ambitious collaborative commitment.
 - ◆ **Establish a Shared Vision** - When partners share a vision of the issues and priorities concerning school health, it is much easier to establish common goals and objectives. The shared vision may occur over time through cooperative partnerships that lead to a collaborative relationship.
 - ◆ **Agree to Disagree in the Process** - Develop a communication process that provides the means to express disagreement. This conflict and its resolution may help the program to move forward rather than becoming bogged down in a process.
 - ◆ **Make Promises You Can Keep** - Create momentum and a sense of accomplishment through setting attainable goals.
 - ◆ **“Keep Your Eyes on the Prize”** - It is important to maintain momentum by focusing on the long term goal and not becoming bogged down in the daily conflicts.
 - ◆ **Build Ownership at All Levels** - Include representatives from involved agencies and keep all staff members informed of changes.
 - ◆ **Avoid “Red Herrings”** - Maintain focus on the goal and work out technical difficulties after objectives have been identified.
 - ◆ **Institutionalize Change** - Objectives developed from the partnership must be incorporated into the institution’s organization so that proposed changes can endure.
 - ◆ **Publicize Your Success** - Publicizing successful results can lead to attracting more funding and opportunities for more innovation.

Funding Sources and Reimbursements. When looking for partnerships, the school division is also looking for funding sources. The funding source may be in a partnership, but it may also come from other sources. Funding sources may include, but are not limited to, the following:

- ◆ Grants from state agencies.
- ◆ Grants from nonprofit organizations, such as the March of Dimes, American Cancer Society, American Heart Association.
- ◆ Centers for Disease Control and Prevention, Division of Adolescent and School Health (CDC/DASH).
- ◆ Local businesses.
- ◆ Large corporations.
- ◆ Internet (search for sponsors or partners that may be interested in a specific part of a school health program). For example: the CDC's School Health Program Finance Project database contains information on federal funding sources for school health programs. Plans are underway to add state-specific and foundation funding information. The internet address is <http://www.cdc.gov/nccdphp/dash/funding.htm>.
- ◆ Local Parent Teacher Association.
- ◆ Medicaid reimbursement.

The Coordinator Role. In most school divisions, the school health coordinator is a school nurse or an administrator with direct responsibilities for school health. The school health coordinator oversees the implementation of the school health services plan and coordinates school health services with the other components of the school health program. Therefore, the role of the coordinator is important in the development and implementation of partnerships. For example, the school health coordinator can provide leadership by coordinating school health services with community-based medical and mental health providers, school-based or school-linked health center staff (if one exists), and local public health officials. The coordinator can act as a liaison between the schools and public health staff and local health care providers who can provide consultation on issues involved with students with special health care needs, school wide health, and health policy. In addition, the coordinator can involve local health care providers in the planning, implementation, and evaluation of programs as well as in policies to develop them.⁶³

Example of a Partnership: School-Based Health Centers and Managed Care Organizations. An example of a partnership in a school health program is between a school-based health center and a managed care organization. When developing a partnership with a managed care organization, the following principles developed by a

⁶³ Marx, E., and Wooley, S.F. (1998) *Health Is Academic: A Guide to Coordinated Health Programs* (pp. 184-185). New York, N.Y.: Teachers College Press.

national workgroup on structuring the relationships between school-based health centers and managed care organizations should be considered.⁶⁴

- ◆ Principle 1: Common Mission - The school health program and the organization with which the partnership is formed should have a common mission. For example, a partnership between a primary care delivery service and a school-based health center may have the common mission to promote quality of care by increasing access to care and providing risk-reduction services, user satisfaction, and early intervention.
- ◆ Principle 2: Scope of and Authorization for Services - When developing the partnership, the scope of services or what services each party will provide and how those services will be authorized should be defined in writing in a contract.
- ◆ Principle 3: Linkages Between the Partners - Each partner should commit to ongoing communication and mutual assistance to ensure quality of care. A policy should be developed to define the frequency and type of communication
- ◆ Principle 4: Linkages Between Agencies Outside the Partnership - Any linkages between agencies outside the partnership (e.g., laboratories, pharmacies, or referrals) should be specified in writing.
- ◆ Principle 5: Confidentiality - Each partner should commit to ongoing collaboration to ensure that confidentiality is maintained.
- ◆ Principle 6: Quality Improvement - Both partners should commit to the development and maintenance of quality improvement. This may include a joint approach to data collection, agreed-upon standards of practice, assessments, and joint mutual utilization review.
- ◆ Principle 7: Reimbursement - A formula for reimbursement should be determined between the partners and specified in writing in a contract.

Resources for Establishing a Partnership Between a School-Based Health Center and Managed Care Organization. Many programs are being developed to facilitate the development of partnerships between managed care organizations and health care providers, such as a school-based health center. “Making the Grade” is a national program of the Robert Wood Johnson Foundation located in the School of Public Health at George Washington University. This national grant program supports state and local

⁶⁴ *A Partnership For Quality and Access: School-Based Health Centers and Health Plans.* (1996). School Health Initiative Policy: New York, N.Y.. A Special Report on the 1995 Work Group Meetings.

partnerships to establish school-based health centers and includes information on developing partnerships with managed care organizations. Information on “Making the Grade” can be obtained by contacting:

Making the Grade
Suite 505
1350 Connecticut Ave., NW
Washington, D.C.
(202)466-3396
(202)466-3467 fax
<http://www.gwu.edu/~mtg>

Building Support for School Health Programs

Overview

Introduction. One of the biggest benefits of a successful school health program can be a closer working relationship between parents and schools. Working with parents, businesses, local health officials, and other community groups, a school can form powerful coalitions to address the health needs of students.

A successful approach to school health programs may look very different in each school, district, community, town, city, or state in which it has been implemented. And while developing the elements of a school health program may seem difficult at first, the reality is that many schools and communities across the country are already utilizing some of the eight components. What's more, when parents, teachers, students, and dedicated members of the community work together and make a commitment to put these different elements in place, the results can be powerful.

School Health Starter Kit. To help policy makers and their staff help schools and communities build support for a coordinated approach to school health, the Council of Chief State School Officers (CCSSO) and the Association of State and Territorial Health Officials (ASTHO) have prepared a "Starter Kit," which is summarized below. The materials are based on the premise that a coordinated approach to school health will make a significant contribution not only to individual students, but also to entire communities, and that these initiatives will clearly demonstrate that *healthy kids make better students and better students make healthy communities*.

The *School Health Starter Kit* materials were developed under contract with two researchers and marketing firms. Both qualitative and quantitative research methods were used to test and refine these materials. Messages found to be effective with target audiences were integrated into the materials. Based on the initial research, a set of prototype materials was developed and reviewed by groups of state health officials, chiefs, and the target audience of parents, teachers, and administrators.

Readers may find excerpts from the *School Health Starter Kit*, which are presented on the following pages, helpful in building support for coordinated school health ensuring healthy successful outcomes for all students.

For additional information about the materials or to order the *School Health Starter Kit*, please contact either of the following persons:

Darcy Steinberg, ASTHO
Director, Adolescent and
School Health Policy
Telephone: (202) 371-9090
Email: dsteinberg@astho.org

Nora Howley, CCSSO
Acting Project Director,
HIV/School Health
Telephone: (202) 336-7033
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Why Support a Coordinated Approach to School Health?

(Source: excerpted verbatim from the *School Health Starter Kit*)

Healthy Kids Make Better Students. Better Students Make Healthy Communities

Why Support School Health?

The Need

The statistics are alarming.

(All statistics in the *Starter Kit* are cited in the Reference Section under *Data Sources*.)

- ◆ **Alcohol Abuse**
In 1997, almost 1 in 3 12th graders, 1 in 4 10th graders, and 1 in 10 8th graders reported heavy drinking (at least 5 drinks in a row).
- ◆ **Tobacco Use**
From 1991-1997, cigarette smoking increased 90% among black high school students, 34% among Hispanic high school students, and 28% among white high school students.
- ◆ **Poor Nutrition**
At least 11% and possibly as many as 25% of US children and adolescents are overweight.
- ◆ **Mental Well-Being**
Nationwide, 1 in 5 students grades 9-12 has seriously considered attempting suicide.
- ◆ **Substance Abuse**
26% of all 12th graders, 23% of 10th graders, and 13% of 8th graders report using illicit drugs.
- ◆ **Violent Crimes**
Youth aged 12-17 are nearly 3 times more likely than adults to be victims of serious violent crimes.
- ◆ **Suicide**
Suicide is the #3 cause of death among 15-24 year olds.
- ◆ **Sexually Transmitted Diseases**
Every year, 3 million adolescents become infected with an STD.
- ◆ **Unintentional Injury Deaths**
Motor vehicle accidents are the number one cause of death among teens. Almost 50% of these are alcohol related.

Now, would you be willing to consider that a lot of these problems—perhaps even most of them—are actually health-related? What’s more, issues like these affect not only our children’s health, but also their ability to learn. Pretty sobering, isn’t it?

As a parent, teacher, school administrator, or health professional, you're probably already concerned about these trends. The simple fact is that for kids to succeed in school, they cannot be hungry, tired, hung over, or worried that violence may erupt at any moment. Kids need a warm place to sleep, nutritious food to eat, people who love them, and a strong sense of personal self-worth. That's only a partial list, but a pretty hard one to fill for many kids in today's complex world.

It's also the very reason to get your community involved—now!

The Opportunity

Schools could do more than perhaps any other single institution in society to help young people, and the adults they will become, live healthier, longer, more satisfying, and more productive lives.

Carnegie Council on Adolescent Development

It's big. Every school day, approximately 46 million students attend more than 100,000 schools across the U.S. That's a fact. What's more, these schools—working closely with parents and communities—have an unparalleled opportunity to make a significant contribution to the health and education of our nation.

But it can only happen if you and those around you take the lead. Schools can play an important role in the process—after all that's where the kids are for a large part of their day. However, the primary responsibility for kids' health belongs to parents. So get those around you involved. The steps we take today will help build the community of tomorrow.

The Starting Point

Coordinated School Health (CSH) is a powerful approach to recognizing and addressing the close relationship between health and learning, and provides opportunities for students to know and practice the health and learning skills they'll need throughout their lives. A coordinated approach to school health recognizes that healthy kids make better students, and better students make healthy communities.

By integrating health topics and activities throughout the curriculum and during the course of the school day, CSH aims to keep kids healthier over time and support their capacity to learn. School health is also about empowering students with the knowledge, skills, and judgment to help them make smart choices in life. Every community will have its own individualized approach to developing and implementing a coordinated approach to school health.

The Benefits

Many schools across the country have already developed their own customized approach to Coordinated School Health. People in different parts of the country who have implemented a coordinated approach to school health report one powerful element in common—results! Some are big, some small.

- ◆ Reduced school absenteeism.
- ◆ Fewer behavior problems in the classroom
- ◆ Improved student performance—higher test scores, more alert students, and more positive attitudes among students
- ◆ New levels of cooperation and collaboration among parents, teachers, school and health officials, and organizations within the community
- ◆ A more positive spirit among educators and their students
- ◆ Young people who are more prepared to become productive members of their communities and who can better cope with the world around them

Because of its nature as an approach rather than one distinct program, the impact of a coordinated approach is difficult to fully evaluate. However, we do know from research that efforts involving schools and communities can reduce risky behaviors, such as smoking, drinking, and drug use. Some evaluated efforts have helped kids learn to eat well, exercise more frequently, or improve their school performance. Others have decreased fighting at school, cut down on course failure, lowered rates of teen pregnancy, and/or decreased depression and suicidal behavior.

About This Kit

The Goal

This is your official (yes, official) CSH *Starter Kit*. It is not available in stores. It is only available to those individuals who are committed to improving a school's approach to health.

It explains lots of things, such as:

- ◆ How to get started.
- ◆ How to identify changes that can be made.
- ◆ How to organize support for those changes.

This *Kit* also:

- ◆ Discusses many of the barriers to change and how to overcome those hurdles.
- ◆ Includes materials (both hard copy and on CD-ROM) to support your efforts—including fact sheets and talking points.
- ◆ Contains real world examples of how changes have been made in other schools.
- ◆ Provides additional resources to help you establish a coordinated approach to school health.

What this *Kit* does not do is tell you exactly what your coordinated approach should look like. Each school is special; each community is unique. Similarly, each school's approach to health must be customized to meet its local strengths, needs, and regulations.

Adopting a coordinated approach doesn't mean changing everything overnight. The goal of this *Starter Kit* is to help you get started. The Council of Chief State School Officers (the leaders of state departments of public education) and the Association of State and Territorial Health Officials (the leaders of state health departments) sponsored the publication under a cooperative agreement from the Centers for Disease Control and Prevention in response to requests from parents, teachers, and administrators across the country who wanted assistance in developing a more coordinated approach toward school health.

We had hoped to make this document shorter, but the topics are so rich and the approaches so diverse, we wanted to give you the benefit of having all the “tools of the trade.”

To truly succeed in bringing a Coordinated School Health approach to communities nationwide, most of us also recognize that the public must believe that both educators and public health officials are committed to addressing their concerns about children's health and education. For that very reason, we also have developed a companion piece to this *Kit*, which has been produced specifically for policy makers and opinion leaders. The booklet for Policy Makers and Opinion Leaders explains the importance of a coordinated approach and provides suggestions about what leaders can do to support it.

Great Ways to School Health

A Coordinated School Health approach is designed to help young people grow into healthy and productive adults by focusing on the physical, emotional, social, and educational development of kids in kindergarten through 12th grade. It strives to provide students with the information and skills they will need to make good choices in life. An effective school health plan works in partnership with parents and extends out into the community. First and foremost, it recognizes that health and learning go hand in hand. Let's get more specific and see how it might work. A coordinated approach to school health can address many aspects of health and education. Included below are some practical examples of each component.

Eight Components Can Be Great...Two or Three Can Be a Super Way to Start!

1. School Environment

To learn effectively, children must be in a school environment in which they feel comfortable and supported. It is also important that parents and other adults working with kids have high expectations about learning and provide support. In addition, the building must be safe, the heat, lighting, and water must function properly, the bathrooms must be clean and safe, and students must observe general rules of conduct—all of which, combined in a coordinated approach to school health, will minimize distractions and maximize students' learning potential. For instance:

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- ◆ Education and administration staff could coordinate with parents and school counselors to hold workshops on conflict resolution and peer pressure resistance to help make schools safer places for students.
 - ◆ School policies can be implemented and enforced to prohibit tobacco, alcohol, and drug use on school grounds.
 - ◆ Community businesses—working with parents, students, educators, and school officials—can undertake a joint effort to help repair older schools, perhaps with repainting, updating bathroom fixtures, or improving physical education equipment to help create a more suitable learning environment.

2. Health Education

School staff—teachers, nurses, administrators, or counselors—can work together to develop an ongoing approach to helping students build health-related knowledge and skills starting in kindergarten and continuing through 12th grade. This effort can play an important role in helping students make healthy lifestyle choices. For example:

- ◆ A health education teacher could incorporate a mix of activities and role playing to teach conflict resolution, refusal skills, or the dangers of alcohol, drug, and tobacco use.
- ◆ The cafeteria can provide opportunities to try healthful foods (which could be discussed in class and reinforced in posters displaying a range of healthy behaviors).

3. School Meals and Nutrition

Many students eat one or two meals a day at school. Thus, schools have the opportunity to examine their meal programs and revamp them to offer more nutritious food, as well as develop coordinated educational activities and projects to encourage students to make healthy eating and good nutrition a priority for life. You may want to consider these suggestions:

- ◆ Parents, students, and school staff can partner to select healthy menus for the cafeteria.
- ◆ Schools can focus on healthy food choices in vending machines.
- ◆ Schools can adopt healthy snack policies for elementary school celebrations.

4. Physical Education

Unfortunately, more American children are obese than ever before. Schools can and should encourage students to lead a physically active lifestyle both in and out of school. One way to start is to emphasize the importance of regular exercise as a lifelong activity. A strong, coordinated effort by schools can have a big impact on the sedentary lifestyles of children. For instance:

- ◆ Develop a calendar of sports activities, not just to turn out star athletes and winning teams, but also to act as a catalyst to building self-esteem, motivation, and leadership skills, and to reduce stress and depression.
- ◆ Challenge parents, teachers, and students to learn the advantages and fun of physical fitness and incorporate these lessons into their daily routines.

5. Health Services

Growing kids require a regularly scheduled health “maintenance” program—including immunizations, dental checkups, physicals, eye exams, other types of screenings, and, in certain instances, daily medication for students with specific medical problems. With the help of health professionals and the local health department, schools can encourage the provision of preventive services that enable students to take proactive measures to stay healthy and get more out of school. Plus, a coordinated approach can benefit busy parents. In some communities, school-based health centers are the only place for kids to access health services. In other communities, kids may have access to regular medical care but it may make sense to provide certain screening and preventive services at school.

- ◆ Parents, schools, health care personnel, and Medicaid can work together to provide critical preventive care.
- ◆ Health departments and communities can be encouraged to sponsor immunization campaigns for students and teachers.
- ◆ Nurses can work with students who have chronic health problems, such as asthma, to help manage symptoms and reduce time lost from school.

6. Counseling, Psychological, and Mental Health Services

In addition to a student’s physical well-being, his or her mental health can be effectively addressed through a coordinated approach to school health. Today, many students have the added stress of coping with emotional challenges stemming from problems such as parental divorce, alcoholism, abuse, and drug addiction. By offering counseling and other mental health services to students, as well as referrals to community mental health professionals, schools can help parents take a big step toward making an even greater difference in a student’s total performance, healthy development, and well-being. Consider:

- ◆ School counselors, social workers, psychologists, and other professionals help develop positive learning environments and positive behaviors by consulting and problem solving with students, families, and teachers.
- ◆ Schools can provide counseling, other mental health services, and referrals to community professionals to support students and their families. Students will get much-needed help, and parents and teachers will benefit because students can focus on learning.
- ◆ Staff can offer parents the opportunity to attend counseling sessions and support groups along with their children and can develop a local community network so that referral services can be made as soon as a problem is identified.

7. Staff Wellness

Students aren't the only ones who need to stay in good health. Educators and school staff are important role models for students. Successful schools have healthy, highly motivated staff with low rates of employee absenteeism. Schools can consider enacting a number of activities to make sure that teachers and staff feel their best and perform at peak levels. Such efforts can include:

- ◆ Seminars, established by the administration and health department staff, on topics such as stress reduction, smoking cessation, physical fitness, and more.
- ◆ Simple health screenings, such as blood pressure, so that staff can identify early symptoms of disease.

8. Parent/Community Partnerships

One of the biggest benefits to a coordinated approach to school health can be a closer working relationship between parents and schools. Working with parents, businesses, local health officials, and other community groups, schools can form powerful coalitions to address the health needs of students. For example:

- ◆ Parents should be encouraged to participate in coordinated school health planning and oversight committees.
- ◆ Community members with special skills can be asked to teach certain health units—such as dietitians focusing on food choices.
- ◆ School facilities can be opened to the public during non-school hours for physical activity and fitness sessions, as well as family health seminars and social and recreational functions.
- ◆ School facilities can also be used as satellite clinics and social service offices during non-school hours.

At first, developing and implementing a coordinated approach to school health may seem difficult. But in reality, many schools and communities are already utilizing some of the eight elements of CSH today. These first steps can form the building blocks to more actively include parents, teachers, administrators, and others in creating additional momentum and ultimately making a difference in the lives of kids all around us! When people work together to put these different elements in place, it adds up to results. Helping kids succeed in school and make smart choices for life is a challenge, but bringing together the resources of parents, the community, and the schools gives us a fighting chance to make sure all kids succeed.

Make It Happen!

You see, there really are no set rules on the topic of a coordinated approach to school health. The options are virtually limitless, and so are the possibilities. So consider what might work best in your local environment and get started-soon! Plus, a coordinated approach to school health can take place without spending additional dollars. “Sweat equity” works just fine.

The school principal or chief administrator is a key player. In schools where family partnerships flourish, the principal has usually taken the first steps towards better communication and collaboration

Don Davies
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Your School Today

Now that you’re concerned about school health and wondering how to make a difference...here is how you can start.

Most schools and communities are already implementing some form of the eight great components of a coordinated approach to school health. To get your school started, you really need to get a snapshot of what’s already happening in your school and community as well as to identify those resources—human, physical, and capital—you can utilize. In other words, it’s a good time to ask a lot of questions.

What’s Happening?

Here are some good questions, for starters...

- ◆ What types of health programs exist?
- ◆ Are there connections among different health program efforts?

- ◆ What's working and what's not working?
- ◆ What's missing?
- ◆ What would truly make your approach to school health a coordinated one?

Step One: Assess

As a first step, it is important to assess the strengths you have to build on around you. Study your local, community, city, and state policies and public health mandates to determine what the law says is necessary in terms of school health. Assessments sometimes involve interviews with key people, written questionnaires distributed to others (including parents, principals, teachers, and staff), and a review of current curriculum, materials, and existing school/community efforts. School districts and local health and education departments collect lots of data on the education and health status of children.

These data can be helpful in assessing community and school health needs. Collect available local data by talking to local officials to determine the health status of children in your community. You may also want to review files of local media articles on the subject through the local library, or conduct a search on the Internet. Take a look at what parts of school health have been publicized and note the names of local or state reporters who write on education, school, and health issues.

Step Two: Identify

Second, you will want to identify those components of a coordinated approach that already exist. At the same time, you may want to determine the level of community support for school health from such sectors as:

- ◆ Parents
- ◆ Religious organizations
- ◆ Public health departments
- ◆ Social service agencies
- ◆ Business
- ◆ Government
- ◆ Mass media/reporters
- ◆ Youth organizations
- ◆ Community groups
- ◆ Health care providers and health organizations

Keep in mind that your state and local departments of education and health can be super resources and key allies in this mission. Check with them to see what they are already doing with mental health departments or offices that administer substance abuse programs. Plus, it is a very good idea to talk to parents, teachers, business leaders, nurses, social workers, psychologists, drug and alcohol prevention coordinators, and others to see how they could be active in, and supportive of, a coordinated approach to school health.

You're probably wondering how to make sure you don't miss anyone important. Short of calling everyone in the phone book, consider the "snowball" method. Conduct interviews with people who represent organizations or constituencies that are respected in the community. Explain what a coordinated approach to school health means for students and

the community, and explore those individuals' views on what role their organization might play in supporting necessary changes. At the end of the interview, ask subjects for names of other organizations or individuals that could potentially contribute to improving school health.

The results? One, you'll really spread the word about CSH. Two, you will begin to hear the same types of groups mentioned repeatedly. Three, you'll realize that you've probably identified and familiarized yourself with the key players who can help make a difference on school health. This represents a large chunk of important work that you've already accomplished!

Step Three: Build School Support

CSH will certainly look different in each school. The needs, issues, and concerns of elementary school students and their families differ dramatically from those of older students and their families. Middle and high school students may be grappling with depression, substance abuse, anger, STDs, HIV, unintended pregnancy, and other pressing health issues. The goal is to identify the most pressing child and adolescent health problems in the local community.

Further, health issues in urban areas often differ greatly from those in suburban and rural areas. Plus, certain health and safety issues—such as floods, earthquakes, tornadoes, lead poisoning, hazardous dump sites, and more—depend on geographic location.

Regardless of the issues, regardless of the location, one element is essential to a coordinated approach to school health: a school principal or assistant who recognizes the importance and value of such an effort. The principal is a key opinion leader and his or her words and actions set the tone for the entire school.

Other opinion leaders to include in building a consensus for school health are:

- ◆ Parents
- ◆ Teachers
- ◆ Counselors
- ◆ School board members
- ◆ Social workers
- ◆ Psychologists
- ◆ Nurses
- ◆ Food service directors
- ◆ School volunteers
- ◆ Drug and alcohol prevention coordinators
- ◆ Physicians
- ◆ Health department administrators and staff
- ◆ State or local voluntary health organization executives

Step Four: Overcome Objections

As you move forward in this process, you may run into some people who are opposed to CSH. To help prepare yourself to persuade those who may be opposed to a coordinated approach to school health, think about the following questions:

- ◆ What are some of the common misconceptions people have about a coordinated approach to school health?
- ◆ What problems do they have with the concept of a coordinated approach?
- ◆ What are the differing views about how these programs will affect children, parents, and the community?
- ◆ Which parts of the coordinated approach present a problem?
- ◆ What needs do those who object to school health have that a coordinated approach might fill?

Step Five: Put It All Together

Once you've covered Steps 1 through 4—which isn't an overnight process by any means—you should have:

- ◆ An assessment of what is and is not happening in school health in your area.
- ◆ Knowledge of community support groups, organizations, and influential individuals, including officials from the departments of health and education.
- ◆ A more detailed view of what constitutes a coordinated approach to school health.
- ◆ A list of media contacts who may be interested in covering the topic (and hopefully building support).
- ◆ An awareness regarding who may be opposed to CSH and how you may address their concerns

Schools offer the most systematic and efficient means available to improve the health of your and enable young people to avoid health risks...

Healthy People 2000
U.S. Public Health Service

Your Community Tomorrow

Start Slow, Build the Base

Now that you have a good read of who in the community is doing what in terms of school health and which issues are on the top of the priority list, it's time to:

- ◆ Identify where to start.
- ◆ Select those individuals, groups, or organizations that are most supportive of the coordinated approach and would be most receptive to working with you.

In terms of a starting point, carefully consider which issues and programs are important, but also identify those which may require the least amount of resources—both human and financial—to implement fully and successfully. It’s important to register a few “wins” early to really get the team and “fans” psyched for a strong season.

Ask Questions to Help Set Priorities

Only you and your colleagues can determine where to begin. Keep in mind that most of us are somewhat resistant to change. It is often a jolting experience. The following group of questions is designed to help you analyze how easy or difficult change will be to implement.

- ◆ How much time and commitment—money, personnel, and materials—will making the change require?
- ◆ Is the change “better”—faster, cheaper, and more beneficial—than the existing way of doing things?
- ◆ To what degree is the change consistent with existing practices, values, and political realities?
- ◆ How complex is the change and how many people (e.g., one department or multiple departments) will be involved in the process?
- ◆ How easy is it to describe the change you envision?
- ◆ Do the benefits—tangible and intangible—outweigh the costs?
- ◆ How much risk and uncertainty does the change involve?
- ◆ Can parts of the change be made over time? Can it be modified to fit the individual school or classroom?
- ◆ Can the elements be modified or “undone” if the desired results are not achieved?

In short, build community confidence. This strategy will help you and your colleagues build a critical mass of support that will carry you through the larger and potentially more controversial issues that need to be undertaken at a later date.

Building support for a coordinated approach will require a multifaceted effort. The following section is designed to provide guidance on how to set up an appropriate structure and how to begin once it is in place.

Step 1: Design a Structure

Successful school-community partnerships can exist on many levels, including the school, district, or state. They can be configured as task forces, coalitions, advisory

committees, or subcommittees to existing groups. Carefully consider the organizations in your community and where they stand on school health to determine if you can work through an existing group, or if you need to establish a new group to address school health.

Regardless of whether you approach school health by working within an existing group, or by forming a new entity, when you recruit members be certain to:

- ◆ Identify the skills and expertise group members will need.
- ◆ Target individuals and/or organizations that have some of the following attributes:
 - Interest in and commitment to the issue.
 - Familiarity and experience with the political system.
 - Credibility in the community.
 - Financial or in-kind resources or fundraising ability.
 - Contacts with other potential allies.
- ◆ Take time to get to know potential members; make certain there is a good match between skills and needs.
- ◆ When you invite people to participate, make sure that they understand how much involvement you expect.
- ◆ Build support in the community through media relations, using the CSH posters developed for this effort, the PowerPoint presentation, and the media tips, all of which are part of the Resource Section of this *Kit*.
- ◆ Develop a leadership structure and set of operating procedures—once the group is established. You'll need:
 - A chair to lead the group and an agenda for the group.
 - A mission statement with goals and objectives.
 - Rules of operation (such as how often the group will meet, how decisions are made, how the work will get done, rules of attendance, who has authority to speak on behalf of the group, and more...).
 - Recognition procedures (coalition versus individual credit).

In short, you'll need a formal structure, which will enable you to accomplish more and extend your power base.

Step 2: Determine Priorities

Once you have formed your group, your next major activity is to determine priorities. Again, the worksheet found in the back pocket of this *Kit* entitled, Questions to Help Set Priorities, may prove helpful in terms of focusing on what changes you want to enact and in what order. Activities that will bring you “small wins” are often a good way to prioritize issues, especially when you may be challenging the way business is normally conducted in your community or school.

Examples of things you can do to gain support initially include:

- ◆ Convene a meeting of representatives of organizations that are concerned with child nutrition (e.g., maternal and child health office in the health department, local PTA/PTO, local dairy council affiliate) and engage them on the issue of nutrition in schools in relation to USDA dietary guidelines.
- ◆ Conduct presentations for local service organizations in your community regarding the health status of children and adolescents using local data you have collected.
- ◆ Access national reports, such as the Carnegie Foundation report on middle schools called “Turning Points,” and use information in presentations to show the importance of school health to education reform.
- ◆ Enlist the help of local pediatricians and/or family practice physicians who can attest to the kinds of health problems they confront in children and adolescents and how school health can help address these problems.

For a longer list of activities, review the information following each chapter of the book *Health Is Academic*.

Step 3: Start to Make It Happen

Now that you have selected key changes to make in school health, approach those groups you have previously identified for participation and/or support. The goal is twofold:

- ◆ Educate them about the advantages of a coordinated approach to school health.
- ◆ Present concrete steps they can take to support the approach and get involved.

Don't forget to celebrate your successes. Over time, as different parts of your community begin to see the tangible benefits of a coordinated approach to school health, you can build on your initial wins and work toward more.

As in any effort of persuasion, carefully consider the benefits of school health to each group you approach. For example:

Parent Organizations

A coordinated approach to school health also reinforces the role of parents in teaching their children to make smart choices for life. Further, it makes certain that parents fully understand how important it is for schools to provide a safe, healthy, and supportive environment conducive to learning.

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- ◆ Ask the local PTA to request school health literature from the national PTA and set up a committee to generate recommendations for implementing coordinated school health locally
 - ◆ Invite the local PTA/PTO to sponsor parent education forums on child/family health issues and include a message on the role of the school in child health

Business Leaders

A strong coordinated approach to health in local schools will help prepare today's students for entering the workplace tomorrow. It also will support working parents by reducing demands on them caused by student absenteeism resulting from illnesses and health care needs.

- ◆ Ask a local hospital or health insurance company to sponsor a health event such as a health fair in the schools.
- ◆ Contact organizations of businesspersons such as the Optimists or Lions Clubs who have national campaigns on adolescent health issues (i.e., drug abuse prevention, mental health) and ask them to support local school health efforts.

Voluntary Health Organizations

A coordinated approach to school health is consistent with and supportive of the mission of these organizations because it emphasizes the importance of students learning to reduce risk factors associated with poor health and mortality.

- ◆ Ask the local American Lung Association affiliate to co-sponsor a family asthma program with schools and local health care providers.
- ◆ Invite the local affiliate of the American Cancer Society to implement a local version of their national campaign to promote a coordinated approach to school health education.

School Administration and School Boards

School health efforts can improve classroom behavior and attendance, as well as teacher and staff morale, while reducing student absenteeism.

- ◆ Invite the school board to appoint a representative to a community task force studying child and adolescent health problems and solutions.
- ◆ Identify superintendents, principals, or other school administrators (e.g., curriculum directors, human resource directors, and food service directors) who are positive health role models and ask them to implement health-related initiatives through their schools or departments.

- ◆ Ask school boards to pass local school district versions of state or federal health regulations, such as smoke-free facilities policies.

Health Departments, Departments of Mental Health and Substance Abuse

School health activities can help state and local health departments and departments of mental health and substance abuse achieve health promotion and improvement plans, such as Healthy People 2000/2010.

Healthy People 2000/2010 is the prevention agenda for the nation. It is a statement of national opportunities—a tool that identifies the most significant preventable threats to health and focuses public and private sector efforts to address those threats.

Health and education agencies share the common goal of improving and protecting the health and well being of young people, so collaboration should be encouraged at all levels.

- ◆ Invite representatives from your health department to serve on your school health committee or coalition.
- ◆ Ask your state health agency to help you implement or evaluate your school health efforts. Ask your health and education departments to create joint efforts that support your community's health and education objectives.

For today's kids to succeed, they need to learn to read, write, and understand math. But they can't learn effectively if they're hungry or tired. They can't study if they're using alcohol, marijuana, or other drugs. They can't concentrate if they're suffering from stress, depression, or concerns about violence.

A coordinated approach to school health is a powerful way of reinforcing positive, healthy behaviors throughout the school day to make it clear that good health and learning go hand in hand. In fact, most people agree that healthy kids make better students and better students make healthy communities.

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Obesity affects 1 in 5 children in the U.S.

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Each day, 3000 children start smoking—1 every 30 seconds.

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1 in 3 high school students reports having consumed 5 or more drinks in a row.

Centers for Disease Control and Prevention. (1998). *CDC Surveillance Summaries*. August 14, 1998. MMWR 1998, 47 (No. SS-3).

Every 4 hours a child in America commits suicide.

Children's Defense Fund. (1998). *The State of America's Children Yearbook 1998*. Washington, D.C.

Alcohol Abuse: In 1997, almost 1 in 3 12th graders, 1 in 4 10th graders, and 1 in 10 8th graders reported heavy drinking (at least 5 drinks in a row).

Federal Interagency Forum on Child and Family Statistics. (1998). *America's Children: Key National Indicators of Well-Being, 1998*. U.S. Government Printing Office, Washington, D.C.

Tobacco Use: From 1991-1997, cigarette smoking increased 80% among black high school students, 34% among Hispanic high school students, and 28% among white high school students.

Centers for Disease Control and Prevention. (1998). *Tobacco Use Among High School Students-United States, 1997*. MMWR 1998, 47 (No. 12), 229-233.

Poor Nutrition: At least 11% and possibly as many as 25% of U.S. children and adolescents are overweight.

Hill J.O., Trowbridge, F.L. (1998). *Childhood Obesity: Future Directions and Research Priorities*. The Causes and Health Consequences of Obesity in Children and Adolescents, supplement to Pediatrics, 101, 570-574.

Mental Well-Being: Nationwide, 1 in 5 students grades 9-12 has seriously considered attempting suicide.

Centers for Disease Control and Prevention. (1998). *CDC Surveillance Summaries*. August 14, 1998. MMWR 1998, 47 (No. SS-3).

Substance Abuse: 26% of all 12th graders, 23% of 10th graders, and 13% of 8th graders report using illicit drugs.

Federal Interagency Forum on Child and Family Statistics. (1998). *America's Children: Key National Indicators of Well-Being, 1998*. U.S. Government Printing Office, Washington, D.C.

Violent Crimes: Youth aged 12-17 are nearly 3 times more likely than adults to be victims of serious violent crimes.

Office of Juvenile Justice and Delinquency Prevention. (1998). *Juvenile Offenders and Victims: 1997 Update on Violence*. U.S. Department of Justice, Washington, D.C.

Suicide: Suicide is the #3 cause of death among 15-24-year-olds.

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Unintentional Deaths: Motor vehicle accidents are the number one cause of death among teens. Almost 50% of these are alcohol-related.

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Davies, D. (1996). *The 10th School: Where School-Family-Community Partnerships Flourish*. Education Week, 15(40), 44, 47. As cited in Health is Academic: A Guide to Coordinated School Health Programs, Teachers College Press, New York.

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Research on School-Linked Efforts

Smoking

A meta-analysis of 90 school-based tobacco programs from 1974-1989 showed that social influence programs that were most effective at 1-year follow-up had the following components: They were delivered to sixth-grade students, used booster sessions, concentrated the program in a short time period, and used an untrained peer to present the program. Under these conditions, long-term smoking prevalence was about 25% lower. (Rooney (1992), as cited in Lynch, B.S. & Bonnie, R.J. (eds.) (1994). Growing up Tobacco Free: Preventing Nicotine Addiction in Children and Youths. National Academy Press, Washington D.C.)

Alcohol

Project STAR is a universal drug abuse prevention program that reaches the entire community population with a comprehensive school program, mass media efforts, a parent program, community organization, and health policy change. Research results on this project have shown positive long-term effects: Students who began the program in junior high, and whose results were measured in their senior year of high school, showed significantly less use of marijuana (approximately 30% less), cigarettes (about 25% less), and alcohol (about 20% less) than children in schools that did not offer the program. The most important factor found to have affected drug use among students was increased perceptions of their friends' intolerance of drug use. (Pentz, et al. (1989); Pentz (1995), as cited in Preventing Drug Use Among Children and Adolescents: A Research Based Guide. (1997). National Institute on Drug Abuse, National Institutes of Health, U.S. Dept. of Health and Human Services.)

Obesity/Nutrition

The 5-a-Day Power Plus program increased lunchtime fruit consumption and combined fruit and vegetable consumption among all children, lunchtime vegetable consumption among girls, and daily fruit consumption and the proportion of total daily calories attributable to fruits and vegetables. (Perry, C.L., et al., (1998). *Changing Fruit and Vegetable Consumption Among Children: The 5-a-Day Power Plus Program in St Paul, Minnesota.*) American Journal of Public Health, 88 (No.4), 603-609.

The SPARK program, a health-related physical education program for fourth and fifth-grade students, was designed to increase physical activity during physical education classes and outside of school. Students spent more minutes per week being physically active in specialist-lead and teacher-led physical education classes than in control classes. After 2 years, girls in the specialist-led condition were superior to girls in the control condition on abdominal strength and endurance and cardio-respiratory endurance. (Sallis, J.F., et al. (1997). *The Effects of a 2-Year Physical Education Program (SPARK) on Physical Activity and Fitness in Elementary School Students.* American Journal of Public Health, 87 (8): 1328-1334.)

School Fights/Violence

Peacebuilders is a K-5 program of Heartsprings, Inc. in Tucson, AZ. The program emphasizes praising others, avoiding negative comments, being aware of injustices, righting wrongs and seeking out “wise people.” The program offers excellent classroom management suggestions, particularly for handling discipline and “unruly” kids. The program also contains many extras including an intensive peace building program for especially disruptive students, a family program, playground program, planning guides for teachers, a leadership guide for administrators, manuals for school staff, bus drivers, cafeteria workers, etc.

Preliminary post-test results of rigorous ongoing CDC evaluation shows significant reductions in fighting-related injury visits to school nurse by students. (Safe Schools, Safe Students: A Guide to Violence Prevention Strategies. (1998). Drug Strategies, Washington, D.C.)

Teen Pregnancy and STDs

The Teen Outreach Program, a nationally replicated and evaluated program sponsored by the Junior League, which includes health education and exploration of life options, was found to have a positive impact on suspension rates, course failure, and female students becoming pregnant.

Suspension rates: Control group at entry 23.8%
Intervention group at entry 17%; at exit, CG-28.7% and IG-13%
Failing: At entry CG-37.8%, IG – 30.3%; at exit CG-48.8%, IG-25.6%
Pregnancy-Entry CG-10%; IG-6.1 %; at exit, CG-9.8%, IG, 4.2%

(Allen J., Philber S., Herrling S., and Kupermic G. (1997). *Preventing Teen Pregnancy and Academic Failure: Experimental Evaluation of a Developmentally Based Approach*. Child Development, 64 (4), 729-742.)

Suicide

Reconnecting Youth Program (grades 9-12) is a school-based prevention program. Research shows that this program improves school performance; reduces drug involvement; increases self-esteem, personal control, school bonding, and social support; and decreases depression, anger and aggression, hopelessness, stress, and suicidal behaviors. (Eggert, et al. (1994, 1995) as cited in (Preventing Drug Use Among Children and Adolescents: A Research Based Guide. (1997). National Institute on Drug Abuse, National Institutes of Health, U.S. Dept. of Health and Human Services.)

Additional Sources of Helpful Print and Electronic Information

Health Is Academic: A Guide to Coordinated School Health Programs details the importance of incorporating students’ health into school programs and policies as a prerequisite for learning. The volume discusses how the eight components of a

coordinated school health program can work together to support students and help them acquire the knowledge and skills to become healthy, productive adults. The publication emphasizes that school more than any other single institution can improve the competence and well-being of youth and provides action steps for schools, districts, state and national organizations, and colleges and universities. It was developed by Education Development Center, Inc. in collaboration with more than 70 national organizations with support from the Centers for Disease Control and Prevention. *Health Is Academic* (ISBN 0-8077-3713-5) is available for \$24.95 plus shipping and handling from:

Teachers College Press
P.O. Box 20
Williston, VT 05495-0020
Phone: (800) 575-6566
Web site: <http://tc-press.tc.columbia.edu/>

The Health Is Academic: Creating Coordinated School Health Programs web site (<http://www.edc.org/HealthIsAcademic>) offers information, ideas, and contacts for anyone interested in building schools' abilities to boost the health—and thus the school performance—of their students. Expanding on the 1998 publication *Health Is Academic: A Guide to Coordinated School Health Programs* (Teachers College Press), the web site provides highlights from the book; action steps for local, state, and national organizations and colleges and universities; and access to a variety of resources. The web site also offers links to numerous national government and nongovernment health and education organizations that are working to improve student health and academic success. The Health Is Academic web site is maintained by Education Development Center, Inc., through a cooperative agreement with the Division of Adolescent and School Health, Centers for Disease Control and Prevention.

School Health Program News, a newsletter published three times a year by Education Development Center, Inc., with support from the Centers for Disease Control and Prevention, reports on state, national, and international school health-related activities, resources, and opportunities. For information contact:

Editor
School Health Program News
Education Development Center, Inc.
55 Chapel Street
Newton, MA 02458-1060
Phone: (617) 969-7100 or (800) 225-4276
Web site: <http://www.edc.org/>

The School Health Program Finance Project database, a joint project of the Centers for Disease Control and Prevention's Division of Adolescent and School Health and the National Conference of State Legislatures contains information on federal, state, appropriation, and foundation funding sources for school health programs. A coordinated approach to school health has the potential to be one of the most efficient means available to improve the health and education of our nation's students. One of the most

critical resources required to develop school health programs is funding. Sources of funds to support a coordinated approach are numerous. These sources and the procedures required to access funds vary from state to state and from block grant to block grant. The data collected through this joint effort helps to identify those procedures and sources in each state and within the federal government.

The Finance Project shares practical information about how states acquire funds for developing and improving school health programs. With guidance from a panel of independent experts, the School Health Finance Project (1) compiles and organizes information about funding sources; (2) tracks and updates changes in funding availability, legislation, and administrative regulations; (3) makes information accessible through electronic online information channels; (4) works with relevant organizations to help national, state, and local staff learn how to use the information; and (5) publishes reports about the evolving availability and nature of the diverse funding sources. The panel of independent experts includes representatives from other federal agencies, state and local health and education professionals, national and non-governmental organizations, and experts in fiscal policy.

In addition to the School Health Finance Project database, the **Division of Adolescent and School Health** web site contains a wealth of information about coordinated school health. Available resources include: selected data from the Youth Risk Behavior Surveillance System; school health program guidelines for preventing tobacco use, promoting physical activity, preventing the spread of HIV and AIDS, and promoting healthy eating; and a description of school health programs.

For more information visit the CDC/DASH web site at: <http://www.cdc.gov/needphp/dash/funding.htm> and the National Conference of State Legislatures Web site at: <http://www.ncsl.org/programs/health/pp/schlfund.htm>

Healthy Nutrition: An Essential Element of a Health-Promoting School makes a strong case for increased support of and attention to health nutrition in schools. It also provides information to help people understand the nature of a health-promoting school and to plan, implement, and evaluate efforts to promote health and healthy nutrition as part of the development of a health-promoting school.

Violence Prevention: An Important Element of a Health-Promoting School addresses three kinds of violence: self-inflicted violence, such as suicide or self-mutilation; interpersonal violence, which is characterized by violent behavior between individuals; and organized violence, or violent behavior of social or political groups motivated by political, economic, or social objectives such as war, racial or religious conflicts, or gang violence. The structure of the document is similar to that of the nutrition publication. It provides advocacy arguments for violence prevention in schools, steps for planning, ways to integrate efforts into various components of a health-promoting school, an overview of evaluation, and recommendations for ensuring continuity in the school and community.

The preceding two documents were published jointly by the World Health Organization (WHO) and Education International, which is working with WHO to promote health in schools worldwide. To learn more about these documents, visit WHO's web site at <http://www.who.org>.

Federal School Health-Related Clearinghouses

CDC, Division of Adolescent and School Health

<http://www.cdc.gov/nccdphp/dash>
(Internet)

CDC National AIDS Clearinghouse

(800) 458-5231
(800) 342-AIDS (English hotline)
(800) 344-SIDA (Spanish hotline)
(800) 243-7012 (TTY/TDD)
(301) 783-6616 (Fax)
(301) 217-0023 (International Line)
<http://www.cdcnac.org> (Internet)

CDC, National Center for Chronic Disease Prevention and Health Promotion

(404) 488-5080
<http://www.cdc.gov> (Internet)

Clearinghouse for Occupational Safety and Health Information

(800) 35-NIOSH
(513) 533-8326
(513) 533-8573 (Fax)
<http://www.cdc.gov/niosh/homepage.html>
(Internet)

Combined Health Information Database (CHID)

(800) 955-0906
<http://www.ovid.com/dochome/flguide/chiddb.htm> (Internet)

CSAP's National Clearinghouse for Alcohol and Drug Information

(800) 729-6686
(301) 468-2600
(800) 487-4889 (TTY/TDD)
(301) 230-2867 (TTY/TDD)
(301) 468-6433 (Fax)
<http://www.health.org> (Internet)

ERIC Clearinghouse on Teaching and Teaching Education

(202) 293-2450
(202) 457-8095 (Fax)
<http://www.aacte.org> (Internet)

Family Life Information Exchange

(301) 585-6636
(301) 588-3408 (Fax)

Food and Drug Administration, Office of Consumer Affairs

(301) 443-3170
(301) 443-9767 (Fax)
<http://www.fda.gov> (Internet)

Food and Nutrition Information Center, U.S. Department of Agriculture

(301) 504-5719
(301) 504-6409 (Fax)
<http://www.nal.usda.gov/fnic>
(Internet)

Indoor Air Quality Information Clearinghouse

(800) 438-4318
(202) 484-1307
(202) 484-1510 (Fax)
<http://www.epa.gov/iaq> (Internet)

National Center for Education in Maternal and Child Health

(703) 524-7802
(703) 524-9335 (Fax)
<http://www.ncemch.org> (Internet)

National Clearinghouse on Child Abuse and Neglect Information

(800) FYI-3366
(703) 385-7565
(703) 385-3206 (Fax)
<http://www.calib.com/nccanch> (Internet)

National Clearinghouse on Family Support and Children's Mental Health, Portland State University

(800) 628-1696
(503) 725-4040
(503) 725-4165 (TTD)
(503) 725-4180 (Fax)
<http://www.rtc.pdx.edu> (Internet)

National Health Information Center

(800) 336-4797
(301) 565-4167
(301) 984-4256 (Fax)
<http://nhic-nt.health.org> (Internet)

National Highway Traffic Safety Administration, U.S. Department of Transportation

(800) 424-9393 (Hotline)
(202) 366-0123 (Hotline)
(202) 366-5962 (Fax)
<http://www.nhtsa.dot.gov> (Internet)

National Information Center for Children and Youth with Disabilities

(800) 695-0285 (Voice/ITT)
(202) 884-8200 (Voice/ITT)
(202) 884-8441 (Fax)
<http://www.nichcy.org> (Internet)

National Injury Information Clearinghouse

(301) 504-0424
(301) 504-0124 (Fax)
<http://www.cpsc.gov> (Internet)

National Maternal and Child Health Clearinghouse

(703) 821-8955, ext. 254 or 265
(703) 821-2098 (Fax)
<http://www.circsol.com/mch> (Internet)

National Oral Health Information Clearinghouse

(800) 402-7364
<http://www.nidr.nih.gov> (Internet)

Office of Minority Health Resource Center

(800) 444-6472
(301) 565-6112 (Fax)
<http://www.omhrc.gov> (Internet)

Office on Smoking and Health, Centers for Disease Control and Prevention

(404) 488-5705
(404) 488-5939 (Fax)
<http://www.cdc.gov/tobacco> (Internet)

President's Council on Physical Fitness and Sports

(202) 272-3430
(202) 504-2064 (Fax)

US Consumer Product Safety Commission Hotline

(800) 638-2772
(800) 638-8270 (TT)
(301) 504-0580
(301) 504-0399 (Fax)
<http://www.cpsc.gov> (Internet)

Pull Quotes

“Schools could do more than perhaps any other single institution in society to help young people, and the adults they will become, live healthier, longer, more satisfying, and more productive lives.”

Carnegie Council on Adolescent Development

“Our school’s approach not only educates kids for themselves but shows them how to care about others in the community. For example, Students Shopping for Seniors shows them they have knowledge (about making healthy food choices) and can share it when they take an elderly person grocery shopping.”

Parent of High School Student, Wheeling, West Virginia

“It costs nothing to measure your buildings for a walking course. We measured the school buildings and posted markers so staff and students can walk the course either before or after school. It was cheap and easy and has served as an excellent opportunity for staff to get to know one another and get some good exercise.”

High School Teacher, South Carolina

“Training in interpersonal, decision-making, and coping skills can help students increase their self-control, help reduce stress and anxiety, and teach them ways to make friends if they are isolated and to assert themselves without resorting to violence.”

Carnegie Council on Adolescent Development

“The school principal or chief administrator is a key player. In schools where family partnerships flourish, the principal has usually taken the first steps towards better communication and collaboration.”

Don Davies, Center on Families, Communities, Schools and Children’s Learning, Northeastern University

“Schools offer the most systematic and efficient means available to improve the health of youth and enable young people to avoid health risks...”

Healthy People 2000, U.S. Public Health Service

“Our state (South Dakota) doesn’t have any mandates when it comes to school health education or programs. We found that we needed some effective survey tools to know what is being done already and where schools would like and need assistance.”

Pat Stewart, Coordinated School Health Director, SD Department of Education, Cultural Affairs

“We have established a great relationship with our State Board of Education. We have time on their agenda every month for a CSH update. This sends a loud message to communities and school staff that CSH efforts are important, valued, and being monitored.”

Mary Thissen-Milder, MN Department of Children, Families, and Learning, MN

“Start small. Identify representatives who should be working on the team and get the “turf” and ownership issues on the table right away. Then find a common mission and goal and begin to discuss elimination of duplication and how to increase efficiency in areas that are already developed.”

Kathy Wilbur, Maine School Site Health Promotion Coordinator

“The greatest resistance we’ve encountered has been due to misconceptions. Some people think that CSH programs must include a school-based clinic with the connotation that the main purpose of the clinic is to dispense birth control pills and condoms. That’s just not true. You need to educate the public about what you want to do and why. There are 101 ways to weave CSH into your school system without hitting some of the hot buttons that might stall the entire initiative.”

Joyce Brannan, Health Education Consultant, Ohio

“There are many people who think implementing school health means you must have a clinic on-site within the school—that’s just not true. School clinics can be great, but that’s not what every community needs. You should use research and data to decide how to best meet the needs of the community and the students. If you communicate effectively, people will realize the needs of the students and the community are one and the same.”

Casi Favre, Coordinator of Magnet Middle Schools, Florida

Acknowledgment

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(End of excerpt from the *School Health Kit*.)

CHAPTER 3

School Health Services

This chapter presents guidelines for use in planning, implementing, and evaluating *school health services*, a component of a school health program. Included within this chapter is information about related codes, policies, and recommendations for appraisal, preventive, and remedial aspects of school health services. Also included is information on planning the school health services facility.

In This Chapter

Overview of School Health Services

- ◆ Deciding on a Model to Provide School Health Services
- ◆ Planning the School Health Services Facility
- ◆ Evaluating Health Services

Conducting Health Assessments

- ◆ Four Common Health Conditions Encountered in the School Health Office
- ◆ Health Information Form Requirements
- ◆ School Entrance Physical Examination Requirements
- ◆ Immunization Requirements
- ◆ Athletic Pre-Participation Physical Examination Requirements
- ◆ Vocational/Technical Medical Assessment

Population-Based Screening Programs

- ◆ Blood Pressure Screening
- ◆ Dental Screening and Oral Health
- ◆ EPSDT and Medicaid/CMSIP
- ◆ Fine/Gross Motor Screening
- ◆ Hearing Screening
- ◆ Height and Weight Screening
- ◆ Scoliosis Screening
- ◆ Speech and Language Screening
- ◆ Vision Screening

Implementing Special Education: Students with Special Needs

- ◆ Implementing IDEA
- ◆ Implementing Part C of IDEA (Formerly Part H)
- ◆ Implementing Section 504 of the Rehabilitation Act
- ◆ Special Education Health Assessment

General Guidelines for Administering Medication in School

- ◆ Epinephrine Protocol
- ◆ Authorization/Parental Consent for Administering Medication
- ◆ Procedure for Administering Medication

Infectious Disease Control

- ◆ Prevention Guidelines for Diseases Spread Through Direct Skin Contact
- ◆ Prevention Guidelines for Diseases Spread Through the Intestinal Tract
- ◆ Prevention Guidelines for Diseases Spread Through the Respiratory Tract
- ◆ Prevention Guidelines for Diseases Spread During Sexual Activity
- ◆ Prevention Guidelines for Sports-Related Infectious Diseases
- ◆ Selected Infectious Diseases

Other School Health Services

- ◆ Managing First Aid Emergencies, Disasters, and Crises
- ◆ Referring to Child Protective Services
- ◆ Home Visits
- ◆ Nursing Liaison Services to Homebound Students
- ◆ Students Requiring Specialized Health Care Procedures

Overview of School Health Services

Health services, depending on the needs and preference of the community, may include services for students with disabilities and special health care needs and the traditional first aid, medication administration, and screening services. Communities make a decision about what level of health services they need. Then they implement the health services based on their decisions. Once implemented, health services should be evaluated to determine if the level of school health services is meeting the needs of the school community.

Subsections

The following subsections contain information on determining a model for health services, how to plan or implement health services, and a tool for evaluating health services.

- ◆ Deciding on a Model to Provide School Health Services
- ◆ Planning the School Health Services Facility
- ◆ Evaluating Health Services

Deciding on a Model to Provide School Health Services

Authorization

There is no requirement that specifies a school-based health services model. There are several different models for the delivery of school health services. The appropriateness of an approach for a school division typically depends on the educational preparation and the scope of practice of the available personnel, the funding available in the particular community, the scope of services available in the community, attitudes, and objectives of the community.⁶⁵

Overview

Definition. Although a universally accepted definition of the term “school health services” has not been adopted, *Health Is Academic: A Guide to Coordinated School Health Programs* presents the following definition:⁶⁶

School Health Services: Prevention services, education, emergency care, referral, and management of acute and chronic health conditions. Designed to promote the health of students, identify and prevent health problems and injuries, and ensure care for students.

The goals and program elements of school health services are derived from “student needs, community resources for health care, available funding, local preference, leadership for providers of school health services, and the view of health services held by school administrators and other key decision-makers in the school divisions.”⁶⁷ The types of services vary based on the goals and objectives of school health services.

Common Elements. While there is no one best universally accepted model of school health services, there are, however, common elements provided by schools across the

⁶⁵ Fox, H.B., Wicks, L.B., and Lipson, D.J. (1992). *Improving Access to Comprehensive Health Care Through School-Based Programs* (Grant #MCJ063500). Prepared with funding from the Maternal and Child Health Bureau, U.S. Department of Health and Human Services.

⁶⁶ Marx, E. and Wooley, S.F. (Eds.) (1998). *Health Is Academic: A Guide to Coordinated School Health Programs* (p.4). New York, N.Y.: Teachers College Press.

⁶⁷ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.) (1997). *Schools and Health: Our Nation's Investment* (p.153). National Academy Press: Washington, D.C.

country. A study conducted by the Institute of Medicine Committee on Comprehensive School Health Programs in Grades K-12 found that although the scope of school health services varies from one school district to another, most schools provide the following services:

- ◆ Screenings.
- ◆ Monitoring student immunization status.
- ◆ Providing first aid.
- ◆ Administering medication.
- ◆ Providing wide range of health services for students with disabilities and special health care needs.⁶⁸

Models. The school health literature identifies the following three major approaches for providing or facilitating access to primary health care, a primary goal of school health services: (1) screening and referral by school nurses, (2) nurse practitioners providing primary care, and (3) school-based clinics providing comprehensive health care services.⁶⁹ Each of these models is described below.

Screening and Referral by School Nurses

School Nurses. This is the traditional model that usually consists of school nurses who provide the following health services:

- ◆ Assessment of the health needs of students and staff.
- ◆ Health screening.
- ◆ Health promotion and disease prevention activities.
- ◆ Individual health education and counseling.
- ◆ First aid and emergency care.
- ◆ Chronic care services for children with disabilities.

⁶⁸ Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (p.7). National Academy Press: Washington.

⁶⁹ Fox, H.B., Wicks, L.B., & Lipson, D.J. (1992). *Improving Access to Comprehensive Health Care Through School-Based Programs* (Grant #MCJ063500). Prepared with funding from the Maternal and Child Health Bureau, U.S. Department of Health and Human Services.

- ◆ Referral of children with health problems to community health care providers for further diagnosis and treatment.

Physician consultation. In the traditional model, physician consultation is typically provided by a consulting medical director/physician who is available to the school health program for providing medical evaluations, consultation, and support to nursing personnel.

Nurse Practitioners Providing Primary Care

Nurse Practitioners. This model expands the direct services provided to the students. In this model, nurse practitioners provide the following comprehensive preventive and primary health care services:

- ◆ Diagnosis and treatment of a range of health conditions in accordance with treatment protocols established by a supervising physician.
- ◆ Health screenings.
- ◆ Assistance to families in visiting appropriate health care providers.
- ◆ Monitoring chronic illnesses.

The school nurse and unlicensed assistive personnel should be a part of this team to provide the traditional school health services.

School-Based Clinics Providing Comprehensive Health Care Services

School-Based Clinics. This model provides for the following comprehensive health care services that are to be delivered by an interdisciplinary team usually made up of physicians, nurses, counselors, lab and medical assistants, and other health care professionals.

- ◆ Comprehensive primary health care services.
- ◆ Promoting positive health behaviors.
- ◆ Preventing such “new morbidities” as intentional and unintentional injuries, teenage pregnancy, and substance abuse.

The school nurse and unlicensed assistive personnel should be a part of this team to provide the traditional school health services.

Recommendation

Need for School Health Services. Schools bring together large populations of students and staff with needs for first aid management, detection of contagious diseases, routine medication administration, specialized health care procedures for students with special health care needs, and so forth. To address these issues, some of which are legislative mandates, a system needs to be in place to reduce risks and liability. In addition, because education and health are linked, health services are needed to promote student health and prevent disease. Therefore, although the primary goal of schools is education, basic school health services are an essential component of today's education program. Roles and responsibilities for school health services should be determined with community input.⁷⁰

Coordination with Student's Health Care Provider/Parents/Guardian. An important component of a school health program is the direct delivery of health care services to students. Health care services include health assessments, population-based screenings, providing emergency care and managing crisis situations, and addressing the day-to-day health care needs of the students.

School health services should be coordinated with the student's health care at home. There should be ongoing communication between the school health services personnel and the student's parents/guardians and health care provider so that the student is able to participate in school at the highest level.

Choosing a Model. Each school health services model can be successful in facilitating or providing access to primary health care—if properly designed and aggressively implemented.⁷¹ Therefore, a school health services model should be determined locally, based on which model, or model combination, best matches a community's needs and characteristics.⁷²

⁷⁰ Adapted from: Allensworth, D., et al editors (1995). *Defining a Comprehensive School Health Program: An Interim Statement* (pp. 6-7). National Academy Press: Washington D.C.

⁷¹ Fox, H.B., Wicks, L.B., & Lipson, D.J. (1992). *Improving Access to Comprehensive Health Care Through School-Based Programs* (Grant #MCJ063500). Prepared with funding from the Maternal and Child Health Bureau, U.S. Department of Health and Human Services.

⁷² Adapted from: Allensworth, D., Lawson, L., Nicholson, L., and Wyche, J. (Eds.). (1997). *School & Health: Our Nation's Investment* (p. 226). National Academy Press: Washington, D.C.

Planning the School Health Services Facility

Authorization

School Building Regulations, Section 55.42 and 55.43.

Excerpt:

The examination room shall have private access to a toilet and there shall be separate restrooms for boys and girls that are adjacent and accessible to the exam room.

Note: This regulation is under review at the time of development of this manual. Please refer to current regulations.

Standards. Standard for a School Health Clinic Environment, Southern Association of Colleges and Schools. According to the Southern Association of Colleges and Schools, the standards for a school health clinic environment include the following:

- ◆ Provision of health services to meet the immediate needs of students enrolled through the school rather than by an outside agency.
- ◆ Provision of appropriate health facilities, equipment, supplies, and personnel to fulfill the needs of students and staff.
- ◆ Development of a plan for handling injuries or illnesses of students and staff and making the faculty and staff familiar with the plan.

Overview

The school health office should be planned to meet the needs of emergency care and outpatient clinic services. The design and equipment should support infection control measures.

Planning for the Facility. In planning a school health facility, the clinic personnel and space or structure should be adequate and provide appropriate privacy for:

- ◆ Projected school enrollment.
- ◆ Make-up of the present student population.
- ◆ Medical supplies needed by the personnel.

- ◆ Services provided.
- ◆ Confidentiality and safety of each person entering the facility.

Facility Functions. The functions of the facility may include the following.⁷³

- ◆ A conference space where the school nurse, health care provider, teacher, pupil, parents, or others concerned with health counseling and guidance can discuss specific health problems of individual students in privacy.
- ◆ A designated space for the care of students who become ill or are suspected of having a communicable disease, until they can be placed under their parent's care or returned to class.
- ◆ A designated space for student health records.
- ◆ A resource center for health education materials.
- ◆ A center to provide a program of expanded school-based primary care services where applicable.
- ◆ A storage area for health supplies and equipment. (Note: It is important to remember that not all school divisions have the same size space available nor the same school health personnel staff. School divisions serving a greater percentage of students with special care needs must adjust the facility to accommodate the needs of these children.)
- ◆ Localities must adapt the school health clinic to their environmental and staff specifications.
- ◆ Services may be decentralized in some schools. For example, immunizations may be given in the school auditorium and hearing and vision screening may be done in the school gymnasium or school library.
- ◆ At all times strict guidelines for infection control measures, safety, confidentiality, and delivery of professional health services must be followed.

Structural Design. The following research article has structural design recommendations for a standard nurse's station for elementary, middle, and secondary schools: McKibben, C., and DiPoala, S. (1997) Promoting The Construction Of An Optimal Nurse's Office Facility: One School District's Experience. *Journal of School Nursing*. Vol. 13, No. 2. pp. 22-29.

⁷³ Massachusetts Department of Public Health. (1995). *Comprehensive School Health Manual* (p. 2-19). Boston, Mass.: Author.

Basic Clinic Environment. The most basic clinic environment should be required to provide space for the following:

- ◆ Waiting and triage.
- ◆ Assessment and treatment.
- ◆ Counseling.
- ◆ Storage.

Recommendations

Furniture and Equipment for a School Health Office. The following guidelines⁷⁴ provide recommendations for the school health clinic that should be considered when new construction is being planned or when school buildings are being renovated. The supervisor/director/coordinator of school health services should be an active part of the advisory group designing any new health services area.

School Health Office: Recommendations for Furniture and Equipment

Location	<ul style="list-style-type: none"> ◆ Located, ideally, in a quiet area of the building, on the ground floor, near administrative offices, with easy access for students and staff. ◆ Conveniently accessible for the disabled—designed with a door(s) leading to the outside, outer hallway, and/or main office to provide for emergency transport and to be wheelchair accessible. ◆ An area that is used <i>only</i> for health-related services and that allows for individual privacy. ◆ An area 600 square feet minimum, including the bathroom (which should be approximately 130 square feet).
Ventilation and Lighting	<ul style="list-style-type: none"> ◆ Adequate ventilation. One outside window without fixed panes for natural lighting and ventilation or an operable skylight would be advantageous. ◆ Proper illumination in health clinic and the bathroom areas, including adjustable overhead lights in rest areas, in the storage closet, and over the first-aid area station.
Accessibility for Disabled	<ul style="list-style-type: none"> ◆ At least one handicapped-accessible toilet facility that has hot and cold running water in accordance with American Disabilities Act guidelines.

⁷⁴ The guidelines are a composite of recommendations from: Massachusetts Department of Public Health. (1995). *Comprehensive School Health Manual* (pp. 2-20 to 2-24). Boston, Mass.: Author. McKibben, C., and DiPoala, S. (1997). Promoting the Construction of an Optimal Nurse’s Office Facility: One School District’s Experience. *Journal of School Nursing*, 13, (2), pp. 22-29.

School Health Office: Recommendations for Furniture and Equipment

Water Sources	<ul style="list-style-type: none"> ◆ Adequate plumbing to ensure hot and cold running water for assessment and treatment area. A water source outside of the bathroom is needed to allow for giving medication and washing hands and wounds while the bathroom is in use. Hot and cold running water in the bathroom is necessary for washing hands and providing special health care procedures.
ELECTRICAL OUTLETS	<ul style="list-style-type: none"> ◆ Each sink should be equipped with a gooseneck faucet and wrist control device, liquid soap, and paper towel dispenser. ◆ Adequate electrical outlets, approximately 1 every 6 feet. A space that is 600 square feet should have 12 accessible outlets distributed throughout the health clinic and bathroom area.
Climate Control	<ul style="list-style-type: none"> ◆ Heating and air-conditioning controls that solely control the health facility environment. ◆ Access to fresh air and exhaust fans is optimal for adequate ventilation.
Floor and Wall Covering	<ul style="list-style-type: none"> ◆ Tile or seamless anti-microbial resinous floor is the preferred floor covering to facilitate proper disinfecting of soiled areas. If the facility includes a private nurse's office, this room may be carpeted. (Note: Carpet is difficult to keep clean and may contain allergens, such as latex.) ◆ Easily cleanable—hard walls are preferred.
Storage	<ul style="list-style-type: none"> ◆ A locked storage cabinet or, preferably, a walk-in closet with floor-to-ceiling shelves for medical and other supplies. A walk-in closet is preferable for storage of scale, crutches, stretcher, wheelchair, privacy screen, and other large items. ◆ In-wall medicine cabinet that has a secure lock, for storing medications and inhaler devices. ◆ Base cabinets that have counter tops would provide a more functional treatment area and storage for supplies and screening equipment. ◆ Refrigerator (approximately 3.9 cubic feet) for storage of medication or snacks for students with special needs, and cold packs. An icemaker—either in a larger refrigerator or a size that is stackable—on top of the refrigerator to provide ice for injuries, sore throats, and so forth is optimal. (Note: For clinics with more than 7600 students, an apartment-sized refrigerator is needed because it contains a larger freezer.)
Area Design Configuration	<ul style="list-style-type: none"> ◆ The clinic design should include four specific areas, including: <ol style="list-style-type: none"> 1. A waiting and triage area. 2. An assessment and treatment area. 3. A private area for conference, counseling, and isolation. 4. The bathroom area. (See “Assessment and Treatment.”)

School Health Office: Recommendations for Furniture and Equipment

Waiting and Triage	<ul style="list-style-type: none"> ◆ Adequate number of chairs for seating in the waiting area (approximately four chairs) and one cot (for approximately every 300 students). ◆ Desk or other suitable writing surface that is visible to the waiting area and has at least one drawer which can be locked. A telephone outlet should be nearby. ◆ Telephone with a direct line outside. ◆ Computer with monitor, disc drive, and printer on table. ◆ Filing cabinets (two or more four-drawer cabinets, depending on the student population) that can be secured and locked for storage of current health records, emergency response cards, instructional information, and daily maintenance files.
Assessment and Treatment	<ul style="list-style-type: none"> ◆ Adequate private rest areas that have cots or beds. (Note: It is recommended that beds/cots have washable surfaces that can be disinfected between student use.) The number of rest spaces should correspond to student enrollment and frequency of use. ◆ Blankets, sheets, pillows, and disposable or plastic pillow cases/covers. (Note: If items cannot be laundered between students, items must be disposable or not used.) ◆ Folding screen or draperies to provide privacy in the rest area. ◆ Rest area visible from the clinic personnel's work station. ◆ Rest area fitted with an outlet for its own light source. ◆ Private room (area) for examination and consultation, preferably with an examination table. ◆ Bathroom that is wheelchair accessible, has grab bar next to toilet, is well lit and ventilated, and has a sink and storage area for supplies and special needs equipment. (ADA guidelines recommend a changing table, washer dryer, and shower area with seat.) (Note: Bathroom should have a mirror.) ◆ Sink that has hot and cold running water and a gooseneck faucet. ◆ Wall-mounted liquid soap dispenser that has soap and is adjacent to all sinks. ◆ Wall-mounted paper towel holders that has paper towels and is adjacent to all sinks. ◆ Pedal-controlled, covered trash receptacles that is lined with polyethylene trash bags. ◆ First-aid station that has washable counter tops (preferably stainless steel), under-counter drawers for storage, and over-counter hanging cabinets with see-through sliding doors are preferable. (Note: May prefer wooden, locked doors to prevent theft.) ◆ Sharps container for disposal of hazardous medical waste. ◆ At least 15 feet of unobstructed space should be available in the school health clinic, if screening programs (e.g., vision and hearing) are conducted in the clinic.
Counseling and Treatment	<ul style="list-style-type: none"> ◆ Space that ensures privacy of sight and sound and is easily accessible. ◆ Private telephone line as well as an extension telephone.

Expendable (Consumable) Supplies for a School Health Office. The following table lists recommended supplies that should be available in a school health office.

Recommendations for Expendable (Consumable) Supplies

Movable Equipment	<ul style="list-style-type: none"> ◆ Book cases ◆ Bulletin boards ◆ Clock that has a second hand ◆ Flashlight or pen light with battery ◆ Gooseneck lamp ◆ Magnifying lamp ◆ Otoscope/ophthalmoscope with battery ◆ Physician's scale that has a height rod and is balanced ◆ Portable crisis kit ◆ Portable first-aid kit ◆ Pure tone audiometer (calibrated annually), tympanometer ◆ Reflex hammer ◆ Sphygmomanometer (calibrated annually) and appropriate cuff sizes ◆ Stethoscope ◆ Table for vision and hearing testing equipment ◆ Tape measure ◆ Vision testing machine, such as Titmus ◆ Wall-mounted height measuring tool ◆ Wheelchair
Suggested First Aid and Other Supplies	<ul style="list-style-type: none"> ◆ Bandages, including adhesive (e.g., Band-Aids) and elastic, of various types and materials ◆ Basins (emesis, wash) ◆ Cold packs ◆ Cotton-tip applicators (swabs) ◆ Cotton balls ◆ CPR masks (pediatric and adult) ◆ Dental floss ◆ Disinfectant for surfaces, spills (fresh [within 24 hours] 1:10 bleach solution or disinfectant approved by the U.S. Environmental Protection Agency) ◆ Disposable gowns ◆ Eye irrigating bottle ◆ Eye pads ◆ Eye wash solution ◆ Fingernail clippers ◆ Latex gloves ◆ Magnifying glass ◆ Masks ◆ Office supplies ◆ Paper cups (drinking, medicine, and pill) ◆ Paper towels ◆ Plastic bags (small and large, resealable) ◆ Physician rollpaper (optional)

Recommendations for Expendable (Consumable) Supplies

- ◆ Record forms (e.g., emergency cards, logs, medical sheets, accident reports, state forms)
- ◆ Ring cutter
- ◆ Safety pins
- ◆ Salt
- ◆ Sanitary pads, individually wrapped (may be used for compression)
- ◆ Scissors (blunt end)
- ◆ Slings
- ◆ Soap (must be in a dispenser)
- ◆ Splints (assorted)
- ◆ Surgi-pads
- ◆ Tape (different widths and hypo-allergenic)
- ◆ Tissues
- ◆ Thermometer (disposable) or other mechanism for measuring temperature, such as temp dots and thermometer sheaths, if applicable
- ◆ Tongue depressors
- ◆ Triangular bandage
- ◆ Tweezers
- ◆ Vinyl gloves (for latex allergies)
- ◆ Washcloths (disposable)

Suggested Reference or Resource Books

- ◆ Benenson, Abram (Ed.). (1995). *Control of Communicable Diseases*. Washington, D.C.: American Public Health Association.
- ◆ Keen, T. (Ed.) with Cox, A, Ford, N., and Henry, J. (Consulting Editors). (1997). *Specialized Health Care Procedures*. Richmond, Va.: Virginia Department of Health.
- ◆ Keen, T. and Ford, N. (Eds.) with Cox, A, Henry, J., Smith, G., and Tarr, J. (Consulting Editors). (1999). *Virginia School Health Guidelines*. Richmond, Va.: Virginia Department of Health.
- ◆ Lewis, K. (1994). *School Health Manual*. Menlo Park, Calif.: Addison Wesley.
- ◆ Tarr, J. (Developer) with Ford, N., Henry, J., and Cox, A. (Eds.). (1998). *First Aid Guide for School Emergencies*. Richmond, Va.: Virginia Department of Health.
- ◆ Pharmacological reference
- ◆ Medical dictionary
- ◆ Physical assessment book

Evaluating Health Services

Authority

- ◆ **Standard.** *Regulations Establishing Standards for Accrediting Public Schools in Virginia* (September 1997), 8 VAC 20-131-260 C, Commonwealth of Virginia, Department of Education.

Recommendation

Please see the following “Guidelines for Evaluation of School Health Services” adapted from:

- ◆ Task Force on Standards of School Nursing Practice. (1983). *Standards of School Nursing Practice*. Kansas City, Mo.: American Nurses’ Association.
- ◆ Task Force on an Evaluation Guide for School Nursing Practice. (1987). *Evaluating School Nursing Practice: A Guide for Administrators*. Kent, Ohio: American School Health Association.
- ◆ *An Evaluation Guide for School Nursing Practice Designed for Self and Peer Review*, Scarborough, Maine: National Association of School Nurses, Inc.
- ◆ *Standards of Nursing Practice*. (1998). Scarborough, Maine: National Association of School Nurses, Inc.

Guidelines for Evaluation of School Health Services	
Criteria	Documentation/Comments
I. GENERAL SCHOOL HEALTH SERVICES	
A. Purposes and scope of the school health program have been defined by written policies.	
B. Specific, written school health procedures are available for: <ol style="list-style-type: none"> 1. Emergency care of ill or injured students. 2. Medications given in the schools (including appropriate storage under double lock). 3. Control of communicable diseases. 4. Reporting child abuse. 5. Compliance with immunization law. 6. Health component of Individuals with Disabilities Education Act (IDEA). 	
C. Responsibilities of different classifications of school health personnel are clearly defined and applied.	
D. Community health resources are used in the school health program.	
E. A school health advisory board has been organized and is functioning effectively.	
F. Consultative services: <ol style="list-style-type: none"> 1. Physicians are available for consultation and advice. 2. Dentists are available for consultation and advice. 3. The public health nursing department is available to the schools. 	
G. Personnel currently certified in first aid and CPR are available and on duty at all times during the school day and school sponsored activities.	
H. Cumulative health records are maintained K-12 on all students and include: <ol style="list-style-type: none"> 1. Major health problems that may be significant educationally or pertain to the child’s safety or the safety of others with whom the child interacts. 2. Designated screening programs are recorded for both pass and fail. 3. All health information obtained on the student is recorded on and/or <i>filed</i> in the health record. 4. Health records are readily accessible to appropriate school personnel. 5. Staff are knowledgeable about confidentiality of student records. 6. Health records are kept in locked files. 	
I. The school health services program undergoes periodic evaluation and revision.	
II. SPECIFIC SCHOOL HEALTH SERVICES	

Guidelines for Evaluation of School Health Services	
Criteria	Documentation/Comments
A. There is a written job description for the school nurse.	
B. There is a written job description for the health clerk and other health personnel, such as technicians, physicians, and health aides.	
C. There are written objectives for the school health program.	
D. A qualified school nurse supervisor, coordinator, or consultant is available to give direction and advice.	
E. School nurses are licensed to practice within the Commonwealth of Virginia.	
F. Channels of communication between the supervisor, administrator, and staff are clearly established and understood.	
G. The number of health personnel is adequate to fulfill the objectives of the school health service program and/or to meet the standards recommended by the Task Force on Standards of School Health Nursing Practice: <ul style="list-style-type: none"> ◆ 1:750 in general school populations. ◆ 1:225 in mainstreamed populations. ◆ 1:125 in severely/profoundly handicapped populations. 	
H. In-service training is available and a reasonable amount of release time is available to permit health personnel to attend staff meetings, workshops, and continuing education programs.	
I. Individual staff evaluations are conducted by peer and/or supervisor.	
J. Health assessments by the school nurse are: <ol style="list-style-type: none"> 1. Completed on all kindergarten students. 2. Completed on all new students in the school division. 3. Completed on students enrolled special educational programs. 4. Completed on all students referred by school personnel or parents for a suspected health problem. 5. Completed as needed on students with a known health problem. 	
K. School entrance physical examinations by a physician are: <ol style="list-style-type: none"> 1. Required for all new students entering the school district K-5. 2. Required annually for all students competing in school athletics. 3. Reviewed by the school nurse to identify and follow up on all health problems. 	

Guidelines for Evaluation of School Health Services	
Criteria	Documentation/Comments
<p>L. Screening programs are conducted as designated by the school nurse or other trained personnel.</p> <ol style="list-style-type: none"> 1. Written procedures are available and being followed for: <ul style="list-style-type: none"> ◆ Identification of health problems. ◆ Vision. ◆ Hearing. ◆ Scoliosis. ◆ Dental. ◆ Height and weight. ◆ Other (List). _____ 2. The school nurse initiates follow-up steps to ensure further evaluation or care for all students failing screening procedures. 3. The teachers are notified of any preferences needed for the student to participate in the classroom. 4. Follow-up checks are made on students for further evaluation or care to see that such services were provided. 5. The school nurse shares evaluation recommendations with the teachers and records them on the student’s health record. 6. Efforts are made to ensure that students with severe conditions receive professional care. 	
<p>M. School personnel-nurse referrals and conferences:</p> <ol style="list-style-type: none"> 1. School personnel are advised and encouraged to observe each student for possible health deviations. 2. Classroom teachers are provided with information on signs to watch for in referring students for health screening and have necessary forms or written procedures to make such referrals. 3. There is an established system by which school personnel can make referrals to the school nurse. 4. The school nurse provides feedback to school personnel on referrals. 5. Teacher-nurse conferences are held to inform teachers of students with health problems, or a list of students with health problems is given to teachers. 6. Inservice training is held, as needed, to inform teachers on how to handle health problems and emergencies in the school setting; i.e., epileptic seizures, diabetic coma, insulin reaction, reporting serious accidents or illness, using universal precautions. 	
<p>N. Health counseling is available to public, parents, and school personnel.</p> <ol style="list-style-type: none"> 1. Parents are encouraged to confer with the school nurse when a school program adjustment is needed for a student with a health problem. 2. Time and privacy are available for students to talk with the school nurse 	

Guidelines for Evaluation of School Health Services	
Criteria	Documentation/Comments
<p>about their concerns or for the school nurse to discuss his/her screening findings with the student.</p> <ol style="list-style-type: none"> 3. The school nurse can make home visits to pupils with special health problems. 4. Parents are informed of the results of health assessments and failures in screening programs either by telephone or written notice. 5. Parents are assisted in locating resources for care of identified health problems. 6. Students are assisted in becoming knowledgeable health consumers. 	
<p>O. Disabled or chronically ill students are identified in the school division.</p> <ol style="list-style-type: none"> 1. Parent-school nurse conferences are conducted to ascertain the student's current health status. 2. Current recommendations are obtained from the student's source of medical care. 3. Special instructions and services are provided for disabled or chronically ill students as indicated. 4. School personnel are informed of the special needs of disabled or chronically ill students if educationally appropriate. 5. The school environment is adapted to accommodate students with disabilities. 	
<p>P. The school nurse is responsible for participating in the appropriate placement of students with exceptional needs.</p> <ol style="list-style-type: none"> 1. The school nurse obtains health history and current health status information on students prior to determining placement. 2. The school nurse helps identify the relationship between the health status and the student's ability to learn. 3. The school nurse serves as a team member to identify and interpret the physical findings and health needs of the student. 4. The school nurse serves on the school team to write goals, objectives, and characteristics for the health component of the individualized education program (IEP) and determines health factors that are pertinent to the student's most appropriate educational placement. 	
<p>Q. Communicable disease control is part of the school health services program.</p> <ol style="list-style-type: none"> 1. School personnel are prepared to recognize signs of suspected communicable diseases in students. 2. School nurses report immediately to the principal and local health agency (by phone) any of the following conditions: diphtheria, rubella, measles, meningococcal disease, polio, public gathering outbreaks (e.g., food poisoning), tuberculosis. 3. School nurses report on a designated basis to the principal and the local health department any other communicable disease. 	

Guidelines for Evaluation of School Health Services	
Criteria	Documentation/Comments
<ul style="list-style-type: none"> 4. Provisions are made for isolating students with a communicable disease until they are removed from school. 5. Students with a communicable disease do not return to school until the condition has been remedied or the student is under treatment. 6. The school health service correlates its plans for disease prevention and control with the community program. 	
<ul style="list-style-type: none"> R. A school health office or adequate workspace is available in every school. <ul style="list-style-type: none"> 1. The nurse has the following equipment available: a desk with drawers, files or cupboards for health records and supplies, and an appropriate number of chairs. 2. A telephone is available in the clinic for confidential conversations concerning student health problems. 3. First aid supplies, including ice, are readily available. 4. Privacy is possible in the school health office for conducting health counseling and health assessments. 5. One cot is available for every 300 students in the school. 6. The cot has a washable surface or disposable cover. 7. A locked cabinet or container is provided for storing prescription drugs. 8. A sink, separate from the bathroom facility, is located in the clinic for use in first aid/skilled care. 9. Bathroom facilities that also accommodated disabled students are available within the clinic area. 	

Conducting Health Assessments

Overview

Process. Health assessment consists of day-to-day health encounters, planned and unplanned, that school health personnel have with students and staff; population-based screening programs; and routine physical examinations. A comprehensive health assessment process involves:

- ◆ School health personnel collecting subjective and objective data related to the student's health and illness behaviors.
- ◆ Analyzing the data for accuracy and completeness.
- ◆ Collecting more data as needed.
- ◆ Analyzing the information for identification of student health risks, problems, and potential stressors.

Student Health Encounters. Students present a range of complaints, from potentially life-threatening situations to more common problems, such as colds and coughs. Students also seek advice, support, or just time out from stress in both the classroom and at home. Although most students go to the health room, informal encounters may occur in any number of locations in the school; for example, a student interacts with a school nurse in the hallway, cafeteria, or playground; a teacher stops the school nurse in the hallway to refer a student; or a school nurse conducts a follow-up visit with a student in the hallway or some other place in the school (following the student's visit to the health room).

School nurses are frequently assigned to cover more than one school, and as such, they are not always readily accessible to students. Often a teacher, health aide, or school secretary is the initial person to see the student, so it is important for them to understand the parameters of a school health encounter and what types of questions should be asked to assist licensed health personnel in making an assessment. Making a health assessment remains the responsibility of the school nurse or other fully qualified and licensed health care professional.

History of the Complaint. When assessing a student, the school nurse needs to obtain subjective data about the complaint or the history of the complaint. The initial person seeing the student must skillfully explore the presenting symptom by analyzing the complaint. Information on the location, frequency, duration and severity, quality, quantity, setting, associated symptoms, and factors that make the symptom better or worse will guide the action taken, including referral to a health care provider, observation in the health office, and/or notifying parents.

Health History. The health history provides additional subjective data as part of the assessment process. School health personnel should ask open-ended questions that encourage a student to describe the problem. It is important to encourage discussion around different areas of the student's life (e.g., home, work, and school), especially if the problem seems to be chronic. For today's student, especially the adolescent, a psychosocial review of systems is as important as the physical examination. A brief psychosocial assessment, including asking questions about any risk behaviors the student may be engaged in, may include the following questions.

- ◆ "Tell me about it."
- ◆ "When did it start?"
- ◆ "Has it ever happened before?"
- ◆ "What did you do?"
- ◆ "Did you tell your parents?"
- ◆ "What did they do?"
- ◆ "Are you taking any medication?"
- ◆ "Are you having problems in your classes?"
- ◆ "What class do you have now?"

Questions may focus on the following categories: home life, food, activities, shelter, supervision, health care, and support systems. (Note: Chronic reoccurring symptoms may be associated with psychosocial problems, such as abuse.) The school nurse should be aware of different cultural, ethnic, or socioeconomic backgrounds of students. (Note: The web site School Health * Culture Zone provides cultural resources for school nurses. The address is <http://courses.international.edu/bc680/nmcgahn/>)

Physical Assessment. Assessment also includes objective data or a physical assessment. The person assessing the student obtains information about signs of an illness (e.g., vital signs) and takes appropriate measures, such as having the student rest in the health room and either returning to class or calling parents if the student is to be sent home, suggesting any follow-up with the student's health care provider, or calling emergency services.

Resources

American Academy of Pediatrics (1991). Policy Statement. School Health Assessments (RE9221). *Pediatrics*, 88 (3), pp. 649-651.

Subsection

The following subsections identify and explain traditional individual student health assessments that are encountered by health care providers in the school environment.

- ◆ Four Common Encounters in the School Health Office
- ◆ Health Information Form Requirements
- ◆ School Entrance Physical Examination Requirements
- ◆ Immunization Requirements
- ◆ Athletic Pre-Participation Physical Examination Requirements
- ◆ Vocational/Technical Medical Assessment

Four Common Health Conditions Encountered in the School Health Office

The four most frequent conditions encountered in the school health office are (1) headaches, (2) sore throat, (3) abdominal pain, and (4) general malaise. The focus of this subsection is on the initial stage of assessment and does not include medical management. The following four examples of encounters were contributed by Simmons College Graduate Program in Primary Health Care Nursing and represent some suggested processes in assessing students. These guidelines are based on current practice and the clinical experience of contributors. If any of these symptoms are brought to the attention of an untrained school staff member, that staff member should refer the student to the appropriate licensed health professional (i.e., registered nurse, school physician, or licensed nurse practitioner).

Headaches

Headaches can be classified as acute, chronic, and recurrent. Acute headaches are of recent onset and frequently are associated with infectious illnesses, such as colds and influenza. Chronic and recurrent headaches may be associated with stress and tension, migraines, or potentially serious medical problems, such as sinusitis, dental problems, concussion, or brain lesion. Up to 20 percent of all school-age children experience frequent, recurrent headaches.

The following list of key questions and key physical examination components are commonly used to obtain subjective and objective information when assessing the student who complains of a headache.

Headache: Questions (Subjective Data)

Question	Action
1. Name and age of student?	Obtain health record.
2. Has there been any recent head injury?	Examine the student's head for evidence of lacerations, bleeding, bumps, or bruises.
3. Where is the location of the headache? What is the severity? How long has the headache persisted?	Any headaches that are characterized as severe, unilateral, or have persisted beyond 12 hours should be evaluated by a licensed health professional immediately.
4. Are there any associated symptoms: vomiting, stiff neck, difficulty with vision, drowsiness, recent behavior, or personality changes?	If positive, the student should be seen by a licensed health professional immediately. These symptoms can be associated with a life-threatening infection, such as meningitis.

Headache: Questions (Subjective Data)

Question	Action
5. Does the student have any other serious chronic medical disorders?	If positive, there may be an association. The student should be evaluated by a licensed health professional that same day.
6. How often does the student get headaches? What has made them feel worse or better?	There may be certain measures the student can take to treat the headache: lie down and rest, take acetaminophen, and apply a cool washcloth to forehead. Medication may require an authorized prescriber's order and parental consent depending on state laws and school policy.
7. Is the student feeling ill in any other way: sore throat, stomachache, chills?	Headaches can be associated with common infectious illnesses, such as colds, strep, pharyngitis, or flu. The student should be seen by a licensed health professional that same day for appropriate testing, diagnosis, and treatment.
8. Has the student eaten recently?	Headaches may be associated with hypoglycemia.

Headache: Physical Examination Components (Objective Data)

Action	Plan
1. Check the temperature.	If temperature is elevated or if there is tenderness or pain on motion of neck, inequality of pupils, or evidence of head trauma, the student needs to be evaluated by a licensed health professional immediately.
2. Neck: Is there tenderness or pain on motion?	
3. Eyes: Are the pupils equal in size?	
4. Head: Are there any lacerations, bleeding, bumps, or bruises?	

Headaches: Potential Causes

Assessment	Plan
1. Acute onset headache.	This may be associated with infectious illnesses, such as strep throat, colds, or influenza.
2. Acute recurrent headache.	This may be migrainous. A student who presents with a severe headache should be sent home to be evaluated by their health care provider.

Headaches: Potential Causes

Assessment	Plan
3. Chronic non-progressive headache (as a result of tension or stress).	<p>This may cause dull, constant pain, commonly located around the forehead and temporal area.</p> <p>The student can often alleviate the pain with rest, dim lighting, a cool washcloth, and non-aspirin pain reliever.</p> <p>Medication may require an authorized prescriber's order and parental consent depending on state law and school policy.</p>

Sore Throat (Pharyngitis)

Infections of the throat may be caused by either viruses or bacteria, but the vast majority of infections are viral. Because it is not possible to know whether the infection is viral or bacterial by inspection, a referral for a throat culture may be necessary in order to identify an infection caused by bacteria, such as *Streptococcus*. An untreated streptococcal sore throat can lead to serious complications, such as rheumatic fever or nephritis. About 10 to 20 percent of children who present with sore throat have a *Streptococcus* infection (strep throat) as the cause of their pharyngitis. The typical incubation period for strep throat is one to three days. Viral infections of the throat usually last three to four days as part of a cold or upper respiratory infection.

The following list of key questions and key physical examination components are commonly used to obtain subjective and objective information when assessing the student who complains of a sore throat.

Sore Throat: Questions (Subjective Data)

Question	Action
1. Name and age of student?	Obtain health record.
2. How long has the sore throat been present? How severe is the discomfort?	Any sore throat that is characterized as very painful or has been present beyond 24 hours should be evaluated by a licensed health professional that same day.
3. Are there any associated symptoms, such as cold, cough?	Sore throat associated with upper respiratory symptoms is likely to be caused by a virus.
4. Does the student have the following symptoms: headache, rash, chills, or abdominal pain?	Sore throat associated with these symptoms is more likely to be caused by bacteria.

Sore Throat: Questions (Subjective Data)

Question	Action
5. Has the student had many sore throats or strep infections in the past?	If positive, the student should have a throat culture in order to rule out strep throat, a potentially serious infection.
6. Does the student have any serious chronic medical disorder, such as kidney disease, diabetes, or congenital heart disease?	If positive, the student should be evaluated by a licensed health professional that same day.
7. Has the student had recent contact with anyone who has had strep throat or impetigo (i.e., skin infection caused by <i>Streptococcus</i>)?	Sore throat following a recent contact with someone who had strep throat or impetigo warrants a throat culture in order to rule out <i>Streptococcus</i> as a cause of the pharyngitis.

Sore Throat: Physical Examination Components (Objective Data)

Action	Plan
1. Check the temperature.	If positive for elevated temperature and enlarged and tender glands with a red and pus-like throat, the student needs to be evaluated by a licensed health professional.
2. Neck: Are the glands in the neck swollen and/or tender?	
3. Mouth: Does the throat appear red? Are the tonsils enlarged? Is pus or exudate present on the throat or tonsils?	

Sore Throat: Potential Causes

Assessment	Plan
1. Viral infections.	If there is no rash, fever, difficulty swallowing, swollen or tender glands, abdominal pain, or headache, the student most likely has a viral infection. The symptoms may be alleviated by taking a non-aspirin pain reliever, gargling with weak, warm salt water, and drinking some fluids. Medication may require an authorized prescriber's order and parental consent depending on state law and school policy.
2. Bacterial infections.	Sore throat associated with such symptoms as fever, difficulty swallowing, swollen and tender glands, abdominal pain, rash, or headache is more likely to be caused by bacterial infections. The student needs to have a throat culture performed. Usually the results are available within 24 to 48 hours. If positive, the student should be placed on antibiotics by the student's primary care provider. Students are considered not contagious after 24 hours of antibiotic therapy.

Abdominal Pain

Abdominal pain, usually classified as acute or recurrent, is a difficult complaint to assess. It can indicate a condition, such as appendicitis, that may require surgery. Other non-abdominal conditions (such as urinary tract infections or pneumonia) can also mimic acute or serious abdominal problems, such as appendicitis.

Recurrent abdominal pain is also a challenge to diagnose since the student usually appears healthy but is complaining of severe pain. Chronic abdominal pain is classified as three or more episodes severe enough to interfere with activity occurring over a three-month period or longer. The etiology is usually unknown but may be psychosomatic in origin and associated with stress at home or in the classroom.

The true incidence of an acute abdominal pain caused by appendicitis is estimated at between 7 and 12 percent; 10 to 12 percent of school-age children are affected by recurrent or chronic abdominal pain.

The following list of key questions and key physical examination components are commonly used to obtain subjective and objective information when assessing the student who complains of abdominal pain.

Abdominal Pain: Questions (Subjective Data)

Question	Action
1. Name and age of student?	Obtain school health record.
2. Analyze the symptom. Ask the student to describe the pain, frequency, location, duration, if it radiates, and what makes it better or worse.	Inspect the area for any obvious recent injury. If pain appears severe and is interfering with activities, the student should be referred to a licensed health professional immediately.
3. Is this a new complaint? If not, how many times has the student complained of this?	If this is a common complaint for this student, it may be indicative of stress-related illness and the student could stay in school.
4. Does the student have associated symptoms, such as nausea, vomiting, diarrhea, constipation, decreased appetite?	If positive, these symptoms may indicate a viral infection but also may be indicative of an acute abdominal condition. Consult a licensed health professional immediately.
5. For girls: Is it associated with frequency or burning on urination? Is it associated with menses?	Urinary tract or vaginal infections need to be diagnosed and treated by a licensed health professional. If positive for the onset of menstrual period, rest, over-the-counter pain reliever (per school protocol or licensed prescriber's order, both with parental consent), and heat may be used to decrease pain and discomfort.

Abdominal Pain: Physical Examination Components (Objective Data)

Action	Plan
1. Check temperature and blood pressure.	If positive for temperature and other signs of severe pain, the student needs to be referred immediately to a licensed health professional to rule out appendicitis or other emergency condition.
2. Abdomen: Is pain localized? Does it radiate? Any signs of injury?	
3. Is student pale? Sweaty?	
4. Is mobility or activity severely restricted?	

Abdominal Pain: Potential Causes

Assessment	Plan
1. Acute abdominal pain.	Appendicitis is the most common cause of acute abdominal pain.
2. Recurrent abdominal pain.	Recurrent pain is associated with urinary tract infection, constipation, gastrointestinal viral infections, stress, and gynecological problems.

General Malaise: “I Don’t Feel Well”

This complaint, frequently heard in school health offices, is vague and nonspecific and can indicate a wide variety of problems, from specific physical problems to psychosomatic or stress-related problems.

School personnel need to obtain accurate information, since this complaint may not be the real reason the student is in the health office. The student may be using this complaint as a means of communicating an underlying problem to the school nurse or other school personnel. This assessment demands a thorough, skillful, and sensitive interview.

The following list of key questions and key physical examination components are commonly used to obtain subjective and objective information when assessing the student who complains of a general malaise.

General Malaise: Questions (Subjective Data)

Question	Action
1. The most efficient way to collect information of a physical nature is to review the body systems. This includes a review of past and present illnesses and usually proceeds head to toe.	Differentiate between physical and psychological etiology.
2. Ask general questions: “Are you having any pain anywhere? Have you been sleeping? Any nausea, vomiting, diarrhea?”	If positive, follow up with more complete information on specific area.
3. Questions concerning family, home, school, and peers need to be open-ended and sensitive. “Has anything changed at home? How is school going?”	If positive, student might just need some “time out” in health office. Assess for further referral for counseling.

General Malaise: Physical Examination Components (Objective Data)

Action	Plan
1. Check temperature.	If positive, this may indicate nonspecific viral or bacterial disease. Refine assessment and refer for further evaluation.

General Malaise: Potential Causes

Assessment	Plan
1. Organic cause.	Vague, nonspecific complaints can still be indicative of physical injuries and illnesses. These need to be ruled out by careful history and data collection before the assumption is made that the complaint is stress related.
2. Psychosomatic or stress related.	Stress-related illness and chronic complaints warrant follow up and counseling by school guidance counselors, or referral to community services.

Note: See sample school health encounter forms in Appendix E.

Health Information Form Requirements

Authorization

Code of Virginia, Section 22.1-270, Preschool Physical Examinations, I. The *Code of Virginia* requires that parents or guardians of entering students shall complete a health information form, which is developed by the Departments of Education and Health or which is developed by school divisions and approved by the Superintendent of Public Instruction.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-270, I.

SUPTS. MEMO. SUPTS. MEMO. No. 22, February 5, 1999, Subject: School Health Form HPE-h12. (See Appendix A for a copy of SUPTS. MEMO.)

Excerpt:

The following form has been deleted: Form HPE-h12, THE SCHOOL ENTRANCE HEALTH INFORMATION FORM (DATED DECEMBER 1983). The information on that form is provided on the School Entrance Physical Examination and Immunization Certification, (MCH 213C) dated October 1991.

Recommendation

Referral and Follow-Up Process. Any issues noted on the health information form may require referral or follow-up activities. The school nurse who is responsible should:

- ◆ Review the completed health information form.
- ◆ Identify health issues.
- ◆ Provide appropriate referrals and follow up.
- ◆ Collaborate with parents and appropriate health care providers to ensure linkages between the school, home, and community.

Documentation

Health Information Form. The following “health information forms” are approved by the Superintendent of Public Instruction (school divisions can develop their own form, but it must be approved by the Superintendent of Public Instruction). (See *Code of Virginia*, § 22.1-270, I.)

- ◆ School Entrance Physical Examination and Immunization Certification: Part I – Health Information Section (MCH-213 C, Rev. 10/91).
- ◆ School Entrance Health Form: Part I – Health Information Form (MCH-213 D, Rev. 1/99).

Note: The School Entrance Health Form (MCH-213 D, Rev. 1/99) should be used beginning with school year 1999-2000, as the form becomes available.

New Form: School Entrance Health Form (MCH-213 D). At the time of development of this manual, the School Entrance Physical Examination and Immunization Certification form (MCH-213 C, Rev. 10/91) was being revised. The revised form, entitled School Entrance Health Form (MCH-213 D, Rev. 1/99), is to be used for school year 1999-2000—when form becomes available—for health information, comprehensive physical examination, and immunization reporting requirements as required by the *Code of Virginia*. The following is a summary of the revised form (MCH-213 D, Rev. 1/99).

- ◆ **Part I - Health Information Form**

Replaces Health Information Form (HPE-h12 12/83), as required by the *Code of Virginia* § 22.1-270, I, Preschool physical examinations.

- ◆ **Part II – Comprehensive Physical Examination Report**

Replaces *School Entrance Physical Examination and Immunization Certification—Part I and Part II* (MCH-213 C, Rev. 10/91), as required by the *Code of Virginia* § 22.1-270, A – H, Preschool physical examinations.

- ◆ **Part III – Certification of Immunization**

Replaces the *School Entrance Physical Examination and Immunization Certification—Part III* (MCH-213 C, Rev. 10/91), as required by the *Code of Virginia* § 22.1-271.2, Immunization requirements.

Copy of Forms. See Appendix D for a copy of the following forms:

- ◆ *School Entrance Physical Examination and Immunization Certification* (MCH-213 C, Rev. 10/91).
- ◆ *School Entrance Health Form: Health Information Form / Comprehensive Physical Examination Report / Certification of Immunization* (MCH-213 D, Rev. 1/99).

School Entrance Physical Examination Requirements

Authorization

Code of Virginia, Section 22.1-270, Preschool Physical Examinations, A. - H. The *Code of Virginia* requires that no pupil shall be admitted for the first time to any public kindergarten or elementary school in a school division unless such pupil shall furnish, prior to admission, (i) a report from a qualified licensed physician of a comprehensive physical examination of a scope prescribed by the State Health Commissioner performed no earlier than 12 months prior to the date such pupil first enters such public kindergarten or elementary school or (ii) records establishing that such pupil furnished such report upon prior admission to another school or school division and providing the information contained in such report. Such physical examination shall not be required of any child whose parent or guardian shall object on religious grounds and who shows no visual evidence of sickness, provided that such parent or guardian shall state in writing that, to the best of his knowledge, such child is in good health and free from any communicable or contagious disease.

Excerpt: See Appendix A for *Code of Virginia* § 22.1-270. A. -H.

Notes: The term “elementary school” is not defined by the *Code of Virginia*, § 22.1-270, for the purpose of the school entrance physical examination. However, *Regulations Establishing Standards for Accrediting Public Schools in Virginia*, (8VAC 20-131-10 et.seq.), Virginia Department of Education, (adopted by the Board of Education, September 1997) refers to schools with grades K-5 as elementary schools, grades 6 to 8 as middle schools, and grades 9 to 12 as secondary schools.

SUPT. MEMO. SUPTS. MEMO. No. 21, January 29, 1993, Subject: Legally Permissible Activities of Licensed Nurse Practitioners. (See Appendix A for copy of SUPTS. MEMO.)

Excerpt:

The attached letter from the Virginia Commissioner of Health contains information about [December 10, 1992] legally permissible activities of licensed nurse practitioners under the regulations of the state Boards of Medicine and Nursing.

For example, LNPs may substitute for licensed physicians in such matters as the routine physical examinations required for school entrance, participation in sports, and eligibility for other services such as homebound instruction for pregnant students.

HEALTH COMMISSIONER LETTER. Letter from State Health Commission to Superintendent of Public Instruction, December 10, 1992: Licensed Nurse Practitioners. (See Appendix A for copy of State Health Commissioner’s Letter.)

Excerpt:

The Virginia Department of Health interprets the code section 22.1-270 that requires the report of a preschool physical examination signed by a “qualified licensed physician” allows the report to be signed by a LNP [licensed nurse practitioner].

Overview

A periodic physical examination is critically important for all children and adolescents and especially for those children who do not have primary care providers and ongoing monitoring of their growth and development. The physical examination is crucial for preventive, diagnostic, or corrective purposes. The objectives of a physical examination are to understand and follow up on health conditions that may adversely affect the student’s well-being and ability to learn. While it is understood that the primary responsibility for a student’s health care rests with the family, the school is responsible for the safety and well-being of students while they are in the school setting. Therefore, the family and the schools are in a partnership when it comes to the physical well-being of a child entrusted to the school division. Adequate and appropriate follow-up intervention is necessary to ensure that all school children have a periodic physical examination.

Recommendation

Procedure and Personnel. In some cases the physical examination may be performed at school. Physical examinations completed in school should be done in the presence of a third person (usually the school nurse), in a private setting, and with sufficient time allotted for an appraisal of both physical and mental health. Line-up examinations are inappropriate because they are insensitive to the individual’s right to privacy and confidentiality.

Parents should be present, if possible. If the parent is present at the time of the physical examination, they should be apprised of all findings concerning the child’s growth and development and the findings of the health appraisal. When the parent is not present written notification of the health care provider’s findings is necessary.

Referral and Follow-Up Process. Any issues noted during the physical examination may require referral or follow-up activities. The school nurse should:

- ◆ Review the completed school entrance physical examination report.
- ◆ Identify health issues.
- ◆ Provide appropriate referrals and follow-up interventions.

- ◆ Collaborate with parents and appropriate health care providers to ensure linkages between the school home and community.

Documentation.

School Entrance Physical Examination Form. The following forms constitute the “scope” of a comprehensive physical examination prescribed by the State Health Commission. (See *Code of Virginia*, § 22.1-270, A. -H.)

- ◆ School Entrance Physical Examination and Immunization Certification: Part II – Certification of School Health Examination (MCH-213 C, Rev. 10/91).
- ◆ School Entrance Health Form: Part II – Comprehensive Physical Examination Report (MCH-213 D, Rev. 1/99).

Note: The School Entrance Health Form (MCH-213 D, Rev. 1/99) should be used beginning with school year 1999-2000, as the form becomes available.

New Form: School Entrance Health Form (MCH-213 D). At the time of development of this manual, the School Entrance Physical Examination and Immunization Certification form (MCH-213 C, Rev. 10/91) was being revised. The revised form, entitled School Entrance Health Form (MCH-213 D, Rev. 1/99), is to be for school year 1999-2000—when the form becomes available—for health information, comprehensive physical examination, and immunization reporting requirements as required by the *Code of Virginia*. The following is a summary of the revised form (MCH-213 D, Rev. 1/99).

- ◆ **Part I - Health Information Form**

Replaces Health Information Form (HPE-h12 12/83), as required by the *Code of Virginia* § 22.1-270, I, Preschool physical examinations.

- ◆ **Part II – Comprehensive Physical Examination Report**

Replaces School Entrance Physical Examination and Immunization Certification—Part I and Part II (MCH-213 C, Rev. 10/91), as required by the Code of Virginia § 22.1-270, A – H, Preschool physical examinations.

- ◆ **Part III – Certification of Immunization**

Replaces the School Entrance Physical Examination and Immunization Certification—Part III (MCH-213 C, Rev. 10/91), as required by the Code of Virginia § 22.1-271.2, Immunization requirements.

Copy of Forms. See Appendix D for a copy of the following forms:

- ◆ *School Entrance Physical Examination and Immunization Certification (MCH-213 C, Rev. 10/91).*

- ◆ *School Entrance Health Form: Health Information Form / Comprehensive Physical Examination Report / Certification of Immunization (MCH-213 D, Rev. 1/99).*

Immunization Requirements

Authorization

Code of Virginia, Section 22.1-271.2, Immunization Requirements. The *Code of Virginia* requires that no student shall be admitted by a school unless at the time of admission the student or his parent or guardian submits documentary proof of immunization to the admitting official of the school or unless the student is exempted from immunization pursuant to subsection C.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-271.2, A. - G.

Code of Virginia, Section 22.1-271.1, Definitions (for Immunization Requirements).

The *Code of Virginia*, for the purpose of § 22.1-271.2, defines the following terms: “admit” or “admission,” “admitting official,” “documentary proof,” “student,” “immunized” or “immunization,” and “school.”

Excerpt: See Appendix A for *Code of Virginia* § 22.1-271.1.

Code of Virginia, Section 32.1-46, Immunization of Children Against Certain Diseases; Authority to Share Immunization Records.

Excerpt: See Appendix A for *Code of Virginia* § 32.1-46.

Code of Virginia, Section 32.1-47, Exclusion From School of Children Not Immunized.

Excerpt: See Appendix A for *Code of Virginia* § 32.1-47.

Minimum Requirements

Commonwealth of Virginia, State Board of Health: Regulations for the Immunization of School Children, Virginia Department of Health, Bureau of Immunization, August 1, 1995, defines immunization requirements for students attending school.

The *Code of Virginia*, §22.1-271.2, mandates the immunization requirements for all children attending school and licensed day care in Virginia. Section 3.00 of the Rules and Regulations for the Immunization of School Children⁷⁵ details the minimum immunization requirements outlined by the State Board of Health for school attendance. (See the Appendix A for copy of this schedule)

⁷⁵ Virginia Department of Health, Bureau of Immunizations. (1995). *Commonwealth of Virginia, State Board of Health: Regulations for Immunizations of School Children*. Richmond, Va.: Author.

The *Code of Virginia*, § 32.1-46, currently requires students to be vaccinated against polio, diphtheria, tetanus, pertussis, measles, mumps, rubella, hepatitis B (for children born on or after January 1, 1994), and *Haemophilus influenzae* type B (for children through 30 months of age). Immunization requirements are revised periodically to reflect the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics (AAP). The regulations for Virginia are revised as needed in accordance with these recommendations. The Virginia Department of Health, Division of Immunization, can provide the most current recommendations. (See Appendix A for the Recommended Childhood Immunization Schedule, United States, January-December 1998 approved by the Advisory Committee of Immunization Practices [ACIP], the American Academy of Pediatrics [AAP], and the American Academy of Family Physicians [AAFP].)

Note. New legislation effective July 1, 1999:

- ◆ **Varicella.** Students born on or after January 1, 1997 are required to receive immunization against varicella zoster (chicken pox), not earlier than 12 months of age. Students who have evidence of immunity as demonstrated by laboratory confirmation of immunity or a reliable medical history of the disease are exempt from the requirement.
- ◆ **Hepatitis B for sixth graders.** Beginning July 1, 2001, all children who have not received three doses of hepatitis B vaccine will be required to receive such immunization prior to entering the 6th grade.

Exceptions

The *Code of Virginia*, §22.1-271.2, provides for exemptions from immunization requirements for religious and medical reasons, responsibilities of admitting officials to insure the immunization status of students, for the exclusion of students who are not in compliance with the immunization requirements, and responsibilities related to documentation of immunizations.

Medical Exemptions. Medical exemptions are issued for a child with a medical contraindication to one or more vaccines. The parent or guardian must present a statement on the MCH-213 form from a licensed health professional or local health department official that the physical condition of the child is such that the administration of one or more of the required immunizing agents is contraindicated and whether the condition is permanent or temporary.

Religious Exemptions. Religious exemptions are issued to a child's parent/guardian by signing the Certificate of Religious Exemption form (Form CRE-1), an affidavit which must be notarized. If the parent maintains the need to continue the religious exemption during a documented school health emergency, the student will be excluded from school for his or her protection until the emergency is concluded.

Recommendation

Procedure and Personnel. To assure immunization compliance in assigned school(s), the school nurse should:

- ◆ Establish a system of documenting immunization compliance on the School Health Record.
- ◆ Issue special exemptions as the principal's designated official. To accomplish this, the school nurse should:
 1. Issue special exemption certificates.
 2. Maintain tickler file on all special exemption certificates issued.
 3. Monitor status to assure legal compliance with the immunization law.
 4. Document status on receipt of valid Certificate of Immunization.
 5. Report to principal any students who fail to provide required documentation and must be suspended from school until this requirement is met.
- ◆ Maintain liaison with state health department immunization representative.

Referral and Follow-Up Process. Representatives of the Virginia Department of Health are authorized to audit school records to insure compliance with the regulation. (A minimum of 10 percent of the state's public schools are selected from a random sample for annual audit.) However, local health department staff will be conducting record reviews for a statistically valid local immunization audit.

Recommended Childhood Immunization Schedule. Please see Appendix A for a copy of the following publication, which has been approved by the Advisory Committee of Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

- ◆ *Recommended Childhood Immunization Schedule*, United States, January-December 1998, approved by ACIP, AAP, and AAFP.

Consultation and Technical Assistance. Although these guidelines are designed to cover most situations, school personnel need to refer to the most recent edition of *Commonwealth of Virginia, State Board of Health: Regulations for the Immunization of School Children*, Virginia Department of Health, Division of Immunization, to ensure that all students attending any public, private, or parochial school and all attendees of licensed child care centers in the Commonwealth are adequately immunized and protected against diphtheria, pertussis, tetanus, poliomyelitis, rubeola, rubella, mumps, haemophilus influenzae type B, hepatitis B disease, and varicella (all students born on or after 1/1/97), as appropriate for the age of the student. In addition, school personnel may contact either their local health department or the Virginia Department of Health, Division of Immunization, (804) 786-6246, for further consultation or technical assistance.

Documentation

Recording Requirement. Every school must record each student's immunizations on the school immunization record, which is provided by the Virginia Department of Health and which must be made part of the mandatory permanent student record. (See *Code of Virginia*, § 22.1-272.2, E.)

Proof of Immunization. "Documentary proof" of immunization includes any of the following appropriately completed forms. (See *Commonwealth of Virginia, State Board of Health: Regulations for the Immunization of School Children*, Virginia Department of Health, Bureau of Immunization, August 1, 1995.)

- ◆ Form MCH-213C (Part III—Certificate of Immunization) or a computer-generated facsimile of Form MCH-213C signed by a physician or his designee or an official of a local health department.
- ◆ The MCH-213C SUPPLEMENT indicating the dates of administration of the required vaccine is acceptable in lieu of recording these dates on Form MCH-213C (Part III—Certificate of Immunization) signed by a physician or his designee or an official of a local health department, as long as the supplement is attached to Form MCH-213C and the remainder of Form MCH-213C (Parts I-II) has been appropriately completed.
- ◆ For a new student transferring from an out-of-state school, any immunization record, which contains the exact date (month/day/year) of administration of each of the required doses of vaccine when indicated and complies fully with the requirements prescribed under Section 3.1 of the *Regulations for the Immunization of School Children* are acceptable. Questions regarding records should be directed to the local health department.
- ◆ School Entrance Health Form: Part III – Certification of Immunization (MCH-213 D, Rev. 1/99).

Note: The School Entrance Health Form (MCH-213 D, Rev. 1/99) should be used beginning with school year 1999-2000, as the form becomes available.

New Form: School Entrance Health Form (MCH-213 D). At the time of development of this manual, the School Entrance Physical Examination and Immunization Certification form (MCH-213 C, Rev. 10/91) was being revised. The revised form, entitled School Entrance Health Form (MCH-213 D, Rev. 1/99), is to be for school year 1999-2000—when the form becomes available—for health information, comprehensive physical examination, and immunization reporting requirements as required by the *Code of Virginia*. The following is a summary of the revised form (MCH-213 D, Rev. 1/99).

- ◆ **Part I – Health Information Form**

Replaces Health Information Form (HPE-h12 12/83), as required by the *Code of Virginia* § 22.1-270, I, Preschool physical examinations.

◆ **Part II – Comprehensive Physical Examination Report**

Replaces School Entrance Physical Examination and Immunization Certification—Part I and Part II (MCH-213 C, Rev. 10/91), as required by the Code of Virginia § 22.1-270, A – H, Preschool physical examinations.

◆ **Part III – Certification of Immunization**

Replaces the School Entrance Physical Examination and Immunization Certification—Part III (MCH-213 C, Rev. 10/91), as required by the Code of Virginia § 22.1-271.2, Immunization requirements.

Reporting Requirement. Within 30 calendar days after the beginning of each school year or entrance of a student, each school admitting official must file an immunization summary report with the local health department, using the most recent edition of the Student Immunization Status Report form (Form SIS-1). (See *Code of Virginia*, § 22.1-272.2 E.)

Compliance. Officials from the Virginia Department of Health and local health departments are authorized to inspect school immunization records. (A minimum of 10 percent of the state’s public schools is selected from a random sample for annual audit.) (See *Code of Virginia* § 22.1-272.2 E.) However, local health department staff will be conducting record reviews for a statistically valid local immunization audit.

Copy of Forms. See Appendix D for a copy of the following forms:

- ◆ School Entrance Physical Examination and Immunization Certification form (MCH-213C).
- ◆ School Entrance Health Form: *Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization* (MCH-213 D, Rev. 1/99).
- ◆ Immunization Record, Virginia Department of Health (MCH-213C-Supplement).
- ◆ Certificate of Religious Exemption, Commonwealth of Virginia (CRE-1).
- ◆ Student Immunization Status Report (Form SIS-1).

Athletic Pre-Participation Physical Examination Requirements

Authorization

Virginia High School League, Inc. (VHSL). The VHSL requires that all high school students complete a pre-participation physical examination in order to be eligible to compete in a varsity sport. The purpose of this examination is to identify a student at risk for injury while participating in competitive sports and to update the medical information in the student’s record previously provided by the parent/guardian.

A separate examination and certification are required for each high school year and are valid from May 1 of the current year through June 30 of the succeeding year. The completed form must be on file in the Office of the Principal. The Medical Advisory Board of VHSL, Inc. is responsible for updating the Athletic Participation/Parental Consent/Physical Examination Form as needed in order to remain consistent with the most recent recommendations and guidelines pertaining to the health and well-being of adolescents.

Separate jurisdictions may choose to require middle school athletes participating in competitive sports, other than intra-mural sports, to submit a pre-participation physical. However, this is not a state requirement and is left up to the discretion of the particular locality. Middle schools that choose to require physical examinations may use this form or provide another form developed by the health care providers of their choice.

Recommendation

Procedure and Personnel. The athletic physical assessment is best performed by the student's primary health care provider. Studies indicate that about 80 percent of high school athletes undergoing sports pre-participation assessments had no other health assessments during the school year. Therefore, students should be encouraged to have this evaluation performed by their health care provider where the assessment can be integrated with other age-appropriate anticipatory guidance and screening. The pre-participation assessment should best occur four weeks before the beginning of the athletic season so that previous injuries can be identified in time so they can be treated with a rehabilitation program to prevent injury.

Referral and Follow-Up Process. The completed forms should be reviewed by the school nurse or other health professional to clarify questionable health information. The school nurse should track such referrals and collaborate with parents.

Documentation

Athletic Pre-Participation Physical Examination.

- ◆ Completed Athletic Participation Parental Consent Physical Examination Form.

Copy of Form. See Appendix D for a copy of the most recent Athletic Participation Parental Consent Physical Examination Form.

Resources

Virginia Department of Health and Virginia Department of Education. (1992). *Virginia School Health Guidelines*. Richmond, Va.: Author.

Massachusetts Department of Public Health. (1995). *Comprehensive School Health Manual*. Boston, Mass.: Author.

American Academy of Pediatrics (1994). Policy Statement. Medical Conditions Affecting Sports Participation (RE9432). *Pediatrics*, 94 (5), pp. 757-760.

Merenstein, G.B. (1997). *Handbook of Pediatrics, 18th ed.* (pp. 685-707). Stanford, Conn.: Appleton & Lange.

Virginia High School League, Inc. (1995-96.) *Virginia High School League Inc., Handbook*. Charlottesville, Va.: Author.

Vocational/Technical Medical Assessment

Authorization

Vocational Program Health Requirements. Certain vocational training programs may have health requirements that were established to minimize transmission of communicable disease in the work setting.

The following list provides examples of what might be required for some vocational programs.

Vocational Program Health Requirements

Program	Health Requirements	Resources
Cosmetology	Annual tuberculin skin test	Health Department Private Physician
Licensed Practical Nursing Emergency Medical Technical	Annual tuberculin skin test Hepatitis B vaccine Tetanus vaccine	Health Department Private Physician
Horticulture	Tetanus vaccine	Health Department Private Physician
Dental Assistant	Annual tuberculin skin test Hepatitis B vaccine Tetanus vaccine	Health Department Private Physician

Recommendation

Procedure and Personnel. Each school division should ascertain the requirements for its own vocational programs; students should be counseled about these requirements and available community resources for meeting them.

Referral and Follow-Up Process. The completed forms should be reviewed by the school nurse or other health professional to clarify questionable health information. The school nurse should track such referrals and collaborate with parents.

Record Keeping and Documentation. It is recommended that documentation of counseling be maintained in the student's file.

Population-Based Screening Programs

Introduction. Population-based screening for health problems, an important component of a school health program, is designed to detect previously unrecognized conditions or pre-clinical illnesses as early as possible in order to provide early intervention and remediation and limit potential disability and negative impact on scholastic performance. The following guidelines are applicable to any screening program in either the school or community.

Assessment. The scope and nature of a screening program should be based on the documented health needs of the population served. These needs may have been identified by a state agency and may be mandated by statute or regulation, or they may be identified by local school or community health personnel, parents, students, or educators. Decisions should be based on the definition of the target population that is at risk for developing an illness or condition that is not likely to be detected unless the screening program is offered.

Planning. Careful planning is the key to an effective screening program. The time invested at the planning stage will make implementation easier and more accurate. The school nurse should play a major role in the planning phase and will need to spend the required time to develop a successful program. The following activities and/or decisions should be addressed during the planning phase:

- ◆ Determine the purpose of the screening program.
- ◆ Define the population to be screened.
- ◆ Decide which screening procedure or test to use.
- ◆ Ensure that adequate resources are available for equipment and supplies; staff training; and staff time to conduct tests and retests, record results, interpret them to students and families, and conduct follow-up interventions.
- ◆ Determine referral criteria.
- ◆ Collaborate with members of the school health team, including community health providers, regarding the following issues: criteria used for referral for diagnosis and treatment, decisions regarding who will be treated, and what resources are available for follow-up interventions, especially for those who are uninsured.
- ◆ Plan the mechanics of the actual screening program, including determination of time required for screening, and designating screening personnel role responsibilities.
- ◆ Decide how to include content regarding the disease or condition and screening procedure into the health education curriculum

- ◆ Determine how to evaluate and report the results of the screening program.

Implementation. Implementation begins with the training of the screening personnel or arranging for training of staff (school nurses, health aides, physical education teachers, volunteers, and so forth). It encompasses the following steps as well:

- ◆ Order supplies.
- ◆ Ensure that the equipment is in good working order (e.g., audiometer, sphygmomanometer, or reflotron calibrated recently).
- ◆ Notify parents of screening.
- ◆ Recruit, orient, and train personnel and/or volunteers, if used.
- ◆ Arrange for space that is appropriate, quiet, and private.
- ◆ Perform the actual screening as planned. Document all test results on student health records.
- ◆ Re-screen students with borderline or questionable results (school nurse usually does this).
- ◆ Refer for follow-up care all those who fail to meet the criteria.
- ◆ Notify parent or guardian by letter and telephone call if appropriate.
- ◆ Notify medical provider by letter, usually via parent or guardian.
- ◆ Obtain reports from the medical provider or other related professionals, such as audiologists or optometrists regarding diagnosis, treatment, and follow-up care.
- ◆ Continue contact with parents or guardians, including home visits or telephone calls, until follow-up care is achieved.
- ◆ Communicate as needed with educational staff. Ensure confidential data handling.
- ◆ Attach follow-up medical reports to the health record.

Evaluation. Use evaluative outcome criteria that focus on the results of the program, measure behaviors, and give dates by which behaviors occur. Tally test data by grade; compare results to expected results based on national or state data. Finally, compare completed referrals to a set goal (e.g., “95% of referrals will be completed”). Work toward increasing the percentage of completed referrals.

Effective screening programs are likely to identify health problems that otherwise would not be identified until a later date, when treatment is less effective or more costly.

Screening does not substitute for a diagnostic evaluation. In addition, screening is useless if appropriate referral and follow-up care are not carried out effectively. Following up is a critical step at which early diagnosis and prompt treatment can effect remediation of the problem before it becomes a disability and/or more costly to treat. Screening and follow-up interventions are essential roles of the school health program.

Waiver Procedure. Waivers for some types of screening are available in order to make local school health programs more relevant to the community. Contact local school division for procedures and waiver requests.

Subsections

The following subsections identify and explain traditional student population health assessments that are typically used by health care providers in the school environment.

- ◆ Blood Pressure Screening
- ◆ Dental Screening and Oral Health
- ◆ Early Periodic Screening and Diagnosis and Treatment (EPSDT) Program and Medicaid/CMSIP
- ◆ Fine/Gross Motor Screening
- ◆ Hearing Screening
- ◆ Height and Weight Screening
- ◆ Scoliosis Screening
- ◆ Speech and Language Screening
- ◆ Vision Screening

Blood Pressure Screening

Authorization

No Specific Legal Mandate. There is no specific legal mandate to provide blood pressure screening. Blood pressure measurement should be included in the physical examination as part of the continuing care of the child, not as an isolated screening procedure. The school entry physical examination and the yearly athletic physical for high school athletes require documentation of a student's blood pressure.

Overview

Blood pressure assessment provides a physiological indicator of cardiovascular status. Hypertension (higher than normal blood pressure) in children is defined as persistent blood pressure elevation that is at or above the blood pressure of 95 percent of children at the same age and sex on initial screening. The detection of high blood pressure during childhood is of potential value in identifying those children who are at increased risk of primary hypertension (hypertension that develops without apparent cause) as adults and who might benefit from earlier intervention and follow-up care. For many children less than 10 years of age, there is an identifiable cause (secondary hypertension) that can be successfully treated. Older children and adolescents are more like to have primary hypertension. Early identification of children with elevated blood pressures may make it possible to halt the hypertensive process and the development of complications. Proper diet, regular exercise, and avoidance of smoking are important in helping to maintain normal blood pressure.

The American Academy of Pediatrics (AAP) recommends blood pressure measurements annually in children between 3 and 6 years of age and every 2 years thereafter. The American Medical Association (AMA) recommends blood pressure measurements annually during adolescence.

Recommendation

Procedure and Personnel. Trained health care personnel should follow standard practices for procedures for measuring blood pressure. To obtain an accurate measurement the cuff must cover two-thirds of the child's arm. Interpretation of the measurement is made by consulting a table of normative pressures for the child's age. Elevated readings should be confirmed on at least two separate occasions and the average computed.

National High Blood Pressure Education Program Working Group on Hypertension Control in Children and Adolescents published percentiles⁷⁶ and suggested the following classification of hypertension by age group, gender, and percentile of height.

Blood Pressure Levels for the 90th and 95th Percentiles of Blood Pressure for Boys Aged 1 to 17 Years by Percentiles of Height

Age Y	Blood Pressure Percentile*	Systolic Blood Pressure by Percentile of Height and mm Hg †							Diastolic Blood Pressure by Percentile of Height and mm Hg †						
		5%	10%	25%	50%	75%	90%	95%	5%	10%	25%	50%	75%	90%	95%
1	90th	94	95	97	98	100	102	102	50	51	52	53	54	54	55
	95th	98	99	101	102	104	106	106	55	55	56	57	58	59	59
2	90th	98	99	100	102	104	105	106	55	55	56	57	58	59	59
	95th	101	102	104	106	108	109	110	59	59	60	61	62	63	63
3	90th	100	101	103	105	107	108	109	59	59	60	61	62	63	63
	95th	104	105	107	109	111	112	113	63	63	64	65	66	67	67
4	90th	102	103	105	107	109	110	111	62	62	63	64	65	66	66
	95th	106	107	109	111	113	114	115	66	67	67	68	69	70	71
5	90th	104	105	106	108	110	112	112	65	65	66	67	68	69	69
	95th	108	109	110	112	114	115	116	69	70	70	71	72	73	74
6	90th	105	106	108	110	111	113	114	67	68	69	70	70	71	72
	95th	109	110	112	114	115	117	117	72	72	73	74	75	76	76
7	90th	106	107	109	111	113	114	115	69	70	71	72	72	73	74
	95th	110	111	113	115	116	118	119	74	74	75	76	77	78	78
8	90th	107	108	110	112	114	115	116	71	71	72	73	74	75	75
	95th	111	112	114	116	118	119	120	75	76	76	77	78	79	80
9	90th	109	110	112	113	115	117	117	72	73	73	74	75	76	77
	95th	113	114	116	117	119	121	121	76	77	78	79	80	80	81
10	90th	110	112	113	115	117	118	119	73	74	74	75	76	77	78
	95th	114	115	117	119	121	122	123	77	78	79	80	80	81	82
11	90th	112	113	115	117	119	120	121	74	74	75	76	77	78	78
	95th	116	117	119	121	123	124	125	78	79	79	80	81	82	83
12	90th	115	116	117	119	121	123	123	75	75	76	77	78	78	79
	95th	119	120	121	123	125	126	127	79	79	80	81	82	83	83
13	90th	117	118	120	122	124	125	126	75	76	76	77	78	79	80
	95th	121	122	124	126	128	129	130	79	80	81	82	83	83	84
14	90th	120	121	123	125	126	128	128	76	76	77	78	79	80	80
	95th	124	125	127	128	130	132	132	80	81	81	82	83	84	85
15	90th	123	124	125	127	129	131	131	77	77	78	79	80	81	81
	95th	127	128	129	131	133	134	135	81	82	83	83	84	85	86
16	90th	125	126	128	130	132	133	134	79	79	80	81	82	82	83
	95th	129	130	132	134	136	137	138	83	83	84	85	86	87	87
17	90th	128	129	131	133	134	136	136	81	81	82	83	84	85	85
	95th	132	133	135	136	138	140	140	85	85	86	87	88	89	89

* Blood pressure percentile determined by a single measurement.

† Height percentile determined by standard growth curves.

⁷⁶ National High Blood Pressure Education Program Working Group on Hypertension Control in Children and Adolescents. (1996). Update on the 1987 Task Force Report on High Blood Pressure in Children and Adolescents: A Working Group Report from the National High Blood Pressure Education Program. *Pediatrics*, 98(4), pp. 649-658.

Blood Pressure Levels for the 90th and 95th Percentiles of Blood Pressure for Girls Aged 1 to 17 Years by Percentiles of Height

Age Y	Blood Pressure Percentile*	Systolic Blood Pressure by Percentile of Height and mm Hg †							Diastolic Blood Pressure by Percentile of Height and mm Hg †						
		5%	10%	25%	50%	75%	90%	95%	5%	10%	25%	50%	75%	90%	95%
1	90th	97	98	99	100	102	103	104	53	53	53	54	55	56	56
	95th	101	102	103	104	105	107	107	57	57	57	58	59	60	60
2	90th	99	99	100	102	103	104	105	57	57	58	58	59	60	61
	95th	102	103	104	105	107	108	109	61	61	62	62	63	64	65
3	90th	100	100	102	103	104	105	106	61	61	61	62	63	63	64
	95th	104	104	105	107	108	109	110	65	65	65	66	67	67	68
4	90th	101	102	103	104	106	107	108	63	63	64	65	65	66	67
	95th	105	106	107	108	109	111	111	67	67	68	69	69	70	71
5	90th	103	103	104	106	107	108	109	65	66	66	67	68	68	69
	95th	107	107	108	110	111	112	113	69	70	70	71	72	72	73
6	90th	104	105	106	107	109	110	111	67	67	68	69	69	70	71
	95th	108	109	110	111	112	114	114	71	71	72	73	73	74	75
7	90th	106	107	108	109	110	112	112	69	69	69	70	71	72	72
	95th	110	110	112	113	114	115	116	73	73	73	74	75	76	76
8	90th	108	109	110	111	112	113	114	70	70	71	71	72	73	74
	95th	112	112	113	115	116	117	118	74	74	75	75	76	77	78
9	90th	110	110	112	113	114	115	116	71	72	72	73	74	74	75
	95th	114	114	115	117	118	119	120	75	76	76	77	78	78	79
10	90th	112	112	114	115	116	117	118	73	73	73	74	75	76	76
	95th	116	116	117	119	120	121	122	77	77	77	78	79	80	80
11	90th	114	114	116	117	118	119	120	74	74	75	75	76	77	77
	95th	118	118	119	121	122	123	124	78	78	79	79	80	81	81
12	90th	116	116	118	119	120	121	122	75	75	76	76	77	78	78
	95th	120	120	121	123	124	125	126	79	79	80	80	81	82	82
13	90th	118	118	119	121	122	123	124	76	76	77	78	78	79	80
	95th	121	122	123	125	126	127	128	80	80	81	82	82	83	84
14	90th	119	120	121	122	124	125	126	77	77	78	79	79	80	81
	95th	123	124	125	126	128	129	130	81	81	82	83	83	84	85
15	90th	121	121	122	124	125	126	127	78	78	79	79	80	81	82
	95th	124	125	126	128	129	130	131	82	82	83	83	84	85	86
16	90th	122	122	123	125	126	127	128	79	79	79	80	81	82	82
	95th	125	126	127	128	130	131	132	83	83	83	84	85	86	86
17	90th	122	123	124	125	126	128	128	79	79	79	80	81	82	82
	95th	126	126	127	129	130	131	132	83	83	83	84	85	86	86

* Blood pressure percentile determined by a single measurement.

† Height percentile determined by standard growth curves.

Referral and Follow-Up Process. All children with blood pressure readings inconsistent with norms for their age, weight, sex, and height should be referred to their health care provider for follow-up care. Every attempt should be made by school health personnel to work with parents, encouraging follow-up care with their health care provider and getting feedback on any changes that the health care provider recommends, in order that school personnel can make the appropriate educational adjustments.

If a student has been identified as having blood pressure measurements that are of concern to their health care provider, the school nurse should work closely with the

student's teachers in order to ensure any necessary adjustments are made in the classroom to provide the child with an optimum learning experience.

Documentation

Recording Recommendation. A record of the blood pressure screening of each student can be kept by recording the results on the following form:

- ◆ Cumulative Health Record (Form LF.009).

Copy of Forms. See Appendix D for a copy of the following form:

- ◆ Cumulative Health Record (Form LF.009).

Dental Screening and Oral Health

Authorization

No Specific Mandate. There is not a specific mandate for dental screening in Virginia.

Overview

Dental screening is an opportunity to detect early dental or oral health problems in children. Screening is not a replacement for a complete examination in a dentist's office. However, dental screening can be an important component of an oral health program and an important element of a school health program.

Oral health is a critical aspect of an individual's overall health, contributing to their general wellness and affecting their quality of life. General physical health, appearance, speech, and interpersonal relations are all impacted by an individual's oral health. Addressing such issues as oral hygiene, the quality of dental care, community water fluoridation, and good nutrition and safety habits at a young age will help determine the quality of a person's oral health throughout their life.

The American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) recommend that a child's first dental visit should occur at the age of 3, with frequency of subsequent visits determined by the dentist. The American Academy of Pediatric Dentistry, the American Society of Dentistry for Children, and the American Dental Association recommend that a child's first dental visit should occur at 6 months of age or when the first tooth erupts, whichever comes later, but no later than 1 year of age, with the frequency of subsequent visits determined by the dentist.

Schools have a unique opportunity to effect the oral/dental health of the community by providing:

- ◆ Dental screening to all students.
- ◆ Dental health education, in an effort to create an awareness of the importance of good dental health and well-balanced nutritious meals as part of the school food service.

In addition, by collaborating with the Virginia Department of Health, Division of Dental Health, and local health departments, schools can help to ensure:

- ◆ Dental care for children who might otherwise not receive treatment, such as fluoride and sealants as determined by dental experts.
- ◆ Fluoridation of the public water supply.

- ◆ Access to services, such as consultation and in-service training for teachers, school nurses, and interested community groups.

Children suffering with oral disease often are unable to concentrate on their school work. They may be experiencing pain related to dental caries or infection and/or be unable to chew, resulting in decreased nutrition. Both of these conditions can severely limit the ability of a child to focus on school work. Additionally, poor oral health can result in a speech defect, poor appearance, and permanent loss of teeth. Consequently, this impairment of a child's overall physical and emotional health can result in an inability to achieve their academic and social potential.

Recommendation

A school health program should attempt to include:

- ◆ Dental screening.
- ◆ Dental health education.
- ◆ Referrals and follow-up care.

Dental Screening. If children are to maintain optimum oral health, they should have a dental examination on a routine basis. Ideally, the examination should be done in the dentist's office. If this is not possible, then less comprehensive inspections or screenings can be done in the school setting. The screening should look for the presence of dental caries (tooth decay), periodontal disease (inflammation of the gums and supporting structures), malocclusion (irregularity of the teeth or jaw), and trauma from oral injuries.

School nurses, using a tongue blade and adequate illumination (e.g., penlight) can detect tooth decay and gum problems (e.g., mild gingivitis). However, x-rays are necessary to detect interproximal caries in the early stages. (Please see Appendix E for a copy of a sample dental referral form.)

Referral and Follow-Up Process. All children with obvious dental caries, mild gum disease, or complaint of oral pain related to possible infection or injury should be referred to their dentist for a more complete examination. Every attempt should be made by school health personnel to work with parents, encouraging follow-up care with the dentist and getting feedback on any changes that the dentist recommends, in order that school personnel can make the appropriate educational adjustments.

Teachers can play an important role in promoting good dental care and oral health. They can identify children in the classroom who are in pain related to dental problems or a child with a speech defect that may be related to a dental problem and possibly expedite a referral. In addition, reinforcement of dental health education issues by teachers, including good daily oral hygiene and good nutritional and safety habits, may contribute to a decrease in the incidence of children with oral health problems.

Dental Education. The schools can promote good oral health and prevent oral problems by educating students and parents. Oral health education should focus on:

- ◆ Prevention of decay through proper methods of oral hygiene (e.g., brushing, flossing).
- ◆ Use of fluoride or fluoridated water.
- ◆ Good nutrition by restricting candy and soft drinks.
- ◆ Prohibiting the possession of tobacco products and providing information on the dangers of all tobacco products, including chewing tobacco.
- ◆ The importance of using mouth-guards in organized high body contact sports. (The National Collegiate Athletic Association has mandated use of mouth-guards for football, hockey, men’s lacrosse, and women’s field hockey. Mouth-guards are recommended for basketball and baseball because many orofacial injuries occur in these sports.)
- ◆ Cautioning children about running, pushing, and shoving other children. (Fractures of teeth frequently occur at drinking fountains as a result of these activities.)
- ◆ The dangers of poorly designed school play equipment. (Schools and the community should work closely to provide safe play equipment for all children.)

Resources. An effective dental screening and oral health education program require the availability and use of resources in the community. Local health departments, the Virginia Department of Medical Assistance Services, and the Virginia Department of Health, Division of Dental Health, provide resources for the children in Virginia. The following chart provides a summary of resources available from the health department and other local and state agencies.

Dental Screening and Oral Health Education Programs

Program	Resources Available
Health Departments	<ul style="list-style-type: none"> ◆ Many local health departments provide dental care for pre-school and school-age children. Charges are on a sliding fee schedule based on family income. Children on free lunch are not charged. ◆ Dental personnel of the local health departments are an excellent resource for consultation, in-service education, screenings, and dental education in the schools.
Department of Medical Assistance Services	<ul style="list-style-type: none"> ◆ Dental care is available through private practitioners and the many local health departments for children eligible for Medicaid. Eligibility is based on income and other factors determined by the local department of social services. Not all dentists accept Medicaid. Check with the dentist before referring children for care.
Virginia	<ul style="list-style-type: none"> ◆ Fluoridation of Public Water Supply—This is the best method

Dental Screening and Oral Health Education Programs

Program	Resources Available
Department of Health, Division of Dental Health.	<p>available to prevent dental decay in a community. The Division will provide funds for any community with a population of more than 800 people to fluoridate the public water supply.</p> <ul style="list-style-type: none"> ◆ School Based Fluoride Mouthrinse Programs—This practice, for use in rural areas without fluoridated water, is another excellent method of reducing dental decay. Children rinse for 1 minute once a week with a diluted fluoride solution. The division will provide training and supplies for the first year and fluoride rinse for subsequent years. Targeted grades are K-6 for this prevention dental program. Approximately 45 counties have schools participating in their programs. ◆ The division will provide consultation on oral health topics and will provide in-service training for teachers and school nurses. Upon request, educational materials are also available on a limited basis. ◆ Dental Surveys and Screenings—The division will conduct dental screenings and perform epidemiological surveys to determine the dental needs of a school division in selected areas of the state. ◆ For further information on any of these services or programs, please contact the Virginia Department of Health, Division of Dental Health, P.O. Box 2448, 1500 East Main Street, Room 136, Richmond, VA, 23218-2448, or call (804) 786-3556.
Local and State Dental and Dental Hygiene Societies	<ul style="list-style-type: none"> ◆ Assistance may be obtained from local dental or dental hygiene societies or the Virginia Dental Association. Please contact one of the local dentist or hygienists in your community for assistance.

Documentation

Recording Recommendation. A record of the dental screening of each student can be kept by recording the results on the following form:

- ◆ Cumulative Health Record (Form LF.009).

Copy of Forms. See Appendix D for a copy of the following form:

- ◆ Cumulative Health Record (Form LF.009).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Medicaid/CMSIP

Overview

This subsection presents a brief summary of Medicaid and school health services, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and the Virginia Children’s Medical Security Insurance Plan (CMSIP). The information is from *Medicaid and School Health: A Technical Assistance Guide*, August 1997, Health Care Financing Administration (HCFA)—the federal agency that administers the Medicare, Medicaid, and Child Health Insurance Programs. Additional information is included throughout this subsection following the word “note.”

The purpose of the *Technical Assistance Guide* is to provide information and technical assistance regarding the specific Federal Medicaid requirements associated with implementing a school health services program and seeking Medicaid funding for school health services. Because of the numerous types of school-based arrangements in existence throughout the country, in the guide, “school health and school-based services” refers to any type of Medicaid-covered school-based health services provided by or within a school system, whether in the school, through a school-based or school-linked clinic or through the Individuals with Disabilities Education Act (IDEA).

For additional information and technical assistance regarding the specific federal Medicaid requirements associated with implementing a school health services program and seeking Medicaid funding for school health services, please refer to:

Medicaid and School Health: A Technical Assistance Guide, August 1997
U.S. Department of Health and Human Services
Health Care Financing Administration
7400 Security Boulevard
Baltimore, MD 21244-1850
Web site: <http://www.hcfa.gov/medicaid/scbintro.htm>

Medicaid

Overview. *Medicaid is a jointly-funded, federal-state health insurance program for certain low-income and needy people. It covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments.*

According to Medicaid and School Health: A Technical Assistance Guide, August 1997, HCFA, the Medicaid Program was authorized by Congress as part of the Social Security Act Amendments of 1965 and became Title XIX of the Act. Medicaid is a health insurance program for certain low-income families with children; aged, blind or disabled

people on Supplemental Security Income; certain low-income pregnant women and children; and people who have very high medical bills.

Medicaid is funded and administered through a state-federal partnership. Although there are broad federal requirements for Medicaid, each state designs and administers its own program, which creates substantial variation among state programs in terms of persons covered, types and scope of benefits offered, and the amount of payments for services. States have authority to:

- ◆ Establish eligibility standards.
- ◆ Determine what benefits and services to cover.
- ◆ Set payment rates.

Each state operates its Medicaid program in accordance with its State Plan for Medical Assistance, a document that describes the state's basic eligibility, coverage, reimbursement and administrative policies. The State Plan must be approved by the Health Care Financing Administration (HCFA), the federal agency that administers the Medicaid program. HCFA administers the Medicaid program through 10 Regional Offices located throughout the country. Each state's State Plan is periodically updated to reflect changes in state policy or to conform to new federal requirements.

Because states have flexibility in structuring their Medicaid programs, there are variations from state to state. All states, however, must cover these basic services: inpatient and outpatient hospital services; laboratory and X-ray services; skilled nursing and home health services; doctors' services; family planning; and periodic health checkups, diagnosis and treatment for children.

Medicaid and School Health Services. According to Medicaid and School Health: A Technical Assistance Guide, August 1997, HCFA, school health services play an important role in the health care of adolescents and children. Whether implemented for children with special needs under the Individuals with Disabilities Education Act (IDEA), or for routine preventive care, on-going primary care and treatment in the form of a school-based or linked health clinic, school-centered programs are often able to provide medical care efficiently and easily without extended absences from school. Recognizing the important role school health services can play, the Medicaid program has been supportive of school-centered health care as an effective method of providing access to essential medical care to eligible children.

There are, however, challenges in the collaboration between the Medicaid program and the schools. Federal Medicaid requirements are complex and the implementation of Medicaid varies by state. Because many schools are unaccustomed to these requirements and the complexity of operating in the "medical services world," understanding and negotiating Medicaid in order to receive reimbursement often has the effect of placing a considerable administrative burden on schools.

In order for Medicaid to reimburse for health services provided in the schools, the services must be included among those listed in the Medicaid statute (section 1905(a) of the Act) and included in the state's Medicaid plan or be available under the Early and Periodic Screening, Diagnostic and Treatment benefit (EPSDT, described below). There

is no benefit category in the Medicaid statute titled “school health services” or “early intervention services.” Consequently, a state must describe its school health services in terms of the specific section 1905(a) services that will be provided. Except for services furnished under EPSDT, a service must be specifically identified in the state’s Medicaid plan to make Medicaid payment available for it.

Issues for School Health Services Providers and Medicaid Managed Care. According to *Medicaid and School Health: A Technical Assistance Guide*, August 1997, HCFA, the pursuit of Medicaid reimbursement for school health services is complicated by the recent growth in Medicaid managed care. A school provider who becomes accustomed to the Medicaid rules under the “traditional” Medicaid fee-for-service practice may find the system and accompanying requirements completely changed if a state decides to move its beneficiaries into Medicaid managed care. Because a state that mandatorily moves Medicaid beneficiaries into managed care does so under a waiver, there are no specific statutory requirements for states to establish relationships between school-based providers and managed care entities. HCFA policy is to strongly encourage states, upon submission and negotiation of their waivers, to promote relationships between the managed care entities and school-based providers. HCFA also encourages schools and school districts to get involved with the state and/or managed care entities during the formation of the waivers in order to establish relationships and ensure a place in the new health delivery system. In this manner, provision of medical services can be coordinated by the school-based providers and the managed care entities in order to ensure children receive necessary services and care is not duplicated.

There are many types of arrangements that states put in place under their waivers to promote and assure the coordination of care between managed care entities and school-based providers. Some states have instituted state laws that require coordination between managed care organizations and school-based health providers. In addition, some school-based health providers have developed formal arrangements, including legal contracts; protocols for referral and treatment; authorization for school based providers to provide services to managed care enrollees and bill Medicaid directly; and commitments to expedite the treatment of patients referred by school-based health providers. Some states, in their waivers, “carve out” school-health services and reimburse those services under the “traditional” Medicaid fee-for-service program. However, most states carve out Medicaid-covered IDEA services in their waivers, and place the responsibility of primary and preventive services with the managed care entity. While formulating such arrangements with managed care entities often entails an administrative burden and can be a cumbersome process, schools and school-based health centers that serve Medicaid beneficiaries in states that move their beneficiaries into managed care must secure a role in the managed care system if they are to be reimbursed for the services provided to children.

Virginia. In Virginia, the Virginia Department of Medical Assistance Services (DMAS) is the organization that is directly responsible for the administration of the Medicaid program. Eligibility determinations and enrollment of eligible children are handled by local Department of Social Services offices.

For more information, please contact:

Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
Telephone (804) 786-7933
Web site: <http://dit1.state.va.us/~dmas/>

Children's Medical Security Insurance Program (CMSIP)

***Overview.** The federal Children's Health Insurance Program matches federal funds to help states expand health care coverage to the nation's estimated 10 million uninsured children. The Children's Health Insurance Program is designed to give states maximum flexibility while ensuring meaningful coverage. States may set eligibility at up to 200 percent of the federal poverty level, or at 50 percent above their current Medicaid eligibility level, whichever is higher. Coverage would include inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and X-ray services, and well baby/child care including immunizations.*

Virginia CMSIP. Virginia's child health insurance program, called the Children's Medical Security Insurance Plan (CMSIP), is designed to provide comprehensive health benefits for uninsured children (under 19 years) of working families with household incomes below 185 percent of the federal poverty level (FPL) who do not qualify for Medicaid. Depending upon the age of the child, the maximum household income for Medicaid eligibility is 100 percent to 133 percent of FPL. Children enrolled in CMSIP receive all the health services provided to Medicaid recipients (inpatient and outpatient hospital care, physician's and surgical services, psychiatric or psychological services, laboratory and radiological health services, and EPSDT) plus additional benefits for substance abuse treatment.

The Virginia Department of Medical Assistance Services administers CMSIP. Eligibility determinations and enrollment of eligible children are handled by the local Department of Social Services offices.

For more information, contact:

Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
Telephone: (804) 786-7933
Web site: <http://www.state.va.us/~dmas/>

Virginia Children's Medical Security Insurance Plan Information Line:
1-877-VA-CMSIP [1-877-822-6747] (toll free)

Early Periodic Screening, Diagnostic and Treatment (EPSDT)

Overview. According to *Medicaid and School Health: A Technical Assistance Guide, Health Care Financing Administration, August 1997, HCFA*, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a mandatory Medicaid benefit for children under the age of 21 which, at a minimum, must include screening services, vision services, dental services, hearing services, and other necessary diagnostic and treatment services within the Medicaid statute whether or not the services are generally included under the state's Medicaid plan.

EPSDT is Medicaid's comprehensive and preventive children's health care program geared toward early assessment of children's health care needs through periodic examinations. The goal is to assure that health problems are diagnosed and treated as early as possible, before the problems become complex and treatment more costly. States must develop periodicity schedules for each service after consultations with organizations involved in child health care.

The following are required EPSDT services (under Section 1905[r] of the Act):

◆ **Screening services**, which must contain the following five elements:

1. Comprehensive health and developmental history, including assessment of both physical and mental health development.

Note: A comprehensive developmental assessment should be obtained by history and observation of the child, by a developmental screening test. Developmental assessment is part of every routine initial and periodic examination, including gross motor development, fine motor development, communication skills or language development, social and emotional development, and cognitive skills.

2. Comprehensive unclothed physical exam.

Note: An unclothed physical exam is performed by physician or licensed nurse practitioner.

Note: State law requires that any suspicion or evidence of physical abuse or neglect be reported the Department of Social Services. (See the section on "Referring Child to Protective Services" within this Chapter).

3. Appropriate immunizations according to the ACIP (Advisory Committee on Immunization Practice) schedule.

Note: All immunizations are covered by EPSDT. Reimbursement of immunizations is for administration only. All vaccines must be obtained through the Virginia Department of Health's Virginia Vaccines for Children (VVFC) program, which is a federally mandated program. For further information about

VVFC, please contact the Virginia Department of Health, Division of Immunization, at (804) 786-6246.

4. Laboratory tests, including blood lead level assessment.

Note: The following laboratory tests are required components of the EPSDT screening program. (See periodicity chart at the end of this section.)

- Hematocrit/hemoglobin
- Sick cell
- Tuberculin
- Lead toxicity screen
- Urinalysis (if age appropriate)

Note: The provider who is performing the services is the one who bills for the services. Therefore, if laboratory work were being sent out to a lab to be processed, the school would only bill for shipping and handling.

Note: Physical and laboratory determination will be useful in assessing nutritional status or consideration for WIC (Women, Infants, and Children's Supplemental Food Program) eligibility. This is only available to children under 5 years old.

5. Health education, including anticipatory guidance.

Note: According to *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*,⁷⁷ anticipatory guidance provides the family with information on what to expect in the child's current and next developmental phases. The wide range of anticipatory topics to be considered for each health supervision visit (e.g., EPSDT visit) include:

- Benefits of a healthy lifestyle and practices
- Prevention of illness and injury
- Nutrition
- Oral health
- Sexuality
- Social development
- Family relationships
- Parental health

⁷⁷ Green M. (Ed.). 1994 *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Arlington, Va.: National Center for Education in Maternal and Child Health.

- Community interactions
- Self-responsibility
- Social/vocational achievement

- ◆ **Vision services**, which at a minimum must include diagnosis and treatment for defects in vision, including eyeglasses.

Note: Vision screening does not require machine testing but should include at a minimum the Snellen or other standard vision chart.

- ◆ **Dental services**, which at a minimum must include relief of pain and infection, restoration of teeth, and maintenance of dental health.

A semi-annual direct referral to a dentist for dental screening is required beginning at age three. Oral screening is not a substitute for examination through direct referral to a dentist.

- ◆ **Hearing services**, which at a minimum must include diagnosis and treatment for defects in hearing, including hearing aids.

Note: Hearing screening should use standard testing methods. If an abnormality is found, schedule a second screening with a physician or audiologist.

Note: Children diagnosed as hearing impaired should be referred to Children Specialty Services via the local health department for evaluation and authorization of hearing devices. If the student is being evaluated for special education, the Director of Special Education should be involved.

- ◆ **Other necessary health care, diagnostic services and treatment services.** As with all Medicaid services, any limitation that the state imposes on EPSDT services must be reasonable and the benefit provided must be sufficient to achieve its purpose. In addition, states must provide other necessary health care, diagnostic services, treatment and other measures described that are listed under the Medicaid statute, to correct and ameliorate defects and physical and mental illnesses and conditions discovered by screening services, whether or not covered in a particular state Medicaid plan.

This means that if the state does not cover an optional service under its state plan, such as occupational therapy, the state would have to make medical assistance available for the service when furnished to a child eligible for EPSDT if occupational therapy is medically necessary. As such, EPSDT constitutes an exception to the comparability requirements in that the state does not have to make comparable services to all Medicaid beneficiaries. This is an important point because this means that if medically necessary, a Medicaid eligible child is entitled to any Medicaid-coverable service, regardless of whether the state covers it in the state plan or not. However, a state may still subject these services to prior authorization for purposes of utilization control.

- ◆ **Provision of medically necessary interperiodic screening.** Interperiodic screenings, outside of the state’s established periodicity schedule, must be made available to EPSDT beneficiaries when an illness or condition is suspected that was not present during the regular scheduled periodic screening. Referrals for interperiodic screens may be made by a physician, school nurse, and parent, or by self-referral. The provider performs the necessary screening components, which need not include all five elements of the required periodic screening, and provides or refers for any additional diagnostic or treatment services.

The referral for interperiodic screening can be made by any health or developmental education personnel who comes in contact with the child, within or outside of the health care system. The purpose of the interperiodic screening is to assure that children are assessed as soon as a problem is suspected even if they are not scheduled for a complete screening for many months. For example, a teacher might suspect a speech delay in a child based on the child’s performance in the classroom. The child could have already received his or her periodic screen. The teacher can refer the child to a speech pathologist (either through or outside the school system) for an interperiodic exam to determine if the child does indeed have a speech delay needing treatment. State Medicaid agencies cannot require prior authorization for either periodic or interperiodic screens as this would be an inappropriate limitation on the very service which is needed to determine that a medical or mental health problem exists.

Because of the proximity of schools to the target population, HCFA has always encouraged the participation of schools in the Medicaid program as they can play a particularly useful role in providing EPSDT services. School-based health services can represent an effective tool that can be used to bring more Medicaid-eligible children into preventive and appropriate follow-up care.

In addition, schools present a wonderful opportunity for Medicaid outreach. That is, because schools are by definition “in the business of serving children,” they can be a catalyst for encouraging otherwise eligible Medicaid children to obtain primary and preventive services, as well as other necessary treatment services.

Resources and Publications

The following lists some resources and publications that provide further information and insight into the relationship of schools to Medicaid managed care. In addition, specific information regarding Medicaid managed care enrollment can be accessed via the Internet at <http://www.hcfa.gov>.

Publications

- ◆ *A Partnership for Quality and Access: School-Based Health Centers and Health Plans.*
The School Health Policy Initiative

Division of Adolescent Medicine
Department of Pediatrics
Montefiore Medical Center
111 East 210th Street
Bronx, NY 10456-2490
(718) 654-4190

- ◆ Hacker K. Integrating School-Based Health Centers into Managed Care in Massachusetts, *Journal School Health*, 66(9) November 1996, 317-321.

Resources

- ◆ National Assembly on School-Based Health Care
666 11th Street, NW, Suite 735
Washington, D.C. 20005
Telephone: (202) 638-5872 or (888) 286-8727 (toll free)
Web site: <http://www.nasbhc.org/>
Note: NASBHC is a nonprofit private association representing school-based health care providers and supporters.
- ◆ *Making the Grade*
(State and Local Partnerships to Establish School-Based Health Centers)
1350 Connecticut Ave., NW, Suite 505
Washington, DC 20036
Telephone: (202) 466-3396
Web site: <http://www.gwu.edu/~mtg/>
Note: MTG is a national program of the Robert Wood Johnson Foundation located in

the School of Public Health and Health Services at The George Washington

University

Virginia

- ◆ *Virginia Medicaid Toll-Free Lines (updated October 16, 1998).*
1-800-552-8627--Medicaid Provider Helpline
1-800-358-5050--Transportation Helpline
1-800-643-2273--Medallion/Health Maintenance Organization (HMO) Helpline
1-800-421-7376--Maternal & Child Health Helpline
1-800-884-9730--Eligibility Helpline
1-877-822-6764--Virginia Children's Medical Security Insurance Plan

Virginia EPSDT Periodicity Schedule: Recommendation for Preventive Health Care

	INFANCY						EARLY CHILDHOOD					LATE CHILDHOOD					ADOLESCENCE			
AGE (m-months, y-years)	By 1 m	2 m	4 m	6 m	9 m	12 m	15 m	18 m	2 y	3 y	4 y	5 y	6 y	8 y	10 y	12 y	14 y	16 y	18 y	20 y
HISTORY Initial/Interval	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MEASUREMENTS																				
Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X	X	X												
Blood Pressure										X	X	X	X	X	X	X	X	X	X	X
SENSORY SCREENING																				
Vision	X	X	X	X	X	X	X	X	X	X _t	X _t	X _t	X _t	X _t	X _t	X _t	X _t	X _t	X _t	X _t
Hearing	X	X	X	X	X	X	X	X	X	X _t	X _t	X _t	X _t	X _t	X _t	X _t	X _t	X _t	X _t	X _t
DEVELOPMENT/ BEHAVIOR ASSESSMENT	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PHYSICAL EXAM	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
ANTICIPATORY GUIDANCE	X	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
PROCEDURES																				
Hereditary/Metabolic Screening	X																			
Immunization		X	X	X			X	X	X			X						X		
Tuberculin Test	<----->				X	>	<----->		X	>	<----->		X	>	<----->		X	>	<----->	
Anemia Testing	<----->				X	>	<----->		X	>	<----->		X	>	<----->		X	>	<----->	
Urinalysis	<----->		X	>	<----->		<----->		X	>	<----->		X	>	<----->		X	>	<----->	
Lead High Risk						X	(x)	X	X	X	X									
Lead Low Risk				(x)	X		(x)	X	(x)											
DENTAL REFERRAL									(x) <---				Semi-Annual Referral							Required ----->

x To be performed

(x) Required if not done when previously scheduled.

x_t Required at this age. Standardized screening method.

1 For high risk groups. Annual TB skin testing is recommended.

2 Present medical evidence suggests the need for reevaluation of the frequency and timing of hemoglobin, EP or hematocrit tests. One determination is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.

3 Present medical evidence suggests the need for reevaluation of the frequency and timing of urinalyses. One determination is therefore suggested during each time period. Performance of additional tests is left to the individual practice experience.

4 Testing is based upon risk. High-risk children with elevated blood tests may require more frequent testing based upon recent medical evidence and according to individual experience.

Fine/Gross Motor Screening

Authorization

Code of Virginia, Section 22.1-214, Board to Prepare Special Education Program for Children with Disabilities.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-214.

Regulations. Virginia Department of Education (Effective January 1994). *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*. Richmond, Va.: Author.

Excerpt: Part III: Responsibilities of LEAS and State Agencies.

§3.2 Identification, Evaluation, and Eligibility.

C. Screening.

2. *The screening process for all children enrolled in the school division is as follows:*

a. *All children within 60 administrative working days of initial enrollment in a public school, shall be screened in the following areas to determine if formal assessment is indicated:*

(1) *Speech, voice, and language; and*

(2) *Vision and hearing.*

b. *All children (through grade three), within 60 administrative working days of initial enrollment in public schools, shall be screened for fine and gross motor functions to determine if formal assessment is indicated.*

c. *Specific measures or instruments will be employed which use:*

(1) *Both observational and performance techniques; and*

(2) *Techniques which guarantee non-discrimination.*

Recommendation

Purpose. Basic gross and fine motor screening is crucial in determining if the student is developing within the “normal range.” The five areas that need to be screened to ensure

normal development include balance, bilateral coordination, upper extremity coordination, visual motor control, and upper extremity speed and dexterity. Fine and gross motor skills are essential building blocks to educational success.

The screening also allows the parents and administrators to be notified when any student shows signs of a significant impairment that should be followed up by a physician. It also gives information to teachers and parents regarding delays in development of gross and fine motor skills of the child.

Procedure

Materials. The following materials are used for the K-3 screening:

- ◆ Playground ball (8 1/2 inches).
- ◆ Playground ball (4 to 5 inches).
- ◆ Piece of paper with a circle.
- ◆ Piece of paper with a curved path that is 3/4-inch wide.
- ◆ Pegboard.
- ◆ Ten small pegs.
- ◆ Stopwatch.

Criteria. The criteria for failing the fine and gross motor screening is that the student must fail two out of the three gross motor sections and both of the fine motor skills. The evaluation sheet should have two sections: one for comments and one for pass/fail. The student is allowed two attempts to pass each skill.

Five Screening Areas. The five areas that need to be screened to ensure normal development include:

- ◆ Balance.
- ◆ Bilateral coordination.
- ◆ Upper extremity coordination.
- ◆ Visual motor control.
- ◆ Upper extremity speed and dexterity.

Gross Motor Skills.

1. Balance

- ◆ Kindergarten: To pass, the child must be able to hold the right foot off the ground for 5 seconds, place it down, and hold the left foot off the ground for 5 seconds.
- ◆ Grades 1 and 2: To pass, the child must hold the right foot off the ground for 10 seconds, place it down, and hold the left foot off the ground for 10 seconds.
- ◆ Grade 3: To pass, the child must hold the right foot off the ground for 12 seconds, place it down, and hold the left foot off the ground for 12 seconds.

2. Bilateral Coordination

- ◆ Kindergarten, Grades 1 and 2: To pass, the student must be able to jump in the air and clap their hands while airborne five times consecutively.
- ◆ Grade 3: To pass, the child must be able to jump in the air and touch both heels with both hands during two out of three trials.

(Examiners should note if the child is unable to perform the claps and jumps in an integrated fashion and if there are any overflow reactions in facial features)

3. Upper Extremity Coordination

- ◆ Kindergarten and Grade 1: To pass, the child must toss an 8 1/2-inch playground ball in the air and catch it five consecutive times. The ball must leave the hands and may be trapped in the body.
- ◆ Grades 2 and 3: To pass, the child must toss a 4- to 5-inch ball into the air and catch it with hands, five times consecutively, with their hands only.

(Examiners should note if the ball does not go above the child's head, if the child stays stationary to catch the ball, and/or if the ball is tossed straight in the air.)

Fine Motor Skills.

1. Visual Motor Skills

- ◆ Kindergarten: To pass, the child must copy a circle and make predominantly circular lines. (See Figure 1 at the end of this section.)
- ◆ Grades 1, 2, and 3: To pass, the child must draw a line within a curved path without making more than two deviations from the curved line. (See Figure 2 at the end of this section.)

(Examiners should note if the child is unable to grasp a pencil properly, does not rotate the paper, and/or if the pencil stays on the paper while the child is duplicating the circle or the path.)

2. Upper Extremity Speed and Dexterity

- ◆ Kindergarten: To pass, the child must place five pegs, using one hand, into a pegboard within 30 seconds.
- ◆ Grades 1 and 2: To pass, the child must place five pegs, using one hand, into a pegboard within 20 seconds.
- ◆ Grade 3: To pass, the child must place five pegs, using one hand, into a pegboard within 15 seconds.

(Examiners should note if the child picks/does not pick up the pegs one at a time, drops the pegs, does not stabilize the pegboard with one hand, and/or does not use the proper pincer grasp on the pegs.)

Referral and Follow-Up Process. Examiners should document the results of the child’s testing, make referrals when the child is unable to meet the screening guidelines, and place all test results in the child’s school record. If the student fails the screening, referral is made to the Child Study Committee for recommendations for further evaluation. It is important to document the fact that a student has difficulty in a particular area of the screening or fails the screening. The administration needs to be involved with the parents/guardians in helping the student.

Summary of Fine/Gross Motor Screening

Gross Motor Functions:

Skill	Grade	Screening Test
Balance	K	Balance on each foot for 5 seconds.
Bilateral Coordination	1-3	Balance on each foot for 10 seconds.
Fine Motor Functions	K-3	Jumping up and down on two feet and landing on both feet while clapping hands.
Upper Extremity Coordination	K-3	Toss and catch ball or bounce and catch, five times.

Fine Motor Functions:

Skill	Grade	Screening Test
Visual Motor Control	K	Copy a circle. (See Figure 1 on following page.)
	1-3	Draw a line within a curved path. (See Figure 2 on following page.)
Upper Extremity Speed & Coordination	K-3	Sort cubes or pegs; or, string beads.

Documentation

Recording Recommendation. A record of the fine and gross motor screenings of each student can be kept by recording the results on the following form:

- ◆ Cumulative Health Record (Form LF.009).

Copy of Form. See Appendix D for a copy of the following form:

- ◆ Cumulative Health Record (Form LF.009).

Figure 1.





Figure 2.

X

Hearing Screening

Authorization

Code of Virginia, Section 22.1-273, Sight and Hearing of Pupil to be Tested. The *Code of Virginia* requires that within the time periods and at the grades provided in regulations promulgated by the Board of Education, the principal of each such school shall cause the sight and hearing of the relevant pupils in the school to be tested, unless such students are pupils admitted for the first time to a public kindergarten or elementary school who have been so tested as part of the comprehensive physical examination required by § 22.1-270 or the parents or guardians of such students object on religious grounds and the students show no obvious evidence of any defect or disease of the eyes or ears.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-273.

Code of Virginia, Section 22.1-214, Board to Prepare Special Education Program for Children with Disabilities.

Excerpt:

The Board of Education shall prepare and supervise the implementation by each school of a program of special education designed to educate and train children with disabilities between the ages defined in § 22.2-213 and may prepare and place in operation such program for individuals of other ages...The program shall require (i) that the hearing of each disabled child be tested prior to placement in a special education program and (ii) that a complete audiological assessment, including tests which will assess inner and middle ear functioning, be performed on each child who is hearing impaired or who fails the test required in clause(i).

Regulations. Virginia Department of Education (Effective January 1994). *Regulations Governing Special Education Programs for Children with Disabilities in Virginia.* Richmond, Va.: Author.

Excerpt: Part III: Responsibilities of LEAS and State Agencies.

§3.2 Identification, Evaluation, and Eligibility.

C. Screening.

2. *The screening process for all children enrolled in the school division is as follows:*
 - a. *All children within 60 administrative working days of initial enrollment in a public school, shall be screened in the*

following areas to determine if formal assessment is indicated:

- (1) Speech, voice, and language; and*
 - (2) Vision and hearing.*
- b. All children (through grade three), within 60 administrative working days of initial enrollment in public schools, shall be screened for fine and gross motor functions to determine if formal assessment is indicated.*
- c. Specific measures or instruments will be employed which use:*
- (1) Both observational and performance techniques; and*
 - (2) Techniques which guarantee non-discrimination.*

E. Evaluation

- 5. The LEA shall establish procedures to ensure*
- a. That each child is assessed by a qualified professional in all areas related to the suspected disability, including, where appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities. This may include educational, medical, sociocultural, psychological, or developmental assessments. Reports from assessments must be provided in writing. However, the hearing of each child with a disability shall be tested during the eligibility process prior to be placement in a special education program. A complete audiological assessment, including tests which will assess inner and middle ear functioning, must be performed on each child who fails two hearing screening tests. The second hearing screening test shall be completed not less than 15 nor more than 45 calendar days after administration of the first screening test.*

SUPTS. MEMO. SUPTS. MEMO. No. 159, August 19, 1987, Subject: Procedure for Implementing School Law 22.1-273. (See Appendix A for copy of SUPTS. MEMO.)

Excerpt:

Because all children are required to have a physical examination when they first enter school, it was determined that this requirement would provide adequate screening for kindergarten students. Therefore, the only health screening required to be done for pupils will be for sight and hearing defects in grades 3, 7, and 10.

SUPTS. MEMO. SUPTS. MEMO. No. 168, September 2, 1987, Subject: Procedure for Implementing School Law 22.1-273. (See Appendix A for copy of SUPTS. MEMO.)

Excerpt:

Existing Board of Education regulations as specified in Regulations Governing Special Education Programs in Handicapped Children and Youth in Virginia, September 1984 stipulate that:

All children, within 60 administrative working days of initial enrollment in a public school, shall be screened in the following areas to determine if formal assessment is indicated: (a) speech, voice, and language; (b) fine and gross motor functions; and (c) vision and hearing.

Additional screening for vision and hearing should now occur in grades 3, 7, and 10.

Summary. *In Virginia, hearing screening is required as follows:*

- ◆ *Component of the School Entrance Health Form: Part II – Comprehensive Physical Examination Report. (See Code of Virginia, § 22.1-270.)*
- ◆ *Grades 3, 7, and 10—unless tested as part of the School Entrance Health Form: Part II – Comprehensive Physical Examination Report. (See Code of Virginia, § 22.1-273.)*
- ◆ *All children within 60 administrative working days of initial enrollment in a public school (see Regulations Governing Special Education Programs for Children with Disabilities in Virginia, effective January 1994).*
- ◆ *The hearing of each child with a disability shall be tested during the eligibility process prior to be placement in a special education program (see Regulations Governing Special Education Programs for Children with Disabilities in Virginia, effective January 1994).*

Overview

The purpose of a school hearing screening program is to identify students with a hearing loss that may impact their intellectual, emotional, social, speech, and/or language development. The subtlety of a hearing loss may lead to a child's hearing loss being overlooked. The school's hearing screening program can play an important role in ensuring no student has a hearing loss that goes undetected and unmanaged, resulting in further developmental or academic delays. Even mild hearing losses may be educationally and medically significant. An undetected hearing loss may result in:

- ◆ A delay in speech and language skills.

- ◆ Language deficits, which may lead to learning problems and limited academic achievement.
- ◆ Difficulties in communication, which may lead to social isolation and poor self-concept, resulting in emotional or behavioral problems.
- ◆ A negative impact on the child's vocational and educational choices.
- ◆ Behavioral problems.

Most children with significant hearing loss are identified prior to school entry. Research indicates that the critical period for screening is birth to 3 years, as auditory stimuli during this period appear to be critical to development of speech and language skills. However, conductive hearing loss in pre-school and school-age children related to otitis media (middle ear infection) that although, if treated, is temporary in nature, can cause hearing loss. Due to this possibility and the incidence of childhood hearing loss that has not been detected, hearing screening in the school setting can prevent the negative impact any hearing loss might have on a child's ability to communicate effectively and achieve academically. Hearing screenings at older age levels are important to identify noise-induced hearing loss.

Note. The incidence of significant permanent (sensorineural) hearing loss in newborns is approximately 6 in 100 live births. With the implementation of universal newborn hearing screening in the state of Virginia, the majority of newborns with significant congenital hearing loss should be identified within the first month of life and entered into the state's follow-up program.

American Academy of Pediatrics, American-Speech-Language Hearing Association and Bright Futures Recommendations. The American Academy of Pediatrics (AAP) recommends objective hearing testing at ages 3, 4, 5, 10, 12, 15, and 18.⁷⁸ *Bright Futures*⁷⁹ concurs with these recommendations up to age 12 and recommends that adolescents exposed to loud noises, with recurrent ear infections, or who report problems should receive objective testing. The American Speech-Language-Hearing Association (ASHA) has recommended annual pure-tone audiometry testing for all children at high risk for hearing impairment.⁸⁰

⁷⁸ American Academy of Pediatrics Committee on Practice and Ambulatory Medicine. (1995). Recommendations for Preventive Pediatric Health Care. *Pediatrics*, 96, pp. 373-374.

⁷⁹ Green, M. (1994). *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*. Arlington, Va.: National Center for Education in Maternal and Child Health.

⁸⁰ American Speech-Language-Hearing Association. (1985). Guidelines for Identification Audiometry. *ASHA*, 27, pp. 49-52.

History. A family and medical history of every child to be screened should be assessed for risk factors for hearing impairment. Whenever possible, parents should be asked about the auditory responsiveness and speech and language development of their child. Parental reports of impairment should be seriously evaluated. If this is not possible, when the results of the hearing screening indicate a problem or potential problem, the past medical history recorded on the school entrance physical examination should be evaluated for changes over time.

Recommendation

Procedure and Personnel. Each school division may set a policy, assigning the personnel responsible for completion of hearing screening. Speech-language pathologists and audiologists are qualified to conduct hearing screening programs. Certification programs for hearing screening are available for other personnel. Non-certified personnel responsible for the screening program should receive instruction in the proper techniques to be used. Training should be conducted by a currently licensed audiologist. Personnel conducting the screening should give an explanation of the test procedure to the class as a group, and individually as needed, prior to the testing to assure that students understand the purpose and process. Individual screening is required as group screening is not valid.

Care should be taken to choose a site for the testing that is in the quietest part of a building. Environmental noise levels should be low enough to allow a person with normal hearing to easily hear the pure tone frequencies through the ear phones. A soundproof room is preferable, if available.

Guidelines for Pure Tone Screening. The pure tone audiometer is used in school-based screening programs and must meet the standards for screening audiometers established by the American National Standards Institute (ANSI). It should have the air conduction frequencies of 500, 1000, 2000, and 4000 Hertz. Proper handling of these machines is required, with at least yearly calibration, in order to ensure accurate readings. The following are general steps for using a pure tone audiometer for testing hearing.

1. The examiner should turn on the machine and listen to screening tones to assure that audiometer is properly functioning, making sure to listen to both right and left earphones. (The recommendation is that the individual responsible for the audiometer should listen to it each day to detect gross abnormalities.) If screening is being done throughout the day, leave the audiometer on to avoid having to wait for the machine to warm up.
2. Have the student sit down positioned so he/she cannot see the examiner operate the audiometer.
3. Give clear, concise instructions. For example, “You are going to wear earphones.” “You will hear beeps. They will be quiet (soft) so you will have to listen carefully.”

- Please indicate when you hear the beep by immediately raising your hand.” “Please put your hand down when you no longer hear the beep. You will hear a louder sound first to let you hear clearly what you are listening for, then the sounds will be softer for testing.”
4. Have the student remove glasses and large earrings. Be sure student is not chewing food, candy, or gum.
 5. Place earphones on each ear (red earphone over student’s right ear; blue earphone over student’s left ear). Be sure that the earphones fit snugly and that nothing interferes with the passage of sound (remove hair from between earphone and ear).
 6. Set the Hearing Threshold Level at 20 dBHL and the frequency at 1000 Hz. Note: If the location is too noisy to use 20 dBHL, a new location must be secured. Screening should never be conducted at intensities greater than 25 dBHL.
 7. Present the tone 1000 Hz for one to two seconds. Right ear first. The tone may be presented twice to make sure the child hears the tone and understands what is supposed to be heard.
 8. Proceed to 2000 Hz, 4000 Hz, then 1000 Hz, and on to 500 Hz.
 9. Repeat the procedure in the left ear. Vary the length, tone, and pauses to prevent establishing a rhythm.
 10. If the student fails to hear any tone, it may be repeated at the same level.
 11. If the student fails to respond in either ear to two or more frequencies, a re-test should be scheduled within a two-week period. Referral should be made if the second screening results are not improved. If the screening is part of the special education eligibility process, the school should be responsible for obtaining an audiological evaluation.
 12. Record all results on the student’s permanent cumulative health record.
 13. Record screening results, per state and local policy, on student’s permanent record.
 14. At the end of the school year record hearing screening results on the School Summary of Screening of Vision and Hearing: Report to Principal (LF.011) and Summary of Screening of Vision and Hearing: School Division Report (LF.010).

Guidelines for Tympanometry Screening. A comprehensive hearing screening program includes tympanometry screening in addition to pure tone screening. Tympanometry screening should not replace pure tone screening. Tympanometry screening is recommended for all students kindergarten through third grade and all preschool-aged students in the early childhood special education programs or 4-year old programs.

The tympanometry equipment should comply with ANSI standards and provide information on tympanogram peak (Peak Y amplitude), width (Peak Y gradient), and volume of the external auditory canal (physical volume).

The probe tip should be cleaned with a fresh alcohol swab before each use. A tip should be selected that is large enough to create a seal in the external canal without having to be inserted too deeply.

Students with flat tympanograms, low static compliance (Peak Y), or abnormally wide tympanogram should be rescreened in 4 to 6 weeks.

Referral and Follow-Up Process. Parents of all students who do not perform satisfactorily on a hearing screening and subsequent re-test (within two weeks) are notified by school health personnel. A repeat failure of the screening indicates that there is sufficient deviation from the norm in the results of the screening test to justify parental notification. Parents should be advised to have the child evaluated by an audiologist or by their health care provider. If the screening is part of the special education eligibility process, the school should be responsible for obtaining an audiological evaluation.

Every attempt should be made by school health personnel to work with parents. Parents should be encouraged to follow up with their health care provider and get feedback on any changes that the health care provider feels need to be made in order that school personnel can make the appropriate educational adjustments.

If a student has been identified as having a hearing disability, speech-language pathologists, audiologists, and school nurses should work closely with classroom teachers to ensure any necessary adjustments are made in the classroom so that the student is provided with an optimum learning experience.

Documentation

Recording Requirement. Every principal must keep a record of the testing of the hearing of the relevant students and must notify the parent or guardian, in writing, of any defect of hearing or disease of the ears found. (See *Code of Virginia* § 22.1-273.)

Proof of Testing the Hearing of Pupils. A record of the testing of the hearing of each student can be kept by recording the results on the following form:

- ◆ Cumulative Health Record (Form LF.009).

Reporting Requirement. Copies of the hearing testing report are to be preserved for use by the Superintendent of Public Instruction, as the Superintendent may require. The following form can be used to preserve summaries of hearing screenings for each school. (See *Code of Virginia* § 22.1-273.)

- ◆ Summary of Vision and Hearing: Report to the Principal (Form LF.011, 3/95). This form is used to record a summary of the hearing screening results for each school, by required grade level. The completed form is sent to the LEA superintendent designee.
- ◆ Summary of Screening of Vision and Hearing: School Division Report (LF.010, 3/95). This form is used to record a summary of hearing screening results for each school division, by required grade level. It is a compliance of each school's LF.011.

Note. Students screened as part of a referral for special education must be referred back to the director of special education for an audiological evaluation.

Copy of Forms. See Appendix D for a copy of the following forms.

- ◆ Summary of Vision and Hearing: Report to the Principal (Form LF.011, 3/95).
- ◆ Summary of Screening of Vision and Hearing: School Division Report (LF.010, 3/95).
- ◆ Cumulative Health Record (Form LF.009).

Resources

American Academy of Otolaryngology. (1996). *Revised Referral Guideline Kit*. Alexandria, Virginia: American Academy of Otolaryngology, Head and Neck Surgery, Inc.

American Nurses Association. (1994). *Clinicians Handbook of Preventive Services*. Waldorf, Md.: Author.

American Speech-Language-Hearing Association. (1997). *Guidelines for Audiologic Screening*. Rockville, Md.: Author.

Massachusetts Department of Public Health. (1995). *Comprehensive School Health Manual*. Boston, Mass.: Author.

National Association of School Nurses. (1998). *The Ear & Hearing: A Guide for School Nurses*. Scarborough, Me.: Author.

U.S. Preventive Services Task Force. (1996). *Guide to Clinical Preventive Services, 2nd Ed.* Report of the U.S. Preventive Services Task Force. Baltimore, Md.: Williams & Wilkins.

Height and Weight Screening

Authorization

No Specific Mandate. There is no specific mandate for annual height and weight screenings in Virginia. However, height and weight measurements are a component of a complete physical examination and both are included in the comprehensive physical examination required for school entry into kindergarten or elementary school and the yearly physical examination for participation in competitive sports in the high school. (See previous subsections on School Entrance Physical Examination Requirements and Athletic Pre-Participation Physical Examination Requirements.)

Overview

Annual height and weight measurements provide a simple, effective method of identifying significant childhood health problems. Poor growth patterns can result from systemic disorders (e.g., malnutrition, intestinal conditions), psychosocial conditions (e.g., eating disorders), congenital disorders (e.g., Turner's Syndrome, intrauterine growth retardation), or conditions of the endocrine system (e.g., hypothyroidism, growth hormone deficiency).

In addition, yearly height and weight measurements can be used as an educational tool for parents, students, and school personnel by:

- ◆ Creating an awareness of the relationship between good nutrition and growth, and good health practices and growth.
- ◆ Stimulating interest in self responsibility for an individual's growth and development.

Major professional authorities—including the American Academy of Family Physicians (AAFP), the U.S. Preventive Service Task Force, and the American Academy of Pediatrics (AAP)—recommend yearly screenings of height and weight. The American Medical Association (AMA) recommends screening adolescents annually for eating disorders and obesity by measuring height and weight and by asking about body image and dieting patterns.

The range of normal height and weight varies for each child, but general growth remains relatively constant. After rapid growth in the first two years of life, growth generally slows down to 2 to 2 1/2 inches per year until puberty (approximately 11 to 13 years). Growth dramatically increases during puberty and lasts about two years until sexual development is achieved. At this point, the child's growth is nearly completed. Growth patterns should follow the normal growth curves of children the same age and sex and fall between the 5th and 95th percentile curves on a standardized growth chart.

Recommendation

Procedure and Personnel. Each school division should set a policy, assigning the personnel responsible for completion of annual height and weight screening. Classroom teachers, physical education teachers, school nurses, or parent volunteers given the responsibility for height and weight screening should receive instruction in proper techniques to be used. Applying appropriate measuring techniques and using well-calibrated equipment is essential. In addition, for accuracy, it may be necessary to take measurements more than once, particularly with young or uncooperative students. Furthermore, it is a good idea for one person to be responsible for taking heights and weights as measurements taken by different individuals may vary.

Growth must be charted on a standardized graph to have meaning to health care providers. Measurements should be interpreted within the context of the individual student's family and growth history.

Although most height and weight screenings are done in large groups, it is important to provide privacy during the actual measurements. This will eliminate the potential for embarrassment and teasing. The individual doing the screening may also try to use this time as an opportunity to gain insight into a particular student's health concerns, acquire information about the student's nutritional and exercise habits, and address particular concerns that student might have.

Equipment. Equipment should include a beam balance scale with non-detachable weights and a wall-mounted stadiometer or metal ruler (which is preferable to a non-stretchable tape measure) attached to a vertical, flat surface, such as a wall. A right-angle head board is also needed for lowering onto the student's head when taking the measurement.

Referral and Follow-Up Process. The school nurse is in an ideal position to ensure the early identification of students at risk for growth problems by providing appropriate assessments and referrals. The following conditions warrant a referral by the school nurse for follow-up care:

- ◆ Weight for height or for age is more than the 95th percentile.
- ◆ Weight for height, weight for age, or height for age is less than the 5th percentile.
- ◆ Student's growth pattern changes dramatically; for example, a student who has been consistently at the 50th percentile drops to the 10th percentile or rises to the 90th percentile.

Documentation

The growth chart should become part of the student's permanent health record. Any indications for referral and follow-up care should be documented in the student's health record.

Scoliosis Screening

Authorization

No Specific Legal Mandate. There is no specific legal mandate to provide scoliosis screening. Scoliosis screening should be included in the physical examination as part of the continuing care of the child, not as an isolated screening procedure.

SUPTS. MEMO. SUPTS. MEMO. No. 159, August 18, 1987, Subject: Procedures for Implementing School Law 22.1.1-273: Attachment. (See Appendix A for SUPTS. MEMO.)

Excerpt:

Practices That Are Encouraged:

That teachers at all grade levels be observant of speech defects, postural deviations, hearing impairments, dental defects, visual problems and significant deviations in height and weight. If observed, they should be recorded on the health record and reported to the school nurse for follow-up.

That scoliosis screening be done for all students in grades 5 through 9.

Overview

Scoliosis, a lateral spinal curve of 11 degrees or greater, can have adverse effects including the progressive development of poor range of motion, back pain, distortion of the position of the ribs, impaired function of the heart and lungs, unpleasant cosmetic deformities, and social and psychological problems, including poor self-image and social isolation. Early detection can prevent scoliosis from progressing and can identify those in need of treatment.

Screening for scoliosis in grades 5 through 9 (ages 10 to 15) has been recommended because the prevalence of scoliosis begins to increase at about age 10 to 11 with the pre-adolescent growth spurt and a lateral spinal curve of 11 degrees or greater is present in about 2 to 3 percent of adolescents at the end of their growth period. Progressive curves occur three or four times more frequently in girls than in boys. Scoliosis tends to run in families, and if scoliosis is diagnosed, other siblings should be evaluated.

Several professional organizations recommend screening for scoliosis. The Scoliosis Research Society recommends annual screening of all children ages 10 to 14. The American Academy of Orthopedic Surgeons recommends screening girls at ages 11 to 13 and screening boys once at age 13 or 14 years of age. The American Academy of Pediatrics has recommended scoliosis screening, with the forward bending test, at routine health supervision visits at ages 10, 12, 14, and 16 years (this recommendation is under

review), and the *Bright Futures* guidelines recommend noting the presence of scoliosis during the physical examination of adolescents and children greater than 8 years old.

Recommendation

Procedure and Personnel. If the school division provides scoliosis screening, school nurses should have the responsibility for organizing and implementing the scoliosis screening program collaboratively with physical education teachers. If the school nurse is unavailable, screening can be done by other licensed health professionals (e.g., physicians, nurses, or physical therapists) who have been trained in scoliosis screening technique. All school personnel participating in scoliosis screening should participate in a training session prior to screening.

The school division should send a letter to parents that explains the screening and ask for permission from the parents for the child to participate in the screening. (See sample letter of explanation/permission to parents related to scoliosis in Appendix E.)

The screening program has two components: (1) an initial educational session held by the screener and (2) the screening itself. The educational session should include information on what scoliosis is, how it is detected, why it is important to screen, what the screening procedure will entail, and what will be done for those with positive findings. It is advisable to suggest to students that they wear their gym uniforms for the screening.

Students should be advised that each screening takes from one to three minutes, depending on the examiner. The schedule for screening should be prepared in advance and coordinated with the various teachers.

Girls and boys are screened separately. An adult screener of the same gender as the student is preferable whenever possible. The optimal view of the spine occurs when the back is bare. Therefore, girls are asked to wear halter tops or a bra and boys will be asked to take off their shirts. Shoes must also be removed.

Every child should be screened in each of the following positions:⁸¹

1. Back View: (The screener should be seated 5 to 8 feet from the tape mark on the floor.) The student should stand erect with back to the screener, toes placed on the tape, feet together knees straight and weight evenly distributed on both feet. Arms should be at the sides and relaxed. Students should be encouraged to avoid slouching or standing at “attention.”

⁸¹ Comprehensive Health and Pupil Services. (1998). *Scoliosis Screening*. Albany, N.Y.: State Education Department, State of New York.



NORMAL

- ◆ Head centered over mid-buttocks.
- ◆ Shoulders level.
- ◆ Shoulder blades level with equal prominence.
- ◆ Hips level and symmetrical; equal distance between arms and body.



POSSIBLE SCOLIOSIS

- ◆ Head alignment to one side of mid-buttocks and one shoulder higher.
- ◆ One shoulder blade higher with possible prominence.
- ◆ One hip more prominent than the other or waist crease deeper on one side than the other and unequal distance between arms and body.

2. Forward Bend Test: The student should stand facing away from the screener. The student should bend forward at the waist 90 degrees, feet 4 inches apart, knees straight, and toes even. Palms of the hands are held together or facing each other and arms hang down, and are relaxed. The head is down.



NORMAL

- ◆ Both sides of upper and lower back symmetrical.
- ◆ Hips level and symmetrical.



POSSIBLE SCOLIOSIS

- ◆ One side of rib cage and/or the lower back showing uneven symmetry.
- ◆ Curve in the alignment of the spinous processes.
- ◆ If prominence is noted, scoliometer measurement should be taken.

3. Right Lateral View: (The screener remains seated.) The student continues to stand erect but is directed to stand first with right side toward the screener.

NORMAL



- ◆ Smooth symmetrical even arc of the back.

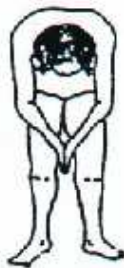


POSSIBLE KYPHOSIS (Round Back)

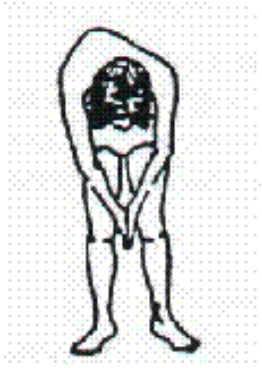
- ◆ Lack of smooth arc with prominence of shoulders and round back.
- ◆ Accentuated prominence of the spine (angular kyphosis of spine).
- ◆ Grossly accentuated swayback (when in upright position).

4. Frontal View: Have the student turn and face the screener and repeat the Forward Bend Test.

NORMAL



- ◆ Even and symmetrical on both sides of the upper and lower back.



POSSIBLE SCOLIOSIS

- ◆ Unequal symmetry of the upper back, lower back, or both.
- ◆ If prominence is noted, scoliometer measurement should be taken.

5. Left Lateral View: Have the student turn and stand with his/her left side toward the screener and repeat lateral view test.

The data and results of the screening should be recorded as normal or using terms that describe any detected discrepancy (e.g., right shoulder higher than left; left arm-to-body distance greater than right) on the student's health record.

Guidelines for Use of Scoliometer. The following are general steps for testing for scoliosis using a scoliometer.

1. Ask student to bend forward slowly, stopping when the shoulders are level with the hips. View the student from the back. For best view, the screener's eyes should be at the same level as the back. Note any rib elevation and/or symmetry in the flank (low back) area.
2. Before measuring with the scoliometer, adjust the height of the person's bending position to the level where the deformity of the spine is most pronounced. This position will vary from one person to another depending upon the location of the curvature. For example, a curve low in the lumbar spine will require that the person bend further forward than one which is present in the thoracic or upper spine.
3. Lay the scoliometer across the deformity at right angles to the body, with the "0" mark over the top of the spinous process. Let the scoliometer rest gently on the skin, do not push down. Read the number of degrees of rotation.

NOTE: If there is asymmetry in both the upper and lower back, two scoliometer readings will be necessary. The curves will almost always go in opposite directions, with the one in the thoracic spine usually to the right and the other in the lumbar spine usually to the left.

4. The screening examination is considered positive if the reading on the scoliometer is 7 degrees or more at any level of the spine. Lesser degrees of rotation may or may not indicate a mild degree of scoliosis. In such cases re-screening is recommended within three to six months.

Referral and Follow-Up Process. All children with positive findings should be scheduled for re-screening. In order to avoid the possibility of unnecessary referral, all students with positive findings for any part of the screening should be re-screened at a separate session by someone other than the original screener. In addition, a scoliometer reading should be obtained and recorded.

If a positive finding is confirmed by another person who does the re-screening, the family should be contacted and advised that the student be examined by their health care provider. Emphasize that this is not an emergency. (Please see Appendix E for a sample referral letter.) The school health professional responsible for notifying the parents should explain the significance of the screening without causing undue anxiety and apprehension.

Every attempt should be made by school health personnel to work with parents. Parents should be encouraged to schedule a follow-up evaluation with their health care provider and obtain feedback on any changes that the health care provider recommends, in order that school personnel can make the appropriate educational adjustments.

If a student has been identified as having scoliosis, school nurses should work closely with classroom teachers to ensure any necessary adjustments are made in the classroom to provide the child with an optimum learning experience.

Documentation

Recording Recommendation. A record of the scoliosis screening of each student can be kept by recording the results on the following form:

- ◆ Cumulative Health Record (Form LF.009).

Reporting Recommendation. If copies of the scoliosis screening results are to be preserved for local administrative purposes, the following form can be used to preserve summaries of scoliosis screenings for each school division.

- ◆ Scoliosis Report, Virginia Department of Education (form does not have an identification number or date).

Copy of Forms. See Appendix D for a copy of the following forms:

- ◆ Scoliosis Report, Virginia Department of Education.
- ◆ Cumulative Health Record (Form LF.009).

Speech and Language Screening

Authorization

Code of Virginia, Section 22.1-214, Board to Prepare Special Education Program for Children with Disabilities.

Excerpt:

The Board of Education shall prepare and supervise the implementation by each school of a program of special education designed to educate and train children with disabilities between the ages defined in § 22.2-213 and may prepare and place in operation such program for individuals of other ages...The program shall require (i) that the hearing of each disabled child be tested prior to placement in a special education program and (ii) that a complete audiological assessment, including tests which will assess inner and middle ear functioning, be performed on each child who is hearing impaired or who fails the test required in clause(i).

Regulations. Virginia Department of Education (Effective January 1994). *Regulations Governing Special Education Programs for Children with Disabilities in Virginia.* Richmond, Va.: Author.

Excerpt: Part III: Responsibilities of LEAS and State Agencies.

§3.2 Identification, Evaluation, and Eligibility.

C. Screening

2. *The screening process for all children enrolled in the school division is as follows:*

a. *All children within 60 administrative working days of initial enrollment in a public school, shall be screened in the following areas to determine if formal assessment is indicated:*

(1) Speech, voice, and language; and

(2) Vision and hearing.

b. *All children (through grade three), within 60 administrative working days of initial enrollment in public schools, shall be screened for fine and gross motor functions to determine if formal assessment is indicated.*

- c. *Specific measures or instruments will be employed which use:*
- (1) *Both observational and performance techniques; and*
 - (2) *Techniques which guarantee non-discrimination.*

Overview

The purpose of screening in the area of speech and language is to identify students who may have a speech-language deficit. As a result of the screening, students may be referred for a special education eligibility assessment or the speech-language pathologist may consult with the teacher or parents regarding the student's speech-language skills.

Recommendation

Personnel and Procedure. The local education agency (LEA) may determine who is responsible for the speech-language screenings. Recommended practice would indicate that screening of early childhood and elementary students should be done by a speech-language pathologist or under that person's supervision and that the screening of middle and high school students be done by the speech-language pathologist, teacher, guidance counselor, or school nurse. If the LEA designates someone other than the speech pathologist to implement speech-language screening at the middle or high school level, in-service training by the speech-language pathologist should be conducted.

Pathology. Speech/language pathology includes:⁸²

1. Identification of children with speech or language disorders.
2. Diagnosis and appraisal of specific speech or language disorders.
3. Referral for medical or other professional attention necessary for the habilitation of speech or language disorders.
4. Provisions of speech and language services for the habilitation or prevention of communicative disorders.
5. Counseling and guidance of parents, children, and teachers regarding speech and language disorders.

⁸² Virginia Department of Education. (1994). *Regulations Governing Special Education Programs for Children with Disabilities in Va.* Richmond, Va.: Author.

Referral and Follow-Up Process. Documentation of testing of children unable to successfully complete the speech and language screenings according to the established criteria should be forwarded to the director of special education or the director's designee.

Screening Instruments. There are a number of commercially available screening instruments. Sample informal screening tools are included on the following pages. Regardless of the instruments used, local norms should be established to determine the validity of the screening instrument for that population. Please contact the speech-language pathologist(s) serving the LEA for further information on screening instruments.

Recording Recommendation. A record of the speech and language screenings of each student can be kept by recording the results on the following form:

- ◆ Cumulative Health Record (Form LF.009).

Copy of Form. See Appendix D for a copy of the following form:

- ◆ Cumulative Health Record (Form LF.009).

Sample Forms.

The sample speech-language screening forms noted below are provided on the following pages.

- ◆ Speech-Language Kindergarten Screening.
- ◆ Speech-Language Screening: Grades 1 – 5.
- ◆ Speech-Language Screening Checklist: Grades 6 – 12.

[SAMPLE]
SPEECH-LANGUAGE KINDERGARTEN SCREENING

Date: _____

NAME: _____ TEACHER: _____ SCHOOL: _____

I. **ARTICULATION:** Say the following words asking the student to imitate them. Write exactly what the student says.

MOM _____	DAD _____	VALUES _____	ZOOS _____
POP _____	TOOT _____	LITTLE _____	SIS _____
WON _____	GAG _____	JUDGE _____	RARE _____
BIB _____	COKE _____	SHUSH _____	THIRTEEN _____
NINE _____	FIFE _____	CHURCH _____	SPRING _____

II. **LANGUAGE**

A. **Body Parts** (Criterion: 5/6)

Show me your:

Head ___ Arm ___ Knee ___ Hand ___ Shoulder ___ Neck ___

B. **Opposites** (Criterion: 2/3)

Brother is a boy, sister is a _____. A turtle is slow, a rabbit is _____.

The sun shine shines during the day, the moon shines at _____.

C. **Distinguishes Prepositions** (Criterion 3/4)

Put the block: on the chair _____ under the chair _____

in front of the chair _____ beside the chair _____

D. **Verbal Expression and Reasoning** (Criterion 3/3)

What do you do when you are tired? _____

What do you do when you are hungry? _____

What do you do when you are cold? _____

E. **Function** (Criterion 4/5)

What do you do with: a cup _____ scissors _____ a brush _____

a shovel _____ a pencil _____

F. **Observations**

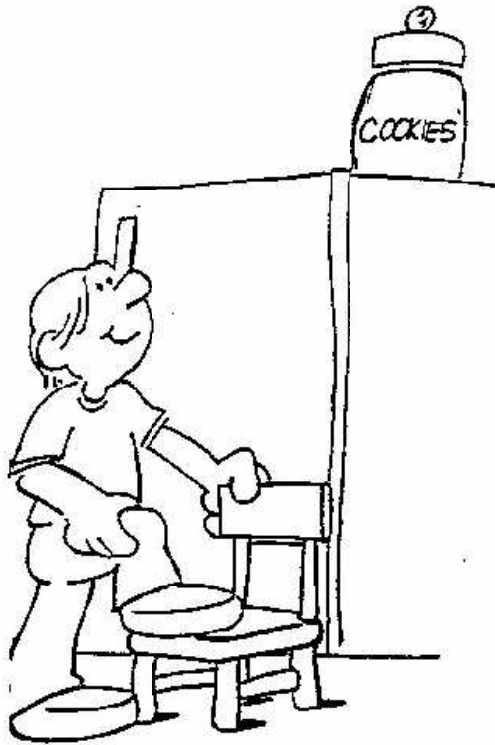
Voice Quality --- Comments: _____

Stuttering --- Comments: _____

Intelligibility --- Comments: _____

RETURN THIS SCREENING FORM TO: _____

GRADES 1-2



Do you see the cookies right here? (Point to the cookies.) Well, this boy did, too. So he got a chair and put it next to the refrigerator. Then he climbed on the chair, watching those cookies all the time. OOPS! The chair turned over and the boy started to fall.

[SAMPLE]

SPEECH-LANGUAGE SCREENING

Grades 1-5

NAME _____ AGE ____ GRADE _____ DATE _____

SCHOOL _____ TEACHER _____ EXAMINER _____

ARTICULATION

Ask the child to repeat the following sentences. Circle the words that the child mispronounced.

1. Today Pete's job was to bake a cake for Kurt.
2. Suzie repaired five television sets.
3. Push the garage door closed.
4. George is watching the magic show.
5. We will ride with Lucy to the yellow house.
6. Nancy found some hangers in my brown bag.

LANGUAGE

For grades 1-5: Engage the student in a conversation and note his use of language, articulation, fluency and voice. Things that you can ask to elicit speech are:

"Why did your family move to _____?"

"How is your other school like (different from) this new school?"

"Tell me about your family, hobbies."

LIKENESSES AND DIFFERENCES

For grades 3-5:

For each pair, tell one way they are alike and tell one way they are different:

watch --- clock (L)

bus ----- train (D)

RETURN THIS SCREENING FORM TO: _____

[SAMPLE]

SPEECH-LANGUAGE SCREENING CHECKLIST

Grades 6 - 12

Student's Name _____ Date _____

DOB ___ / ___ / ___ Age ____ School _____

Student's Counselor _____ ID# _____

Homeroom Teacher _____ Date Entered School _____

This checklist is to be completed for every student who is new to this school by the student's Language Arts teacher.

This student has been ridiculed by his/her peers for (specify): _____

F=Frequently O=Occasionally N=Not at all N=Not Observed

F O N N.O.

This student avoids talking in class. _____

This student appears frustrated when trying to talk. _____

This student avoids talking to peers/adults. _____

This student seems concerned about his/her speech. _____

This student withdraws from group activities. _____

I feel uncomfortable when trying to communicate with this student. _____

Academic

This student is experiencing difficulties with:

Listening skills _____

Concept work _____

Following directions _____

Oral reading _____

Reading comprehension _____

Other (Specify) _____

OBSERVATIONS

Voice Quality ---Comments: _____

Stuttering---Comments: _____

Intelligibility---Comments: _____

Articulation---Comments: _____

RETURN THIS SCREENING FORM TO: _____

Vision Screening

Authorization

Code of Virginia, Section 22.1-273, Sight and Hearing of Pupil to be Tested. The *Code of Virginia* requires that within the time periods and at the grades provided in regulations promulgated by the Board of Education, the principal of each such school shall cause the sight and hearing of the relevant pupils in the school to be tested, unless such students are pupils admitted for the first time to a public kindergarten or elementary school who have been so tested as part of the comprehensive physical examination required by § 22.1-270 or the parents or guardians of such students object on religious grounds and the students show no obvious evidence of any defect or disease of the eyes or ears.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-273.

Code of Virginia, Section 22.1-214, Board to Prepare Special Education Program for Children with Disabilities.

Excerpt:

The Board of Education shall prepare and supervise the implementation by each school of a program of special education designed to educate and train children with disabilities between the ages defined in § 22.2-213 and may prepare and place in operation such program for individuals of other ages...The program shall require (i) that the hearing of each disabled child be tested prior to placement in a special education program and (ii) that a complete audiological assessment, including tests which will assess inner and middle ear functioning, be performed on each child who is hearing impaired or who fails the test required in clause(i).

Regulations. Virginia Department of Education (Effective January 1994). *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*. Richmond, Va.: Author.

Excerpt: Part III: Responsibilities of LEAS and State Agencies.

§3.2 Identification, Evaluation, and Eligibility.

C. Screening.

2. *The screening process for all children enrolled in the school division is as follows:*
 - a. *All children within 60 administrative working days of initial enrollment in a public school, shall be screened in the*

following areas to determine if formal assessment is indicated:

- (1) Speech, voice, and language; and*
 - (2) Vision and hearing.*
- b. All children (through grade three), within 60 administrative working days of initial enrollment in public schools, shall be screened for fine and gross motor functions to determine if formal assessment is indicated.*
- c. Specific measures or instruments will be employed which use:*
- (1) Both observational and performance techniques; and*
 - (2) Techniques which guarantee non-discrimination.*

SUPTS. MEMO. SUPTS. MEMO. No. 159, August 19, 1987, Subject: Procedure for Implementing School Law 22.1-273. (See Appendix A for copy of SUPTS. MEMO.)

Excerpt:

Because all children are required to have a physical examination when they first enter school, it was determined that this requirement would provide adequate screening for kindergarten students. Therefore, the only health screening required to be done for pupils will be for sight and hearing defects in grades 3, 7, and 10.

SUPTS. MEMO. SUPTS. MEMO. No. 168, September 2, 1987, Subject: Procedure for Implementing School Law 22.1-273. (See Appendix A for copy of SUPTS. MEMO.)

Excerpt:

Existing Board of Education regulations as specified in Regulations Governing Special Education Programs in Handicapped Children and Youth in Virginia, September 1984 stipulate that:

All children, within 60 administrative working days of initial enrollment in a public school, shall be screened in the following areas to determine if formal assessment is indicated: (a) speech, voice, and language; (b) fine and gross motor functions; and (c) vision and hearing.

Additional screening for vision and hearing should now occur in grades 3, 7, and 10.

Note: Individual school divisions with the available resources may choose to expand the vision screening program based on the current research that suggests that all children,

beginning in the newborn period, benefit from age appropriate vision screening. Early identification of conditions that interfere with vision is important, because visual stimuli are critical to the development of normal vision.

Summary. In Virginia, vision screening is required as follows:

- ◆ *Component of the School Entrance Health Form: Part II – Comprehensive Physical Examination Report. (See Code of Virginia, § 22.1-270.)*
- ◆ *Grades 3, 7, and 10—unless tested as part of the School Entrance Health Form: Part II – Comprehensive Physical Examination Report. (See Code of Virginia, § 22.1-273.)*
- ◆ *All children within 60 administrative working days of initial enrollment in a public school (See Regulations Governing Special Education Programs for Children with Disabilities in Virginia, effective January 1994).*

Overview

Vision screening and eye examination are essential for detecting visual impairment. Conditions that lead to visual abnormalities may lead to inadequate school performance and prevent students from obtaining maximum benefits from their educational experience. Undetected impairments of the visual process can lead to permanent loss of vision in the affected eye, loss of depth perception, decreased integration of visual and motor skills, potential decrease in learning ability, and problems in school adjustment.

Vision screening should be carried out as part of the regular plan for continuing care beginning at the age of 3. Vision screening guidelines have been endorsed by the American Academy of Pediatrics (AAP), the American Association for Pediatric Ophthalmology and Strabismus (AAPOS), and the American Academy of Ophthalmology (AAO) for use by all pediatric vision screening professionals (including physicians, nurses, educational institutions, and public health departments) to standardize the process of vision screening and to detect children with vision impairments who might be overlooked.

The school screening programs generally focus on visual acuity and color discrimination. However, all children should receive a complete eye examination, including testing for ocular alignment, by their health care provider or an eye specialist. Ocular alignment in the preschool and early school-age child is of considerable importance. The development of ocular muscle imbalance may occur at any age in children and may represent not only simple strabismus (i.e., deviation of the eye in or out) but also serious orbital, intraocular, and intracranial diseases.

Finally, history of vision or eye problems, family history of vision or eye problems, and parental concerns about a child's visual functioning are all important to the complete assessment of a child's vision. Every attempt should be made to examine the child's previous medical record prior to evaluation. If this is not possible, when results of the

eye screening indicate a problem or potential problem the past medical history recorded on the Health Information Form (Part I of MCH 213 form) should be examined for changes over time.

Recommendation

Procedure and Personnel. Each school division may set a policy, assigning the personnel responsible for completion of vision screening. Classroom teachers, physical education teachers, school nurses, or parent volunteers given the responsibility for vision screening should receive instruction in the proper techniques to be used. In addition, personnel should understand that vision screening is designed *only* to identify students who may need further attention. It is not for the purpose of diagnosis. No attempt should be made by screening personnel when contacting the parents of a child who does not meet the screening criteria to provide a diagnosis. Personnel conducting the screening should give an explanation of the test procedure to the class as a group, and individually as needed, prior to the testing to assure that students understand the purpose and the process. Confidentiality needs to be maintained; therefore, students should be screened in a private setting.

Testing Procedures for Assessing Visual Acuity. Several eye charts are available for testing visual acuity in children. In order of decreasing cognitive difficulty, these are: Snellen Letters, Snellen Numbers, Tumbling E, HOTV, Allen Figures, and LH (Leah Hyvarinen) Test. (Note: The Titmus tester may be used in place of charts. The MTI Photo Screener may be used in the identification of serious eye disorders and with small children who are difficult to screen.) The test with the highest level of difficulty that the child is capable of performing should be used. In general, the Snellen Eye Chart or Tumbling E will be appropriate for school vision screening.

Guidelines for Use of Eye Chart. Visual acuity may be tested at 10, 15, or 20 feet (using the appropriate chart). For young children, a distance of 10 feet may result in better compliance due to closer interaction with the examiner. Care should be taken to select for testing a room that is without distractions and that has diffuse lighting and is without glare, to make sure the child stands at the appropriate distance from the chart (the distance may be marked off with a piece of masking tape or paper feet placed at the measured distance) and that the child does not “peek” with the eye that is covered and not being tested.

Directions for use of an eye chart vary based on the chart being used. The tester should carefully review screening procedures for the specific chart that is used. The following are general steps for using an eye chart for testing visual acuity.

1. Each eye is tested separately. Tell the student to keep both eyes open during testing. Test the right eye first by covering the left eye with an occluder, a card, or paper cup. Note: A child who has corrective eyeglasses should be screened wearing the glasses. However,

- eyeglasses prescribed for use while reading should not be worn when distance acuity is being tested.
2. Instruct the student to read the letter to which you point. (Pointing should be done below the symbol or letter.) Note: With younger children, start with a large line to assure that the student understands the directions.
 3. If a student fails the practice line, move up the chart to the next larger line. If the student fails this line, continue up the chart until a line is found that the student can pass. Then move down the chart again until the student fails to read a line. After the student has correctly identified two symbols on the 10/25 line, move to the critical line (10/20 or 20/40 equivalent). To pass a line, a student must identify at least four of the six symbols on the line correctly. Repeat the above procedure covering the right eye.
 4. Record results. If a visual acuity of 20/40 or less is established for either eye, arrange a second screening within two weeks to one month. Referral should be made if the second screening results are not improved. In addition, record the name of the test administered.
 5. Record screening results, per state and local policy, on student's permanent health record.
 6. At the end of the school year record vision screening results on the School Summary of Screening of Vision and Hearing: Report to Principal (LF.011) and Summary of Screening of Vision and Hearing: School Division Report (LF.010).

Note to Examiners. Vision results are written and spoken of as one number over another (e.g., 20/20). The figures refer to the distance at which a standard object can be recognized. The top number refers to the number of feet from the eye chart, and the lower number refers to the line of the chart the person is able to read. A person who is nearsighted (myopia) may only be able to recognize at 20 feet an object that a person with perfect vision (20/20) can recognize at 100 feet. In this case, the results would be recorded as 20/100.

Testing Procedures for Assessing Color Discrimination. Ideally, screening for color deficiency is recommended in the second semester of the first grade because of educational or vocational implications. There is no treatment. The Ishihara Test is the recommended test and comes with instructions with which the examiner should be familiar before beginning the testing. A room with adequate lighting should always be used.

Children's Vision Screening Training. *Prevent Blindness Virginia[®] provides training by certified instructors on the nation's first nationally certified Children's Vision Screening Program. At the time of development of this manual, Prevent Blindness' Children's Vision Screening Training is endorsed by Virginia Society of Ophthalmology, Medical Society of Virginia, and Virginia Optometric Association.*

The screening test includes the following components:

- ◆ *Observation: Screener checks the youngster's eyes for signs of problems (e.g., watering eyes and swollen or crusted lids, child's behavior, constant rubbing of the eyes or tilting the head).*

- ◆ *Distance Acuity: Screener checks the child's distance acuity, choosing from recommended charts, to measure a child's ability to see detail from a distance.*
- ◆ *Stereopsis: For children through age nine or third grade, the screener checks if the child's eyes appear to be working together. The screener puts a pair of "special" sunglasses on the child and asks the child to point to which card has a picture. Children whose eyes are not working together do not see a picture. These youngsters run a high risk for having "lazy eye" or amblyopia," which can cause permanent loss of sight in the affected eye. The disorder is treatable when detected early.*

Prevent Blindness Virginia[®] is an affiliate of Prevent Blindness America,[®] the nation's leading volunteer eye health and safety organization dedicated to fighting blindness and saving sight.

For further information on the Prevent Blindness' Children's Vision Screening Training program, vision, and eye health and safety, please contact:

*Prevent Blindness Virginia[®]
9840-R Midlothian Turnpike
Richmond, VA 23235
Telephone: (888) 790-2020, Virginia toll free; (804) 330-3195, Richmond Area
Web site: <http://www.pbv.org/>*

Referral and Follow-Up Process. Parents of all students who do not perform satisfactorily on a vision screening and subsequent re-test (within two weeks to one month) should be notified by school health personnel. On average, approximately 7 to 8 percent of students screened nationwide are referred for further evaluation. A referral means *only* that there is sufficient deviation in the child's visual condition to justify a more complete examination by a qualified eye specialist.

Every attempt should be made by school health personnel to work with parents, encouraging follow-up care with their health care provider and getting feedback on any changes that the health care provider recommends, in order that school personnel can make the appropriate educational adjustments.

If a student has been identified as having a visual impairment, school nurses should work closely with classroom teachers to insure any necessary adjustments are made in the classroom so that the student is provided with an optimum learning experience.

Documentation

Recording Requirement. Every principal must keep a record of the testing of the sight of the relevant students and must notify the parent or guardian, in writing, of any defect of vision or disease of the eyes found. (See *Code of Virginia*, § 22.1-273.)

Proof of Testing the Sight of Pupils. A record of the testing of the sight of each student can be kept by recording the results on the following form:

- ◆ Cumulative Health Record (Form LF.009).

Reporting Requirement. Copies of the sight testing report are to be preserved for use by the Superintendent of Public Instruction, as the Superintendent may require. The following form can be used to preserve the reports as below. (See *Code of Virginia* § 22.1-273.)

- ◆ Summary of Vision and Hearing: Report to the Principal (Form LF.011, 3/95). This form is used to record a summary of the vision screening results for each school, by required grade level. The completed form is sent to the LEA superintendent designee.
- ◆ Summary of Screening of Vision and Hearing: School Division Report (LF.010, 3/95). This form is used to record a summary of vision screening results for each school division, by required grade level. It is a compilation of each school's LF.011.

Copy of Forms. See Appendix D for a copy of the following forms:

- ◆ Summary of Vision and Hearing: Report to the Principal (Form LF.011, 3/95).
- ◆ Summary of Screening of Vision and Hearing: School Division Report (LF.010, 3/95).
- ◆ Cumulative Health Record (Form LF.009).

Resources

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Implementing Special Education: Students With Special Needs

Introduction. The number of children and adolescents with special health care needs in Virginia schools has increased over the last 20 years due to legislation requiring education be provided to all children in the least restrictive environment, changing social attitudes that promote inclusion of children with special needs in schools and other community groups, improvements in medical technology, and advances in educational research of special needs populations. Determination of a child's need and eligibility for services at the earliest possible time leads to better educational outcomes for the child. School nurses and other school health personnel are involved in identifying and serving students with special needs.

Historical Perspective: Key Federal Legislation

Listed below are summaries of some key special education federal laws and acronyms of special education.

Early Education for Handicapped Children Program of 1970. In 1970, Congress passed the Early Education for Handicapped Children Program, providing seed money for the development and operation of experimental, demonstration, and outreach preschool and early intervention programs for handicapped children. This was the federal government's first major effort in early intervention.

Rehabilitation Act of 1973 (Public Law 93-112). The Rehabilitation Act of 1973 prohibits discrimination on the basis of disability in programs conducted by federal agencies, in programs receiving federal financial assistance, in federal employment, and in the employment practices of federal contractors. The standards for determining employment discrimination under the Rehabilitation Act are the same as those used in Title I of the Americans with Disabilities Act of 1990.

- ◆ **Section 504.** Section 504 of the 1973 Rehabilitation Act is the basic civil rights legislation prohibiting discrimination against persons with "handicapping conditions" in programs that receive federal funds. This includes public schools.
- ◆ **Handicapping Condition.** The definition of "handicapping condition" in Section 504 is: a handicapped student is one who has a physical or mental impairment that substantially limits one or more life activities (such as working, eating, dressing, breathing). The Office of Civil Rights, which oversees enforcement of the statute, has determined that this may include drug and alcohol addiction, attention deficit disorder, AIDS, hospitalization due to depression, and other conditions not typically

qualifying under special education. Federal special education funds cannot be used to comply with 504.⁸³

Education Amendments of 1974 (Public Law 93-380). In 1974, to assure appropriate education opportunities for children with special needs, Congress passed the Education Amendments of 1974, which guarantees due process and provision of education in the least restrictive environment.

Education for All Handicapped Children Act of 1975 (Public Law 94-142). In 1975, Congress passed a law called the Education for All Handicapped Children Act (EHA). This law established legal standards and requirements for the education provided to children with disabilities. This law required all states to provide a “Free, appropriate public education” to school-age children with handicaps in the “least restrictive environment.”

- ◆ **Section 619.** Section 619 of the EHA provided incentives to states to serve handicapped children ages 3 to 5.
- ◆ **Handicapped Children.** Under this law, “handicapped children” were defined as those who are mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, other health impaired, or who have specific learning disabilities, and who by reason of these handicaps require special education and related services.
- ◆ **Related Services.** Under this law, “related services,” which included school health-related services, were among those services that must be provided to sustain these children’s attendance. These services are described in P. L. 94-142 and include, among others, school health services; physical, occupational, and language therapy; modification of classroom schedules; and if necessary, actual physical alterations of the school.
- ◆ **Least Restrictive Environment.** To the extent possible (given the nature and severity of the child’s handicap), the child should be educated in the regular classroom with peers who are not handicapped.

Note: The EHA was to be re-enacted every 4 years, resulting in numerous changes in the Act over the intervening two decades.

Public Law 98-109 of 1983. In 1983, believing that it was time to encourage states to expand services to preschool children, infants, and toddlers with handicaps, Congress passed P.L. 98-109. That legislation set aside money for planning, development, and implementation grants dealing with the preschool populations—allowing states to apply

⁸³ Adams, Richard M. (1995). *School Nurse’s Survival Guide: Ready-to-Use Tips, Techniques & Materials for the School Health Professional* (p. 277). Englewood Cliffs, N.J.: Prentice Hall.

for grants to provide services to disabled children age birth through 3 years. In the first quarter of 1985, 20 states received such grants.

Education of the Handicapped Act Amendments of 1986 (Public Law 99-457). In 1986, Congress enacted P. L. 99-457, the Education of the Handicapped Act Amendments of 1986. This legislation amended the Education of All Handicapped Children Act (EHA) to, among other things, replace the preschool grants program (Part B, Section 619) and create a new early intervention program for infants and toddlers (Part H). The least restrictive environment concept was continued.

- ◆ **Part B, Section 619.** Replaced the preschool grants program authorized by P.L. 94-142 with a new program (Part B, Section 619) for children with disabilities, ages 3 through 5.
- ◆ **Children with Disabilities.** Under this law, the term “handicapped children” was replaced with “children with disabilities.” This term means mentally retarded, hard of hearing, deaf, speech or language impaired, visually handicapped, severely emotionally disturbed, orthopedically impaired, or other health impaired, or children with specific learning disabilities, who by reason thereof require special education and related services. (20 U.S.C. § 1401 [a].)
- ◆ **Infant and Toddlers Program.** Created a new state grant program (Part H) to encourage states to plan, develop, and implement early intervention services to infants and toddlers with developmental delay and their families. States participating in the Part H program were permitted five years (1988-1993) to develop programs to provide appropriate services to eligible children and their families.
- ◆ **Infants and Toddlers with Disabilities.** Under this law, the term “infants and toddlers with disabilities” is defined as children from birth through age 2 who required early intervention services because they (a) are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive development, physical development, language and speech development, psychosocial development, or self-help skills, or (b) have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. (20 U.S.C. § 1472.)

Individuals with Disabilities Education Act of 1990 (Public Law 101-476). In October 1990, Congress passed P.L. 101-476, which reauthorized the Education for All Handicapped Children Act (EHA), Parts C through G, through fiscal year 1994, changed the name to the Individuals with Disabilities Education Act (IDEA), and made minor changes to Parts B and H. There were some changes in the definition categories for special education and related services, including new categories of traumatic brain injury, developmental delay, and autism. Also, additional services, such as transition and assistive technology, were added.

Americans with Disabilities Act of 1990. The Americans with Disabilities Act (ADA) was signed into law on July 26, 1990. The ADA prohibits discrimination on the basis of

disability in employment, programs and services provided by state and local governments, goods and services provided by private companies, and in commercial facilities. The ADA protects every person who either has, used to have, or is treated as having a physical or mental disability that substantially limits one or more major life activity. Individuals who have serious contagious and non-contagious diseases—such as HIV/AIDS, cancer, epilepsy or tuberculosis—are also covered under the auspices of ADA. The ADA extends the coverage of Section 504 of the Rehabilitation Act of 1973.

- ◆ **Public Schools.** The ADA accords persons with disabilities meaningful access to programs and facilities of public schools, as well as most business. It requires employer to make “reasonable accommodation” for disabled persons to enable them to perform the job.⁸⁴

Individuals with Disabilities Education Act Amendments of 1997 (Public Law 105-17). The Individuals with Disabilities Education Act Amendments of 1997 (IDEA 97) were signed into law on June 4, 1997. (Final implementing regulations released March 12, 1999.) The new law consists of four parts: Part A—General Provisions, Part B—Assistance for Education of All Children with Disabilities, Part C—Infants and Toddlers with Disabilities (formerly Part H), and Part D—National Activities to Improve Education of Children With Disabilities. An overview of implementing IDEA 1997 in Virginia is provided in the next subsection.

- ◆ **Children with Disabilities.** Under this law, the term “children with disabilities” is defined as those children evaluated in accordance with the federal special education regulations as having mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, specific learning disabilities, deaf-blindness, or multiple disabilities, and who, because of those impairments, need special education and related services.
- ◆ **Related Services.** Under this law, “related services” are defined as follows: transportation, and such developmental, corrective, and other supportive services—including speech language pathology and audiology, psychological services, physical and occupational therapy, recreation (including therapeutic recreation and social work services), and medical and counseling services (including rehabilitation counseling), except that such medical services shall be for diagnostic and evaluation purposes only—that may be required to assist a child with a disability to benefit from special education. (IDEA, 20 U.S.C. 1401 [17].) The term also includes school health services, social work services in the schools, and parent counseling and training. (34 C.F.R. 300.1 3[a].)

⁸⁴ Adams, Richard M. (1995). *School Nurse’s Survival Guide: Ready-to-Use Tips, Techniques & Materials for the School Health Professional* (p. 271). Englewood Cliffs, N.J.: Prentice Hall.

Subsections

The following subsections provide guidance on implementing key legislation and regulations.

- ◆ Implementing IDEA
- ◆ Part C (Formerly Part H)
- ◆ Implementing Section 504 of the Rehabilitation Act
- ◆ Special Education Assessment

Note: School nurses, teachers, and other staff members are encouraged to refer to the following manual for guidance on caring for students with special health care needs in the school setting: Keen, T. (Ed.) with Ford, N., Henry, J., and Cox A. (Consulting Eds.). (1996). *Guidelines for Specialized Health Care Procedures*. Richmond, Va.: Virginia Department of Health.

Implementing IDEA

Authorization

Individuals with Disabilities Education Act (IDEA). The IDEA (formerly called Public Law 94-142 or the Education for All Handicapped Children Act of 1975) requires public schools to make available to all eligible children with disabilities a free appropriate public education in the least restrictive environment, appropriate to their individual needs. The Individuals with Disabilities Education Act Amendments of 1997 (Public Law 105-17) were signed into law on June 4, 1997.

Note. The Virginia regulations were under revision to comply with IDEA regulations at the time this manual was being developed.

Code of Virginia Section 22.1-213, Definitions (special education program for children with disabilities). The *Code of Virginia*, § 22.1-213 defines “children with disabilities” as those persons:

1. *ho are aged two to twenty-one, inclusive [i.e., ages 2 through 21], having reached the age of two by the date specified in § 22.1-254.* W
2. *ho are mentally retarded, physically disabled, seriously emotionally disturbed, speech impaired, hearing impaired, visually impaired, multiple disabled, other health impaired including autistic or who have a specific learning disability or who are otherwise disabled as defined by the Board of Education.* W
3. *ho because of such impairments need special education.* W

Excerpt: See Appendix A for *Code of Virginia* § 22.1-213.

Code of Virginia § 22.1-214, Board to Prepare Special Education Program for Children With Disabilities. The *Code of Virginia* requires the Board of Education to ensure that each school division in Virginia has a special education program to educate and train children with disabilities. Virginia requires that all children with disabilities between the ages of 2 and 21, inclusive (i.e., ages 2 through 21), be identified, evaluated, and have made available to them a free and appropriate public education (FAPE). School divisions are mandated to comply with these regulations under Article VIII, Section I of the Constitution of Virginia, Title 22.1 of the *Code of Virginia*, and the federal Individuals with Disabilities Education Act (20 U.S.C. Section 1400-1485).

Excerpt: See Appendix A for *Code of Virginia* § 22.1-214.

Regulations. The Board of Education has established regulations governing the implementation of special education and related services for students with disabilities in Virginia. After the federal regulations are finalized, the Virginia Board of Education will update its special education regulations to comply with those at the federal level. Until this is completed, information regarding special education regulations in Virginia is taken from: Virginia Department of Education (Effective January 1994). *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*. Richmond, Va.: Author.

Definitions. Key general definitions from *Regulations Governing Special Education Programs in Handicapped Children and Youth in Virginia*, Virginia Department of Education, effective January 1994, are included in the following chart.

General Definitions of Terms Associated With Special Education

Term	Definition
Children with Disabilities	Those children evaluated as having autism, deaf-blindness, a developmental delay, a hearing impairment (which may include deafness), mental retardation, multiple disabilities, an orthopedic impairment, other health impairment, a serious emotional disturbance, a severe and profound disability, a specific learning disability, a speech or language impairment, a traumatic brain injury, or a visual impairment (which may include blindness), who, because of these impairments, need special education and related services.
Age of Eligibility	All eligible children with disabilities who have not graduated from a secondary school or completed a program approved by the Board of Education whose second birthday falls on or before September 30, and who have not reached their twenty-second birthday on or before September 30.
Free, Appropriate Public Education (FAPE)	Special education and related services that: <ol style="list-style-type: none"> 1. Are provided at public expense, under public supervision and without charge. 2. Meet the standards of the Board of Education. 3. Include preschool, elementary school, middle school, or secondary schools, and/or vocation education. 4. Are provided in conformity with an individualized education program. FAPE is a statutory term, which requires special education and related services to be provided in accordance with an individualized education program (IEP).
Individualized Education Program (IEP)	Written statement for each child with a disability, developed in any meeting by a representative of the local education agencies (LEA) who shall be qualified to provide, or supervise the provision of specially designated instruction to meet the unique needs of children with disabilities, the teacher, the parents of such child, and whenever appropriate, such child.

Note: Categorical definitions of disability as defined by federal and state guidelines, and definitions of services and supports that are contained in the *Regulations Governing*

Special Education Programs in Handicapped Children and Youth in Virginia, Virginia Department of Education, effective January 1994, are provided in the Appendix A.

Process and Procedures for Implementing IDEA

Note. The following information reflects the IDEA Amendments of 1997 and aspects of the Virginia Special Education Regulations (1994).⁸⁵

Child Find. Public awareness responsibilities of local school divisions include:

- ◆ Conducting a public awareness campaign annually that involves parents and community members in child find and community awareness campaign.
- ◆ Maintaining an active and continuing child find program to locate children birth through 21, in need of special education.

Screening. Each local school division is responsible for establishing and maintaining screening. Screening is to include the following within 60 days of initial enrollment: (Please refer to the section on “Population-Based Screening” within this chapter, for specific screening information.)

1. Speech, voice, and language.
2. Vision and hearing.
3. Fine and gross motor function (through grade three).

Child Study. Formal committee established in each school to review records and performance of students referred through a screening process or by another source and to decide what course of action is indicated. The committee may be termed “Instructional Support Team,” “Teacher Assistance Team,” or other similar terminology. The school nurse may be a part of this committee.

Evaluation. Procedures used to determine whether a child has a disability under IDEA. Each local school division shall have established policies and procedures related to the evaluation of referred students. Policies and procedures include parental consent, confidentiality, written notification, nondiscriminatory testing, qualified personnel, and notification of parental rights.

⁸⁵ Virginia Department of Education (Effective January 1994). *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*. Richmond, Va.: Author.

A team of individuals, including the parents, determines what will be assessed. These may include health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities. Virginia law requires hearing screening for all students evaluated for special education. This is typically accomplished through the assessment of components that are contained in the following chart.

Assessment Components of Suspected Disability

Component	Description
Educational	Written report describing current educational performance and identifying instructional strengths and weaknesses in academic skills and language performance.
Medical	Written report from a licensed physician indicating general medical history and any medical/health problems that may impede learning.
Sociocultural	Written report from a qualified visiting teacher or school social worker that describes family history, structure, and dynamics; developmental and health history; and social/adaptive behavior in the home, school, and community. The information is obtained through interviews with parents or primary caretakers in addition to use of other social appraisal methods.
Psychological	Written report from a qualified psychologist based on the use of a battery of appropriate instruments that shall include individual intelligence test(s) and psycho-educational tests.
Developmental	Written report of assessment of how the child functions in the major areas of development (such as cognition, motor, social/adaptive behavior, perceptions, and communications), where required in the regulations for assessing the specified handicapping conditions.
Other	Where indicated (e.g., audiological, speech-language). All assessments must be provided in written format and must be conducted by qualified personnel. To be qualified, professionals must meet any applicable licensing requirements.

Eligibility. A committee made up of persons representing the disciplines providing the assessments and the special educator administrator or designee shall determine if the student has a disability under IDEA and if the student requires special education and related services. The school nurse may be a part of this committee. A written summary of its deliberations and findings is prepared, and if the child is found to be eligible, the summary is forwarded to the IEP committee.

Individualized Education Program (IEP). A written program for each child with a disability that is developed by a committee consisting of a representative of the local school division who is qualified to provide or supervise the provision of special education, the child's teacher (general and special education), the child's parents, the

child (if appropriate), and other individuals at the discretion of the parents (may include an advocate) or local school division (may include a member of the evaluation team or related service provider). The school nurse may be a part of the committee and will perform an important role in the development of goals, objectives, and services for students with special health needs.

The written plan must include the following components:

- ◆ A statement of the child's present level of educational performance.
- ◆ A statement of annual goals and objectives.
- ◆ A statement of specific special education and related services to be provided.
- ◆ Objective criteria and evaluation procedures and schedules.
- ◆ A statement of the needed transition services, if age 14 or older.
- ◆ Discussion of communication, assistive technology, Braille, limited English proficiency, and behavior needs as appropriate.
- ◆ A statement of provision regarding the Virginia literacy assessment program.

The parent shall be given a copy of the IEP and information regarding due process procedural safeguards that stipulate their rights as parents of the student with a disability. The IEP should be revised at least annually.

Instruction. Instruction is provided according to the terms of the IEP.

Placement. Educational placement is based on the child's IEP, is determined at least annually, and occurs as close as possible to the child's home. Unless indicated otherwise by the IEP, the child is educated in the school that the child would attend if nondisabled. Alternative placements follow a continuum, including integrated service delivery with general education, special classes, special schools, home instruction, instruction in hospitals or institutions, or residential placement.

Annual Review. Each local school division is responsible to initiate and conduct meetings periodically to review each child's IEP and, where appropriate, revise its provisions. A meeting must be held for this purpose at least once a year. A reevaluation is conducted at least every three years.

Implementing Part C of IDEA (Formerly Part H)

Authorization

Individuals with Disabilities Education Act (IDEA). The IDEA was amended in 1986 with legislation designed to help states establish a statewide, comprehensive system of early intervention services for infants and young children with special needs and their families. Part H of this legislation, P.L. 99-457, mandated services for children beginning at age three with the option to provide services for children who were developmentally delayed or at risk for developmental delays from birth through the second year of life. This bill established a national policy on early intervention that provided assistance to states to build systems of service delivery and recognized the unique role of families in the development of their young child with disabilities. Virginia opted to participate in the optional early intervention program for infants and toddlers from birth through age 2. Virginia had required special education for children, beginning at age 2, since prior to the first passage of Federal legislation in 1975. The IDEA Amendment in 1997, reauthorized the infant and toddler program and renamed the program in Part C.

Implementation of Part C

Goals. The goals of the Part C program include:

1. To develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with, or at-risk for, disabilities, and their families.
2. To facilitate the coordination of payment for early intervention services from federal, state, local, and private sources.
3. To enhance states' capacity to provide quality early intervention services and expand and improve existing services.

Early Intervention. Early intervention is a service that can begin at birth and is designed to facilitate the process of development as well as enhance the family's capacity to meet the child's special needs. These services are tailored to meet the unique needs of children with developmental delays and their families and include:

- ◆ Service coordination.
- ◆ Family training, counseling, home visits.
- ◆ Health services necessary to enable the infant or toddler to benefit from the other early intervention services,

- ◆ Occupational therapy.
- ◆ Physical therapy.
- ◆ Psychological services.
- ◆ Social work services.
- ◆ Speech/language pathology services.
- ◆ Audiology services.
- ◆ Other support services.

State Agency Authority

The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) has been designated as Virginia's lead agency for Part C. A state-level interagency council (Virginia Interagency Coordinating Council - VICC) meets to advise and assist the lead agency in performing its responsibilities. VICC members are appointed by the governor and include a representative from the major state agencies that are engaged in providing services to young children with disabilities, parent representatives, and community members. There are 40 Local Interagency Coordinating Councils (LICCs) across the Commonwealth. These LICCs typically are composed of representatives from the local school division, community services board, health department, social services department, parents, and direct care providers.

Implementing Section 504 of the Rehabilitation Act

Definitions

Section 504. Section 504 of the Rehabilitation Act of 1973 (29.U.S.C. 701 et. Seq.) prohibits discrimination on the basis of handicap in any program or activity receiving federal financial assistance.

Qualified Person. A qualified person under Section 504 covers a broader population than the definition of a child with a disability under IDEA. A qualified handicapped individual under Section 504 is any person who meets one or more of the following criteria:

- ◆ Has a physical or mental impairment that substantially limits one or more major life activities.
- ◆ Has a record of such an impairment.
- ◆ Is regarded as having such an impairment.

Physical or Mental Impairment. Physical or mental impairment can be:

- ◆ Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems: neurological, musculoskeletal, sense organs, respiratory, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, and endocrine.
- ◆ Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning abilities.

Major Life Activities. Major life activities means such functions as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Record of Impairment. Record of impairment means that the individual has a history of or has been classified as having a mental or physical impairment that substantially limits one or more major life activities.

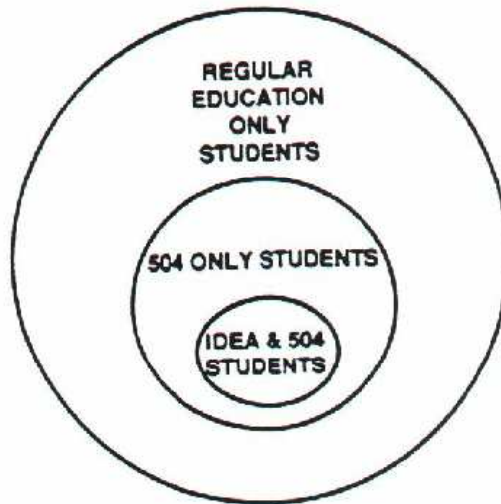
Regarded as Having an Impairment. Regarded as having an impairment means:

- ◆ Has a physical or mental impairment that does not substantially limit major life activities but is treated as constituting such limitation.
- ◆ Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment.

- ◆ Has none of the impairments defined in section one but is treated by a recipient as having such an impairment.

Some students with disabilities may not qualify for special education and services under IDEA but may qualify for services under Section 504. Figure 3 compares eligibility under IDEA and Section 504.

Figure 3. IDEA and 504 Eligible Student Population Comparisons ⁸⁶



IDEA/504 STUDENTS

Students are qualified under one or more of 13 IDEA disabling condition categories. Specially designed individualized education programs (IEP) are planned for each student by IEP Teams.

SECTION 504 STUDENTS ONLY

Due to substantial mental or physical impairments that limit one or more of the student’s major life activities, special accommodations to the student’s program are required. A 504 accommodation is designed for each student according to individual need.

Examples of potential 504 handicapping conditions not typically covered under IDEA are:

- ◆ Communicable diseases—HIV, Tuberculosis.
- ◆ Medical conditions— asthma, allergies, diabetes, heart disease.
- ◆ Temporary medical conditions due to illness or accident.
- ◆ Attention Deficit Disorders (ADD, ADHD).
- ◆ Behavioral difficulties.
- ◆ Drug/alcohol addiction.
- ◆ Other conditions.

⁸⁶ Adapted from *Student Access, A Resource Guide for Educators: Section 504 of the Rehabilitation Act of 1973*. Council of Administrators of Special Education, Inc.

Similarities and Differences Between Section 504 and IDEA

All students who are disabled under the IDEA are also considered to be handicapped and, therefore, protected under Section 504. Some students who are not eligible for IDEA services are deemed handicapped under Section 504. For the purpose of clarification in this manual, the term “handicapped” refers to students who are protected under the regulations of Section 504 only; the term “disabled” is reserved for students who are eligible for service under IDEA.

The IDEA defines as eligible only students who have certain specified types of disabilities and who, because of one of those conditions, need special education. Section 504, on the other hand, protects all handicapped students, defined as those having any physical or mental impairment that substantially limits one or more major life activities. Section 504 covers all students who meet this definition, even if they do not meet the IDEA criteria for having a disability and requiring special education.

Application of this definition would pertain to a student who has juvenile arthritis but who is not eligible for special education and related services through IDEA. Such a student has a health impairment and is handicapped for purposes of Section 504, if their condition substantially limits their ability to function at school. Accommodations and related services and aids must be provided for the student to benefit from education. Thus, the school division must evaluate the student and, if qualified under Section 504, must develop and implement a plan for the delivery of all needed services.

The following chart provides a comparison between components of IDEA and Section 504.⁸⁷

IDEA and Section 504 Comparison

Component	IDEA	Section 504
General Purpose	Is a federal funding statute whose purpose is to provide financial aid to states in their efforts to ensure adequate and appropriate services for disabled children.	Is a broad civil rights law that protects the rights of individuals with handicaps in programs and activities which receive federal financial assistance from the U.S. Department of Education.

⁸⁷ Adapted from *Student Access, A Resource Guide for Educators: Section 504 of the Rehabilitation Act of 1973*. Council of Administrators of Special Education, Inc.

IDEA and Section 504 Comparison

Component	IDEA	Section 504
Who is Protected?	Identifies all students (3 through 21 years of age) who fall within one or more categories of qualifying conditions.	Identifies all school-age children as handicapped who meet the definition of qualified handicapped person; i.e., (1) has or (2) has had a physical or mental impairment that substantially limits a major life activity, or (3) is regarded as handicapped by others. Major life activities include walking, seeing, hearing, speaking, breathing, learning, working, caring for oneself, and performing manual tasks. The handicapping condition need only substantially limit one major life activity in order for the student to be eligible.
Responsibility to Provide a Free and Appropriate	Both laws require the provision of a free appropriate public education to eligible students covered under them including individually designed instruction. The Individualized Education Program (IEP) of IDEA will suffice for Section 504 written plan.	
Public Education (FAPE)	Requires a written IEP document with signed consent and a required number of specific participants at the IEP meeting.	Does not require a written IEP document but does require a plan. It is recommended that the school division document that a group of persons knowledgeable about the student convened and specified the agreed upon services.
	“Appropriate education” means a program designed to provide educational benefit. Related services are provided if required for the student to benefit from specially designed instruction.	“Appropriate” means an education comparable to the education provided to non-handicapped students, requiring that reasonable accommodations be made. Related services, independent of any special education services as defined under IDEA, may be the reasonable accommodation.
Special Education vs. Regular Education	A student is only eligible to receive IDEA services if the multidisciplinary team determines that the student is disabled under one or more of the specific qualifying conditions and requires specially designed instruction to benefit from education.	A student is eligible so long as he/she meets the definition of qualified handicapped person; i.e., (1) has or (2) has had a physical or mental impairment that substantially limits a major life activity, or (3) is regarded as handicapped by others. It is not required that the handicap adversely affect educational performance or that the student need special education in order to be protected.

IDEA and Section 504 Comparison

Component	IDEA	Section 504
Funding	Provides additional funding for eligible students.	Does not provide additional funds. IDEA funds may not be used to serve children found eligible only under Section 504.
Accessibility	Requires that modifications must be made if necessary to provide access to a free appropriate education.	Has regulations regarding building and program accessibility, requiring that reasonable accommodations be made.
Procedural Safeguards	Both require notice to the parent or guardian with respect to identification, evaluation, and/or placement. IDEA procedures will suffice for Section 504 implementation.	
	Requires written notice.	Does not require written notice.
	Delineates required components of written notice.	Written notice not required but indicated by good professional practice.
	Requires written notice prior to any change in placement.	Requires notice only before a “significant change” in placement.
Evaluations	A full comprehensive evaluation is required, assessing all areas related to the suspected disability. The child is evaluated by a multi-disciplinary team or group.	Evaluation draws on information from a variety of sources in the area of concern; decisions made by a group knowledgeable about the student, evaluation data, and placement options.
	Requires informed consent before an initial evaluation is conducted.	Does not require consent, only notice. However, good professional practice indicates informed consent.
	Requires reevaluations to be conducted at least every 3 years.	Requires periodic reevaluations. IDEA schedule for reevaluation will suffice.
	A reevaluation is not required before a significant change in placement. However, a review of current evaluation data, including progress monitoring, is strongly recommended.	Reevaluation is required before a significant change in placement.
	Provides for independent educational evaluation at school division expense if parent disagrees with evaluation obtained by school and hearing officer concurs.	No provision for independent evaluations at school division expense. Divisions should consider any such evaluations presented.

IDEA and Section 504 Comparison

Component	IDEA	Section 504
Placement Procedures	When interpreting evaluation data and making placement decisions, both laws require school divisions to:	
	<p>A. Draw upon information from a variety of sources.</p> <p>B. Assure that all information is documented and considered.</p> <p>C. Ensure that the eligibility decision is made by a group of persons, including those who are knowledgeable about the child, the meaning of the evaluation data, and placement options.</p> <p>D. Ensure that the student is educated with the student’s non-handicapped peers to the maximum extent appropriate (least restrictive environment).</p>	
	An IEP review meeting is required before any change in placement.	A meeting is not required for any change in placement.
Grievance Procedure	Does not require a grievance procedure nor a compliance officer.	Requires districts with more than 15 employees to (1) designate an employee to be responsible for assuring district compliance with Section 504 and (2) provide a grievance procedure for parents, students, and employees.
Due Process	Both statutes require school divisions to provide impartial hearings for parents or guardians who disagree with the identification, evaluation, or placement of a student.	
	Delineates specific requirements.	Requires that the parent have an opportunity to participate and be represented by counsel; other details are left to the discretion of the local school district. Policy statements should clarify specific details.
Exhaustion	Requires the parent or guardian to pursue administrative hearing before seeking redress in the courts.	Administrative hearing not required prior to Office of Civil Rights involvement or court action; compensatory damages possible.
Enforcement	Enforced by the U.S. Office of Special Education Programs. Compliance is monitored by the State Department of Education and the Office of Special Education Programs.	Enforced by the U.S. Office of Civil Rights.
	The State Department of Education resolves complaints.	State Department of Education has no monitoring, complaint resolution, or funding involvement.

Process for Implementation of Section 504 Protections/Services

Referral. The first step of the process is referral. Students falling under the auspices of Section 504 generally are those who meet one or more of the following descriptions:

- ◆ Are experiencing academic difficulty (below grade level performance), and it is suspected that the medical condition is or will adversely affect classroom functioning.
- ◆ Need medically-related adaptations to perform in a general education classroom placement.
- ◆ Need or may need homebound instruction on an intermittent basis due to medical condition.

The building principal is generally the central figure in any process involving special services for students assigned to the school. It is the responsibility of all staff (e.g., secretaries, teachers, visiting teachers, health professionals, psychologists, and other support personnel) to immediately make the principal aware of any student who may need 504 services. Parents may also refer their children or request services.

Every effort should be made to review health information on all students when they enroll. The school nurse may assist the 504 coordinator of the local school division by notifying the principal of students with disabilities who are not receiving special education.

Screening. The school division may elect to have either a centralized committee or a school-based building screening committee. The committee may consist of principal/designee, student's general education teacher(s), specialist(s), school nurse, licensed nurse practitioner, public health nurse, parents and/or referring source, and any other persons deemed necessary.

As a member of this committee, the school nurse may assist in determining whether a complete comprehensive assessment and/or any single or multiple assessment is necessary in order to make a determination of the child's needs. The school nurse may recommend that the screening committee request additional information, reports or records, and classroom observation or intervention.

The 504 evaluation may consist of the following written components:

- ◆ Medical.
- ◆ Psychological.
- ◆ Educational.
- ◆ Socio-cultural.

- ◆ Others as appropriate to the student's suspected disability; for example, an audiological may be requested to determine a student's eligibility for hearing impairment services.

Evaluation. Procedures should be developed for this evaluation that ensure the following:

- ◆ Evaluation materials are appropriate for intended use.
- ◆ Evaluators are properly trained.
- ◆ Evaluation materials used should test relevant areas of educational need and not merely IQ.
- ◆ Selection and administration of tests should accommodate sensory, manual, and speaking deficiencies.

Eligibility. A committee to determine 504 eligibility may consist of the following individuals: director of special services, school psychologist, school social worker, school nurse, educational diagnostician, representative from the referring school, student, family member, and individuals representing the assessment components as required. Each school division will determine the membership based on local needs. The school nurse may be a part of this committee when necessary.

The purpose of the eligibility meeting is to determine whether or not there is a handicapping condition.

Section 504 Evaluation Committee. The Section 504 Evaluation Committee is responsible for determining the following:

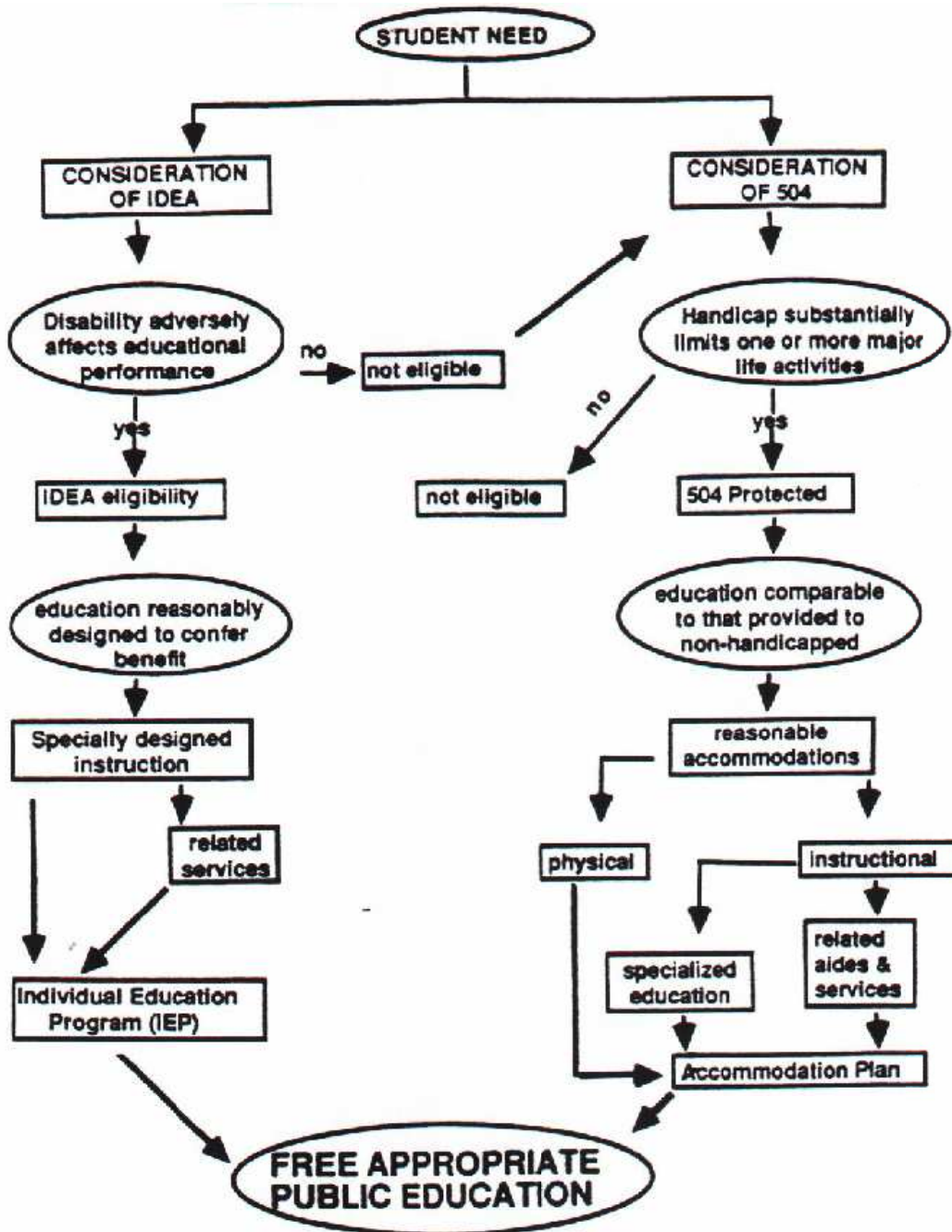
- ◆ Whether the student is handicapped.
- ◆ The type of handicap.
- ◆ The effect of any handicap on the student in the school setting.

The 504 Plan. A Section 504 Educational Plan must be developed to incorporate the services that the student needs in the educational setting. If there are educational implications, accommodations must be made.

Development of the plan should be made within 30 days of identification. The school nurse may assist in developing the components of the 504 Educational Plan that deal with health issues.

The following figure summarizes the similarities and differences between the IDEA and Section 504 processes and procedures. Note: This chart was developed prior to the adoption of the 1997 Amendments to IDEA.

Figure 4. IDEA Flow Chart for Process for Implementation of Section 504 Protections/Services⁸⁸



⁸⁸ *Student Access, A Resource Guide for Educators: Section 504 of the Rehabilitation Act of 1973*. Council of Administrators of Special Education, Inc.

Special Education Health Assessment

Overview

An important component of the special education assessment is a complete medical history and physical examination. The school nurse may play an integral part by taking the medical history. A complete physical examination should be performed by a licensed physician or licensed nurse practitioner (directly supervised by a physician).

Health History ⁸⁹

School Nurse's Role in Medical/Health History. Obtaining a complete medical history is the most important aspect of a health examination. For younger children, the parents are the primary informants. If the school nurse completes the health history, the salient facts should be reviewed by the examiner prior to medical assessment. The following guidelines detail information necessary for a complete health history. However, a child not accompanied by a parent is unlikely to be able to provide answers to some of the questions posed by the school nurse. The school nurse should use professional judgment to determine which questions are appropriate to ask of a child and which questions will need to be deferred for a later interview with a parent.

Setting. The school nurse responsible for completing a health history must be cognizant of the importance of this interview in establishing communication and rapport with the student. In addition, this first step is key in setting up a successful physical assessment. The interview should be conducted in a room that is private, bright, and nonthreatening. The school nurse should define the scope of the interview, assure complete confidentiality, and tailor communication strategies to the age and developmental level of the student being interviewed. If a parent is present, the school nurse must inform the parent of the relevance of the information they are about to give as well as who has access to the information the parent and student share with the school nurse.

The school nurse may already have access to identifying data about a particular student (e.g., name, nickname, parents' names, home phone, and so forth). If the school nurse does not have this information, it should be elicited in the interview if the student is able to provide it. If not, the school nurse should follow up with a parent after the interview.

Health History Categories. The categories the school nurse should address when taking a health history include:

- ◆ Past medical history.

⁸⁹ Engel, J. (1997). *Pocket Guide to Pediatric Assessment, Third Edition*. St. Louis, Mo.: Mosby.

- ◆ Growth and development.
- ◆ Family history (when possible).
- ◆ Systems review.

Past Medical History. Past medical history includes:

- ◆ General state of health, including appetite, recent weight losses or gains, fatigue, and stresses.
- ◆ Birth history (if a parent is present). Birth history is especially important if the child is younger than 2 years of age or is experiencing developmental or neurological problems. Questions should relate to significant prenatal history, birth complications, and neonatal history (e.g., respiratory distress, cyanosis, jaundice, seizures, poor feeding, patterns of sleeping).
- ◆ Previous illnesses, operations, or injuries, including:
 1. Dates of hospitalizations.
 2. Reasons for hospitalizations.
 3. Accidents, specifically head injuries. (It is important to inquire about a history of fainting spells.)
- ◆ Chronic illnesses, such as asthma, seizure disorders, cardiac disease, and diabetes.
- ◆ Current medications, including prescription and non-prescription drugs, dose, frequency, and duration of use.
- ◆ Allergies, including the agent (e.g., environment, medication).
- ◆ Immunization status.
- ◆ Developmental disabilities or other disabilities.

Growth and Development.

- ◆ Physical development, including height and weight (when indicated, approximate height and weight at 1, 2, 5, and 10 years of age and tooth eruption/loss should be obtained).
- ◆ Developmental history, including developmental milestones (e.g., ages at which child rolled over, sat alone, crawled, walked, spoke first words, spoke first sentences, and dressed without help). Note: For children already participating in school, academic achievement may be included in this section.

- ◆ Social history, including issues relating to:
 1. Temperament (e.g., congeniality, aggressiveness, withdrawal): Children and adolescents should be asked if they ever feel sad or down; if yes, they should be asked if they have ever thought of killing themselves.
 2. Attention span.
 3. Adjustment to school, including school absences and relationship to peers (in and out of school).
 4. Tobacco, alcohol, and drug use.
 5. Relationships with family members.
 6. Toileting habits (where appropriate).

Review of Systems. Review of systems includes inquiry as to the student's or parent's understanding of the child's general health status. Areas to be addressed include:

1. General health status
2. Skin
3. Head and neck
4. Ears
5. Eyes
6. Face and nose
7. Thorax and lungs
8. Cardiovascular
9. Abdominal
10. Genitourinary/reproductive
11. Musculoskeletal
12. Neurologic

Physical Examination⁹⁰

A complete physical examination should be performed by a licensed physician or licensed nurse practitioner (directly supervised by a physician). The health care provider should address the following areas during the physical examination:

- ◆ General appearance, demeanor, and cooperation.
- ◆ Pulse, respiration, and blood pressure.
- ◆ Height, weight, and nutritional status.
- ◆ Posture, gait, flexibility (assessment for scoliosis at appropriate age).
- ◆ Eyes and vision.
- ◆ Nose, mouth, teeth, throat, and neck.
- ◆ Chest and lungs.
- ◆ Heart.
- ◆ Abdomen.
- ◆ Genitalia, hernia, pubertal status (Tanner stage).
- ◆ Extremities (tone and range of motion).
- ◆ Behavior and mental status.

Referral and Follow-Up Process. School nurses and health care providers involved in the interviewing and examination of students may identify medical and non-medical issues requiring follow-up interventions. Effective follow up requires a knowledge of community health resources and good communication between school health personnel, parents, health professionals, and community agencies.

Documentation

The entire special education assessment is confidential. Any information should be documented in the student's record. The record is the responsibility of the director of special education or pupil personnel services. A copy of the medical/health history must be available for the school nurse.

⁹⁰ Engel, J. (1997). *Pocket Guide to Pediatric Assessment, Third Edition*. St. Louis, Mo.: Mosby.

General Guidelines for Administering Medication in School

Note: The following information is a reprint from: Keen, T. (Ed.) with Ford, N., Henry, J., and Cox A. (Consulting Eds.). (1996). Medication Administration. *Guidelines for Specialized Health Care Procedures*. Richmond, Va.: Virginia Department of Health. This reprint contains some updated information, which is contained within brackets: [].

Overview

Administering prescriptive and over-the-counter medication during school hours is a complex issue. In order for many students with chronic illnesses or disabilities to remain in school, they must receive medication. However, administering medication in school has the potential for many problems, such as storage problems, who will administer the medication, potential undesirable side effects, and emergency situations which may arise as a result of the medication. Medication must be administered under the safest possible conditions. Therefore, these guidelines are offered to assist school divisions in developing a policy for administering medication to students at school. The following guidelines were developed to provide guidance for administering medication to students who have specialized health care needs.

Prior to Administering Medication

Prior to administering any prescriptive medication the following three items should be addressed:

- ◆ Authorization for medication.
- ◆ Labeling for the medication.
- ◆ Parental consent.

Note: Policies for over-the-counter medications vary greatly from one school division to another. **Refer to local school division policies for policies for over-the-counter medications.**

Medication Authorization. The use of all prescriptive medications should be authorized in writing by a licensed prescriber, which includes physicians, dentists, physician assistants, or licensed nurse practitioners. The written authorization should include the following information:

- ◆ Student's name.

- ◆ Licensed prescriber's name, telephone number, and signature.
- ◆ Date prescription written.
- ◆ Name of the medication.
- ◆ Dosage.
- ◆ Time of day to be given.
- ◆ Anticipated length of treatment.
- ◆ Diagnosis or reason the medication is needed (unless reason should remain confidential).
- ◆ Serious reactions that the student might experience.
- ◆ Any serious reactions that may occur if the medication is not administered.
- ◆ Special handling instructions.

(See example of a medication authorization/parental consent form at the end of this section.)

Any changes in the original medication authorization require a new written authorization and a corresponding change in the prescription label. Faxed authorizations may be acceptable as long as there is a signed parental consent for the medications authorized by fax. Changes in medications via the telephone should be taken only under extreme or urgent circumstances. Telephone changes should be taken directly from the licensed prescriber by a licensed nurse only if this is consistent with the local school division policy. The telephone authorization for changes in medications should be recorded on the student's record and be a one-time-order only. A telephone authorization should be followed by a written order from the licensed prescriber within 24 hours.

Medication authorizations should be received on a standardized authorization form. However, authorizations on stationary or prescription pads from the licensed prescriber or an acceptable label on the prescription container (see medication labeling below) are acceptable if the parents/legal guardian sign and date the form/label.

Parental Consent. In addition to the authorization for administering medication, parental consent must be obtained before a medication is given to a student. For each medication, the parental consent should include the following information:

- ◆ Student's name.
- ◆ Parent's name.
- ◆ Parent's emergency/daytime phone number.

- ◆ Statement of parental consent.
- ◆ Date of consent.
- ◆ Allergies.
- ◆ Name of the medication (if not on medication authorization form).
- ◆ Reason for the medication (if not on medication authorization form).
- ◆ Duration of treatment (if not on medication authorization form).

If a medication is administered over a long period, a renewed consent form should be obtained every six months, or if it is a standing order, parental consent should be renewed yearly. (See example of a medication authorization/parental consent form at the end of this section.)

Medication Labeling. The final area that should be addressed prior to administering medication is labeling. The medication must be in its original container before it is given to a student. The pharmacist can divide the medication into two containers—one for home and one for school. The original container should be labeled with the student’s name, name of medication, directions for dosage, frequency to be administered, the licensed prescriber’s name, and the date the prescription was filled. **Medications in plastic bags or other non-original containers are not acceptable.**

Administering Medication

School Staff. In schools where school nurses are available on a daily basis, it is recommended that school nurses assume responsibility for arranging the administration of medication to students. In schools where school nurses are not available on a daily basis, it is recommended that the principal assume responsibility for arranging the administration of the medication. If an aide is assigned to administer the medication, the medication authorization, parental consent, and medication label should be reviewed by the school nurse, principal, or principal’s designee prior to giving the first dose. [Note: First dose of a new medication should be given at home.]

It is recommended that the principal or school nurse ensure that:

- ◆ Medication is given correctly and documented appropriately.
- ◆ The appropriate forms are completed prior to giving a medication to include authorization and parental consent. (See sample form at end of this section.)
- ◆ The medication is properly labeled and stored properly in a secure, safe place.

Documentation of Administering Medication. When medication is brought to school, the amount of medication in the container should be noted (e.g., the number of capsules or the volume of liquid). Each time a medication is administered a record should be kept of who administered it (initials may be used as long as a complete signature that corresponds with the person's initials is noted on the record), to whom it was given, the name of the medication, the time it was given, the dose given, the manner in which it was delivered (e.g., by mouth, in ear), the effect of the medication, and any side effects or reactions. Any changes in the type or dosage of the medication or the time it is to be given, should be accompanied by a new medication authorization/parent consent form, and a newly labeled medication container from the pharmacy. The school nurse or principal should establish the date when written medication renewals will be required.

Storage of Medications. A two-week supply or less of medications (unless medication is taken on a daily basis throughout the school year) should be kept in an appropriately labeled container which is locked and secured in a designated space (e.g., a locked box stored within a locked cabinet). Access to keys for the storage space in which medication is kept should be limited to the school nurse, the principal, and authorized staff. A listing of authorized staff should be maintained by the principal and updated routinely. Keys to the medication storage area should never leave the school grounds. Arrangements need to be made for medications requiring refrigeration. The school nurse or principal should establish a date when any unused medication should be picked up by parents.

Parents/Guardian. Prior to administering a medication at school the parents should:

1. Provide the school with a written authorization from the licensed prescriber that includes the following information: the student's name, name of the medication, dosage, hours to be given, method by which it is to be given, name of the licensed prescriber, date of the prescription, expected duration of administration of the medication, and most importantly, possible toxic effects and side effects. For any changes in medication, the parents must provide a written authorization signed by the licensed prescriber.
2. Provide the medication in a container labeled as required.
3. Provide a completed parental consent form.
4. Administer the first dose of any new medication, unless the medication is an "in school" medication only.
5. Transport medication to the school so that the student is not responsible for bringing the medication to school.

(See example of a medication authorization/parental consent form at the end of this section.)

Unused medication should be picked up by parents within one week of the expiration date. After one week the medication should be destroyed by the school nurse, principal,

or the principal's designee. Medication given on a daily basis throughout the year should be destroyed two weeks after the last day of school. It is advisable that the destruction of the medication be witnessed by another person. [Note: School divisions should establish their own policy regarding disposal of medications based on available staff after the last day of school.]

Self-Administration of Medications

Many school divisions do not allow self-administration of medication except under special circumstances with a physician's order and under the supervision of the school nurse, principal or the principal's designee. School divisions that allow self-administration of medication should consider the following questions when developing a policy for self-administration of medication:

- ◆ Has the student demonstrated his/her capability for self-administration and an understanding that medication is not to be shared?
- ◆ Is there a need for a medication order stating that the student is qualified and/or able to self-administer the medication?
- ◆ Is there a need for parental consent for self-administration?
- ◆ What medication will the student be allowed to carry and administer?
- ◆ Does the medication require refrigeration or security?
- ◆ Is there a need for notification of appropriate team members (such as teachers, principals, support persons) of all self-testing or self-administration of medication?
- ◆ Is there a need for staff to be appropriately prepared for working with the student?
- ◆ Should there be recognition that self-administration of medication is a privilege which can be taken away if medication policies are abused or ignored?

Some school divisions that allow self-administration of medication use a "medication pass" system. Each student who is allowed to self-administer medication receives a pass that states the student's name, the name of the medication that the student can self-administer, date issued, who issued the pass, when the pass expires (e.g., seven days, end of school year), when it is to be taken (as needed, on a schedule), and any monitoring that is required. The student should carry the pass at all times.

It should be noted that the guidelines listed previously for prescription and over-the-counter medication should be followed with medication that is self-administered.

Field Trips

At least one day prior to a field trip, the person who administers the medication should be made aware of the event so that arrangements can be made to meet the student's needs for medication. Medication given on field trips should be administered according to the guidelines for administering medications, which include administering the medication from the original medication container.

[Note: Since the publication of "Medication Administration" in *Guidelines for Specialized Health Care Procedures*, the following clarification of the term "administer" medication was set forth in the guidance document adopted by the Board of Pharmacy on June 11, 1998 and the Board of Nursing on concurred July 21, 1998:

If the advance preparation is to assist in the administration of medications to students during a single-day field trip, such advance preparation shall not be made prior to the last working day before the day of the field trip and shall not exceed a one-day supply. Any packaging used in such advance preparation shall include the student's name and any other appropriate student identifier; physician's name; drug name and strength, and quantity; and appropriate directions for administration. For any field trip which is longer than one day in length, a student's prescription should be provided by the student's parent or guardian in a properly labeled prescription vial which has been dispensed from a pharmacy and, for oral medications, which contains only the quantity needed for the duration of the field trip.]

Emergency Medications

Written policies should be available for any emergency medication that is given to students. The epinephrine protocol included at the end of this section is another example of a policy that may be needed.

Epinephrine Protocol ⁹¹

(To be used in conjunction with a physician's order in an EMERGENCY situation.)

Use of subcutaneous epinephrine should be considered in the following situation:

Asthma with any of the following:

1. Breathing rate of less than 12 or greater than 36 times a minute.
2. An anxious student or a student with decreased consciousness.
3. Shortness of breath or inability to speak more than a 3 to 5 word sentence.
4. Difficulty breathing (significant use of accessory muscles for breathing or poor air movement).
5. Cyanosis or significant pallor.

Allergic reaction with any of the following:

1. Heart rate greater than 120 times a minute, systolic blood pressure less than 80.
2. Breathing rate less than 12 or greater than 36 times a minute.
3. Significant wheezing or poor air movement.
4. Overwhelming generalized urticaria (hives) or sudden onset of swelling.
5. An anxious student or a student with decreased consciousness.
6. Drooling, hoarse voice, and/or inability to swallow.

Bee sting in a student with a history of bee sting allergy for whom an epipen has been authorized.

- ◆ **Dosage of Epinephrine:** Two dosages of epinephrine are available—0.3 ml and 0.15 ml of 1:1000 epinephrine (i.e., single dose of epipen). Epinephrine should be administered in the prescribed dosage subcutaneously as directed on epipen directions.
- ◆ **In All Situations Except Category 3 (bee sting):** Before administering the epipen, the student's primary health care provider should be contacted or if the primary health care provider can't be reached then a hospital emergency room physician should be contacted.

At the same time as contact with the primary health care provider is attempted, assisting personnel should activate the 911 system for transportation of the student to the hospital emergency room. [Parents should be notified also.]

⁹¹ Policy adapted from protocol developed by Susan Werner, Chairperson Culpeper County School Health Advisory Committee.

Authorization/Parental Consent for Administering Medication

On the following page is an example of an authorization/parental consent form for administering medications to a student. This form can be reproduced and used or can be modified as needed for local school division use.

[**Note.** Before adapting any of the sample forms, please refer to local school board policies and regulations regarding medications and the code of conduct.]

Licensed Prescriber's Signature _____ Date _____

Procedure for Administering Medication

Procedure

Points to Remember

General Procedure

1. Wash hands.
2. Assemble:
equipment
medication
container for administering (if applicable)
3. Review the medication authorization, medication label, and parental consent for administering medication.
4. Review Health Care Plan for documentation of any student-specific techniques that are recommended for administering the medication.
5. Remove medication from storage area. Compare label on medication container with medication authorization. Ensure that the dosage, time given, student's name, and licensed prescriber's name on the medication label is identical to the medication authorization. Read the label 3 times before administering the medication.
6. Prepare medication. An accurate means for measuring the medication should be readily available. Liquid medication may be poured into a cup with marked measurements, a medicine spoon with marked measurements, or pulled up into a syringe. A tablet or capsule may be placed in a cup.
7. Place remaining medication back into the designated storage area.
8. Explain the procedure to the student at his/her level of understanding. Encourage the student to participate as much as possible.

The first dose of the medication should be given at home unless the medication is a "school only" medication.

Prior to administering medication, it is essential that the method used for giving the medication at home be known. This method should be followed in the school setting.

Helps to ensure that the right medication is given to the right student.

*The person preparing the medication should be the person giving the medication.
1 teaspoon = 5 milliliters (mls)*

By encouraging the student to assist in the procedure, the care giver is helping the student achieve maximum self-care skills.

Procedure**Points to Remember****Oral Medications**

9. Positioning for special situations:

Small students at infant developmental level:

- ◆ Hold student in the cradle position.
- ◆ Stabilize student's head against your body.
- ◆ Hold student's arm with your free arm.
- ◆ Press on student's chin to open mouth.

Large student at infant developmental level

- ◆ Allow student to remain in wheelchair.
- ◆ Support student's head against your body.
- ◆ Press on student's chin to open mouth.

Students with tongue thrust

- ◆ Medications may need to be rescued from the student's lips or chin and re-administered.

10. Administering medication:

Dropper

- ◆ Squirt medication to the back and side of the student's mouth in small amounts.

Syringe

- ◆ Place syringe to the back and side of the student's mouth.
- ◆ Give the medication slowly, allowing the student to swallow.

Nipple

- ◆ Pour medication into the nipple after it has been measured. Allow the student to suck the medication from the nipple. Follow the medication with a teaspoon of water.

Medicine Cup

- ◆ Place the medication in the cup. If the student is capable of drinking the medication without help, allow him/her to do so; if the student is unable to hold the cup, then hold the cup and allow the student to drink the medication.

Tablets

- ◆ If the student is able to swallow a tablet, place it on the middle of the tongue, then student can swallow tablet with juice or water.
- ◆ Tablets that may be chewed or crushed and placed in a fruit syrup or applesauce.
- ◆ Tablets may be crushed between 2 spoons.

When holding or supporting the student, it is important that the student is relaxed to prevent choking.

A relaxed position may be achieved by flexing the student's neck, rounding the shoulders, and positioning the student in a slightly forward or flexed position.

In smaller children, 3 to 4 squirts per 5 milliliters (ml) is recommended.

Whole tablets should not be given to children less than 5 years old because of the potential for aspiration.

It is important to check with pharmacist to see if drug action will be affected by crushing the medication.

Make sure that medication does not cling to

Procedure

- ◆ Unscored tablets should not be divided. If medication authorization requires unscored tablet to be divided, please consult with pharmacist prior to dividing the medication.
- ◆ Do not force a student to take a tablet if he/she resists because of the potential for aspiration.

Capsules

- ◆ Place the capsule on the back of the tongue and have the student swallow lots of fluid.
- ◆ Some capsules may be opened and sprinkled on a spoonful of food. Check with pharmacist to see if this can be done.

11. Before student leaves your presence, make sure that he/she has received and swallowed all of the medication.

Nose Drops

9. For young children/developmentally young children, cradle student in your arms, stabilizing head with arm, and tilt student's head slightly back OR place student's head over a pillow.

10. Squeeze prescribed drops into each nostril.

11. Older students may give their own medication, if they are able to sniff the medication.

Ear Drops

9. Tilt student's head away from affected ear. Pull pinna (outer edge of ear) upwards and back.

10. Instill ear drops as ordered into the student's ear.

11. Student should maintain this position for 5 to 10 minutes. Then place a small piece of cotton ball into the ear canal.

Eye Drops or Ointment

9. Place student in a supine position (lying down on his/her back).

Points to Remember

spoon, so that student receives all of the prescribed medication.

Division of unscored tablets may adversely affect their absorption by the body.

Check with parents to determine how the medication is given at home.

Many medications are designed to be time-released. It is important not to disrupt this formulation because it affects the absorption of the medication and may cause potential harm to the student.

Students may hold medication in their mouth and spit it out at a later time.

The lowered position is necessary when the student can not sniff the medication.

Keeps medication from flowing out of the ear.

Procedure	Points to Remember
<p>10. Drops - Pull lower eyelid down and out to form a cup. Drop solution into the cup. Close eye gently and attempt to keep eye closed for a few moments.</p>	<p><i>Avoid touching dropper to eye to avoid contamination of the medication.</i></p>
<p>11. Ointment - Pull lower eyelid down, apply ointment along edge of lower eyelid from the nose side of the eyelid to the opposite side.</p>	<p><i>Avoid touching tip of medication container to the eye to avoid contamination of the medication.</i></p>
<p>Rectal Medications</p>	
<p>9. Place student in side-lying or prone position (on his/her stomach)</p>	
<p>10. Lubricate suppository with water-soluble gel.</p>	
<p>11. Using a finger cot, gently insert the suppository into the rectum.</p> <ul style="list-style-type: none"> ◆ Do not insert finger more than 1/2 inch. ◆ Hold buttocks together for 5 to 10 minutes. 	<p><i>It is important that privacy be provided.</i></p> <p><i>Prevents quick expulsion of the medication so that the medication has adequate time to be absorbed.</i></p>
<p>Enzyme Replacement Therapy (Used with students with cystic fibrosis to provide pancreatic enzymes.)</p>	
<p>9. Enzymes should be given prior to a meal or snack.</p>	<p><i>Pancreatic enzymes aid in digestion and absorption of food; therefore, they should be given prior to eating.</i></p>
<p>10. Microspheres or microtablets should not be crushed or chewed.</p>	<p><i>Enzymes should dissolve in the higher pH environment of the intestines rather than the mouth. The enzymes are coated with an enteric coating that prevents the enzyme from being dissolved till it reaches the intestine. If the coating is disrupted by crushing or chewing, the enzyme will not dissolve in the proper place.</i></p>
<p>11. For infants and small children, the capsules should be broken open and mixed with a lower pH food, such as applesauce.</p>	
<p>12. Document medication given, time given, amount given, how it was given, who gave it, and the student's name. Also, document any problems or side effects.</p>	<p><i>Notify parents and/or physician of any problems or side effects.</i></p>

Possible Problems

Observations**Reason/Action**

Incomplete dose of medication

If the student spits or vomits the medication, administer the medication again. Investigate why the student spit or vomited. Perhaps a smaller portion of medication may be given at more frequent times, or medication may be mixed with juice to make it more palatable.

Incorrect medication

Notify parents and physician immediately with name of medication and dosage given. Follow physician's orders.

Medication not given

Report immediately to parents and/or physician. Determine when medication should be given next.

Choking

Stop giving medication immediately. When student begins to breathe regularly and has completely recovered, medication can be given. If the student does not recover and is believed to have an obstructed airway, perform the Heimlich Maneuver, activate the emergency medical system, and begin CPR as indicated.

Response to medication

Any side effects should be reported to the parents. If the student has an allergic reaction, the medication should be discontinued.

Resources

Cystic Fibrosis Foundation. (1990). Nutritional Assessment and Management in Cystic Fibrosis. *Consensus Conferences, Concepts in Care, 1*.

Graff, J., Ault, M., Guess, D., Taylor, M., and Thompson, B. (1990). Medication Administration. In *Healthcare for Students With Disabilities: An Illustrated Medical Guide for the Classroom* (pp. 29-41). Baltimore, Md.: Paul H. Brookes Publishing.

Skale, N. (1992). Medication Administration. In *Manual of Pediatric Nursing Procedures* (pp. 117-123). Philadelphia, Pa.: J.B. Lippincott Company.

Woolridge, N.H. (1994). Nutrition Management of Cystic Fibrosis. *Nutrition Focus*, 9 (6), pp.1-8.

Infectious Disease Control

Authorization

Code of Virginia. The following sections of the *Code of Virginia* **include** information related to infectious disease control:

Section 32.1-39, Surveillance and Investigation of Reportable Diseases.

Excerpt: See Appendix A for *Code of Virginia*, § 32.1-39.

Section 22.1-272, Contagious and Infectious Diseases.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-272,

Sections 22.1-271.1 Definitions and 271.2, Immunization Requirements.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-271.1 and 271.2.

Section 32.1-47, Exclusion From School of Children Not Immunized.

Excerpt: See Appendix A for *Code of Virginia*, §32.1-47.

Section 22.1-271.3 Guidelines for School Attendance for Children Infected with Human Immunodeficiency Virus; School Personnel Training Required; Notification of School Personnel in Certain Cases.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-271.3.

Note: A list of reportable diseases, which are subject to control under isolation and quarantine regulations and general reporting duties, is provided in Appendix A.

Overview

Communicable disease is an illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host. Communicable diseases are one of the major problems that school health programs face, causing both staff and student absences, as well as discomfort, all of which can interfere with academic performance.

While this section of the manual is intended to provide school health services personnel with a ready source of information on managing the control of communicable diseases in the school setting, it should be used for guidance purposes only. It is not intended to replace more inclusive textbooks, regulations and legal requirements, or state and local policies, or be

a therapeutic guide, but to be a source of basic information on which initial action can be taken.

Definitions

The following are technical meanings of terms used in this section. The sources of definitions are taken from the following resources:

- ◆ Benenson, A.S. (Ed.). (1995). *Control of Communicable Diseases Manual* (16th edition). Washington D.C.: American Public Health Association.
- ◆ Thomas, C.L. (Ed.). (1993). *Tabor's Cyclopedia Medical Dictionary* (17th edition). Philadelphia: F.A. Davis Company.

Carrier: A person or animal that harbors a specific infectious agent in the absence of discernible clinical disease and serves as a potential source of infection.

Case: Individuals that have the disease or illness.

Communicable disease: An illness due to a specific infectious agent or its toxic products that arises through the transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host; either directly or indirectly through an intermediate plant or animal host, vector, or the inanimate environment. (Synonym: infectious disease.)

Communicable period: The time or times during which an infectious agent may be transferred directly or indirectly from an infected person to another person, from an infected animal to man, or from an infected person to an animal, including arthropods.

Contact: A person or animal that has been in such association with an infected person or animal or a contaminated environment as to have had an opportunity to acquire the infection.

Contagious: Transmitted readily from one person to another either directly or indirectly (i.e., communicable).

Contamination: The presence of an infectious agent on a body surface, in clothes, bedding, toys, surgical instruments or dressings, or other inanimate articles or substances including water and food. **Pollution** is distinct from contamination and implies the presence of offensive, but not necessarily infectious, matter in the environment. Contamination of body surfaces does not imply a carrier state.

Epidemic: The occurrence in a community or region of excess of an illness (or an outbreak) with a frequency clearly in excess of normal expectancy.

Host: A person or other living animal, including birds and arthropods, that affords subsistence or lodgment to an infectious agent under natural (as opposed to experimental) conditions.

Inapparent infection: The presence of an infection in a host without recognizable clinical signs or symptoms. Inapparent infections are identifiable only by laboratory means, such as a blood test or by the development of positive reactivity to specific skin tests.

Incubation period: The time interval between initial contact with an infectious agent and the first appearance of symptoms associated with the infection.

Infected individual: A person or animal that harbors an infectious agent and who has either manifest disease (see Patient or sick person) or inapparent infection (see Carrier). An **infectious person** or animal is one from whom the infectious agent can be naturally acquired.

Infection: The entry and development (of many parasites) or multiplication of an infectious agent in the body of persons or animals. Infection is not synonymous with infectious disease; the result may be inapparent (see Inapparent infection) or manifest (see Infectious disease). The presence of living infectious agents on exterior surfaces of the body, or on articles of apparel or soiled articles, is not an infection, but represents contamination of such surfaces and articles. (See Infestation and Contamination.)

Infectious agent: An organism (virus, a minute organism that needs a living cell in order to reproduce; rickettsia, occupies an intermediate position between viruses and bacterium; bacteria, a unicellular microorganism; fungus, a plant-like organism that includes molds and yeasts; protozoan, includes simplest animals; or helminth, a worm-like animal) that is capable of producing infection or infectious disease.

Infectious disease: A clinically manifest disease of humans or animals resulting from an infection. (See Infection.)

Infestation: For persons or animals, the lodgment, development, and reproduction of arthropods (e.g., lice, fleas, ticks, mites) on the surface of the body or in the clothing. Infested articles or premises are those that harbor or give shelter to animal forms, especially arthropods and rodents.

Organism: Any living thing, plant, or animal. The principal causes of infection are organisms (i.e., infectious agents) belonging to the following groups.

- ◆ **Viruses:** Minute organisms that require a living cell for reproduction and growth.
- ◆ **Rickettsia:** Intermediate microorganisms (between virus and bacteria) that require living cells for growth.
- ◆ **Bacteria:** Unicellular microorganisms.
- ◆ **Fungi:** Plant-like organisms that include molds and yeasts.
- ◆ **Animal Parasites:** Live within, upon, or at expense of another organism, known as the host, without contributing to the survival of the host.

Patient or sick person: A person who is ill.

Report of a disease: An official report notifying an appropriate authority of the occurrence of specified communicable or other disease in humans or animals.

Reservoir (of infectious agents): Any person, animal, arthropod, plant, soil or substance (or combination of these) in which an infectious agent normally lives and multiplies, on which it depends primarily for survival, and where it reproduces itself in such manner that it can be transmitted to a susceptible host.

Transmission of infectious agents: Any mechanism by which an infectious agent is spread from a source or reservoir to a person. These mechanisms are as follows:

1. **Direct Transmission:** Direct and essentially immediate transfer of infectious agents to a receptive portal of entry through which human or animal infection may take place. This may be by **direct contact** (e.g., touching, biting, kissing, sexual intercourse) or by **direct projection** (droplet spread) of droplet spray onto the conjunctiva or onto the mucous membranes of the eye, nose, or mouth during sneezing, coughing, spitting, singing, or talking (usually limited to a distance of about 1 meter or less).
2. **Indirect Transmission:** Indirect transfer of infectious agents through contaminated inanimate materials or objects (e.g., toys, handkerchief, soiled clothing, bedding, or cooking or eating utensils); substances (e.g., water, food, and biological products such as blood); and mechanical (e.g., carriage by crawling or flying insects).
3. **Airborne:** The dissemination of microbial aerosols to a suitable portal of entry, usually the respiratory tract. Microbial aerosols are suspensions of particles in the air consisting partially or wholly of microorganisms. They may be suspended in the air for long periods of time, some retaining and others losing infectivity or virulence. Particles in the 1 to 5 μ m range are easily drawn into the alveoli of lungs and may be retained there. Not considered as airborne are droplets and other large particles that promptly settle out (see Direct Transmission).

Infectious Disease Control Measures

Infectious disease control measures in school include:

- ◆ Requiring certain immunizations.
- ◆ Identifying children who have communicable diseases.
- ◆ Preventing illnesses from spreading.
- ◆ Temporarily excluding some children who are ill.
- ◆ Reporting illnesses regulated by Virginia Department of Health.
- ◆ Being prepared by having policies, procedures, and trained personnel.

Resources

- ◆ *Virginia Department of Health
Office of Epidemiology
P.O. Box 2448
Richmond, VA 23218
Telephone (804) 786-6029
Web site: <http://www.vdh.state.va.us/epi/newhome.htm>*
- *Division of Surveillance and Investigation
Telephone: (804) 786-6261*
- *Division of Immunization Telephone:
(804) 786-6246*
- *Division of Tuberculosis Control
Telephone: (804) 786-6251*
- *Division of STD/AIDS
Telephone: (804) 786-6267*
- ◆ *Fact Sheets: Prepared by Virginia Department of Health, Office of Epidemiology.
Web site: <http://www.vdh.state.va.us/epi/epifacts.htm>*
- ◆ *Wall Chart: Communicable Disease Reference Chart for School Personnel, Revised 9/98.
Virginia Department of Health, Office of Epidemiology
To order, call (804) 786-6261*
 - ◆ *List of Reportable Diseases in Virginia
Web site: <http://www.vdh.state.va.us/epi/list.htm>
(List is reprinted in Appendix A.)*
- ◆ *Virginia STD/AIDS Hotline: 1-800-533-4148
(Voice/TTD Accessible)
In Spanish: 1-800-344-7432*
 - ◆ *Regulations for Disease Reporting and Control
Commonwealth of Virginia
State Board of Health
January 1999
Virginia Department of Health
To order, call (804) 786-6261*
- ◆ *Control of Communicable Diseases Manual
Abram S. Benenson, Editor
Sixteenth Edition, 1995
American Public Health Association
1015 Fifteenth Street, NW
Washington, DC 2005
To order, call ANA Publication Sales at (301) 893-1894 or order online at <http://www.apha.org>*

Subsections

The following subsections contain prevention guidelines for control of infectious diseases in the school setting and a description of selected infectious diseases.

- ◆ Prevention Guidelines for Diseases Spread Through Direct Skin Contact
- ◆ Prevention Guidelines for Diseases Spread Through the Intestinal Tract
- ◆ Prevention Guidelines for Diseases Spread Through the Respiratory Tract
- ◆ Prevention Guidelines for Diseases Spread During Sexual Activity
- ◆ Prevention Guidelines for Sports-Related Infectious Diseases
- ◆ Selected Infectious Diseases

Note: The information presented in the following subsections is a composite of information from the following references.

American Academy of Otolaryngology-Head and Neck Surgery. Public Service Brochure. Web site: <http://www.netdoor.com/entinfo/omaa.html>.

American Academy of Pediatrics. (1997). *1997 Red Book, Report of the Committee on Infectious Diseases* (24th Edition). Elk Grove Village, Ill.: American Academy of Pediatrics.

Berkow, R. (Editor-in-Chief). (1992). *The Merck Manual of Diagnosis and Therapy*. Merck & Co., Inc. Web site: <http://www.merck.com>.

Benenson, A.S., Editor. (1995). *Control of Communicable Diseases Manual* (16th edition). Washington, D.C.: American Public Health Association.

Boynton, R.W., Dunn, E.S., Stephens, G.R. (1994). *Manual of Ambulatory Pediatrics* (3rd Edition). Philadelphia: J.B. Lippincott Company.

Donowitz, L.G. (1996). *Infection Control in the Child Care Center and Preschool* (3rd edition). Baltimore, Md.: Williams & Wilkins.

Massachusetts Department of Public Health. (1995). *Comprehensive School Health Manual*. Boston, Mass.: Author.

Merensteing, G.B. (1997). *Handbook of Pediatrics* (18th edition). Stamford, Conn.: Appleton & Lange.

National Center for Infectious Diseases, Center for Infectious Disease Control and Prevention. Web site: <http://www.cdc.gov/ncidod/>.

Virginia Department of Health. *Sexually Transmitted Diseases*. (October, 1994). Richmond, Va.: Virginia Department of Health.

Virginia Department of Health, Office of Epidemiology. (1997). *Virginia Disease Control Manual*. Richmond, Va.: Virginia Department of Health.

Taber's Cyclopedic Medical Dictionary (17th edition). (1997) Philadelphia, Pa.: F.A. Davis Company.

Prevention Guidelines for Diseases Spread Through Direct Skin Contact

Overview

Communicable infectious diseases that are usually spread through direct skin contact—including those commonly known as head lice, impetigo, pink-eye, scabies, and ringworm—can be spread from person to person by direct or indirect transfer of the disease-causing organism (infectious agent). Organisms that cause such diseases include bacteria, parasites, and fungi.

Direct transmission of the organisms can occur by direct contact with an infected or infested person (e.g., direct skin-to-skin contact, immediate contact with infected lesions or discharges). Indirect transmission of the organism can occur, though usually to a lesser extent, through contaminated inanimate materials or objects (e.g., shared clothing, headgear, or shower stalls). For some of the diseases, it is possible to transmit the organism through other modes (e.g., autoinfection, airborne spread).

These diseases are common and, when treated, are not serious. Because students constantly touch the people around them and their surroundings, these diseases are easily spread among students and staff.

Listed below are some examples of how the disease-causing organisms can be transmitted.

- ◆ A student's arm has sores with discharge. During interaction, this discharge gets on another individual's arm and into a cut or scratch.
- ◆ A hat belonging to a student with head lice is used by another student. A louse from the hat crawls onto the head of the second student.
- ◆ A student with runny eyes rubs them with his or her hands before picking up a book, pen, or pencil, contaminating them with eye discharge. Other students become infected by picking up those objects and then rubbing their own eyes with contaminated hands.

School Exclusion Guidelines

See Appendix C for specific disease.

Prevention Guidelines for Diseases Spread Through Direct Skin Contact

1. Follow hand washing and cleanliness guidelines that include:

- ◆ Making sure staff and students thoroughly wash their hands after contact with any possible infected areas.
 - ◆ Using liquid soap dispensers whenever possible.
 - ◆ Always using disposable tissues or towels for wiping and washing.
 - ◆ Never using the same tissue or towel from more than one student.
 - ◆ Disposing of used tissues and paper towels in a lined and covered container that is kept away from food and materials.
 - ◆ Washing or vacuuming frequently-used surfaces (e.g., tables, counters, furniture, and floors) daily.
2. Do not permit students to share personal items, such as combs, brushes, hats, or clothing.
 3. Provide adequate individual areas for students to keep their outer clothing items, such as coats, hats, scarves, and mittens.
 4. Wash and cover sores, cuts, and scrapes promptly, and keep infected eyes wiped dry.
 5. Report rashes, sores, runny eyes, and severe itching to a student's parents so they may contact their health care provider for diagnosis and appropriate treatment.

Prevention Guidelines for Diseases Spread Through the Intestinal Tract

Overview

Communicable infectious diseases that are usually spread through the intestinal tract—including those commonly known as campylobacteria, giardia, hepatitis A, hepatitis E, pinworms, rotavirus, salmonella, and shigella—can be spread from person to person by direct or indirect transfer of the disease-causing organism (infectious agent). Organisms that cause such diseases include bacteria, viruses, and parasites.

Direct transmission of the organisms, for most of the diseases, can occur by hand-to-mouth transfer of the organism from the stool of an infected person (i.e., fecal-oral route), especially in institutions and day care centers. Indirect transmission of the organisms can occur, though usually to a lesser extent for some of the diseases, through contaminated inanimate materials or objects (e.g., ingestion of organism in food, unpasteurized milk, water). For some of the diseases, it is possible to transfer the organisms through other modes (e.g., contact with an infected pet, possibly fecal-respiratory route). Some organisms, such as *Campylobacter* and *Salmonella* bacteria, must be ingested in large quantities to cause illness.

Students or staff who have hand-stool contact may facilitate transmission of these organisms. Students or staff with disease-causing organisms in their stool may not act or feel sick or have diarrhea. Laboratory tests are the only means of confirming the presence of this type of organism in a particular stool and may be performed as part of an effort to control an outbreak of disease.

Because students and staff who have intestinal tract diseases do not always feel sick or have diarrhea, the best method for preventing spread of disease is to have a constant prevention program in place. In the school setting, this program should include hand washing before preparing or eating food and after using the bathroom. All school bathrooms should have adequate supplies of soap, running water, paper towels, and toilet paper.

School Exclusion Guidelines

- ◆ When students or staff have uncontrolled diarrhea and fever or vomiting (or have severe or bloody diarrhea) or if diarrhea cannot be contained by diapers (in those students using them), they should be excluded from school until their fever or diarrhea are gone and they have been treated as determined by a health care provider.
- ◆ When students or staff have mild diarrhea but are not sick, special precautions should be taken or they should be excluded from school.

- ◆ When students or staff who do not prepare food or feed students are found to have infectious diarrheal germs in their stool (positive stool cultures) but have no diarrhea or illness symptoms, special precautions should be taken but they should not be excluded from school. (If necessary, make sure they receive appropriate management from a health care provider.) During outbreaks a negative stool culture may be required before returning to school.
- ◆ When staff who normally prepare food or feed children have positive stool cultures, do not permit them to prepare food or feed students until they have one negative stool culture taken 48 hours after medication is completed, if antibiotics are used. During outbreaks, two consecutive negative stool cultures may be required.

See Appendix C for specific disease.

Return Guidelines

Excluded students and staff may come back to school after treatment and when severe diarrhea is gone. During outbreaks, negative stool cultures may be required before excluded students and staff may come back to school.

Prevention Guidelines for Diseases Spread Through the Intestinal Tract

1. Strictly enforce proper handwashing after using the bathroom, diapering, and before preparing or eating food. **Handwashing is the best way to prevent spread of infectious diseases caused by organisms that are transmitted by the fecal-oral route.**
2. Pay attention to environmental cleaning and sanitation.
3. Keep track of the number of cases of diarrhea.
4. If there is an increase in the number of cases expected in the school, call the local health department for guidelines on additional precautionary measures to be taken to ensure the protection of students and staff from further spread of illness.

Prevention Guidelines for Diseases Spread Through the Respiratory Tract

Overview

Communicable infectious diseases that are usually spread through the respiratory tract—including those commonly known as chickenpox, common cold, flu, measles, bacterial meningitis, tuberculosis, and whooping cough—can be spread from person to person by direct, indirect, or airborne transfer of the disease-causing organism (infectious agent). Organisms that cause such diseases include bacteria and viruses. When a person infected with such a disease coughs, sneezes, blows their nose, sings, or talks (usually limited to about 1 yard) they can produce infected droplets (large infected particles that settle out of the air) or infected airborne particles (microbial aerosols that do not settle out of the air for a long time).

Direct transmission of the organisms can occur by direct contact with the mucous membranes of the infected person (e.g. touching or kissing) or direct projection (spray) of the droplets onto the eye, nose, or mouth. Indirect transmission of the organisms can occur, for most of the diseases, by hands and articles (e.g., handkerchiefs, toys, pencils, books, desks) freshly soiled by droplets, discharges from nose and throat, or secretions from lesions of an infected person—the organisms are transmitted by contaminated hands carrying organisms to the mucous membranes of the eye or nose. Furthermore, transmission of the organisms can occur by inhalation of airborne particles.

Diseases spread through the respiratory tract can be mild (e.g., viral colds) or life-threatening (e.g., bacterial meningitis). People who are infected with such diseases and do not wash their hands after touching their eyes, nose, or mouth increase the likelihood of spreading the disease by contaminating articles with discharges from their respiratory tract. The organisms can easily be transferred to others through those contaminated articles. In addition, people who are infected with respiratory disease and do not cover their mouths and nose when coughing or sneezing can increase the likelihood of airborne spread, which can predominate among crowded populations in enclosed spaces (e.g., school buses).

School Exclusion Guidelines

- ◆ Most children will not need to be excluded from school for mild respiratory tract illnesses, because transmission is likely to have occurred before symptoms developed in the child or is a result of contact with children with asymptomatic infection.
- ◆ Exclusion from school of children with respiratory tract symptoms that are due to common cold, croup, bronchitis, pneumonia, sinusitis, and/or otitis media probably will not decrease the spread of infection.

- ◆ Separation from other children is indicated when one or more of the following conditions exist:
 1. The illness has a specific cause that requires exclusion or treatment prior to returning to school as outlined under the discussion of the specific illness.
 2. It interferes with the child's ability to concentrate and limits the child's comfortable participation in school activities.
 3. Results in a need for care from staff members that compromises the health and safety of other children.

See Appendix C for specific disease.

Prevention Guidelines for Diseases Spread Through the Respiratory Tract

1. Hand washing and other hygiene practices are essential to decreasing the spread of all respiratory tract diseases. Students and staff should be encouraged to wash their hands after wiping or blowing their noses; after contact with any nose, throat, or eye secretions; and before preparing or eating food.
2. A supply of tissues should be available in each classroom. Encourage children to cough or sneeze into a tissue and away from other people. Tissues should be properly disposed of and hand washing should follow.
3. Dispose of tissues contaminated with nose, throat, or eye discharges in a step-can with a plastic liner. Keep soiled tissues away from food and other classroom materials.
4. Discourage the sharing of food.
5. Surface areas, toys, and other inanimate materials and objects shared by children in the classroom should be properly cleaned

Note: Aspirin (or products containing salicylate) should *never* be administered to children for fever control of any viral illness, but particularly if influenza or chickenpox is suspected. There is an association with Reye's syndrome (vomiting, liver problems, and/or coma) and the use of aspirin in the treatment of these types of illnesses.

Prevention Guidelines for Diseases Spread During Sexual Activity

Overview

Sexually Transmitted Diseases (STDs) refer to a group of diseases that are spread from person to person during sexual activity. This term includes such conditions as AIDS and HIV infection, chlamydia, crabs (pubic lice), genital warts, gonorrhea, hepatitis B (HBV), genital herpes, syphilis, and vaginitis (yeast infections, trichomoniasis).

The organisms that cause an STD can be spread during oral (mouth), anal, or vaginal sexual activity. Some STDs are spread from skin-to-skin contact with an infected partner's genital area—not just through intercourse.

STDs are very common in the United States and some are increasing. All STDs are preventable. Left untreated, some STDs can cause serious long-term health problems. A pregnant woman can pass an infection to her baby.

***Symptoms.** The symptoms, transmission, and treatment of STDs are specific for each disease. However, listed below are some of the symptoms that might indicate that a person is infected with an STD.*

Females

- ◆ *Any odor or unusual discharge (fluid) that comes from vagina.*
- ◆ *Itching or burning around vagina.*
- ◆ *Pain during sex.*
- ◆ *Bleeding other than during menstrual period.*
- ◆ *Pain in the lower abdominal area that does not go away.*
- ◆ *Left untreated, some STDs can cause Pelvic Inflammatory Disease (PID)—a very serious condition. PID can develop when untreated infections spread further into the reproductive organs. Symptoms are usually serious and, left untreated, can cause sterility.*

Males

- ◆ *A discharge or drip (fluid) from penis.*
- ◆ *Pain or soreness in the area of testicles.*

Males and Females

- ◆ *Pain or burning with urination.*
- ◆ *Any blisters, sores, ulcers, bumps, or warts on or around sex organs or anus.*
- ◆ *Any burning, itching, swelling, or redness on or around sex organs.*

- ◆ *Persistent flu-like symptoms, such as tiredness, fever, aches, chills, night sweats, weight loss, or diarrhea.*

Note: Sometimes a person may not have ANY symptoms whatsoever but might still have an STD.

Treatment

Physicians can identify and treat STDs. In addition, most local health departments have special clinics just for STDs.

School Exclusion Guidelines

See Appendix C for specific disease.

Prevention Guidelines

The only sure way to avoid getting an STD is to not have sex. The following is a summary of how to prevent getting an STD.

- ◆ *Abstain from sex.*
- ◆ *Having a faithful (monogamous) relationship with one uninfected partner is the next best thing. However, if the partner is having sex with other people, the other partner can get an STD.*
- ◆ *The best protection for a sexually active person is to use a latex condom every time that person has sex. This means for vaginal, anal, and oral sex. Condom use has been proven to reduce the risk of getting HIV, hepatitis B, herpes, gonorrhea, genital ulcers, pelvic inflammatory disease, chlamydia, syphilis, and other infections.*

Prevention Guidelines for Sports-Related Infectious Diseases

Overview

The spread of communicable infectious diseases among students in the school setting is a problem shared by all educational institutions. Contact in the classroom, cafeteria, or school yard can facilitate the spread of infectious diseases. In addition to the exposures that students face in these common situations, student athletes may contract or spread infectious diseases while participating in sporting activities. Teachers, coaches, and athletic staff, school/team physicians, school nurses, and others responsible for the health and safety of athletes need to be aware of the infectious disease spread that can occur during training, competition, or even during physical education class activities.

Risk of Exposure

There may be risk of exposure for the individual athlete, the team, and spectators. Transmission of infectious diseases in sports settings usually occurs via direct contact, the fecal-oral route, common-source exposure, or airborne and/or droplet spread. In some cases, disease transmission is unavoidable due to infectiousness before symptoms become apparent. In other cases, the spread of disease occurs as a result of many people congregating together or sharing water bottles or other eating/drinking utensils. The following chart lists some infectious diseases that have occurred due to sports-related activities.

Sports-Related Infectious Diseases		
Disease	Mode of Transmission	Sports Involved
Herpes simplex virus (HSV), (<i>herpes gladiatorum</i>) <i>Staphylococcus aureus</i> Group A streptococci, fungi	Direct contact	Wrestling, rugby, basketball, football
Enteroviruses (coxsackievirus, echoviruses)	Common-source or fecal-oral	Team sports
<i>Pseudomonas aeruginosa</i>	Common-source	Swimming
Meningococcal illnesses	Saliva exchange	Team sports
Measles	Airborne or droplet	Tournaments involving gymnastics, basketball, wrestling, other indoor sports

School Exclusion Guidelines

See Appendix C for specific disease.

Prevention Guidelines

Some concern has been raised about the possibility of sports-related transmission of blood-borne pathogens. Team physicians, trainers, school nurses, physical education teachers, and others involved with the health of the student athlete should not only be able to recognize and manage acute problems but should also institute policies for the prevention of disease transmission. These policies should include, but not be limited to, the following, which are taken from Goodman, et. al. (1994).⁹²

⁹² Goodman, R.A., et al. (1994). Diseases in Competitive Sports. *JAMA*, 271(11): pp.862-867.

1. In order to decrease transmission of diseases spread by mucous membrane contact or the fecal-oral route, coaches, trainers, and physical education instructors should be educated about the need to prevent exposures of athletes sharing water bottles and pails during sports-related activities.
2. Students diagnosed with skin infections should be cautioned about their participation in sports involving close physical contact. Players with open lesions that cannot be covered should not be permitted to participate in sports where they could transmit disease to others.
3. All athletic equipment in contact with student's skin or secretions should be routinely cleaned after use. This would include, but not be limited to, gymnastic and wrestling mats, mouth guards, and other protective equipment. Sanitizing of mats with a dilute bleach solution (1 tablespoon bleach to 1 quart of water) and airing of mats is also recommended as a standard precaution.
4. All students must be vaccinated against communicable diseases as described in Chapter III, Immunization Requirements.
5. When airborne diseases occur, a mechanism should be in place to inform everyone exposed, including athletes, staff, and spectators.
6. Athletes with symptoms of an infectious disease should not be permitted to participate in sports activities until they have been evaluated by their health care provider and are no longer infectious.
7. Public health officials should be immediately notified of a case or suspected case of a reportable disease in an athlete. Timely reporting of even a suspected case of an infectious disease may help to prevent further spread among athletes, spectators, and the community.

Selected Infectious Diseases

Please refer to Appendix C for a description of selected infectious diseases that may occur in the school setting and measures to prevent their spread. Responsibility for the care of the individual student rests with the family and his/ her health care provider.

Other School Health Services

In addition to health assessments, population screening, services associated with the students with special needs, and medication administration, school divisions may offer a variety of health services. A few services that are typically offered by school divisions in Virginia have been selected and highlighted in this section.

Subsections

The following subsections contain information on other health services that may be offered by school divisions.

- ◆ Managing Illnesses/Injuries, and Crises
- ◆ Referring to Child Protective Services
- ◆ Home Visits
- ◆ Nursing Liaison Services to Homebound Students
- ◆ Students Requiring Specialized Health Care Procedures
- ◆ Infectious Disease Control

Managing Illnesses/Injuries and Crises

Each school is responsible for the safety and well-being of students, staff, and visitors during school hours on school property, and during school-sponsored activities. Schools and their staff must be ready to manage first aid emergencies, disasters, and crises that occur in the school or impact the school from outside. It is important that schools have written procedures and policies for managing first aid emergencies, disasters, and crises. In addition, the school and staff need to have the knowledge of the policies and procedures so that they can handle these situations competently.

Authorization

Code of Virginia, Section 54.1-2969, Authority to Consent to Surgical and Medical Treatment of Certain Minors.

Excerpt: See Appendix A for *Code of Virginia*, § 54.1-2969.

Code of Virginia, Section 8.01-225, Persons Rendering Emergency Care, Obstetrical Services, Exempt From Liability.

Excerpt: See Appendix A for *Code of Virginia*, § 8.01-225.

Code of Virginia, Section 22.1-274 E, School Health Services (Certification of School Employees in CPR).

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-274.

Code of Virginia, Section 22.1-278.1, School Safety Audits Required.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-278.1.

Managing Illnesses and Injuries

Note: The following information, on managing illnesses and injuries, is adapted from the following publications:

- ◆ *School Health: A Guide for Health Professionals* (1997 Revision)
Committee on School Health
American Academy of Pediatrics
141 Northwest point Boulevard
P.O. Box 927
Elk Grove Village, IL 60009-9027

- ◆ *School Nursing and Health Services: A Resource Guide* (June 1998)
Cindy Ericksen, RN-C, MSN, FNP
Consultant, School Nursing/Health Services
Wisconsin Department of Public Instruction
Madison, WI 53293-8782
Telephone: (800) 243-8782

- ◆ *First Aid Guide for School Emergencies* (1998)
Tarr, J. (developer) with Ford, N., Henry, J., Cox, A. (editors)
Virginia Department of Health
P.O. Box 2448
Richmond, VA 23218-2448
Telephone: (804) 786-7367

Introduction. Many minor injuries and illnesses occur in students and staff during the course of the school day. Students, employees, and visitors may have medical emergencies at school or off the school premises (e.g., on the school bus or field trips). Students with chronic health problems or disabilities often are at greater risk for injury, illness, or extreme medical emergencies. School personnel and selected students in elementary and secondary schools should be able to provide first aid in emergencies and know how to perform cardiopulmonary resuscitation (CPR). Timely and appropriate administration of first aid and CPR can save lives and minimize disability.

Standing Orders and Nursing Protocols. Standing orders and nursing protocols are helpful in meeting the health needs of school children. Both standing orders and nursing protocols help in the management of medical problems and are useful in the school setting. Standing orders and nursing protocols help to insure convenience, consistency, completeness, and continued learning. Additionally, health professionals can use the standing order to defend their actions. Standing orders and nursing protocols serve as the primary guidelines for health care providers at all levels of expertise (e.g., registered nurses, licensed practical nurses, and unlicensed healthcare providers).

Standing orders (i.e., *general orders*) refer to those orders, rules, or regulations that have been determined by a physician and are used by other health professionals in carrying out medical procedures. They apply to any student for whom the order may be applicable and must be based on federal/state laws and regulations and local school policy. Standing orders are used to provide the school nurse or nurse practitioner with specific orders of treatment for specific medical problems, such as ipecac in certain poisonings; epinephrine in allergic reactions (anaphylaxis); or acetaminophen for fever, headaches, sprains, or menstrual cramps.

When legally sanctioned and indicated for the safety of the student body, a standing order may also be used to provide school personnel other than nurses with instructions for action and treatment on specific medical emergency. A standing order for personnel who are not health professionals must be more detailed and provide more direction. The

school division is responsible for seeing that school staff have sufficient training in emergency techniques to carry out the standing order.

The registered nurse and the school's physician or medical advisor should review standing orders on an annual basis and revise as necessary.

Samples of standing orders are presented in the book *School Health: A Guide for Health Professionals*, 1997 Revision, Committee on School Health, American Academy of Pediatrics.

Note: *Student-specific treatment orders* (i.e., *specific orders*) for known health problems are written by the individual student's health care provider—in consultation with the student's parents and school nurse—and are part of the student's individualized healthcare plan (IHP). Standing orders for the general student body do not supplant medical orders for individual students. Permission from the student's parent(s)/guardian(s) must be acquired for implementing either of the two types of orders: *standing orders* or *specific treatment orders*.

Nursing protocols are explicit or general guidelines that describe steps to be taken in the nursing management of specific health problems. In contrast to standing orders, protocols usually include strategies for obtaining relevant historical data and significant physical findings as well as plans of action.

Nursing protocols are used to enhance standardization of care and thoroughness of service throughout the school division. Standardized nursing routines direct the health care of children at school. Some are based on accepted nursing practice, as outlined by each state's Nursing Practice Act. (See Appendix A, *Code of Virginia*, § 53.1-3000, for the Virginia Nurse Practice Act.) Nursing protocols are most appropriately used in circumstances in which the outcome of care given can be predicted with considerable accuracy.

Nursing protocols provide guidelines for the observation of a medical condition, its management, referral and recommendations to the student, the student's parent(s)/guardian(s), and school staff. A typical protocol describes the physical characteristics of a medical problem, states what the nurse should do, and recommends follow-up.

Nursing protocols can be utilized in sports programs, in screening programs, and in the management of specific health problems or complaints. The degree to which protocols are used depends upon the school division's responsibility for providing health care services. Nursing protocols must reflect the level of training of the school's health care personnel.

Protocols for nurse practitioners may include guidelines for in-depth clinical assessment and management of a wide range of primary health care problems, but call for referral to a pediatrician or other specialist when indicated.

Protocols for the registered nurse (RN) involve guidelines for the clinical assessment and management of routine primary health problems. Referral is made to the school nurse practitioner, physician, or other health care provider when in-depth assessment and management are indicated.

Protocols developed for the licensed practical nurse (LPN) and unlicensed healthcare personnel (UAP) must be much more specific and emphasize information gathering and early referral to a registered nurse or other appropriate health professional.

Protocols can be written by the registered nurse (in consultation with the student's parents and health care provider) for use by the classroom teacher in the event that a set of symptoms, medical complications, or other problems occur. This type of protocol would provide the classroom teacher with specific guidelines for managing a child with a known health problem until professional help was available.

Samples nursing protocols can be obtained from School Health Alert, P.O. Box 150127, Nashville, TN 37215, Web site: <http://www.schoolnurse.com/index.html>, and are presented in the book *School Health: A Guide for Health Professionals*, 1997 Revision, Committee on School Health, American Academy of Pediatrics.

First Aid. First aid involves the administration of emergency assistance to individuals who have been injured or otherwise disabled, prior to the arrival of a physician or transportation to a hospital or a physician's office. First aid should never be the substitution for definitive medical care.⁹³

- ◆ Please refer to the latest edition of the flipbook *First Aid Guide for School Emergencies*, published by the Virginia Department of Health, for guidance on administering immediate and temporary care to an ill or injured person. It contains practical, step-by-step instructions that describe what to do when caring for an injured or ill individual. The flipbook is designed for use by teachers, school nurses, clinic aides, and other staff members who are responsible for the health and safety of students and others in the school setting. (See Appendix B for a copy of the 1998 flipbook, which has been reformatted for this manual.)
- ◆ The flipbook *First Aid Guide for School Emergencies* should be posted in a place that is easily accessible to all staff members. It is recommend that all staff become familiar with the contents of the flipbook prior to handling an emergency.

Written Procedures. Each school division should have written procedures for managing emergencies involving students, school personnel, and visitors. The school division staff should be knowledgeable about the emergency management procedures. The school is responsible for the safety and well-being of students, staff, and visitors during school

⁹³ Thomas, Clayton L. (Ed). (1993). *Taber's*® *Cyclopedic Medical Dictionary*, Philadelphia, Pa.: F.A. Davis Company.

hours on school property and during school-sponsored activities. Therefore, local school division policies should address:

- ◆ Preventive measures to limit injuries.
- ◆ Policies to define what action will be taken when a serious injury or medical emergency occurs.
- ◆ Facilities and supplies to accommodate basic first aid and care of ill or injured students, staff members, or visitors.

Please refer to Appendix A for *Code of Virginia*, § 54.1-2969, Authority to consent to surgical and medical treatment of certain minors, and for *Code of Virginia*, § 8.01-225, Persons rendering emergency care, obstetrical services, exempt from liability.

Procedures.

1. Prior to an emergency:

- ◆ The most recent edition of the flipbook *First Aid Guide for School Emergencies* (Appendix B) should be readily available in the school health office (i.e., school clinic) of each school building. This guide contains a comprehensive listing of first aid measures needed to manage student, school personnel, and visitor emergencies.
- ◆ An emergency information card system for students should be maintained in the school health office. A similar system for staff members should be maintained following local school division policies.
- ◆ Each school should have contingency plans for emergencies that include staff certified in cardiopulmonary resuscitation.⁹⁴

Note: The *Code of Virginia*, §22.1-274, requires that

Each school board shall ensure that, in school buildings with an instructional and administrative staff of ten or more, at least two instructional or administrative employees have current certification in cardiopulmonary resuscitation or have received training, within the last two years, in emergency first aid and cardiopulmonary resuscitation. In school buildings with an instructional and

⁹⁴ Virginia Board of Education. (September, 1997). *Regulations Establishing Standards for Accrediting Public Schools in Virginia*. Richmond, Va.: Virginia Department of Education.

administrative staff of fewer than ten, school boards shall ensure that at least one instructional or administrative employee has current certification in cardiopulmonary resuscitation or has received training, within the last two years, in emergency first aid and cardiopulmonary resuscitation.

2. When an emergency occurs

- ◆ See *First Aid Guide For School Emergencies*, Virginia Department of Health, 1998, (Appendix B) for guidance on administering immediate and temporary care to an injured or ill individual.
- ◆ Parents/guardians of students should be notified of all emergencies/injuries so that further observation/follow-up care can be provided at home.
- ◆ Injuries should be carefully documented to preclude misinformation and to provide an accurate recording of events prior to the injury and the subsequent administration of first aid.
- ◆ The teacher or other staff member who is responsible for the student at the time an injury occurs should complete and file an injury report according to local school division policies.
- ◆ Staff members sustaining work-related injuries should follow the appropriate guidelines for Worker's Compensation Insurance.

3. Ongoing Evaluation

- ◆ The *Code of Virginia*, § 22.1-278.1, requires an assessment of the safety conditions in each public school to:
 - (i) identify and, if necessary, develop solutions for physical safety concerns, including building security issues and
 - (ii) identify and evaluate any patterns of student safety concerns occurring on school property or at school-sponsored events. Solutions and responses may include recommendations for structural adjustments, changes in school safety procedures, and revisions to the school board's standards for student conduct. (*See Appendix A for complete excerpt.*)
- ◆ *School nurses should have knowledge of the school safety audit process and are encouraged to participate as part of the audit team.*
- ◆ *School nurses should audit injury reports to identify areas of high risk in the school, including causative factors, and submit a report of findings to the principal for corrective action.*

- ◆ *School nurses should supplement the curriculum with classroom health lessons and individual health counseling as necessary, based on information derived from environmental monitoring and/or review of injury reports.*

Extreme Emergencies.

- ◆ All school personnel should be able to identify members of the response team and initiate the local school division's established system of triage for extreme medical emergencies.
- ◆ In extreme emergencies, the school principal or his/her designee may make arrangements for immediate hospitalization of injured or ill students, contacting parents/guardians in advance, if possible.
- ◆ The school nurse and/or other designated school personnel, with the emergency information card, should accompany the student to the hospital and remain until the parent/guardian assumes responsibility.

Chronically Ill. Individual health plans for chronically ill children should address potential emergency situations based on each student's health condition and provide precise instructions/physician's orders for specific treatments in certain defined emergency circumstances. Local school division policies for managing school emergencies should be reviewed and approved by a consulting physician (e.g., school physician, private physician, local health department medical director or physician, school health advisory board).

Report Forms. Please see Appendix E for sample student injury report form.

Managing Crises

Note: The following information, on Managing Crises, is from the following publication:

Resource Guide for Crisis Management in Schools

Division of Instruction

Office of Compensatory Programs

Virginia Department of Education

P.O. Box 2120

Richmond, VA 23218-2120

Telephone: (804) 225-2871

Effective Crisis Management. A crisis can occur at anytime whether or not schools plan for it. It is unlikely that any school will escape the necessity of responding to a significant crisis. A crisis can impact a single building or the entire school division, depending on the nature of the crisis. Establishing a *Crisis Management Plan* anticipates potential problems and establishes a coordinated response to minimize school community stress and disruption.

Crisis management is that part of a school division's approach to school safety that focuses more narrowly on a time-limited, problem-focused intervention to identify,

confront, and resolve the crisis, restore equilibrium, and support appropriate adaptive responses.

The essential elements of crisis management in schools include the following:

- ◆ **Policy and Leadership.** Provides both a foundation and a framework for action. The chances of effectively managing a crisis are increased with a division level plan and individual building plans that operate within the framework of the division plan but are tailored to the conditions and resources of the individual school. Leadership is necessary to ensure effective implementation of plans and maintenance or preparedness.
- ◆ **The Crisis Response Team.** A school Crisis Response Team can be a highly effective organizational unit for dealing with a variety of crises. Such teams can operate at three levels: (1) individual school building, (2) central office, and (3) community. Well-functioning teams at each level provide a network that can support action whenever crises arise.
- ◆ **The School Crisis Management Plan.** A school that is *prepared* before a crisis occurs will be much more likely to manage students and staff effectively. *An unprepared school is asking for chaos.*
- ◆ **Communications.** When a crisis occurs, effective communication is essential—within the school and the school division, with parents and the community at large, and with the media. Effective communication can speed the restoration of equilibrium; poor communication can make a bad situation much worse.
- ◆ **Training and Maintenance.** Preparation for and response to crises rely on people understanding policies and procedures and knowing what they are to do. These are achieved through *training*. Maintaining preparedness is an ongoing process that involves debriefing following crises, periodic review and updating, and ongoing training.

Policy and Leadership. Policy provides both a foundation and a framework for crisis management. Leadership, however, is necessary to ensure effective implementation and maintenance of preparedness.

School division policies typically include the following elements:

- ◆ A definition of “crisis.”
- ◆ A requirement that each school establish a crisis management *team* and develop a crisis management *plan*.
- ◆ Specifications for *membership* of the crisis management team, usually including provision for accessing, in the event of crisis, additional resources from within the school division and/or community.

- ◆ Specifications for issues to be addressed in each school's crisis management plan, usually including designation of chain of *command*, development of *protocols* for management of specific types of crises, coordination of *communications*, provisions for *support services*, staff inservice *training*, and periodic *review* of the plan.

Note: A sample policy is presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

Leadership at the central office includes developing a division plan as a management plan. *Resource Guide for Crisis Management in Schools* presents the following six major phases in the plan's development:

1. **Analysis of resources.** Encompasses review of current policies and procedures, determination of geographic location of schools in terms of proximity to hazards and resources, assessment of transportation and communications capabilities, and examination of the compatibility of school division's plan with individual plans.
2. **Development of the emergency plan.** Includes identification of tasks and assignment of roles for division personnel, establishment of alternative communications and evacuation systems, and developing preparation for both on- and off-campus emergencies.
3. **Coordination of the division plan with school and community plans.** Involves inclusion of and coordination with fire, law enforcement, and emergency officials—including many different views results in a more comprehensive and effective plan.
4. **Making the plan public.** Includes broad dissemination of plan, particularly to school and community groups who might be able to contribute to the management of an emergency.
5. **Training all staff and volunteer personnel.** Involves provision of school-based training to all personnel. The plan cannot be implemented properly unless school personnel, including volunteers, understand the plan and what is expected of them.
6. **Sharing the plan with state and local agencies.** Entails sending copies of plan to local fire, law enforcement, and emergency agencies.

Note: Sample central office personnel roles and responsibilities are presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

Leadership of the principal at the individual school level is crucial for effective crisis management. As the highest level executive in the school, the principal bears responsibility for all decision and actives. *Resource Guide for Crisis Management in Schools* presents the following actions for crisis preparation, as recommended by the National School Safety Center (1995):

- ◆ Review district-wide emergency policies.

- ◆ Identify community resources.
- ◆ Establish a clear chain of command.
- ◆ Identify a command post.
- ◆ Appoint a crisis response team.
- ◆ Assign roles.
- ◆ Established inservice training program.
- ◆ Establish a warning signal.
- ◆ Prepare an emergency kit.
- ◆ Establish procedures to identify wounded or dead.
- ◆ Prepare students.
- ◆ Develop plans for transportation, crowd control, student release, and evacuation.

Establishing the Crisis Response Team. A school Crisis Response Team can be a highly effective organizational unit for dealing with a variety of crises, such as injuries, drug overdoses, suicides, incidents of violence, and weather emergencies. Crisis Response Teams in a school division can operate at three levels: individual building, central office, and community response teams. Well-functioning teams at each level provide a network that can take action whenever a crisis arises.

The crisis network should include a *building-level team* in each school. The principal usually leads the building-level crisis team, with an alternate leader designated in the principal's absence. In addition to teachers, the team might include a coach, guidance counselor, school nurse, school psychologist, school social worker, school security personnel, school secretary, and custodian. The team typically has responsibility for the following:

1. Establishing a protocol for dealing with crises.
2. Establishing a systematic approach for identifying, referring, and intervening with students identified as at-risk for suicide or other destructive behaviors.
3. Orienting staff to procedures and training to fulfill designated roles, including conducting drills.
4. Providing information to students, staff, and community on crisis management.
5. Providing assistance during a crisis in accordance with designated roles and providing follow-up activities.
6. Conducting debriefing at the conclusion of each crisis episode to critique the effectiveness of the building's Crisis Management Plan.

Note: Sample building-level personnel roles and responsibilities are presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

In addition to a building-level team in each school building, the crisis network should include a *central-office team*. This central-office crisis team might include the

Superintendent or someone designated by the Superintendent, a representative of each school crisis team, administrator(s) for school security, and for pupil services, including school psychology and social work supervisors. It might also include consultants outside the school system. The central-office crisis team might have responsibility for the following:

1. Overseeing and coordinating the building-level teams.
2. Authorizing resources for areas where they are most needed.
3. Collecting and disseminating educational materials to schools for training crisis team members and faculty.
4. Establishing a central library of materials on violence, suicide, and other crisis management issues for use by faculty, staff, and students.
5. Conducting mock crisis events to test the crisis management procedures.
6. Evaluating response to crises with a report to the Superintendent and a plan for follow-up.
7. Establishing a community support team and encouraging input and support from its members.

Note: Sample central office personnel roles and responsibilities during school emergencies are presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

Furthermore, in addition to the building-level and central-office level crisis teams, the crisis network should include a **community support network**. This community support network should include representatives from the community and government agencies. Additionally, this network might include personnel from mental health and law enforcement agencies, emergency medical personnel, and specialized resources, such as domestic violence shelters, rape, runaway, and victim's advocacy services.

Schools should maintain periodic contact with community agencies and organizations and invite them to participate in meetings with school Crisis Management Teams.

Developing the School Crisis Management Plan. In setting up a Crisis Management Plan, the following activities are important:

1. Decide who will be in charge during the crisis.
2. Select the Crisis Response Team.
3. Develop clear and consistent policies and procedures.
4. Provide training for the Crisis Response Team.

5. Establish a law enforcement liaison.
6. Establish a media liaison and identify suitable facilities where reporters can work and news conferences can be held.
7. Establish a working relationship with community health agencies and other resources groups.
8. Set up “phone trees.”
9. Plan to make space available for community meetings and for outside service providers involved in crisis management.
10. Develop necessary forms and information sheets.
11. Develop a plan for emergency coverage of classes.
12. Establish a code to alert staff.
13. Develop a collection of readings.
14. Have a school attorney review crisis response procedures and forms.
15. Hold a practice “crisis alert” session.
16. Hold an annual in-service meeting on general crisis intervention.

Note: Sample crisis management plan checklists, procedures, reports, and postvention guidelines and handouts are presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

School Communications. Communication is a critical part of crisis management. School staff members and students must be told what is happening and what to do. Parents of students and families of staff members must be informed about the situation, including the status of their child or family member. Timely contact with law enforcement and other emergency services is necessary for effective response. School Board members must be kept informed and updated information must be transmitted to central office and to other affected schools. The press must be informed and kept updated. Additionally, groups that are part of the school community (e.g., PTA, school health advisory board) can assist with getting accurate information into the community.

Note: Guidance on dealing with rumors, using technology for communication, voice and hand signals, using code messages, and sample communication announcements are presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

Training and Maintaining Preparedness. A crisis management plan cannot be implemented properly unless staff members know what the plan is and what is expected of them in the event of an emergency. In addition to staff training, it is important for students to know (and practice) emergency procedures. School-based training should be provided to all personnel, including instructional, custodial, and food service employees,

temporary employees, and volunteers. Inviting parent leaders (e.g., PTA officers) should be considered—they have important roles in communicating with other parents and in helping restore equilibrium in the event of a major crisis. The training should include practice scenarios. A mock disaster drill coordinated with local emergency preparedness groups may also be conducted.

Training and inservice activities should be designed to meet three distinct needs:

1. How to prevent certain types of emergencies.
2. How to respond when emergencies occur.
3. How to deal with the aftermath of an emergency.

Note: Guidance on training content and sample training agendas, scenarios, and plans are presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

Quick Guide to Crisis Management. The following samples of guidelines and checklists for the management of specific types of crises are presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

- ◆ Minor Injuries at School
- ◆ Injuries to and From School
- ◆ Aircraft Disaster
- ◆ Allergic Reaction
- ◆ Angry Parent/Employee/Patron
- ◆ Assault by Intruder
- ◆ Bomb Threat
- ◆ Bus/Auto Injuries
- ◆ Chemical Spill
- ◆ Childnapping or Lost Child
- ◆ Death (destruction of part or whole building; e.g., tornado, plane crash, bomb)
- ◆ Disaster
- ◆ Disaster Preventing Dismissal (e.g., hurricane, tornado, sniper, plane crash)
- ◆ Fighting (violence between two or more students; i.e., physical fighting)
- ◆ Fire Arson, or Explosives
- ◆ Gas Leak
- ◆ Hostage, Armed / Dangerous Intruder
- ◆ Injury
- ◆ Intruder or Trespasser
- ◆ Life-Threatening Crisis (major life-threatening crisis to individual)
- ◆ Perceived Crises
- ◆ Poisoning
- ◆ Power Failure / Lines Down
- ◆ Rape
- ◆ Shootings, Woundings, Attacks

- ◆ Suicide Threats (for potentially suicidal students)
- ◆ Vandalism
- ◆ Weapons Situation
- ◆ Weather (e.g., tornado, inclement weather, earthquake)

Resources

- ◆ National School Safety Center
141 Duesenberg Drive, Suite 11
Westlake Village, CA 91362
Telephone: 805-373-9977
Web site: <http://www.nssc1.org/>
- ◆ Federal Emergency Management Agency (FEMA)
Office of Emergency Information
500 C. Street S.W., Room 824
Washington, D.C. 20472-0001
Telephone: (202) 646-4600,
Web site: <http://www.fema.gov/>
- ◆ Virginia Department of Education
Safe and Drug-Free Schools and
Community Program
Office of Compensatory Programs
P.O. Box 2120
Richmond, VA 23218-2120
Telephone: (804) 225-2871
Web site:
<http://www.pen.k12.va.us/VDOE/Instruction/comp.html>
- ◆ Virginia Department of Emergency Services
10501 Trade Court
Richmond, VA 23236
Telephone: (804) 897-6500
Telephone: (804) 674-2499
Web site:
<http://www.vdes.state.va.us/>
- ◆ Virginia Department of Health
Center for Injury and Violence
Prevention
P.O. Box 2448
Richmond, VA 23218-2448
Telephone: (804) 692-0104
Web site:
<http://www.vdh.state.va.us/fhs/injury/center.htm>
- ◆ Virginia Department of State Police
Comprehensive Crime Prevention
Program
P.O. Box 27472
Richmond, VA 23261-7472
Telephone: 1-800-552-9965
Web site:
<http://www.vsp.state.va.us/vsp.html>

Note. Please see “Injury and Violence” in Chapter III for additional resources.

Referring to Child Protective Services

Authorization

Code of Virginia, Section 63.1-248.2, Definitions (of Abuse and Neglect). The *Code of Virginia*, § 63.1-248.2 defines an “abused or neglected child” as any child less than 18 years of age:

1. *Whose parents or other person responsible for his care creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon such child a physical or mental injury by other than accidental means, or creates a substantial risk of death, disfigurement, or impairment of bodily or mental functions.*
2. *Whose parents or other person responsible for his care neglects or refuses to provide care necessary for his health. However, no child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall for that reason alone be considered to be an abused or neglected child.*
3. *Whose parents or other person responsible for his care abandons such child.*
4. *Whose parents or other person responsible for his care commits or allows to be committed any act of sexual exploitation or any sexual act upon a child in violation of the law.*
5. *Who is without parental care or guardianship caused by the unreasonable absence or the mental or physical incapacity of the child’s parent, guardian, legal custodian or other person standing in loco parentis.*

Excerpt: See Appendix A for *Code of Virginia*, § 63.1-248.2.

Code of Virginia, Section 63.1-248.3, Physicians, Nurses, Teachers, Etc., to Report Certain Injuries in Children; Penalty for Failure to Report.

Excerpt: See Appendix A for *Code of Virginia*, § 63.1-248.3

Code of Virginia, Section 63.1-248.4 Complaints by Others of Certain Injuries to Children.

Excerpt: See Appendix A for *Code of Virginia*, § 63.1-248.4

Code of Virginia, Section 63.1-248.5 Immunity of Person Making Report, Etc., From Liability.

Excerpt: See Appendix A for *Code of Virginia*, § 63.1-248.5

***Code of Virginia* Section 63.1-248.10 Authority to Talk to Child or Sibling**

Excerpt: See Appendix A for *Code of Virginia*, § 63.1-248.10

***Code of Virginia* Section 63.1-248.13 Photographs and X Rays of Child; Use as Evidence**

Excerpt: See Appendix A for *Code of Virginia*, § 63.1-248.13

***Code of Virginia* Section 63.1-248.17 Cooperation by State Entities.**

Excerpt: See Appendix A for *Code of Virginia*, § 63.1-248.17

Note. Certain situations have not been considered abuse/neglect by the courts. These include:

1. Failure to provide immunizations to children. (§ 32.1-46 of the *Code of Virginia* requires that parents/guardians immunize their children at designated intervals. However, not immunizing a child does not constitute abuse or neglect under Virginia statutes.)
2. Parental substance abuse where there is no demonstrated adverse impact on the care of the child, is not reportable to Child Protective Services (CPS). However, chronic parental substance abuse where the child's health or safety has been neglected or endangered is reportable to CPS.
3. Virginia law requires the use of seat belts. The intent of the law is to protect children from serious injury in the event of an accident. However, this is a civil law, with designated fines and penalties, to be implemented by law enforcement authorities.

Overview

School personnel are in a unique position to assist children who may be victims of abuse/neglect. The day-to-day contact teachers and other school staff have with students provides the opportunity for immediate and ongoing assessment of children who may be in need of assistance. For this reason it is important for all school personnel to be familiar with:

- ◆ Reasons for abuse, types of abuse, and those at particular risk for abuse.
- ◆ The legal responsibilities for reporting actual proof of or suspicion of abuse.
- ◆ The method for reporting (including that which is specific to the particular school division where the individual is employed).

- ◆ Resources available for the individual reporting the abuse and the individual being subjected to the abuse.

Reasons for Abuse and Neglect

Child abuse and neglect are universal problems that occur across economic, cultural, and ethnic lines. Research indicates that there are circumstances which increase the likelihood abuse and neglect may occur in some families. (It is important to remember that the abuser is not always a parent and can be any childcare provider, teacher, foster parent, or anyone responsible for the care of a child.) Circumstances that may predispose a person to abuse and neglect include:

- ◆ A parent or individual who may have been abused or neglected as a child may continue this pattern when raising their own children.
- ◆ Increase in stress in life, including marital, financial, and employment difficulty.
- ◆ Substance abuse in the home.
- ◆ Parents and child care providers who lack the skill and knowledge for the role.
- ◆ Individual's inability to tolerate frustration and inability to control the impulse to act.
- ◆ Families and individuals who feel isolated from family, friends, and community.

Operational Definitions of Abuse

Physical Abuse. Physical abuse is defined as any act, whether intentional or not, that causes harm to a child. Intentional physical injury usually is related to severe corporal punishment; however, physical abuse ranges from minor cuts and bruises to severe neurologic trauma and death.

Physical Neglect. Physical neglect occurs when caretakers do not provide for a child's physical survival needs (including adequate food, clothing, shelter, hygiene, supervision, and medical and dental care) to the extent that the child's health or safety is endangered.

Sexual Abuse. Sexual abuse is defined as acts of sexual assault or sexual exploitation of minors. This category includes a wide spectrum of activities and may occur only once in a child's life or may be a long term situation of sexual abuse or exploitation. Specifically, sexual abuse includes the following sexual acts: incest, rape, intercourse, oral-genital contact, fondling, sexual propositions or enticement, indecent exposure, child pornography, and child prostitution. Sexual abuse is most commonly carried out by someone a child knows and does not always involve violence. Males and females,

infants and adolescents are all subject to sexual abuse. The abuser may be an adult or another child.

Emotional Maltreatment. Emotional maltreatment is a pattern of acts by the child's caretaker that results in psychological or emotional harm to the child's physical health and development. Patterns of emotional maltreatment include rejection, intimidation, ignoring, ridiculing, or isolation.

Assessing for Signs of Abuse and Neglect

The following are guidelines for school personnel to consider for the overall assessment of a suspected case of child abuse.

Physical Abuse/Neglect. A significant factor in distinguishing whether an injury is unintentional or as the result of abuse is an inconsistency between the history of an injury and the injury itself. When considering a physical injury consider the information that is summarized in the following chart.

Type of Information and Rationale Used to Distinguish Unintentional Injuries From Those That Result From Abuse

Information	Rationale
Location of the injury	Children are more likely to sustain unintentional injuries on the knees, elbows, shins, and forehead. Injuries located on nonprotuberant areas (such as the back, thighs, genital area, buttocks, back of the legs or face) are more likely the result of intentional injury.
Number and frequency of injuries	Unless a child has been in a serious accident, he/she is unlikely to have a number of injuries concurrently nor is it likely that the injuries would be at various stages of healing.
Size and shape of the injury	Unintentional injuries rarely have a defined shape. Intentional injuries, such as burns (e.g., from cigarettes, immersion in hot liquids, burns from irons, and ropes) or other objects (e.g., sticks, belts, hairbrushes, and human bite marks), will have a definitive, definable appearance.
Description of how the injury occurred	Unintentional injuries, when described by a child, generally have a reasonable explanation and one that is consistent with the appearance of the injury. Descriptions of injuries by a child that are inconsistent with the presentation are cause for suspicion.
Consistency of injury with the child's developmental capability	A child presenting with an injury that he/she is developmentally or physically incapable of causing (e.g., child is too small to generate a force sufficient to create that type of injury) should be considered for intentional abuse by their child caretaker.
Behavioral indicators of physical abuse/neglect	School personnel should also observe children for behaviors that may result from intentional physical abuse/neglect by a child's caretaker. Examples include: wariness of physical contact with adults,

Type of Information and Rationale Used to Distinguish Unintentional Injuries From Those That Result From Abuse

Information	Rationale
	apprehension when another child cries, fear of his/her parent(s), stated fear of going home or crying when it is time to go, and report of an injury inflicted by a parent.

Mental Abuse/Neglect. There are a variety of behaviors a child may exhibit as a result of mental abuse/neglect. It is important when assessing for this type of abuse to examine specific behaviors of a child as well as develop an overall picture of the child’s ability to interact and communicate with children and other adults. When assessing a child for mental abuse/neglect, it is important to place the behavior within the context of the child’s developmental, emotional, and physical age. The following chart lists particular behaviors and interaction styles that may be indicators of mental abuse or neglect.

Behaviors and Interaction Styles That May be Indicators of Mental Abuse or Neglect

Behavior	Example
Habit Disorders	<ul style="list-style-type: none"> ◆ Biting. ◆ Sucking. ◆ Rocking. ◆ Enuresis. ◆ Over- or under-eating without physical cause.
Conduct Disorders	<ul style="list-style-type: none"> ◆ Withdrawal. ◆ Antisocial behavior, such as destructiveness, cruelty, and stealing.
Neurotic Traits	<ul style="list-style-type: none"> ◆ Sleep disorders. ◆ Speech disorders. ◆ Inhibition of play.
Others	<ul style="list-style-type: none"> ◆ Psychoneurotic traits. ◆ Overly compliant, passive, and undemanding. ◆ Extremely aggressive, demanding, or angry behavior. ◆ Over-adaptive behaviors that are either inappropriately adult or infantile. ◆ Delays in physical, emotional, and intellectual development. ◆ Attempts at suicide. ◆ Frequent comments and behavior suggesting low self esteem.

Sexual Abuse. A child that has been a victim of sexual abuse—whether it is a single incident or a long term pattern of sexual abuse—is unlikely to reveal this information directly to anyone. More than likely, a child will send signals to those around him/her that something is wrong. School personnel need to be attuned to the type of clues that may indicate a child is in a sexually abusive situation. The signs may be physical, emotional, and or reflected in developmentally inappropriate behavior by the child.

The information below has been divided into two age groups: the younger child and the older child. The information of potential signs of sexual abuse is by no means a complete list of the possible behaviors a child might exhibit when involved in a sexual abuse/neglect situation. School personnel may refer to this list as a guideline for further exploration and to

classify behaviors they might be seeing in a child. It is strongly recommended that school personnel become familiar with available resources.

Young Child. A young child (i.e., toddlers, preschoolers, early elementary school-age) may have difficulty verbalizing their fears and concerns as well as the actual sexual abuse to which they are being subjected. This is especially true for children with disabilities. The following chart summarizes behavioral and physical signs that may be indicators of sexual abuse in the young child.

Signs That May Indicate Sexual Abuse in the Young Child

Type of Sign	Sign
Behavioral	<ul style="list-style-type: none"> ◆ Reports sexual abuse. ◆ Sleep disturbances, such as fear of falling asleep and nightmares. ◆ Sudden changes in behavior and/or regressive behavior. ◆ Excessive masturbation. ◆ Detailed and age-inappropriate understanding and verbalization of sexual behavior. ◆ Highly sexualized play. ◆ Inappropriate behavior with peers and adults that is seductive in nature.
Physical	<ul style="list-style-type: none"> ◆ Stomach aches. ◆ Dysuria (painful urination) or enuresis (involuntary urination after the age at which bladder control should have been established). ◆ Encopresis (involuntary soiling with feces after the age at which control of defecation should have been established). ◆ Complaints of genital irritation, laceration, abrasion, bleeding, discharge, or infection. (Venereal disease should be considered in children with anal or genital infection, discharge, or irritation.) ◆ A gagging response, sore throat, or mouth or throat lesions (as the result of oral-genital contact). ◆ Other signs of physical abuse.

Older Child. Older children may be able to verbalize and label what is happening to them in a sexually abusive situation; however, feelings of embarrassment, humiliation, guilt, a sense of responsibility, and fear may prevent them from talking with anyone. In fact, like young children, signs of sexual abuse in older children may emerge in regressive or sudden behavioral changes, physical signs of injury, or withdrawal. The following chart summarizes behavioral and physical signs that may be indicators of sexual abuse in the older child.

Signs That May Indicate Sexual Abuse in the Older Child

Type of Sign	Sign
Behavioral	<ul style="list-style-type: none"> ◆ Reports sexual abuse. ◆ Poor relationships with peers. This may take the form of withdrawal from established relationships; an inability to establish new relationships; aggressive, violent, or sexually promiscuous behavior. ◆ Poor self esteem. ◆ General feelings of shame or guilt.

Signs That May Indicate Sexual Abuse in the Older Child

Type of Sign	Sign
	<ul style="list-style-type: none"> ◆ Eating disorders (bulimia and anorexia). ◆ Excessive concern about homosexuality (especially boys). ◆ Deterioration in academic performance. ◆ Role reversal with parent and overly concerned about younger sibling(s). ◆ Running away. ◆ Drug abuse. ◆ Moderate to severe anxiety or depression.
Physical	<ul style="list-style-type: none"> ◆ Attempts at suicide. ◆ Unexplained vaginal discharge, pregnancy, and/or venereal disease. ◆ Bruises and/or bleeding of external genital, vaginal, or anal areas and inner thighs. ◆ Gagging response, sore throat, or mouth or throat lesions (as the result of oral-genital contact). ◆ Difficulty sitting or walking. ◆ Other signs of physical abuse.

Other Information. Other information about the child and their family is important to incorporate into an evaluation of possible sexual abuse of a child. In a family where there is a history of the following, a suspicion of sexual abuse may be warranted: abuse of the child or other children; alcoholism; isolation of the family as a whole; overly restrictive control by a father of his female children; expectations by parents that children act more like adults; or vague reports by a parent that their child may have been sexually abused by a stranger or a member of their family.

Inappropriate Sexual Activity Between Children. There are situations in which children sexually abuse other children. These are not situations in which the activity is considered to be the normal sexual curiosity that is developmentally appropriate. These are situations in which (1) a child is the victim of another child, (2) violence may be a component, (3) there is a lack of adult supervision that enables this activity to take place, (4) a child is in a caretaker role of another child, and (5) it is possible that the child inflicting the abuse may be a victim of abuse themselves. These situations must be examined carefully. Children who abuse and victimize other children need to be referred for evaluation. Children 12 years and older engaging in repetitive sexual abuse and violence against other children should be referred to law enforcement for court supervision and services.

Reporting Abuse/Neglect

Who Makes the Report. Anyone may report abuse or neglect; however, under Virginia law, certain professionals are required to report when they suspect that a child is an abused or neglected child. These professionals include:

- ◆ Persons licensed to practice medicine or any of the healing arts.

- ◆ Hospital residents or interns.
- ◆ Nurses.
- ◆ Social workers.
- ◆ Probation officers.
- ◆ Teachers or other persons employed in a public or private school, kindergarten, or nursery school.
- ◆ Persons providing full- or part-time child care for pay on a regular basis.
- ◆ Accredited Christian Science practitioners.
- ◆ Mental health professionals.
- ◆ Law enforcement officers.
- ◆ Any mediator eligible to receive court referrals.
- ◆ Professional staff persons employed by a public or private hospital, institution, or facility in which children are placed.
- ◆ Person associated with or employed by any private organization responsible for the care, custody, and control of children.

Suspicion of Abuse/Neglect. The law does not require the professional to have proof or be convinced abuse or neglect has taken place. Suspicion is all that is needed. The *Code of Virginia*, § 63.1-248.5, provides protection from criminal and civil liability to persons reporting abuse/neglect and/or participating in judicial proceedings related to a report of abuse/neglect unless the report has been made with malicious intent or bad faith. The reporter must make available to the local Department of Social Services all information that is the basis for the suspicion. This can include confidential information about the child/family that is contained in the school record. In fact, under the *Code of Virginia*, § 63.1-248.3, not reporting suspicion of abuse/neglect in a timely manner (medical professionals must make a report within 72 hours of first suspicion) is a misdemeanor and the individual is referred to the Commonwealth Attorney for judicial action.

How and to Whom the Report is Made. The law makes allowances for “chain of command” reporting. The school division or school can establish a policy that states that a person (possibly a classroom teacher or school nurse) who suspects that a child is abused or neglected can report their suspicion to a designated person in the school, who in turn reports the matter to the local Department of Social Services. The chain of command must respond immediately with a report of suspected child abuse. It is suggested that each school/school division develop a plan for reporting child abuse and identify the contact person(s) for the local Department of Social Services.

The *Code of Virginia*, § 63.1-248.17, requires all law enforcement departments, other state and local departments, agencies, authorities, and institutions to cooperate with each local Department of Social Services in the detection and prevention of child abuse. Reports can be made to the local Department of Social Services during working hours or to the State Child Abuse Hotline in Richmond (1-800-552-7096). The hotline operates 24 hours a day, year round. Information received on the hotline is forwarded to the appropriate locality for investigation. Reports can be made anonymously. Documentation is completed according to school/school division policy. It is suggested that as part of the school/school divisions' plan for reporting child abuse, appropriate forms for documentation be developed.

What Information Should be Provided. When making a report of suspected abuse/neglect have the following information available.

- ◆ The name, address, and telephone number of the child and parents or other person(s) responsible for the child's care.
- ◆ The child's birth date, age, sex, and race.
- ◆ Names and ages of siblings and what schools or grades they attend.
- ◆ Names and ages of other people who live with the child and their relationship to the child.
- ◆ As much information as possible about the incident involving the child, especially where, when, and who was present.
- ◆ History of prior injuries or maltreatment of the child or siblings if this is the case.
- ◆ Any other pertinent information that the school may have available.
- ◆ Reporting person's name, address, and phone number.

When describing an injury (e.g., cut, mark, bruise) be specific.

- ◆ Note the exact location on the body.
- ◆ Note the size of the mark—estimate in inches or in relation to a common object (e.g., size of a quarter, size of an egg, shape of an iron).
- ◆ Note the color of the injury. Injuries often change color with the passage of time. The colors can range from red to black to purple to green and yellow. Note the presence of bruising in multiple areas that may be in various stages of healing.

In general, relate exactly what the child said in his/her own words. Be careful not to interpret what the child said.

Interviewing the Child

When interviewing the child:

- ◆ Make sure the child is comfortable. Remain calm and reassuring. Do not rush. If the interviewer reacts with shock, anger, or disgust at what the child tells, the child may interpret that he/she is at fault and has done something wrong, and may be unwilling to reveal further information.
- ◆ Attempt to gain pertinent information, using open-ended questions.
- ◆ Be careful not to plant ideas or interpretations of what happened in the child's mind.
- ◆ Explain the purpose of the interviews in language appropriate to the child's developmental level.
- ◆ Let the child know the interviewer will be talking to someone who will try to help him or her, without making any promises to the child that cannot be kept.

What Happens After a Report is Made

Many times school personnel are unaware of what occurs after a report is made and may not understand why what appears to be an "obvious" situation cannot be investigated. There are specific criteria that must be met for the local Department of Social Services to proceed with an investigation once they receive the information. The criteria are:

- ◆ The child must be under 18 years of age.
- ◆ There must be a caretaker relationship between the victim and the alleged abuser/neglector (a caretaker is anyone, including a teenager, sibling, or adult, who is responsible for that child).
- ◆ The allegation must fall into a definition of abuse/neglect.
- ◆ The department must have jurisdiction for that report in order to pursue an investigation.

If the above criteria are met, the department is obligated to investigate. The law gives the department 45 days to complete an investigation. There is no standard at this time that states how soon an investigation must start. Generally, that is a function of how severe the risk to the child appears to be from the information presented. If the department does not have the legal authority to investigate the allegations, the report may be handled differently. If the person responsible for the suspected abuse was not a "caretaker" (and the Department of Social Services could not intervene), the suspected incident should be referred directly to the parents, police, or another agency. The local Department of Social Services will be able to identify other options.

How an Investigation of Abuse/Neglect is Conducted

Once the department has accepted a report, it will be investigated. The social worker investigating the allegations tries to interview a child in a neutral setting, such as a school. The *Code of Virginia*, § 63.1-248.10, gives the Child Protective Services social worker the authority to interview the child and any siblings without the prior consent of the parent/guardian. The child and siblings may be interviewed without the presence of the parent, guardian, school personnel or any other individual standing in loco parentis. Additionally, the *Code of Virginia*, § 63.1-248.13, allows the social worker to take photographs of the child without the consent of the parent/guardian.

The investigative worker will also talk with the alleged abuser/neglector, the parents/guardians (if different) and any other individual who may have information about the child's care related to the allegations—such as a doctor, teacher, and neighbors.

The decision as to whether or not child abuse or neglect occurred must be made within 45 days after a report is received. The decision is based on the information gathered during the investigation. There are two possible findings:

- ◆ “Founded”— Abuse/neglect has occurred.
- ◆ “Unfounded”— No evidence that abuse/neglect has occurred.

The Child Protective Services Investigation and any subsequent services provided to the child and the family are confidential. If the person reporting the abuse is not an anonymous reporter, the department may notify that person very briefly of the investigative outcomes. The only time more detailed information is released is when the family gives express written consent.

If a Report of Suspected Child Abuse or Neglect is Not Accepted by Child Protective Services

If the criteria for investigation are not met, Child Protective Services will not pursue the report. When CPS does not investigate a report, it usually means that the situation does not meet the legal definition of abuse/neglect, law enforcement has the responsibility to investigate, or the family's problems can be more effectively addressed by a different type of service. If the person reporting the abuse disagrees with the decision not to pursue the investigation, then the school personnel responsible for the reporting of abuse/neglect situations may discuss their concerns with the CPS supervisor.

If the situation is labeled "unfounded," it does not mean that the family may not be having problems. It just means that according to the law and the Department of Social Services policy the situation cannot be labeled as abusive/neglectful. The social worker may recommend a course of action, including other community based services available (e.g., mental health treatment, substance abuse services, court services, and shelter care).

The school may be instrumental in providing assistance to the family to prevent the abuse or neglect of children. Such prevention programs may be in the form of support groups and educational programs as well as students utilizing the many programs developed for awareness and education of family problems and situations.

Professionals who have had unsatisfactory reporting experiences in the past may be reluctant to report a second case of abuse/neglect to the local Department of Social Services. It is possible that the experience the professional had may have been unsatisfactory and that they may have developed a distrust of the system for investigating abuse/neglect situations, feeling that nothing will be done again. **Professionals must keep in mind that they are legally bound to report a case of suspected child. In addition, if the incident is not reported nothing will be done. Abused and neglected children cannot be protected unless they are first identified, and the key to identification is reporting.**

Resources

Struck, L.M. & Bar-on M. (1995). *Assistance for Medical Professionals in the Diagnosis and Management of Suspected Child Abuse and Neglect*. Commonwealth of Virginia, Department of Social Services, Child Protective Services, in collaboration with Medical College of Virginia, Virginia Commonwealth University, Children's Medical Center.

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Home Visits

Authority

Regulations. Some regulations that govern the delivery of services to students may require the use of home visits for students who are confined for periods of time that prevent normal school attendance. See the following:

- ◆ *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*, (Effective January 1994).⁹⁵
- ◆ *Regulations Establishing Standards for Accrediting Public Schools in Virginia*, (September, 1997).⁹⁶

Overview

Home visits made by members of the interdisciplinary team offer an excellent opportunity to foster communication between school and home. Advantages include:

- ◆ Convenience for the family.
- ◆ Option for those families unwilling or unable to travel.
- ◆ Family control of the setting and the potential for active participation in meeting the student's health needs.
- ◆ The opportunity to gain a more accurate assessment of the student's family structure and behavior in the natural environment.
- ◆ The opportunity to make observations of the home environment and to identify both barriers and support for reaching family health promotion goals.

⁹⁵ Virginia Department of Education (Effective January 1994). *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*. Richmond, Va.: Author.

⁹⁶ Virginia Board of Education. (September, 1997). *Regulations Establishing Standards for Accrediting Public Schools in Virginia*. Richmond, Va.: Virginia Department of Education.

Recommendation

Objectives for a Home Visit. During home visits, school health personnel can:

- ◆ Establish rapport with the student's family support system.
- ◆ Assess family strengths and needs, including limitations and barriers to the student's achievements, the student's need for community health resources, and the student's behavior and reactions to home situations.
- ◆ In partnership with the family, plan school health services that promote and support family goals to maximize functional capabilities, including the student's self-care, independence, and future school attendance.
- ◆ Provide for family/student participation in health promotion, maintenance, and restoration, including providing information needed to make decisions and choices about using health care resources.

Procedure for a Home Visit. In preparing for the home visit, school health personnel should:

- ◆ Review available school and health records prior to home visit.
- ◆ Review current health care plans.
- ◆ Identify objectives for the visit.
- ◆ Contact student's health care provider, when appropriate, for questions and/or concerns.
- ◆ Plan time of visits to optimize safety and effectiveness.
- ◆ Make an appointment in advance of the visit.
- ◆ Log in and out at school office, noting the telephone number and address of the home to be visited, time of departure, and expected return.
- ◆ Wear identification (e.g., name badge).
- ◆ Avoid going alone to neighborhoods known to be dangerous.

During the home visit, school health personnel should:

- ◆ Explain purpose of the visit.
- ◆ Observe the home and surrounding environment, significant sociocultural influences, and interaction of family members.

- ◆ Identify health care needs/problems, based on subjective and objective data, and involve the family members in the process.
- ◆ List problems in order of importance in accordance with family perceptions.
- ◆ Discuss alternative solutions and available community resources.
- ◆ Make referrals as necessary to appropriate health care providers.
- ◆ Assist in the development of a plan for the appropriate interventions(s) and establish a time to evaluate the effectiveness of the plan.
- ◆ Share the plan with appropriate persons involved in the health care of the student.

After the home visit, school health personnel should record and document:

- ◆ Subjective and objective data, problems identified, and plan of action including time line for achieving planned interventions.
- ◆ Future plans and recommendations for home visits.

Resources

For more information, refer to:

Stanhope, M. and Lancaster, J. (1991). *Community Health Nursing: Process and Practice for Promoting Health*, 3rd Edition. St. Louis, Mo.: The C. V. Mosby Company.

American Nurses Association. (1998). *Standards of Clinical Nursing Practice*. Kansas City, Mo.: Author.

School Health Program Manual. (1990). South Carolina Department of Health and Environmental Control.

National Association of School Nurses, Inc. (1998). *Standards of Professional School Nursing Practice*. Scarborough, Maine: Author.

Nursing Liaison Services to Homebound Students

Authority

Regulations. Virginia Board of Education. (September, 1997). *Regulations Establishing Standards for Accrediting Public Schools in Virginia*. Richmond, Va.: Virginia Department of Education.

Regulations. Virginia Department of Education (Effective January 1994). *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*. Richmond, Va.: Author.

Overview

Students with acute and chronic illnesses, severe injuries, medically high-risk pregnancies, or recovering from surgery may require periods of homebound instruction. Though medical/nursing care will be provided by the private medical provider or a community agency, the school nurse may serve as a liaison between the school, family, and medical provider in planning for the transition from homebound status to school attendance.

The rationale for homebound instruction includes the following:

- ◆ Extended absence from school contributes to desocialization, isolation, and potential dropout of students, especially those who have a chronic illness or are pregnant.
- ◆ School nursing intervention is essential to facilitate appropriate case management of chronically ill or pregnant students and reduce absences caused by short-term illnesses.
- ◆ Appropriate case management and coordination of services support the transition from homebound to school attendance.

Recommendation

Procedure. The following procedure is recommended for school nurse visits to homebound students:

1. When homebound instruction is deemed necessary, the school nurse will be notified by the appropriate school personnel.

2. The school nurse contacts the family and student through telephone calls and home visits to assist the family in the utilization of appropriate community health care services.
3. The school nurse interprets medical information for school personnel and assists the student in making the transition from hospital and/or home to school.
4. Frequently it will be necessary to have a written individualized healthcare plan (IHP) that has been implemented prior to the student's return to school. The IHP should be developed by the registered nurse (RN), in collaboration with the school health team, consisting of the parents, student, physician, school administrator, classroom teacher, homebound teacher and other appropriate personnel. The IHP should be shared with all persons who interact with the student at school.

Resources

For more information, refer to:

Gerber, Mary L. Villars, Kulb, Kathleen M., Luehr, Ellen, Miller, Wanda R., Silkworth, Cynthia K., and Will, Susan I.S. (1993). *The School Nurse's Source Book of Individualized Healthcare Plans*. North Branch, Minn.: Sunrise River Press.

Note: In 1996, the Virginia Department of Health sent *The School Nurse's Source Book of Individualized Healthcare Plans* to all Virginia school divisions via the School Nurse Coordinator/Contact Person.

Virginia Board of Education. (September, 1997). *Regulations Establishing Standards for Accrediting Public Schools in Virginia*. Richmond, Va.: Virginia Department of Education.

Virginia Department of Education (Effective January 1994). *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*. Richmond, Va.: Author.

Virginia Department of Education. (1990). *Guidelines for Homebound Instruction*. Richmond, Va.: Author.

Students Requiring Specialized Health Care Procedures

Resource. Refer to Keen, T. (Ed.). with Ford, N., Henry, J., and Cox, A. (Consulting Eds.). (1996). *Guidelines for Specialized Health Care Procedures*. Richmond, Va.: Virginia Department of Health.

Guidelines for Specialized Health Care Procedures is a resource document for school and public health personnel. The manual is intended to enhance the educational process by providing guidance to school administrators, school nurses, teachers, and other staff members on the care of students with special health care needs. It presents up-to-date, practical health information and recommendations for developing local programs and policies related the health care services to be provided for these students.

Note. In 1996-97, the Virginia Department of Education sent the manual, *Guidelines for Specialized Health Care Procedures*, to all Virginia public schools and accredited nonpublic schools.

CHAPTER 4

Health Education

This chapter presents general guidelines for use in planning and implementing *school health education*, a component of a school health program. Included within this chapter is information about related codes, policies, and recommendations for addressing three high-risk behaviors: (1) unhealthy dietary behaviors, (2) inadequate physical activity, and (3) tobacco use. Incorporated within this chapter is basic information pertaining to two other components of a school health program: *school nutrition services* and *physical education*.

In This Chapter

Implementing Health Education in a School Health Program

Planning Health Education Programs

- ◆ Nutrition
- ◆ Physical Activity
- ◆ Injury and Violence
- ◆ Tobacco
- ◆ Alcohol and Other Drugs
- ◆ Early Sexual Activity

Implementing Health Education in a School Health Program

Authorization

Code of Virginia, Section 22.1-207, Physical and Health Education.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-207.

Code of Virginia, Section 22.1-207.1, Family Life Education.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-207.1.

Overview

Definition. Although a universally accepted definition of the term “school health education” has not been adopted, *Health Is Academic: A Guide to Coordinated School Health Programs* presents the following definition:

Comprehensive school health education: Classroom instruction that addresses the physical, mental, emotional, and social dimensions of health; develops health knowledge, attitudes, and skills; and is tailored to each age level. Designated to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors.⁹⁷

Health Risks and School Performance Variables. The Centers for Disease Control and Prevention (CDC) finds that most major health problems in the United State today are caused by the following six categories of health-related risk behaviors.⁷⁸

- ◆ Tobacco use.
- ◆ Unhealthy dietary behaviors.
- ◆ Inadequate physical activity.
- ◆ Alcohol and other drug use.

⁹⁷ Marx, E., and Wooley, S.F. (Eds.). (1998). *Health Is Academic: A Guide to Coordinated Health Programs* (p. 4). New York, N.Y.: Teachers College Press.

- ◆ Sexual behaviors that may result in HIV infection, other sexually transmitted diseases, and unintended pregnancies.
- ◆ Behaviors that may result in intentional injuries (violence and suicide) and unintentional injuries (motor vehicle crashes).

According to Kolbe,⁹⁸ behaviors and attitudes about health that are initiated during childhood are responsible for most of the leading causes of death, illness, and disability in the United States today. Comprehensive school health education programs represent one effective way of providing students with the knowledge and skills to prevent health-impairing behaviors.

In addition, according to Davaney, B., et al., literature in education and health promotion confirm a strong relationship between student involvement in specific health-related risk behaviors and negative outcomes on the following selected measures of school performance:⁹⁹

- ◆ *Educational measures*, including graduation rates, class grades, and performance on standardized rates.
- ◆ *Educational behaviors*, including student attendance, dropout rates, behavioral problems at school, and degree of involvement in school activities, such as homework and extracurricular pursuits.
- ◆ *Student attitudes*, including those toward school, such as aspirations for postsecondary education and feelings about safety on school property, and personal attitudes, such as self-esteem and locus of control.

Health Education and Children's Health Status. Hundreds of studies have evaluated health education and concluded that it is effective in reducing the number of teenage pregnancies, decreasing smoking rates among young people, and preventing the adoption of high risk behaviors. But its effectiveness depends upon such factors as teacher training, comprehensiveness of the health program, time available for instruction, involvement, and community support.^{100 101} Further, sequential school health education

⁹⁸ Kolbe, L. J. (1993). An essential strategy to improve the health and education of Americans. *Preventive Medicine*, 22(4), pp. 1-17.

⁹⁹ Davaney B., Schochet P., Thornton C., Fasciano N., and Gavin A. (1993). Evaluating the Effects of School Health Interventions on School Performance: Design Report. Princeton, N.J.: Mathematica Policy Research, Inc. In Symons, C. et al., Bridging Student Health Risks and Academic Achievement Through Comprehensive School Health Programs. *Journal of School Health*, 67 (6), p. 221.

¹⁰⁰Seffrin, J. R. (1990). The Comprehensive School Health Curriculum: Closing The Gap Between State-Of-The-Art and State-Of-The-Practice. *Journal of School Health*, 60(4), pp. 151-156.

programs for K-12 students have been found to be more effective in changing health-related risk behaviors than occasional programs on single health topics.¹⁰²

National Health Education Standards

Joint Committee for National School Health Education Standards. To assist schools in developing and evaluating comprehensive health education programs, the Joint Committee for National School Health Education Standards (1995) has developed guidelines for school health standards. The committee was composed of representatives from the Association for the Advancement of Health Education; the American Public Health Association; the American School Health Association; and the Society of State Directors of Health, Physical Education and Recreation. The committee was sponsored by the American Cancer Society.

The committee's goal was to assess the need for school health education and create a framework for local school boards to use in determining content of the health curriculum in their communities. There are seven broad standards that promote health literacy, which is the capacity of individuals to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways that enhance health.¹⁰³

Description of the Standards. Each of these standards is correlated with the ten traditional health education content areas and the six categories of health-related risk behaviors identified by the Centers for Disease Control and Prevention (CDC). Performance indicators for each standard are developed to help educators determine the knowledge and skills that students should possess by the end of grades 4, 8, and 11. In addition, the standards identify the support needed at the local, state, and national levels, and the support needed within the school and the community, and through institutions of higher education curricula, to successfully implement quality health education.

¹⁰¹ Gold, R. S. (1994). The Science Base for Comprehensive School Health Education. In P. Cortese & K. Middleton (Eds.), *The Comprehensive School Health Challenge: Promoting Health Through Education* (Vol. 2) (pp. 545-573). Santa Cruz: Elk Associates.

¹⁰² Kolbe, L.J. (1993). Developing a Plan of Action to Institutionalize Comprehensive School Health Education Programs in the United States. *Journal of School Health*, 63(1),12-13.

¹⁰³ Joint Committee on National Health Education Standards. (1995). *National Health Education Standards*. Available from the American School Health Association P.O. Box 708, 7263 State Route 43, Kent, OH 44240; the Association for the Advancement of Health Education; 1900 Association Drive, Reston, VA 22091; or the American Cancer Society at 1-800-ACS-2345.

Standards. The following standards were developed by the Joint Committee on National Health Education Standards in 1995.¹⁰⁴

I. Students will comprehend concepts related to health promotion and disease prevention.

Performance indicators for this standard focus on identifying what good health is, recognizing health problems, and ways in which lifestyle, the environment, and public policies can promote health.

II. Students will demonstrate the ability to access valid health information and health-promoting products and services.

Performance indicators focus on identification of valid health information, products, and services, including advertisements, health insurance and treatment options, and food labels.

III. Students will demonstrate the ability to practice health-enhancing behaviors and reduce health risks.

Performance indicators include identifying responsible and harmful behaviors, developing health enhancing strategies, and managing stress.

IV. Students will analyze the influence of culture, media, technology, and other factors on health.

Performance indicators are related to describing and analyzing how one's cultural background, messages from the media, technology, and one's friends influence health.

V. Students will demonstrate the ability to use interpersonal communication skills to enhance health.

Performance indicators relate to interpersonal communication, refusal and negotiation skills, and conflict resolution.

VI. Students will demonstrate the ability to use goal-setting and decision-making skills to enhance health.

Performance indicators focus on setting reasonable and attainable goals and developing positive decision-making skills.

VII. Students will demonstrate the ability to advocate for personal, family, and community health.

Performance indicators relate to identifying community resources, accurately communicating health information and ideas, and working cooperatively to promote health.

Planning Health Education Programs

Assessment

To determine what type of programs to offer within the health education component of a school health program, data should be gathered on student knowledge, skill, attitudes, and

¹⁰⁴ Joint Committee on National Health Education Standards. (1995). *National Health Education Standards*. Available from the American School Health Association; P.O. Box 708, 7263 State Route 43, Kent, OH 44240; the Association for the Advancement of Health Education; 1900 Association Drive, Reston, VA 22091; or the American Cancer Society at 1-800-ACS-2345.

health-related risk behaviors to decide the priority areas in which to offer the program. (Please see “Assessment” in Developing a Program: Infrastructure and Planning Process Steps, Chapter I.)

School Health Education Program Content

The school health education program should be based upon local needs and the health behaviors and problems within the school population as well as national data suggesting the health status of children and youth. Experts have identified the following ten content areas as necessary for a comprehensive school health education curriculum:¹⁰⁵

1. Community health.
2. Consumer health.
3. Environmental health.
4. Personal health and fitness.
5. Family life education.
6. Nutrition and healthy eating.
7. Disease prevention and control.
8. Safety and injury prevention.
9. Prevention of substance use and abuse (alcohol, tobacco, drugs).
10. Growth and development.

The objective of a school health education program should be to offer an ongoing, sequenced, and developmentally appropriate program that is consistent with community needs.

Effective Methods of Instruction

The most effective methods of instruction in health are student-centered approaches, hands-on activities, cooperative learning techniques, and activities that include problem-solving and peer instruction to help students develop skills in decision-making, communication, setting goals, resistance to peer pressure, and stress management.^{106 107} As with other instructional

¹⁰⁵ American School Health Association. (1994). *Guidelines for Comprehensive School Health Programs, 2nd Edition*. Kent, Ohio: Author.

¹⁰⁶ Kane, W. M. (1993). *Step-By-Step to Comprehensive School Health: The Program Planning Guide*. Santa Cruz, CA: ETR Associates. ED360304

areas, the teacher should promote parental involvement by sending materials home, involving parents in classroom activities, and creating assignments that involve parents.

Subsection

The following subsections contain information for use in planning school health education programs that will motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors.

- ◆ Nutrition
- ◆ Physical Activity
- ◆ Tobacco
- ◆ Injury and Violence
- ◆ Alcohol and Other Drugs
- ◆ Early Sexual Activity

Centers for Disease Control and Prevention's Guidelines for School Health Programs.

Included within the subsections are the following school health program guidelines, published by the Centers for Disease Control and Prevention:

1. Promoting Lifelong Healthy Eating.
2. Promoting Lifelong Physical Activity.
3. Preventing Tobacco Use and Addiction.

¹⁰⁷ Seffrin, J. R. (1990). The Comprehensive School Health Curriculum: Closing the Gap Between State-Of-The-Art and State-Of-The-Practice. *Journal of School Health*, 60(4), pp. 151-156.

Nutrition

Authorization

Code of Virginia, Section 22.1-207, Physical and Health Education.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-207.

Code of Virginia, Section 22.1-207.3, School Breakfast Program.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-207.3.

Overview

Definition. Although a universally accepted definition of the term “school nutrition services” has not been adopted, *Health Is Academic: A Guide to Coordinated School Health Programs* presents the following definition:¹⁰⁸

School Nutrition Services: Integration of nutritious, affordable, and appealing meals; nutrition education; and an environment that promotes healthy eating behaviors for all children. Designed to maximize each child’s education and health potential for a lifetime.

Services Provided. As reported in *Health Is Academic: A Guide to Coordinated School Health Programs*, school food and nutrition services vary significantly among schools. This variation depends on the perceived needs, resources, and priorities of schools and communities. School food and nutrition services can be categorized as follows:¹⁰⁹

- ◆ Federally supported, nonprofit school lunches, breakfasts, and snacks, including those for students with special health care needs.
- ◆ For-profit food programs, including snack bars, school stores, vending machines, à la carte items sold in school cafeterias, and special functions for students or staff.
- ◆ Nutrition education activities integrated with classroom instruction.

¹⁰⁸ Marx, E., and Wooley, S.F. (Eds.). (1998). *Health Is Academic: A Guide to Coordinated Health Programs* (p. 4). New York, N.Y.: Teachers College Press.

¹⁰⁹ Marx, E., and Wooley, S.F. (Eds.). (1998). *Health Is Academic: A Guide to Coordinated Health Programs* (pp.174-175). New York, N.Y.: Teachers College Press.

- ◆ Nutrition screening, assessments, and referral.
- ◆ Food service provided for nonschool populations, including child care, Head Start, elderly feeding, summer feeding, and contract services that meet the needs of local communities.

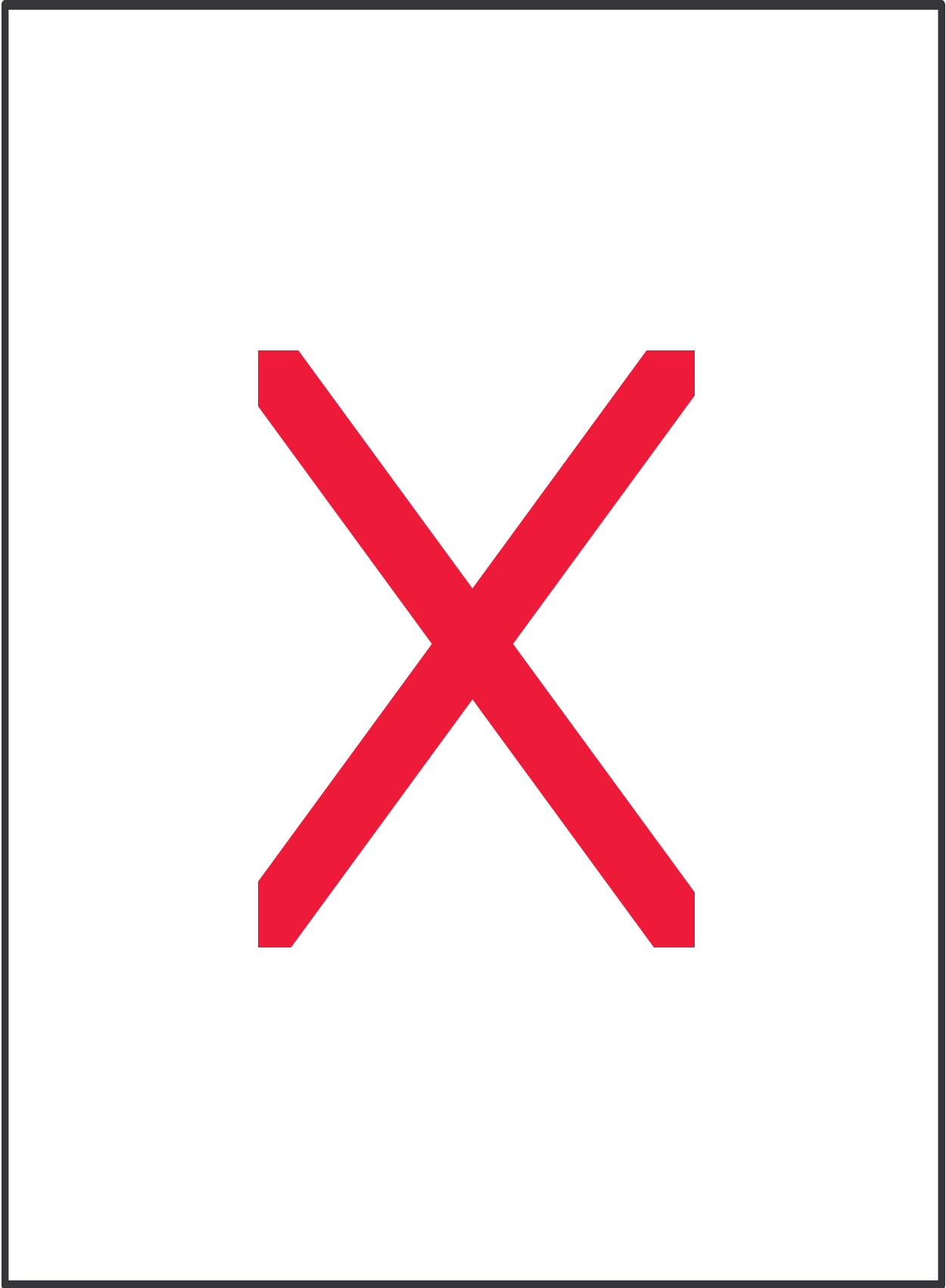
Nutrition and Food Services in Virginia. For information on school food and nutrition services in Virginia public schools, please see the nutrition resource list at the end of this subsection.

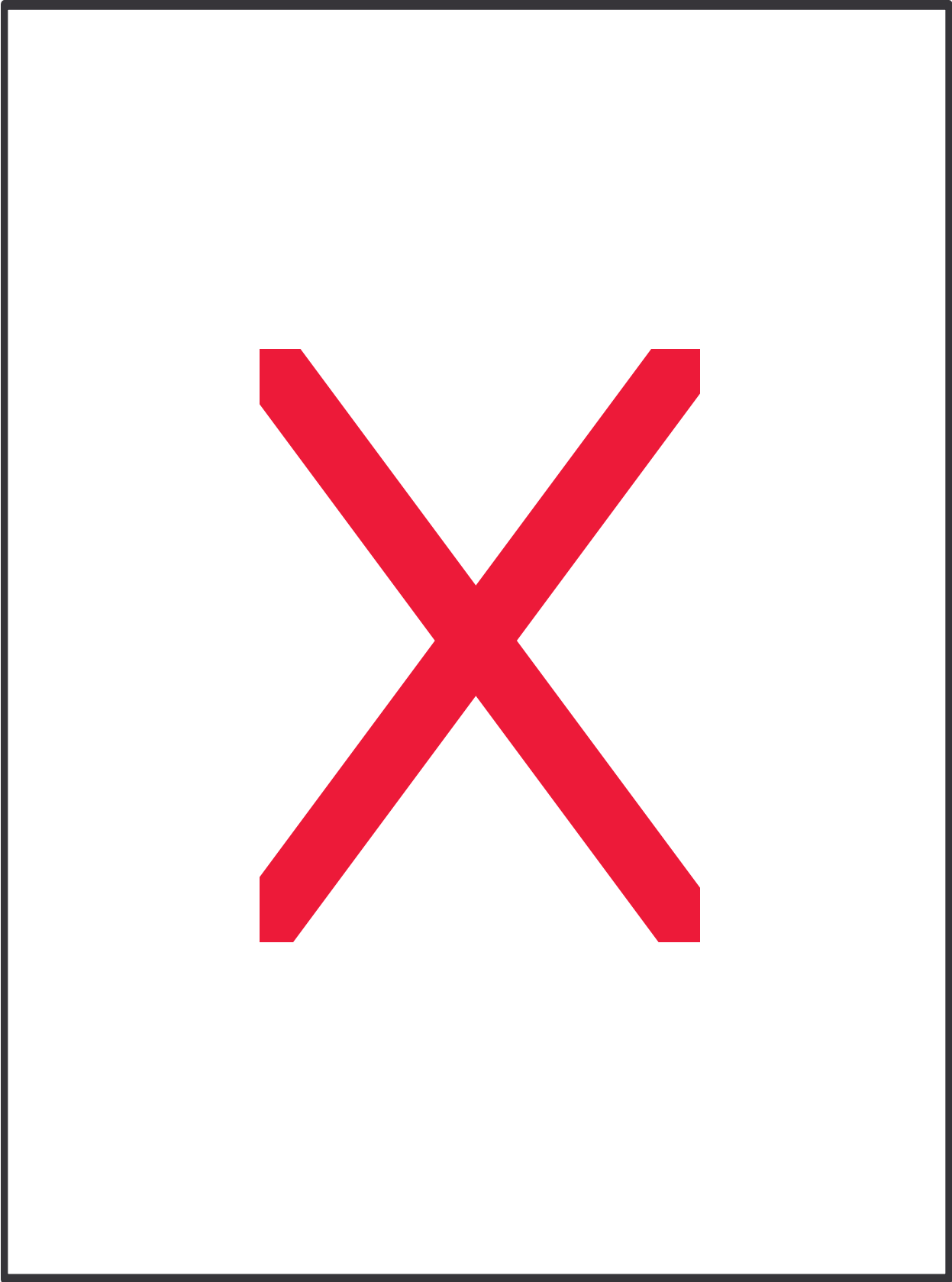
Recommendation

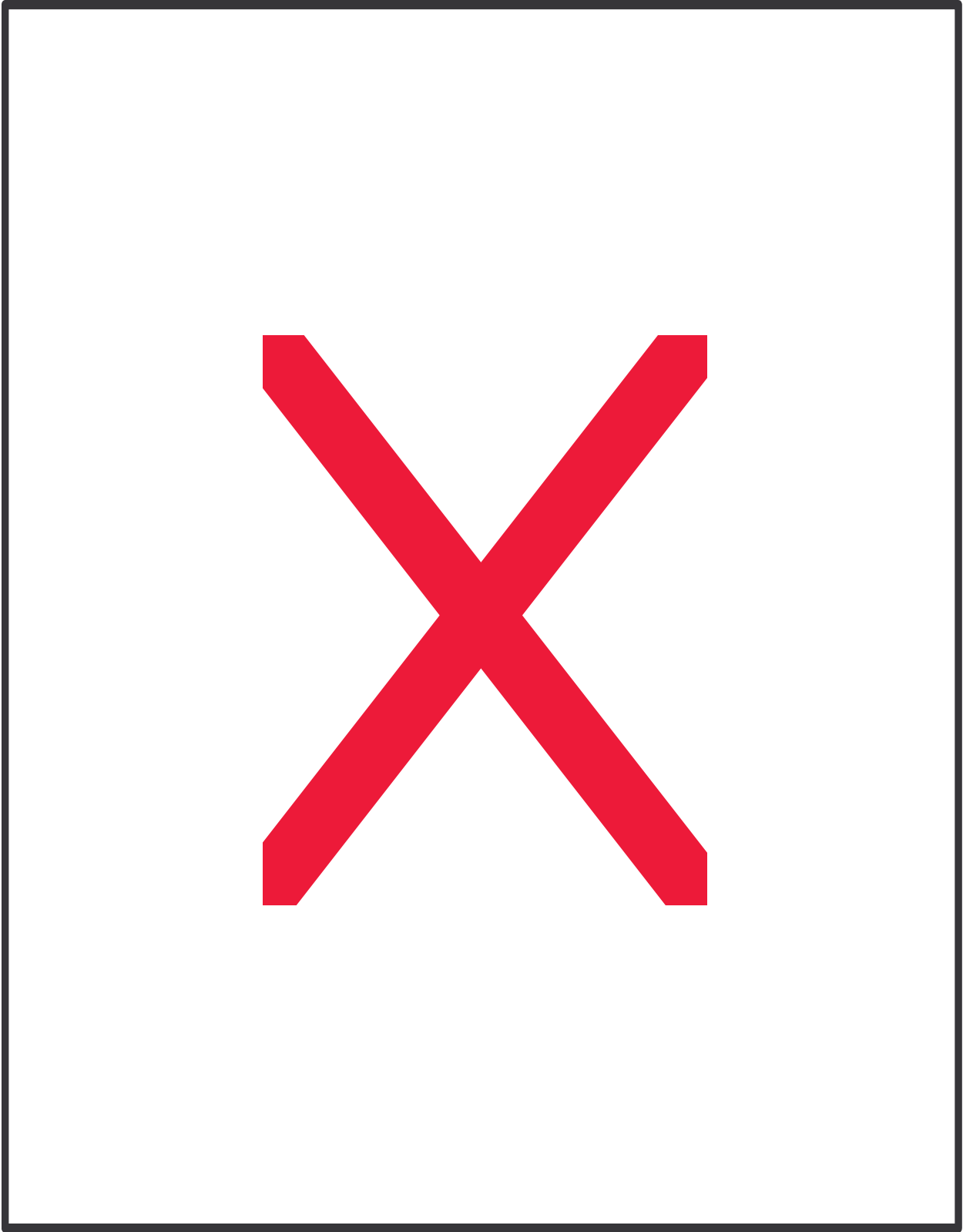
Centers for Disease Control and Prevention’s Guidelines for Promoting Lifelong Healthy Eating. The following guidelines, which are reprinted on the following pages, identify strategies most likely to be effective in promoting lifelong healthy eating among young people. The guidelines were developed by Centers for Disease Control and Prevention (CDC) staff in collaboration with experts from other federal agencies, state agencies, universities, voluntary organizations, and professional associations.

- ◆ Guidelines Report At-A-Glance—Summarizes benefits of healthy eating, consequences of unhealthy eating, and data on eating habits of young people; identifies key principles for effective policies and programs; and lists guidelines recommendations.
- ◆ How You Can Help—Identifies specific actions that parents, students, teachers and coaches, school administrators and board members, community sports and recreation program coordinators, and everyone else who cares about the health of young people can take to help implement guidelines recommendations.
- ◆ Fact Sheet—Highlights statistics on the effects of diet on health and academic performances; overweight and obesity; and the eating habits of young people.
- ◆ Nutrition Education Resource List—Provides contact information for government agencies, professional associations, and voluntary organizations.

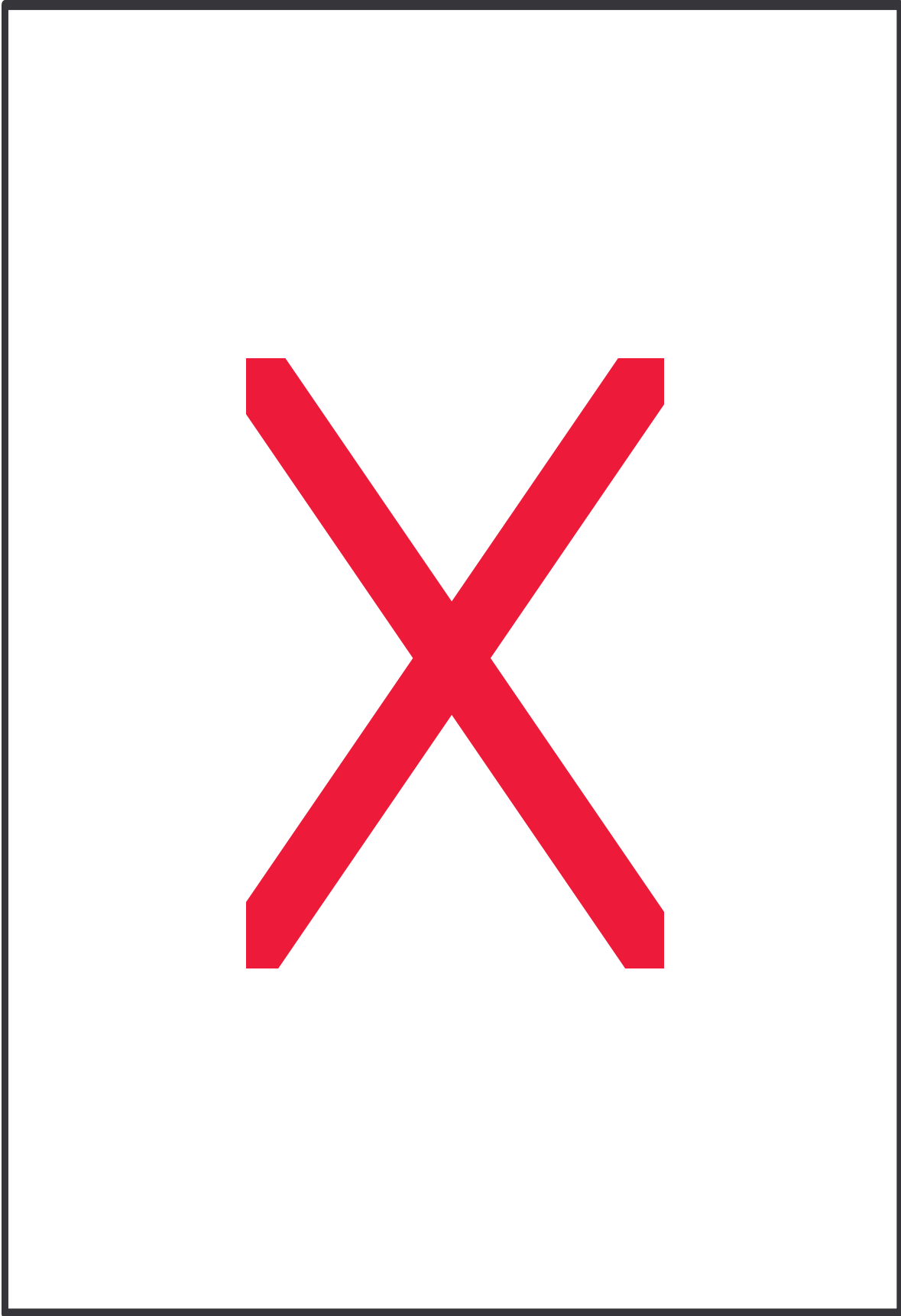
The above guidelines and the complete report, *CDC’s Guidelines for School Health Programs Promoting Lifelong Healthy Eating*, are available on the web at <http://www.cdc.gov/nccdphp/dash/nutguide.htm>.

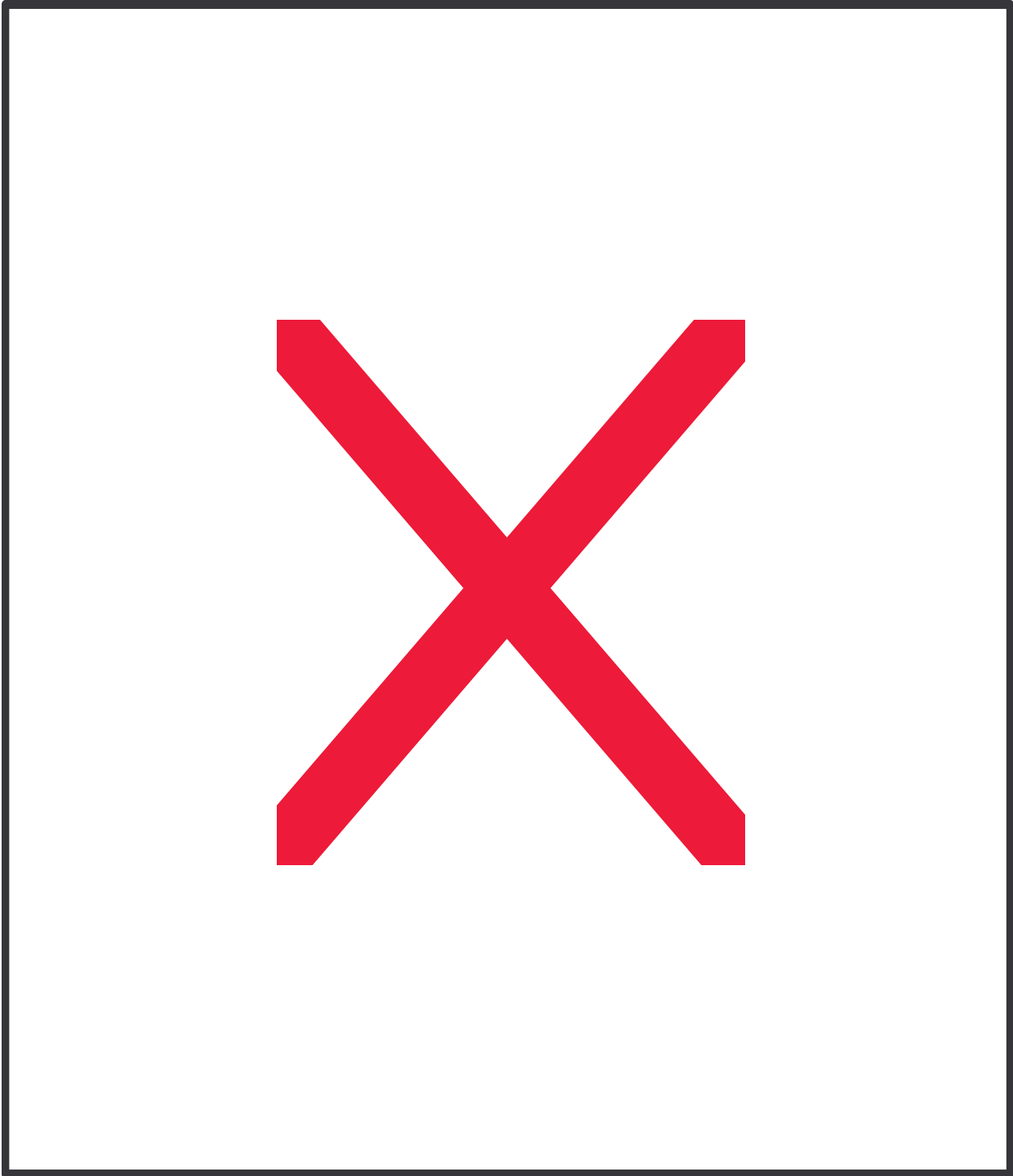


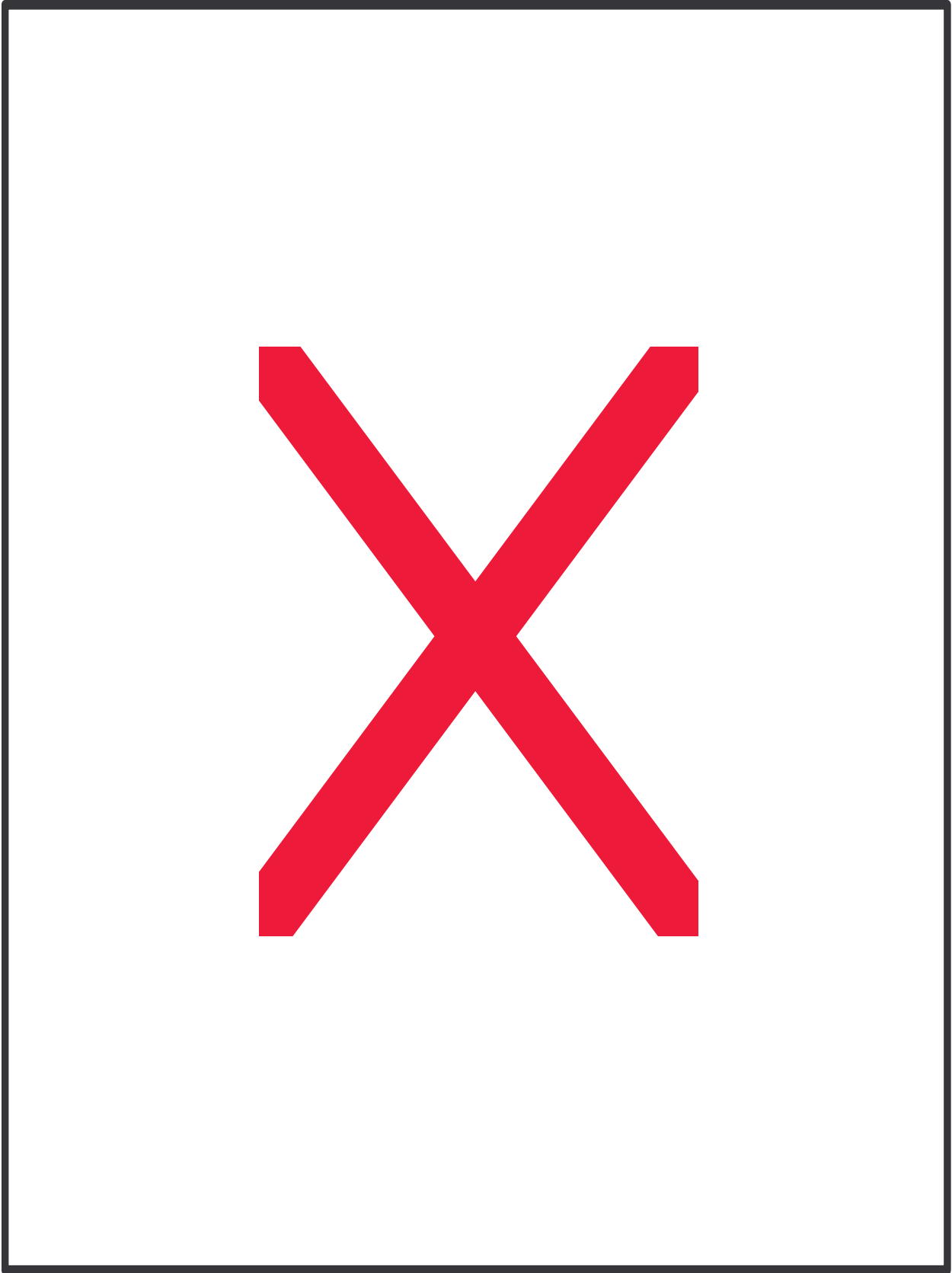




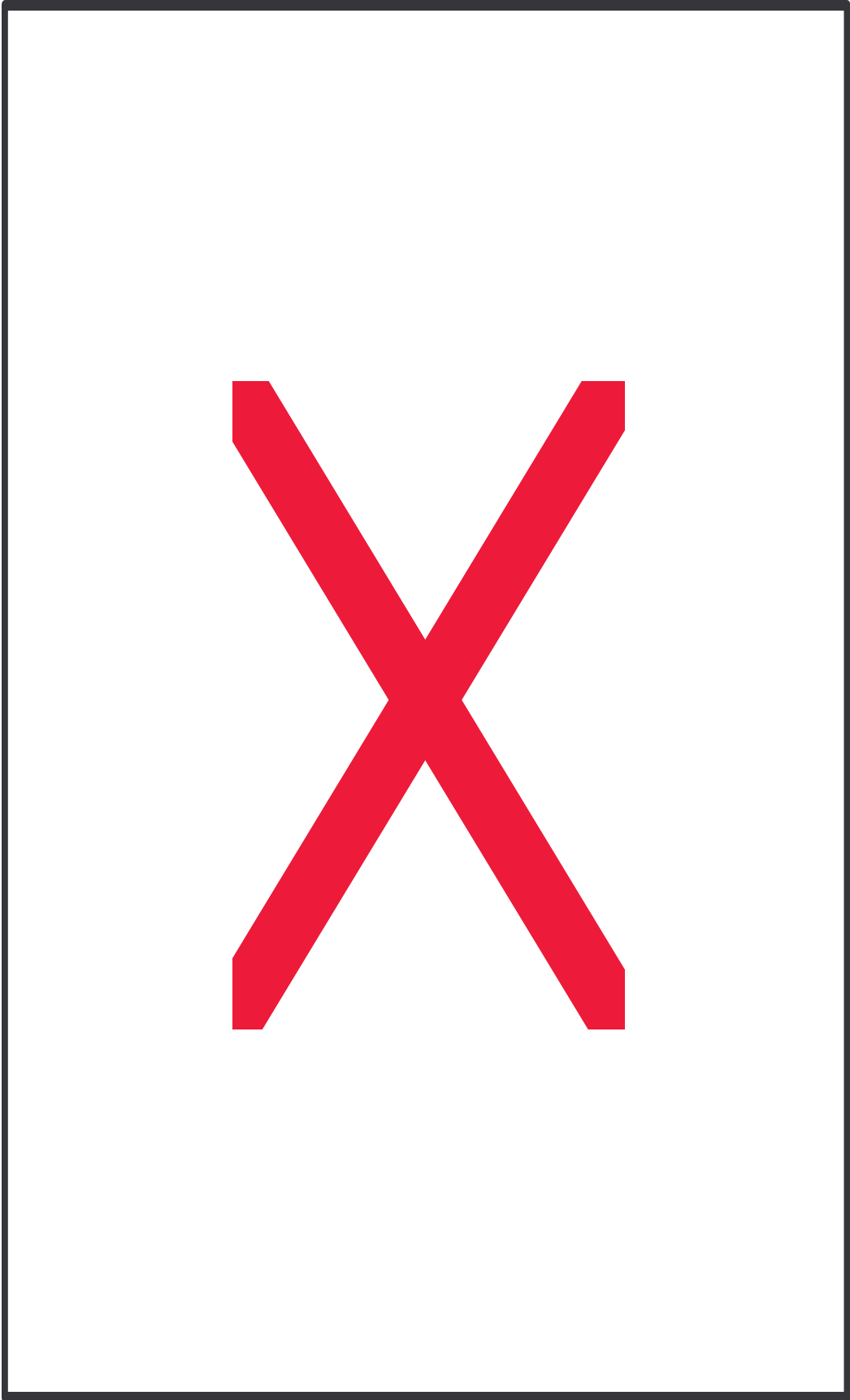












VIRGINIA NUTRITION EDUCATION RESOURCE LIST

- ◆ *Virginia Department of Education*
School Nutrition Programs
P.O. Box 2120
Richmond, VA 23218
Telephone: (804) 225-2074 or 1-800-292-3820 (toll free)
- ◆ *Virginia Department of Health*
Division of Chronic Disease Prevention and Nutrition
P.O. Box 2448
Richmond, VA 23218
Telephone: (804) 786-5420
Web site: <http://www.vdh.state.va.us/fhs/chronic/chronic.htm>
- ◆ *Virginia Cooperative Extension*
Virginia Tech
Department of Human Nutrition, Foods and Exercise
338 Wallace (0430)
Blacksburg, VA 24061-0430
Telephone: (540) 231-4672
Web site: <http://www.ext.vt.edu/>

Note: Extension is a joint program of Virginia Tech, Virginia State University, the U.S. Department of Agriculture, and state and local governments.
- ◆ *Virginia Dietetic Association*
P.O. Box 439
Centreville, VA 20122
Telephone: (703) 815-8293
- ◆ *Virginia School Food Service Association*
Route 6 Box 166
Harrisonburg, VA 22801
Telephone: (540) 434-3756 or (888) 867-3195 (toll free)

Physical Activity

Authorization

Code of Virginia, Section 22.1-207, Physical and Health Education.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-207.

Overview

Definition. Although a universally accepted definition of the term “physical education” has not been adopted, *Health Is Academic: A Guide to Coordinated School Health Programs* presents the following definition.¹¹⁰

***Physical Education:** Planned, sequential instruction that promotes lifelong physical activity. Designed to develop basic movement skills, sports skills, and physical fitness as well as to enhance mental, social, and emotional abilities.*

Objectives for Physical Education Program. The National Standards for Physical Education identify what a physical education student should know and be able to do as the result of a quality physical education program. According to the National Standards for Physical Education, a physically educated person should be able to:¹¹¹

1. Demonstrate competency in many movement forms and proficiency in a few movement forms.
2. Apply movement concepts and principles to the learning and development of motor skills.
3. Exhibit a physically active lifestyle.
4. Achieve and maintain a health-enhancing level of physical fitness.
5. Demonstrate responsible personal and social behavior in physical activity settings.

¹¹⁰ Marx, E., and Wooley, S.F. (Eds.). (1998). *Health Is Academic: A Guide to Coordinated Health Programs* (p. 4). New York, N.Y.: Teachers College Press.

¹¹¹ Centers for Disease Control and Prevention. (May, 1998). *Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young People*. Available: <http://www.cdc.gov/nccdphp/dash/physact.htm>.

6. Demonstrate understanding and respect for differences among people in physical activity settings.
7. Understand that physical activity provides opportunities for enjoyment, challenge, self-expression, and social interaction.

Diversified physical education programs include a range of activities and concepts in the areas of wellness related fitness: individual and dual sports, team sports, gymnastics, rhythm and dance, track and field, aquatics, and outdoor activities. These programs must be planned and implemented in ways that maximize the goals of physical education and establish a healthy lifestyle.¹¹²

Physical educators are increasingly focusing on relevance rather than tradition, and participation rather than competition. The current national trend is to teach activities that prepare students for a lifetime of wellness with emphasis on teaching noncompetitive team sports skills. For example:¹¹³

- ◆ A basketball skills class may be taught with every student having a basketball, thus eliminating waiting in line. Students may learn backyard basketball games involving two to four people (such as knockout, hot shot, or “2 on 2”), rather than waiting for the opportunity to play in a full court game. Playing with two basketballs simultaneously adds an aerobic component.
- ◆ Participation in volleyball class may be enhanced by modifying the rules using unlimited hits, two serves, or a softer ball. Students can aerobicize volleyball by playing “2 on 2,” “3 on 3,” or “4 on 4.”
- ◆ Traditional large group games popular with younger students, such as “Capture the Flag,” may be altered to remove the elimination factor and increase the aerobic factor. Instead of sending the students to “jail” or out of a game, students may be required to jog a distance and immediately return to play.

Regardless of the activities offered in a physical education curriculum, wellness-related fitness is the underlying theme. Students should have an understanding of the wellness related fitness concepts and be able to apply them to their own lifestyle.¹¹⁴

¹¹² Massachusetts Department of Health. (1995). *Comprehensive School Health Manual* (p.10-3). Boston, Mass.: Author.

¹¹³ Massachusetts Department of Health. (1995). *Comprehensive School Health Manual* (p10-3). Boston, Mass.: Author.

¹¹⁴ Massachusetts Department of Health. (1995). *Comprehensive School Health Manual* (p10-3). Boston, Mass.: Author.

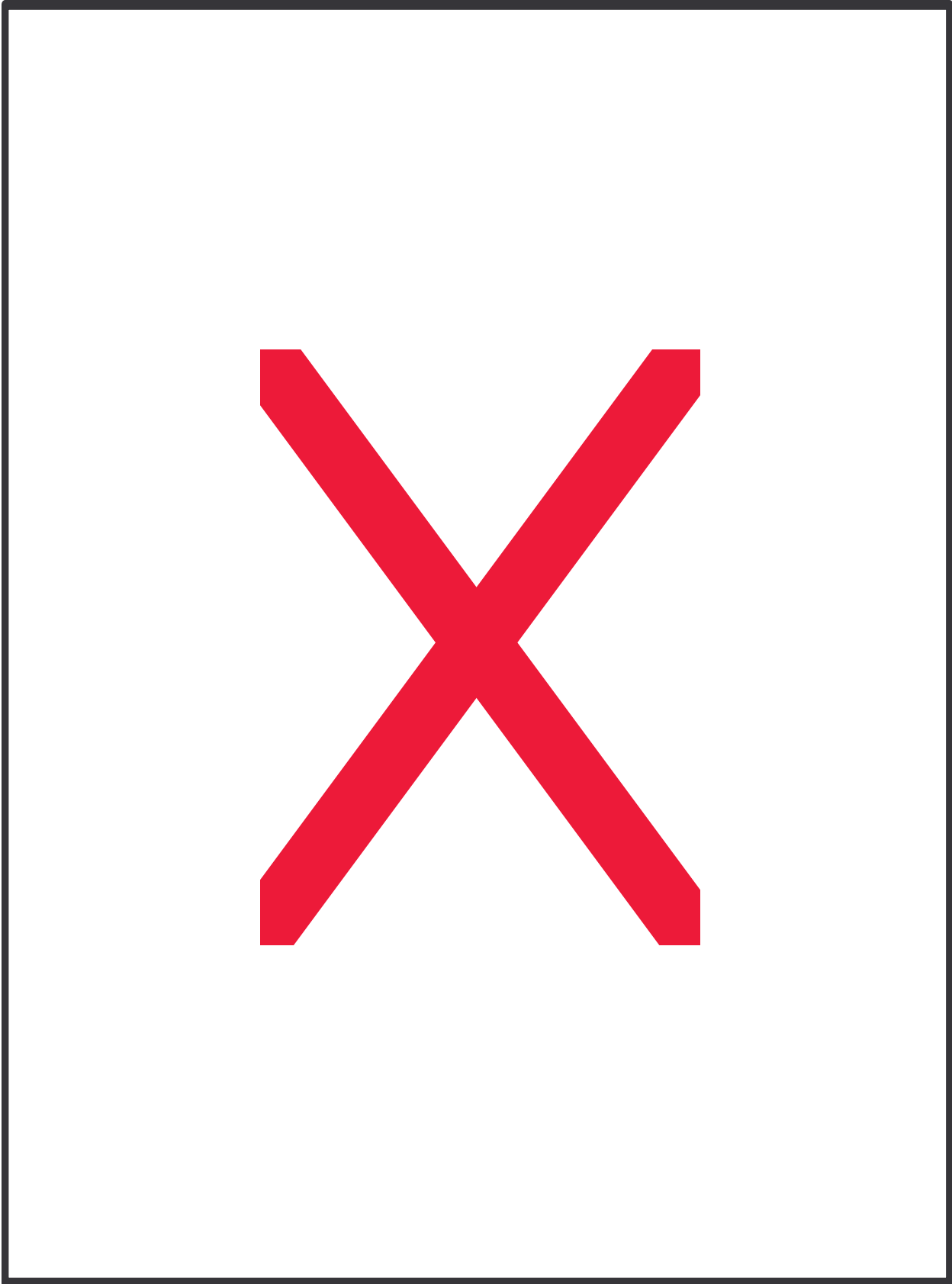
Recommendation

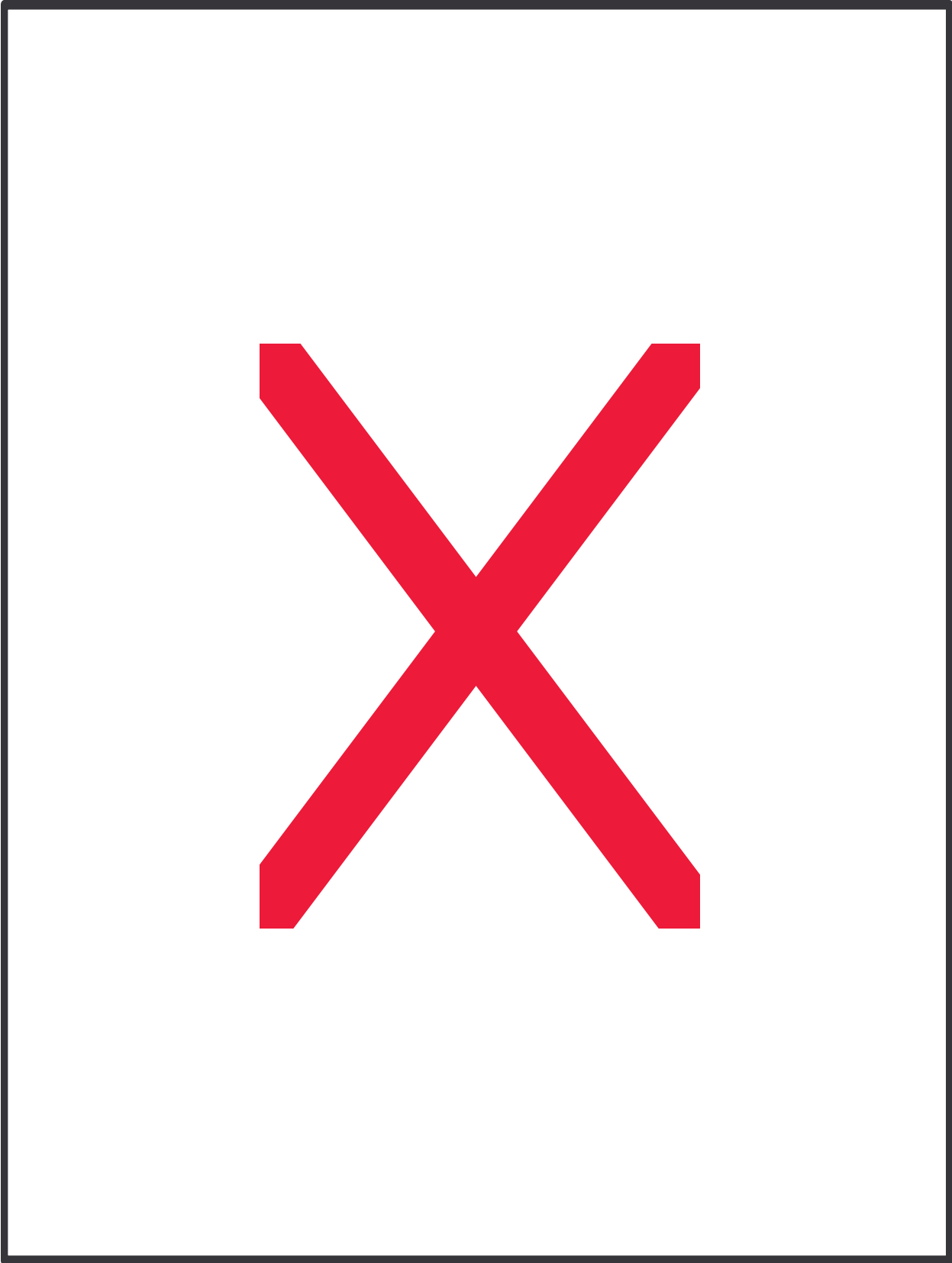
Centers for Disease Control and Prevention’s Guidelines for Promoting Lifelong Physical Activity. The following guidelines, which are reprinted on the following pages, identify strategies most likely to be effective in helping young people adopt and maintain a physically active lifestyle. The guidelines were developed by Centers for Disease Control and Prevention (CDC) staff in collaboration with experts from other federal agencies, state agencies, universities, voluntary organizations, and professional associations.

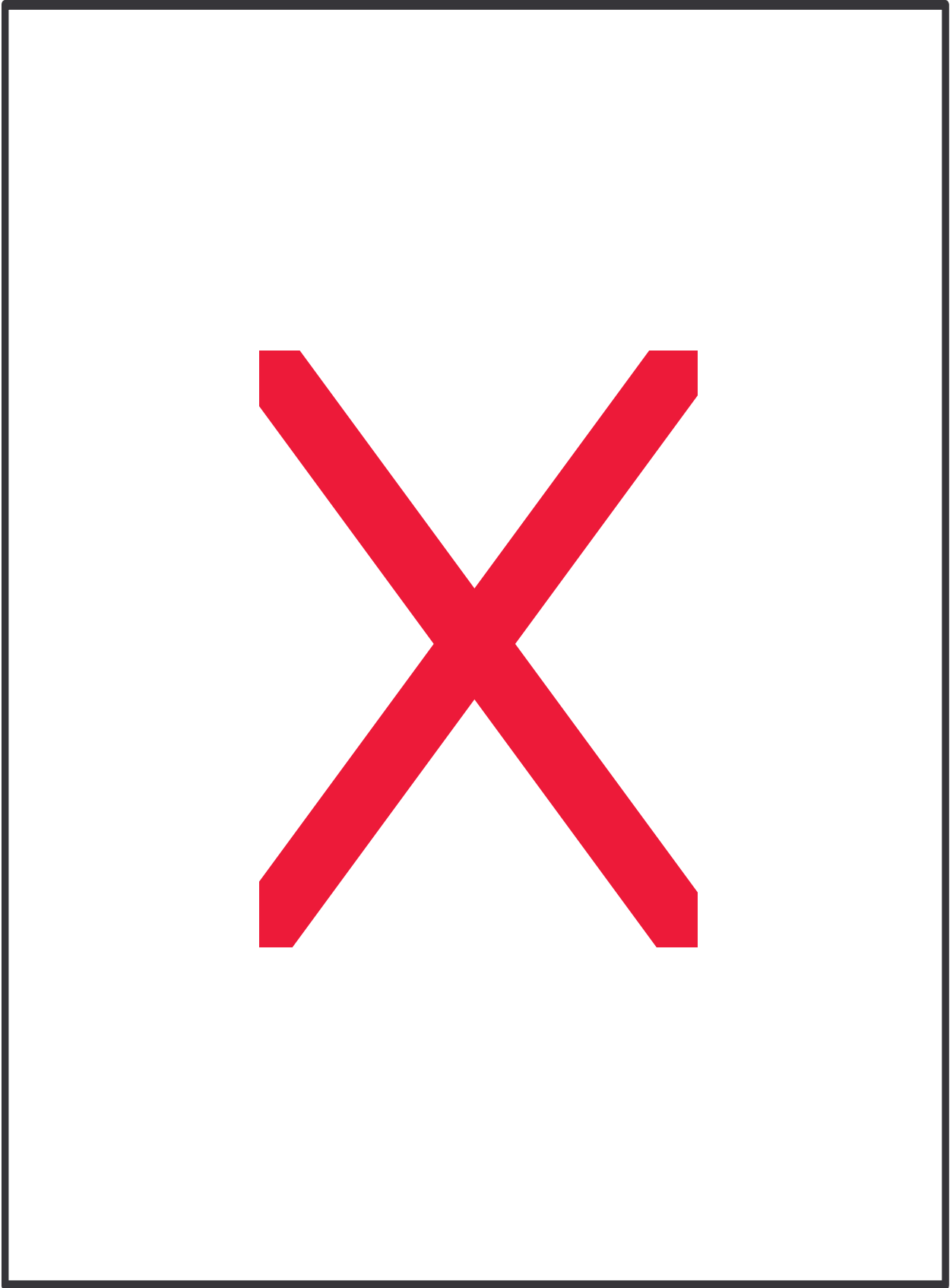
- ◆ Guidelines Report At-A-Glance—Summarizes benefits of physical activity, consequences of physical inactivity, and data on participation in physical activity by young people; identifies key principles for effective policies and programs; and lists guidelines recommendations.
- ◆ How You Can Help—Identifies specific actions that parents, students, teachers and coaches, school administrators and board members, community sports and recreation program coordinators, and everyone else who cares about the health of young people can take to help implement guidelines recommendations.
- ◆ Fact Sheet—Highlights statistics on the benefits of regular physical activity; the long-term consequences of physical inactivity; overweight and obesity; and participation by young people in physical activity and physical education classes.
- ◆ Physical Activity Information Resource List—Provides contact information for government agencies, professional associations, and voluntary organizations promoting safe and enjoyable physical activity among young people.

The above guidelines and the complete report, *CDC’s Guidelines for School and Community Programs to Promoting Lifelong Physical Activity*, are available on the web at <http://www.cdc.gov/nccdphp/dash/physact.htm>.

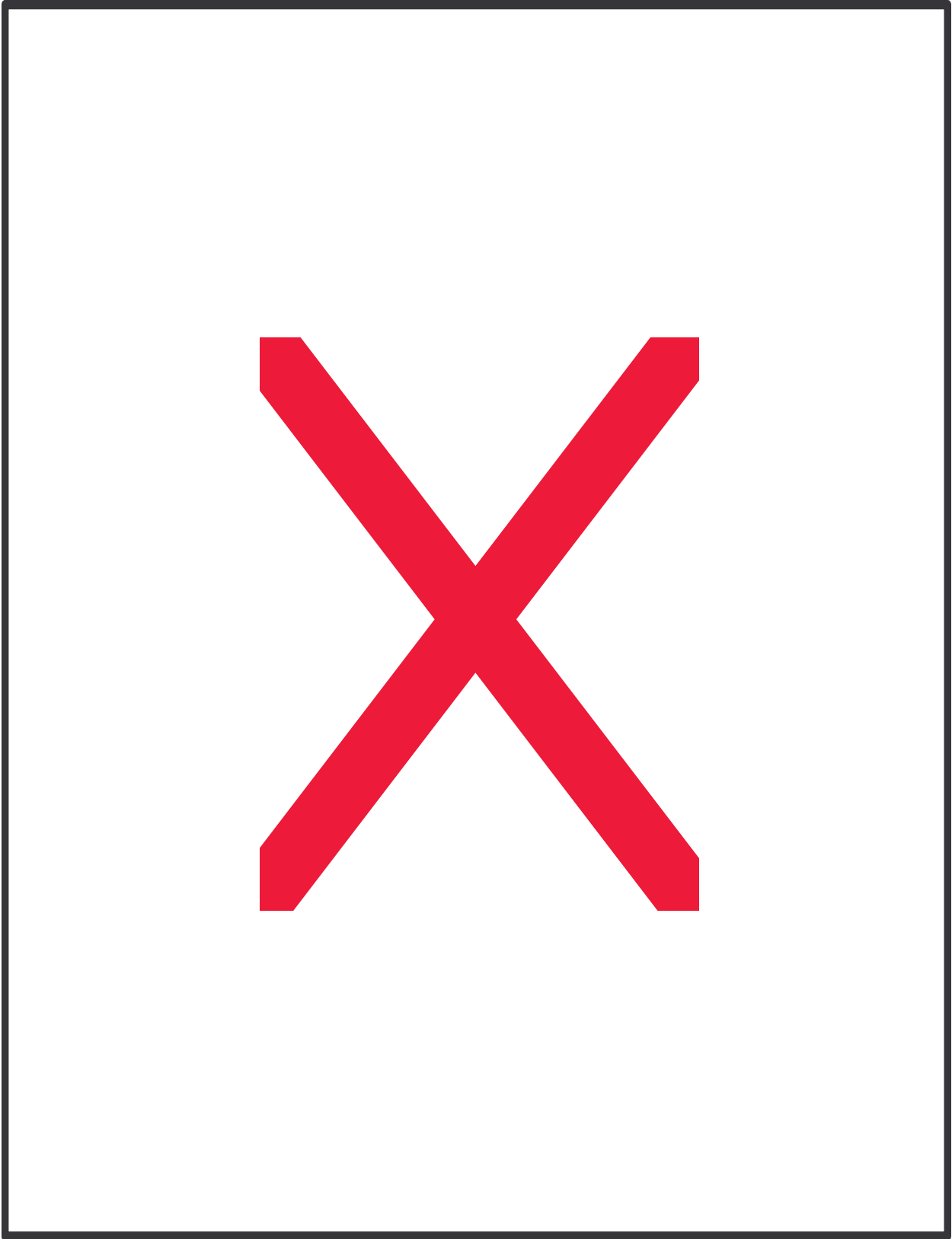




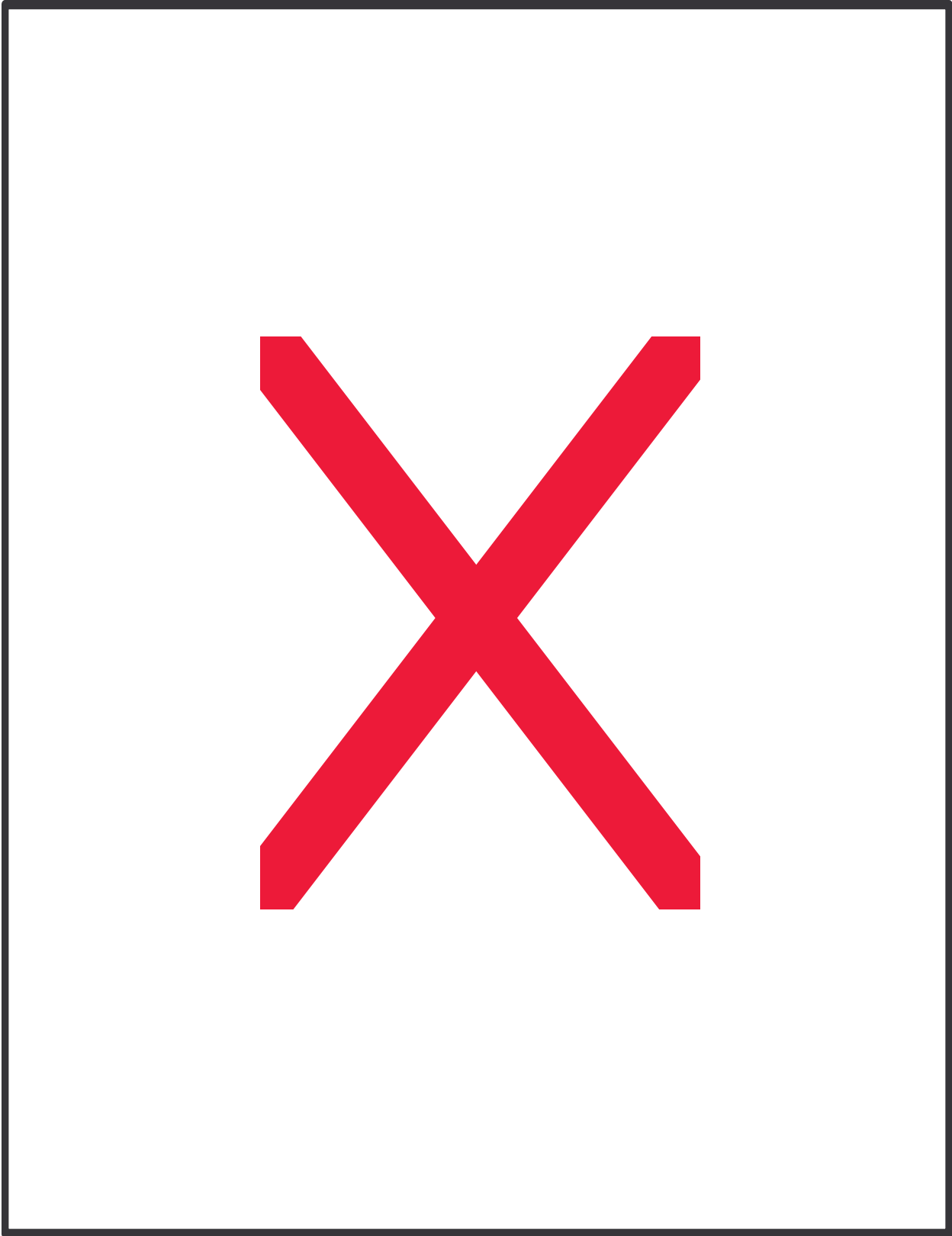


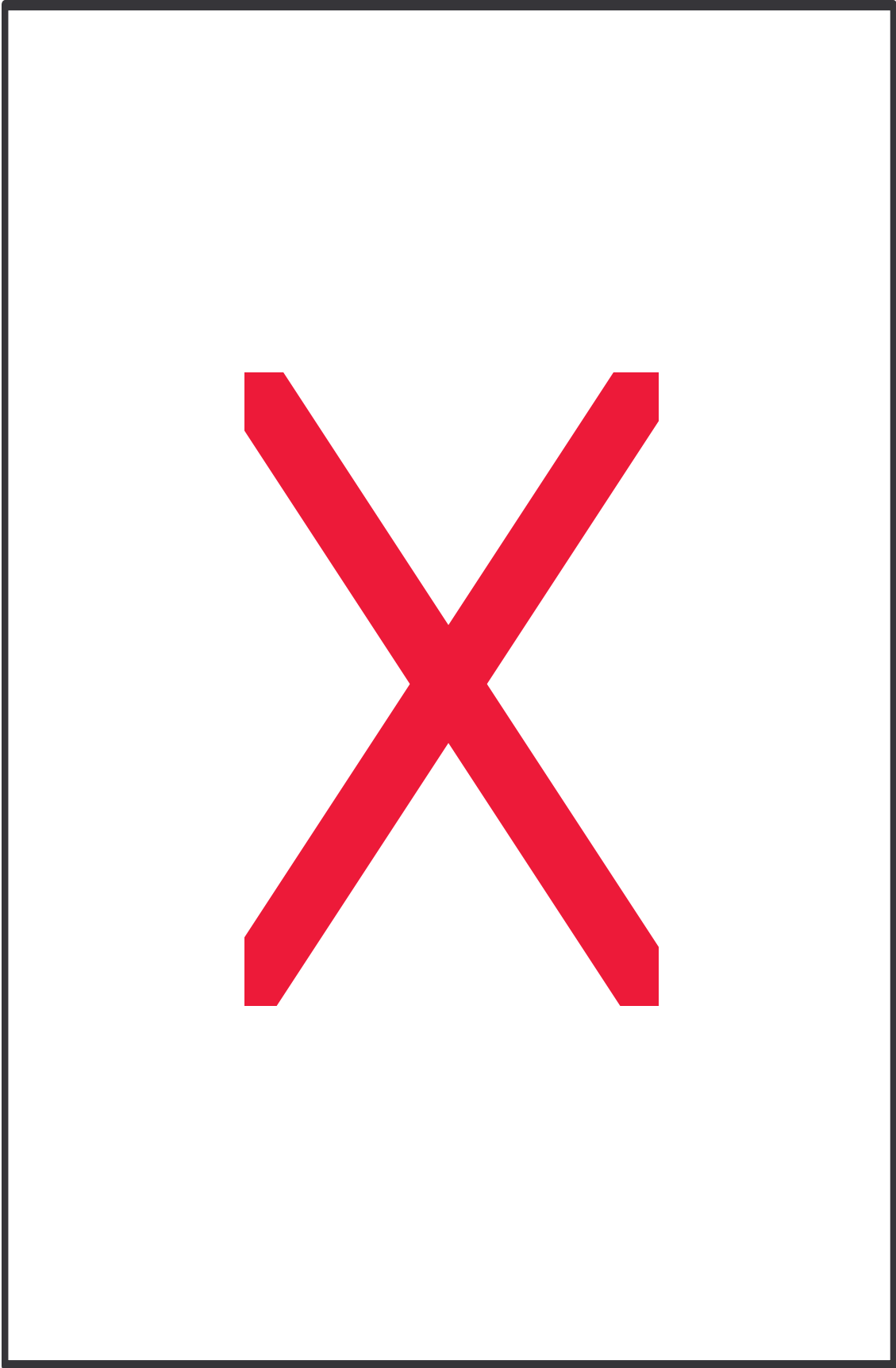












VIRGINIA PHYSICAL ACTIVITY INFORMATION RESOURCE LIST

- ◆ *Virginia Department of Education
Health, Physical Education and Driver Education
P.O. Box 2120
Richmond, VA 23218
Telephone: (804) 225-3300 or 1-800-292-3820 (toll free)*

- ◆ *Virginia Association for Health, Physical Education, Recreation and Dance (VAHPERD)
126 Westmoreland Street
Richmond, VA 23226
Telephone: (804) 335-6955 or 1-800-918-9899 (toll free)
Web site: <http://www.vahperd.vt.edu/>*

Injury and Violence

Authorization

Code of Virginia, Section 22.1-207, Physical and Health Education.

Excerpt: See Appendix A for *Code of Virginia* § 22.1-207.

Code of Virginia, Section 22.1-278.1, School Safety Audits Required.

Excerpt: See Appendix A for *Code of Virginia* § 22.1-278.1.

Overview

Leading Cause of Death and Disability. Injuries are the leading cause of death and disability for children and adolescents in Virginia. Between 1994 and 1997, 1,682 youth died as a result of injury before reaching their 20th birthday, and 21,346 were hospitalized.

*“An estimated 10-25 percent of these injuries occur in and around schools. Injuries are one of the most frequent conditions cared for by school health personnel. Over a two-year period, an estimated 80% of elementary school children, for example, will see a school nurse for injury related complaints.”*¹¹⁵

Prevention Strategies

School Role. *“Educators, school nurses, public health professionals, coaches, and administrators together can play a powerful role in preventing injuries at school. The following strategies are recommended: regular review of school injury reports and close monitoring of causes of injuries; development of school safety policies; drafting a comprehensive injury prevention plan; establishment of a school safety committee to deal with both unintentional and intentional injuries.”*¹¹⁶

School-based implementation of a quality, age-appropriate injury prevention curriculum will provide children with the knowledge and skills they need to make safer choices and

¹¹⁵ Children's Safety Network at Education Development Center, Inc. (1997). *Injuries in the School Environment: A Resource Guide* (Second Edition). Newton, Mass.: Education Development Center, Inc.

¹¹⁶ Di Scala, C. et al. (November, 1997). Causes and Outcomes of Pediatric Injuries Occurring at School. *Journal of School Health*, 67, (9).

to avoid injury at school, at home and in the community. Motor vehicle, bike and pedestrian safety; fire and burn, choking, drowning, poisoning and fall prevention; gun safety; and violence prevention are all areas that can be addressed. Community resources (e.g. police, fire, health care providers, and other safety educators) are readily available and can complement school-based injury prevention.

Examples. The following is a list of prevention strategies for school injuries, which focus on environmental changes.¹¹⁷

Removal of Physical Hazards

- ◆ Glass in doors.
- ◆ Asphalt under playground equipment.
- ◆ Bleachers on playing field lines.
- ◆ Uneven surfaces (holes or ruts) on playing fields.

Maintenance of Equipment and Facilities

- ◆ Protective guards on shop equipment.
- ◆ Playground equipment in good repair.
- ◆ Working smoke detectors.
- ◆ Active grounds maintenance committee.

Addition of Safety Features and Equipment

- ◆ Padded mats on concrete gym equipment.
- ◆ Use of helmets and mouth guards during sports.
- ◆ Locks on roof doors.
- ◆ Metal detectors.
- ◆ Increased lighting.
- ◆ Storage for student knapsacks.
- ◆ Low shrubbery at blind corners of buildings.

Enforced Policies and Regulations

- ◆ Collection and review of injury report forms by a designated staff person.
- ◆ Completion of a school safety audit.
- ◆ Development of school-wide safety policies based on injury reports.
- ◆ Development of injury response and emergency treatment protocol for school staff.
- ◆ Enforcement of rules, especially for sports and recreational activities.

¹¹⁷ Di Scala, C. et al, Causes and Outcomes of Pediatric Injuries Occurring at School (1997, November). *Journal of School Health*, 67, (9).

- ◆ Monthly safety checks of school premises, including recreational areas.
- ◆ In school suspensions for minor infractions and fighting.
- ◆ Identification of clear policies for injuries in the absence of medical personnel or athletic trainer on site.

Modification of Behaviors

- ◆ Education of staff on hazards and prevention.
- ◆ Education of staff on completing injury report forms and their usefulness for prevention.
- ◆ Training of coaches, gym teachers and other school personnel in emergency first aid and CPR.
- ◆ Increased supervision of students during recess and recreational time.
- ◆ Training of students as peer mediators for conflict resolution.
- ◆ Curriculum activities for students oriented to safety education on school grounds (and training of children to make safer choices and avoid injury at school, at home, and in the community).

Violence

Incidents of school violence can result in injuries to students and staff. Data show that the incidence of crime and violence in schools is declining, but the severity of those incidents and the likelihood of multiple injuries and deaths have increased (Source: Ronald Stephens, Executive Director, National School Safety Center, 1998.)

The *Code of Virginia*, § 22.1-280.1, Reports of certain acts to school authorities, requires that

Reports shall be made to the principal or his designee on all incidents involving (i) the assault, assault and battery, sexual assault, death, shooting, stabbing, cutting, or wounding of any person on a school bus, on school property, or at a school-sponsored activity; (ii) any conduct involving alcohol, marijuana, a controlled substance, imitation controlled substance, or an anabolic steroid on a school bus, on school property, or at a school-sponsored activity; (iii) any threats against school personnel while on a school bus, on school property or at a school-sponsored activity; or (iv) the illegal carrying of a firearm onto school property.

Note: Please see Appendix A for complete excerpt of *Code of Virginia*, § 22.1-280.1.

Violent incidents that are included in *Code of Virginia*, § 22.1-280.1, are listed and defined below:

- ◆ **Fighting.** A mutual physical confrontation between two (or more) individuals. The confrontation may result in physical injury. Fighting can be classified as:
 1. Fighting: Resulting in *no injury*.

Any fight involving two or more individual in which no individual sustains serious or minor injuries.
 2. Fighting: Resulting in *minor injury*.

Any fight involving two or more individuals in which one or more individual sustains a minor injury. Minor injuries do not required professional medical attention. Minor injuries may include, but not be limited to: (a) scrape on body (e.g., knee, elbow, hand) and (b) minor bruising.
 3. Fighting: Resulting in *serious injury*.

Any fight involving two or more individuals in which one or more individual sustains an injury requiring professional medical attention. Serious injury may include, but not be limited to, the following: (a) a bullet wound, (b) fractured or broken bones, (c) concussion, (d) cuts requiring stitches, and (e) any injuries with profuse or excessive bleeding.
- ◆ **Homicide.** Any death resulting from causes other than natural, accidental, or suicide.
- ◆ **Physical Assault.** For the purposes of this manual, physical assault means an unlawful beating, victim and an offender can be clearly identified, and a minor or serious injury results.
- ◆ **Rape.** Sexual penetration (e.g., oral, anal, or vaginal) without consent. This category also includes statutory rape which, for the purposes of this manual, is defined as sexual penetration with or without the consent of a minor.

Documentation

Student Injury Report Form. During the 1996-97 school year, Henrico County Public Schools, Virginia, agreed to pilot a Student Injury Report Form (SIRF) in 54 schools. The pilot SIRF was developed by the Childhood Injury Prevention Program, Department of Pediatrics, Medical College of Virginia Hospitals at Virginia Commonwealth University based on one used in Arizona for five years. A SIRF was completed by school nurses and/or clinic attendants for each school injury seen or treated during the school day that occurred during a school activity and required parental notification.

Based on an analysis of the data and feedback from school nurses and clinic attendants, it was concluded that the SIRF documents valuable information about injuries occurring in the school environment that could be used to target prevention strategies, and that while thorough, some form changes were necessary to make its use less time-consuming.

The SIRF was subsequently revised to resemble one used statewide in Utah and, at the time of development of this manual, is being used in Henrico County Schools to document school injuries.

Please see Appendix E for a copy of the Henrico County Schools Student Injury Report Form.

NATIONAL INJURY AND VIOLENCE INFORMATION RESOURCE LIST

- ◆ U.S. Department of Education: Keeping Schools and Communities Safe
Web site: <http://www.ed.gov/offices/OESE/SDFS/safeschools.html>

Note: The following USDOE publications are available online:
Early Warning, Timely Response: A Guide to Safe Schools
<http://www.ed.gov/offices/OSERS/OSEP/earlywrn.html>

Preventing Youth Hate Crime
<http://www.ed.gov/pubs/HateCrime/start.html>

Creating Safe and Drug-Free Schools: An Action Guide
<http://www.ed.gov/offices/OESE/SDFS/actguid/index.html>

Conflict Resolution Education
<http://www.ncjrs.org/txtfiles/160935.txt>

School Uniform Manual
<http://www.ed.gov/updates/uniforms.html>

American Association of School Administrators/Safe Schools Planning
1801 North Moore Street
Arlington, VA 22209
Telephone: (703) 528-0700
Web site: <http://www.aasa.org/SA/feb9601.htm>

Note: The following AASA publication is available online at the above Web site:
The Art of Safe School Planning: 40 Ways to Manage and Control Student Disruptions
- ◆ Center for Effective Collaboration and Practice
1000 Thomas Jefferson St., NW
Suite 400
Washington, D.C. 20007
Telephone: 1-888-457-1551
Web site: <http://www.air-dc.org/cecp/>
- ◆ Center for the Prevention of School Violence
20 Enterprise Street, Suite 2
Raleigh, NC 27607-7375
Telephone: (800) 299-6054
Web site: <http://www2.ncsu.edu/ncsu/cep/PreViolence/index.html>
- ◆ Center for the Study and Prevention of Violence
Institute of Behavioral Science
University of Colorado at Boulder
Campus Box 442
Boulder, CO 80309-0442
Telephone: (303) 492-8465
Web site: <http://www.colorado.edu/cspv/>
- ◆ Center for Mental Health in Schools
School Mental Health Project
Department of Psychology
UCLA
405 Hilgard Ave.
Los Angeles, CA 90095-1563
Telephone: (310) 825-3634
Web site: <http://smhp.psych.ucla.edu/>
- ◆ Educational Resources Information Center, U.S. Department of Education
P.O. Box 1398
Jessup, MD 20794-1398
Telephone: (877) 4-ED-PUBS
Web site: <http://oeri.ed.gov/pubs/edpubs.html>

- ◆ Children's Safety Network
National Injury and Violence
Prevention Resource Center
Education Development Center, Inc.
55 Chapel Street
Newton, MA 02458-1060
Telephone: (617) 969-7101, ext. 2207
Web site: <http://www.edc.org/HHD/csn/index.html>

- Note: The following CSN publication
is available online:

*Injuries in the School Environment: A
Resource Guide* (2nd Edition, 1997)
<http://www.edc.org/HHD/csn/schoolinj/cov.html>

- ◆ National Alliance for Safe Schools
P.O. Box 1068
College Park, M.D. 20741
Telephone: (301) 935-6063
Web site: <http://www.safeschools.org/>

- ◆ National Association of Attorneys
General and National School Boards
Association "Keep Schools Safe"
Web site: <http://www.keepschools.safe.org/>

- Note: The above Web site includes the
following online NAAG/NSBA
resources:
Crisis Management
Student Participation
Parent Participation
Law Enforcement Partnership
Environmental Design
Drug and Alcohol Prevention
Crime Reporting/Tracking
School Security
Training for School Personnel
Concise Discipline Code

- ◆ National Center for Conflict Resolution
Education
110 W. Main Street
Urbana, IL 61801
Telephone: (800) 308-9419
Web site: <http://www.nccre.org/>

- ◆ National Program for Playground
Safety
School of HPELS
University of Northern Iowa
Cedar Falls, IA 50614-0618
Telephone: (800) 554-PLAY (7529)
Web site: <http://www.uni.edu/playground/>

- ◆ National Resource Center for Safe
Schools
Northwest Regional Educational
Laboratory
101 SW Main, Suite 500
Portland, OR 97204
Telephone (503) 275-9500
Web site: <http://www.nwrel.org/safe/index.html>

- ◆ National SAFE KIDS Campaign
1301 Pennsylvania Ave, NW
Suite 1000
Washington, D.C. 20004-1707
Telephone: 202-662-0600
Web site: <http://www.safekids.org>

- ◆ Safe & Drug-Free Schools Program
U.S. Department of Education
Telephone: 202-260-2812.
Web site: <http://www.ed.gov/offices/OESE/SDFS/>

**NATIONAL INJURY AND VIOLENCE INFORMATION RESOURCE LIST
(continuation)**

- ◆ Office of Juvenile Justice and Delinquency Prevention: School Violence Resources
810 Seventh Street, NW
Washington, D.C. 20531
Telephone: (202) 307-5911
Web site:
<http://ojjdp.ncjrs.org/hlights/svresources.html>

Note: The following publications are available online at the above OJJDP

Web site:

An Overview of Strategies to Reduce School Violence
The Art of Safe School Planning: 40 Ways to Manage and Control Student Disruption
Combating Fear and Restoring Safety in Schools
Combating Violence and Delinquency: The National Juvenile Justice Action Plan
Conflict Resolution Education: A Guide to Implementing Programs in Schools, Youth-Serving Organizations, and Community and Juvenile Justice Settings
Crime in the Schools: A Problem Solving Approach
Early Warning, Timely Response: A Guide to Safe Schools
Preventing Violence in Schools
Promising Strategies to Reduce Gun Violence
Strategies to Reduce Gun Violence
Violence Among Middle School and High School Students: Analysis and Implications for Prevention
- ◆ National School Safety Center
141 Duesenberg Drive, Suite 11
Westlake Village, CA 91362
Telephone: 805-373-9977
Web site: <http://www.nssc1.org/>

Note: The following NSSC resources are available online:
Checklist for Characteristics of Violent Youth
<http://www.nssc1.org/reporter/checklist.htm>

School Associated Violent Deaths Report
<http://www.nssc1.org/savd/savd.htm>

◆ RISK WATCH™ Curriculum
National Fire Protection Association
1 Batterymarch Park
Quincy, MA 02269-9101 USA
Telephone: 1-800-344-3555
Web site: <http://catalog.nfpa.org/>

Note: Teaches facts, safety skills, and positive attitudes (preschool through grade 8).

◆ Partnerships for Preventing Violence
Harvard School of Public Health
718 Huntington Ave., 1st Floor
Boston, MA 02115
Telephone: (617) 432-0814

VIRGINIA INJURY AND VIOLENCE INFORMATION RESOURCE LIST

- ◆ Virginia Department of Education
School Safety Resource Center
P.O. Box 2120
Richmond, VA 23218-2120
Telephone: (804) 225-2928
Web site: <http://www.pen.k12.va.us/VDOE/Instruction/safety.html>

Note: The following DOE materials are available online:

School Safety Audit Guidelines
<http://www.pen.k12.va.us/go/VDOE/Instruction/schoolsafety/audit.html>

Checklist for the Safety and Security of Buildings and Grounds
<http://www.pen.k12.va.us/go/VDOE/Instruction/schoolsafety/checklis.html>

School Safety and Violence Prevention
<http://www.pen.k12.va.us/VDOE/News/violprev.html>
- ◆ Virginia Department of Education
Health, Physical Education and Driver Education
P.O. Box 2120
Richmond, VA 23218-2120
Telephone: (804) 225-3300
Web site: <http://www.pen.k12.va.us/VDOE/Instruction/PE/>
- ◆ Virginia Department of Criminal Justice Services
Crime Prevention Center
805 E. Broad Street, 10th Floor
Richmond, VA 23219
Telephone (804) 371-0863
Web site: <http://www.dcjs.state.va.us>
- ◆ Virginia Department of Health
Center for Injury and Violence Prevention
P.O. Box 2448
Richmond, VA 23218
Telephone: (804) 692-0104
Web site:
<http://www.vdh.state.va.us/fhs/injury/center.htm>
- ◆ American Red Cross: Richmond Chapter
PO Box 655
Richmond, VA, 23205-0655
Telephone: (804) 780-2250
- ◆ Curry School of Education at the University of Virginia
Youth Violence Project
405 Emmet Street
Charlottesville, VA 22903-2495
Telephone: (804) 924-7472
Web site:
<http://curry.edschool.virginia.edu/curry/centers/youthvio/>

Note: The following Curry information is online:

Preventing Gun Violence at School
<http://curry.edschool.virginia.edu/curry/centers/youthvio/latebreaking/news.html>

Tobacco

Authorization

Code of Virginia, Section 22.1-207, Physical and Health Education.

Excerpt: See Appendix A for *Code of Virginia, § 22.1-207.*

Recommendations

Centers for Disease Control and Prevention’s Guidelines For Preventing Tobacco Use and Addiction. The following guidelines, which are reprinted on the following pages, identify strategies most likely to be effective in preventing tobacco use and addiction among young people. The guidelines were developed by Centers for Disease Control and Prevention (CDC) staff in collaboration with experts from other federal agencies, state agencies, universities, voluntary organizations, and professional associations.

- ◆ Guidelines Report At-A-Glance—Summarizes benefits of preventing tobacco use, consequences of tobacco use, and data on tobacco use by teens; identifies key principles for effective policies and programs; and lists guidelines recommendations.
- ◆ How You Can Help—Identifies specific actions that parents, students, teachers, school administrators and board members, and everyone else who cares about the health of young people can take to help implement guidelines recommendations.
- ◆ Fact Sheet—Highlights statistics on tobacco use by young people; health effects of tobacco use by young people; nicotine addiction among adolescents; and tobacco sales and promotion to youth.

The above guidelines and complete report, *CDC’s Guidelines for School Health Programs Preventing Tobacco Use and Addiction*, are available on the web at <http://www.cdc.gov/nccdphp/dash/nutptua.htm>.

CDC's Guidelines for School Health Programs

Preventing Tobacco Use and Addiction

At-A-Glance

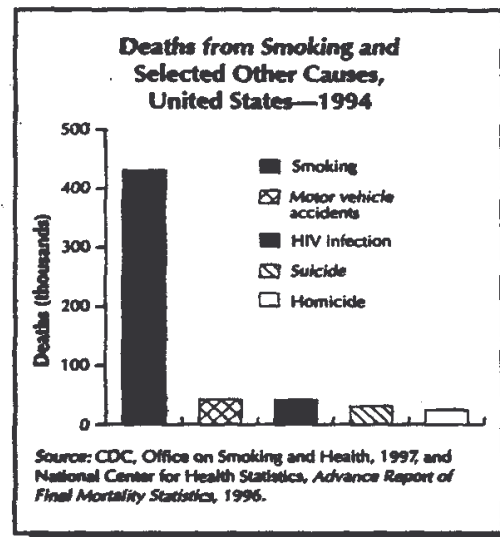
Each day, more than 3,000 young people across the United States become daily smokers. Most start this deadly habit not fully understanding that nicotine in tobacco is as addictive as heroin, cocaine, or alcohol. Most also underestimate the health consequences, even though tobacco use is the leading cause of preventable death in the United States. School programs to prevent tobacco use among young people can make a major contribution to the health of the nation, particularly when these programs are coordinated with community efforts.

BENEFITS OF PREVENTING TOBACCO USE AMONG YOUNG PEOPLE

- Helps prevent long-term health problems and premature death.
- Promotes optimal health and decreases school days missed because of respiratory illnesses.
- Dramatically decreases the likelihood that a young person will become a regular tobacco user as an adult.

CONSEQUENCES OF TOBACCO USE

- Tobacco use causes more premature deaths in the United States than any other preventable risk. Of all people less than 18 years old in 1995, an estimated 5 million will die prematurely from smoking-related illnesses.
- Cigarette smoking causes heart disease; stroke; chronic lung disease; and cancers of the lung, mouth, pharynx, esophagus, and bladder.
- Cigarette smoking increases coughs, shortness of breath, and respiratory illnesses; decreases physical fitness; and adversely affects blood cholesterol levels.
- Smokeless tobacco is not a safe alternative to cigarettes. Using it causes cancers of the mouth, pharynx, and esophagus; gum recession; and an increased risk for heart disease and stroke.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 Centers for Disease Control and Prevention
 National Center for Chronic Disease Prevention and Health Promotion
 June 1997



**TOBACCO USE
BY TEENS**

- Smoking cigars increases the risk of oral, laryngeal, esophageal, and lung cancers.
- Second-hand tobacco smoke can cause respiratory illnesses, increase the risk of lung cancer and heart disease, and trigger asthma attacks.
- Tobacco use causes stained teeth, bad breath, and foul-smelling hair and clothes.

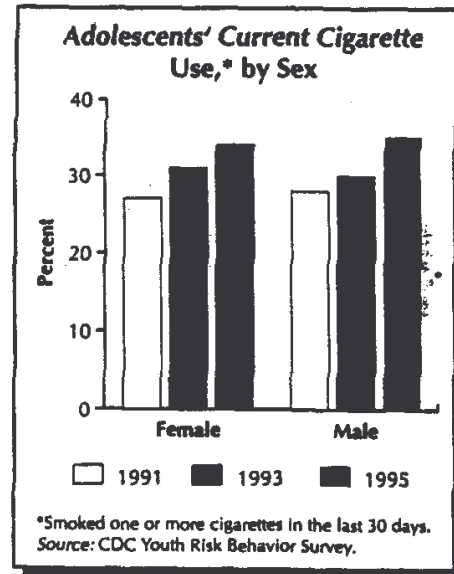
- The rate of teen smoking is rising: 35% of high school students were current smokers in 1995, compared with 28% in 1991.

- 71% of high school students have tried cigarettes.

- The younger people are when they start using tobacco, the more likely they are to become strongly addicted to nicotine.

- 89% of persons who ever smoked daily first tried a cigarette at or before age 18; 25% of high school students smoked a whole cigarette before age 13.

- 11% of high school students use smokeless (snuff or chewing) tobacco; 27% have smoked a cigar in the past year.



- 3 out of 4 teenage smokers have tried to quit at least once—but failed.

THE OPPORTUNITY

Well-designed, well-implemented school programs to prevent tobacco use and addiction

- Have proved effective in preventing tobacco use.
- Provide prevention education during the years when the risk of becoming addicted to tobacco is greatest.
- Provide a tobacco-free environment that establishes nonuse of tobacco as a norm and offers opportunities for positive role modeling.
- Can help prevent the use of other drugs, especially if the program addresses the use of these substances.

Preventing Tobacco Use and Addiction Among Young People

How You Can Help

Everyone can play a part in helping young people avoid using tobacco products. If you are a parent or guardian, student, teacher, athletic coach, school administrator or board member, health professional, or anyone else who cares about the health of young people, here are some steps you can take to make a difference in their lives.

Everyone Can

- ✓ Teach young people that using cigarettes and smokeless tobacco (snuff or chew) puts them at risk for health problems and addiction.
- ✓ Ask merchants and managers of hotels and restaurants to locate vending machines where they will not be accessible to young people.
- ✓ Voice your support for tobacco-free schools and effective tobacco-use prevention education to school administrators and board members.
- ✓ Speak at a meeting or submit a letter to a local newspaper to discuss the importance of clean indoor air restrictions and policies that limit young people's access to tobacco products.
- ✓ Encourage merchants to limit the number of tobacco ads in their stores, remove self-service displays, and comply with the law by checking IDs and refusing to sell tobacco products to minors.
- ✓ Encourage coordination between school and community programs to prevent tobacco use and addiction.

Parents or Guardians Can

- ✓ Set a good example by not using tobacco and give clear, consistent messages about the dangers of tobacco to your children.
- ✓ Help your children critically analyze messages that glamorize tobacco use on television, in movies, and in magazines and other print media.
- ✓ Provide your children with a tobacco-free environment at home.
- ✓ Join a school health committee and guide policies to prevent tobacco use.
- ✓ Support comprehensive school health programs and insist that they include tobacco-use prevention education.
- ✓ Volunteer to help school staff implement tobacco-use prevention activities.
- ✓ Help your children who use tobacco set realistic goals for stopping and give them positive reinforcement and encouragement.
- ✓ Work with the school board to provide assistance programs, rather than punishment, for students who violate tobacco-use policies.
- ✓ Help your children who use tobacco identify the underlying reasons for its use and substitute positive activities such as physical activity or stress management to compensate.
- ✓ Share tobacco-use prevention information with your children and talk with them about related homework assignments and projects.

Students Can

- ✓ Teach peers and younger students about the importance of not using tobacco.
- ✓ Ask for and support tobacco-free schools and communities.
- ✓ Encourage the school to ban ads for tobacco products from student publications and events.
- ✓ Take elective courses in health.
- ✓ Volunteer to help in community efforts to prevent tobacco use.
- ✓ Suggest that the school paper print a story about tobacco advertising and promotion campaigns aimed at young people.

Teachers Can

- ✓ Set a good example by not using tobacco.
- ✓ Use curricula and teaching methods that meet the criteria in CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*.
- ✓ Work with other school staff to coordinate tobacco-use prevention efforts and give students consistent, reinforced messages.
- ✓ Teach tobacco-use prevention issues in a variety of classes, such as science, history, and English.
- ✓ Encourage and support the efforts of students and school staff to quit using tobacco.
- ✓ Prohibit tobacco use by students participating in sports and stress the adverse effects of tobacco on sports performance.
- ✓ Involve families and community organizations in tobacco-use prevention activities.
- ✓ Find and use national, state, and local resources for tobacco-use prevention education.
- ✓ Participate in tobacco-use prevention training and share experiences with other teachers.
- ✓ Evaluate tobacco-use prevention activities and student progress.

School Administrators and Board Members Can

- ✓ Organize a school health committee that includes all key groups and has a mandate to develop tobacco-use prevention policies and programs based on the CDC guidelines.
- ✓ Enact and enforce policies that require school facilities, grounds, and events to be tobacco free.
- ✓ Communicate tobacco-use prevention policies to staff, students, parents, and the community.
- ✓ Require tobacco-use prevention education for students in grades K-12.
- ✓ Encourage the establishment of tobacco cessation programs for students and staff.
- ✓ Involve teachers and other staff, families, and community members in key decisions about tobacco-use prevention programs.
- ✓ Hire teachers with preservice training in preventing tobacco use and provide ongoing in-service training that focuses on teaching strategies for promoting healthy behaviors.
- ✓ Encourage activities to evaluate the effectiveness of programs to prevent tobacco use.

*For more information about what you can do to prevent tobacco use among young people, please see the Centers for Disease Control and Prevention's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*. This document is available from CDC, Division of Adolescent and School Health, ATTN: Resource Room, 4770 Buford Highway, Mailstop K-32, Atlanta, GA 30341-3724; phone: (770) 488-3082; website: <http://www.cdc.gov/nccdphp/dash>.*

June 1997.

CDC's Guidelines for School Programs to Prevent Tobacco Use

CDC's Guidelines for School Health Programs to Prevent Tobacco Use and Addiction were designed to help achieve national health and education goals. They were developed in collaboration with experts from 29 national, federal, and voluntary agencies and are based on an extensive review of research and practice.

KEY PRINCIPLES

School programs to prevent tobacco use and addiction will be most effective if they

- Prohibit tobacco use at all school facilities and events.
- Encourage and help students and staff to quit using tobacco.
- Provide developmentally appropriate instruction in grades K–12 that addresses the social and psychological causes of tobacco use.
- Are part of a coordinated school health program through which teachers, students, families, administrators, and community leaders deliver consistent messages about tobacco use.
- Are reinforced by community-wide efforts to prevent tobacco use and addiction.

RECOMMENDATIONS

1 Policy

The guidelines include seven recommendations for ensuring a quality school program to prevent tobacco use.

Develop and enforce a school policy on tobacco use. The policy—developed in collaboration with students, parents, school staff, health professionals, and school boards—should

- Prohibit students, staff, and visitors from using tobacco on school premises, in school vehicles, and at school functions.
- Prohibit tobacco advertising (e.g., on signs, T-shirts, or caps or through sponsorship of school events) in school buildings, at school functions, and in school publications.
- Require that all students receive instruction on avoiding tobacco use.
- Provide access and referral to cessation programs for students and staff.
- Help students who violate smoking policies to quit smoking rather than just punishing them.

2 Instruction

Provide instruction about the short- and long-term negative physiologic and social consequences of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills. This instruction should

- Decrease the social acceptability of tobacco use and show that most young people do not smoke.
- Help students understand why young people start to use tobacco and identify more positive activities to meet their goals.

- Develop students' skills in assertiveness, goal setting, problem solving, and resisting pressure from the media and peers to use tobacco.

Programs that only discuss tobacco's harmful effects or attempt to instill fear do not prevent tobacco use.

3 Curriculum

Provide tobacco-use prevention education in grades K-12.

- This instruction should be introduced in elementary school and intensified in middle/junior high school, when students are exposed to older students who typically use tobacco at higher rates.
- Reinforcement throughout high school is essential to ensure that successes in preventing tobacco use do not dissipate over time.

4 Training

Provide program-specific training for teachers. The training should include reviewing the curriculum, modeling instructional activities, and providing opportunities to practice implementing the lessons. Well-trained peer leaders can be an important adjunct to teacher-led instruction.

5 Family Involvement

Involve parents or families in support of school-based programs to prevent tobacco use. Schools should

- Promote discussions at home about tobacco use by assigning homework and projects that involve families.
- Encourage parents to participate in community efforts to prevent tobacco use and addiction.

6 Tobacco Cessation Efforts

Support cessation efforts among students and school staff who use tobacco. Schools should provide access to cessation programs that help students and staff stop using tobacco rather than punishing them for violating tobacco-use policies.

7 Evaluation

Assess the tobacco-use prevention program at regular intervals. Schools can use CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* to assess whether they are providing effective policies, curricula, training, and cessation programs.

This brochure and the complete text of CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* can be reproduced and adapted without permission. The guidelines and this brochure are on the Internet at <http://www.cdc.gov/nccdphp/dash>. (Click on "Strategies" and then select "School Health Programs.") Print copies are available from: CDC, Division of Adolescent and School Health, ATTN: Resource Room, 4770 Buford Highway, Mailstop K-32, Atlanta, GA 30341-3724; phone: (770) 488-3082. CDC's Division of Adolescent and School Health also distributes guidelines for school health programs to prevent the spread of AIDS, to promote healthy eating, and to promote physical activity.

Tobacco and the Health of Young People

Fact Sheet

TOBACCO USE BY YOUNG PEOPLE

- Each day, approximately 6,000 young people try a cigarette, and 3,000 become daily smokers.¹ If current tobacco use patterns persist, an estimated 5 million people who were younger than 18 years old in 1995 will die prematurely from a smoking-related illness.²
- The proportion of high school students who smoke increased from 28% in 1991³ to 35% in 1995.⁴ In 1995, 16% of high school students were frequent smokers (i.e., had smoked cigarettes on 20 or more of the 30 preceding days).⁴
- Non-Hispanic white high school students are about twice as likely to smoke cigarettes as non-Hispanic black students (38% vs. 19%). However, the prevalence of smoking among non-Hispanic black male high school students doubled from 14% in 1991 to 28% in 1995.⁴
- Among people who have ever smoked daily, 89% tried their first cigarette and 71% began smoking daily before age 19. The average age at which smokers try their first cigarette is 14 ½ years; 25% of high school students smoked a whole cigarette before age 13.⁵
- More than 11% of high school students (20% of males and 2% of females) use smokeless tobacco.⁴ In some states, more than 1 of every 3 male high school students use smokeless tobacco.⁶
- Among high school seniors who use smokeless tobacco, almost 75% began before the 9th grade. Adolescents who use smokeless tobacco are more likely than nonusers to become cigarette smokers.⁵
- 27% of high school students report having smoked a cigar in the past year.⁷

HEALTH EFFECTS OF TOBACCO USE BY YOUNG PEOPLE

- Cigarette smoking causes heart disease; stroke; chronic lung disease; and cancers of the lung, mouth, pharynx, esophagus, and bladder.⁵
- Cigarette smoking by young people leads to serious health problems, including cough and phlegm production, an increase in the number and severity of respiratory illnesses, decreased physical fitness, adverse changes in blood cholesterol levels, and reduced rates of lung growth and function.⁵
- Use of smokeless tobacco causes cancers of the mouth, pharynx, and esophagus; gum recession; and an increased risk for heart disease and stroke.⁵
- Smoking cigars increases the risk of oral, laryngeal, esophageal, and lung cancers.⁷



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
June 1997



NICOTINE ADDICTION AMONG ADOLESCENTS

- Several studies have found nicotine to be addictive in ways similar to heroin, cocaine, and alcohol. Because the typical tobacco user receives daily and repeated doses of nicotine, addiction is more common among tobacco users than among other drug users. Of all addictive behaviors, cigarette smoking is the one most likely to become established during adolescence.³
- 84% of smokers aged 12–17 consider themselves addicted. The younger people are when they start to smoke cigarettes, the more likely they are to become strongly addicted to nicotine.⁵
- Young people who try to quit smoking suffer the same nicotine withdrawal symptoms as adults who try to quit.⁵
- About 2 out of 3 teenage smokers say they want to quit;⁵ 3 out of 4 teenage smokers have made at least one serious attempt to quit smoking;⁹ and 70% say that if they could choose again, they would never start smoking.⁸
- Only 5% of high school seniors who smoke daily think they will be smoking in 5 years—but almost 75% of them are still smokers 5 years later.¹⁰

TOBACCO SALES AND PROMOTION TO YOUTH

- All states have laws making it illegal to sell cigarettes to anyone under the age of 18, yet 39% of high school students younger than 18 who smoke say they usually buy cigarettes in a store.⁴
- Among high school students younger than age 18 who smoke, 78% report not being asked for proof of age when they buy cigarettes in a store.⁴
- The tobacco industry generated about \$190 million in profit from the illegal sale of cigarettes to minors in 1991. In that year, teenagers smoked an average of 28.3 million cigarettes per day.¹¹
- About 86% of adolescent smokers who bought their own cigarettes in 1993 bought Marlboro, Camel, or Newport—the 3 most heavily advertised brands. However, these brands accounted for only 32% of all cigarettes sold that year.¹²
- In a 1991 survey, 30% of 3-year-olds and 91% of 6-year-olds recognized the Joe Camel character (the same recognition level for Mickey Mouse) and linked him to cigarettes.¹³

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12. Centers for Disease Control and Prevention. Changes in the cigarette brand preferences of adolescent smokers—United States, 1989–1993. *Morbidity and Mortality Weekly Report* 1994;43:577–81.
13. Fischer PM et al. Brand logo recognition by children aged 3 to 6 years. *JAMA* 1991;266:3145–8.

Resources

For more information, contact the following:

Virginia Department of Health
Division of Chronic Disease Prevention and Nutrition
Tobacco Use Control Programs
P.O. Box 2448
Richmond, VA 23218
Telephone: (804) 692-0005
Web site: <http://www.vdh.state.va.us/fhs/chronic/tobacco/Tobacco.htm>

Alcohol and Other Drugs

Authorization

Code of Virginia, Section 22.1-207, Physical and Health Education.

Excerpt: see Appendix A for *Code of Virginia* § 22.1-207.

Code of Virginia, Sections 22.1-16, Bylaws and Regulations Generally, and 22.1-206, Instructions Concerning Drugs and Drug Abuse.

See Appendix A for *Code of Virginia* § 22.1-16 and § 22.1-206.

Regulations of the Virginia Board of Education. *Rules Governing Instructions Concerning Drugs and Substance Abuse, 8 VAC 20-310-10. Health education program.*

Excerpt:

The Board of Education recognizes that the illegal and inappropriate use of certain substances constitutes a hazard to the development of students. Elementary and secondary schools shall include in the health education program instruction in drugs and abuse.

Therefore, the public schools of the Commonwealth shall:

1. Be concerned with education and prevention in all areas of substance use and abuse.
2. Establish and maintain a realistic, meaningful substance abuse prevention and education program that shall be developed and incorporated in the total education program.
3. Establish and maintain an ongoing in-service substance abuse prevention program for all school personnel.
4. Cooperate with government and approved private agencies involved with health of students relating to the abuse of substances.
5. Encourage and support pupil-run organizations and activities that will develop a positive peer influence in the area of substance abuse.
6. Create a climate whereby students may seek and receive counseling about substance abuse and related problems without fear of reprisal.

Resources

- ◆ *Virginia Safe and Drug-Free Schools and Communities Programs*

*Virginia Department of Education
Office of Compensatory Programs
P.O. Box 2120
Richmond, VA 23218-2121
Telephone: (804) 225-2871.*

For publications, training opportunities, and technical assistance related to Safe and Drug-Free Schools and Communities Programs.

◆ *Virginia Community Services Boards*

Community Services Boards (CSBs) throughout Virginia engage in Community-Based Prevention Planning, which involves identification of community risk and protective factors and of community resources. The Department of Mental Health, Mental Retardation, and Substance Abuse Services maintains a current list of community service boards. (Telephone 804-786-3921)

◆ *Virginia Offices on Youth*

Offices on Youth are locally run commissions that provide a variety of prevention and early intervention services. Many have conducted community needs assessments and are likely to have gathered data valuable for planning Safe and Drug-Free Schools and Communities Programs. The Department of Juvenile Justice maintains a current list of offices on youth. (Telephone 804-371-0700)

Local Advisory Council Primer¹¹⁸

The Primer was developed to assist local Safe and Drug-Free School and Communities Act (SDFSCA) Advisory Council members in understanding the requirements of SDFSCA, the nature and scope of local Advisory Council responsibilities, Principles of Effectiveness that govern such programs, and what prevention research report what is and what is not effective. Included in the Primer are key Virginia and national resources.

¹¹⁸ Atkinson, A.J. and Travis, R.H. (November 1998). Local Advisory Council Primer. Harrisonburg, VA: Virginia Effective Practice Project.

*To order the Primer contact:
Virginia Effective Practices Project (VEPP)
Office of Substance Abuse Research
MSC 4004
James Madison University
Harrisonburg, VA 22807
Telephone: (540) 568-2736
Web site: <http://www.jmu.edu/cisat/seep/>*

- ◆ *Chart on Commonly Used and Abused Drugs
The following table includes commonly used and abused drugs with their street names, how they are taken, and effects and health hazards.*

Commonly Used and Abused Drugs ¹¹⁹

Major Classification	Drug	Street name	How it is taken	Effects	Health Hazards
Stimulants	Cocaine/Crack	Coke, flake, girl, blow, nose candy, C, rock, lady	Inhaled through nose, injected, smoked	Increased heart and respiratory rates, raised blood pressure, dilated pupils, decreased appetite, increased alertness, sweating, headache, shakiness, blurred vision, sleeplessness, dizziness, moodiness, restlessness, anxiety, runny nose (if inhaled)	<ul style="list-style-type: none"> ◆ If inhaled, may cause ulcers in nasal passages. ◆ Extremely high doses can cause rapid or irregular heartbeat, tremors, loss of coordination or physical collapse (stroke, heart failure). ◆ Using large amounts over a long time cause psychosis (hallucinations, delusions, paranoia). ◆ Can cause psychological and physical dependency; tolerance develops rapidly. ◆ If injected with shared needles, user may contract AIDS or other diseases.
	Amphetamines (e.g., Dexedrine, Benzedrine)	Dexies, speed, uppers, bennies, black beauties, pep pills, copilots, Christmas trees, ice	Taken orally, injected, inhaled through nose		
	Caffeine	Tea, cola, cocoa, coffee	Taken orally		
	Nicotine	Butts, squares, coffin nail	Smoked, chewed		
Depressants	Alcohol	Booze, fire water, juice, oils	Taken orally	Relaxation, slurred speech, staggering gait, altered perception, slowing down of reflexes and mental processes, calmness	<ul style="list-style-type: none"> ◆ Very large doses can cause respiratory depression, coma, and death. ◆ Combining alcohol and other depressants can multiply the effects and the risks. ◆ Can cause psychological and physical dependence; tolerance can develop. ◆ Withdrawal symptoms range from restlessness, insomnia, and anxiety to convulsions and death.
	Barbiturates (e.g., Amytal, Seconal)	Downers, barbs, blue or red devils, yellow jackets	Taken orally		
	Methaqualone (e.g., Quaaludes)	Ludes, sopors	Taken orally		
	Tranquilizers (e.g., Valium, Librium)	Muscle relaxers, sleeping pills, goof balls	Taken orally		
Narcotics	Heroin	Smack, horse, H, junk, stuff	Injected, smoked, Inhaled through nose	Euphoria, relief from pain, contentment, drowsiness, nausea, constricted pupils, watery eyes, itching	<ul style="list-style-type: none"> ◆ An overdose may produce stow and shallow breathing, clammy skin convulsions, coma ◆ Can cause psychological and physical dependency; tolerance develops rapidly. ◆ If injected with shared needle, user may contract AIDS or other diseases.
	Morphine	Dreamer, M, Emma	Injected, smoked, taken orally		
	Methadone	Dollies	Injected, taken orally		
	Opium	Dope, monkey	Smoked, eaten		
	Codeine	Syrup, schoolboy	Taken orally, injected		
Cannabis sativa	Marijuana	Pot, grass, weed, reefer, Mary Jane, joint, gold, Thai sticks	Eaten, smoked	Relaxation, sleepiness, impairment of short-term memory and comprehension, altered sense of time, poor concentration and coordination, anxiety, confusion, distortion of perception, red eyes, increased heart rate, increased appetite.	<ul style="list-style-type: none"> ◆ Smoke is damaging to lungs. ◆ May cause psychological dependence. ◆ Can produce paranoia and psychosis. ◆ May damage liver. ◆ May affect maturation or function of reproductive system.
	Tetrahydrccan nabnol	THC	Taken orally, smoked		
	Hashish	Hash	Eaten, smoked		
	Hashish Oil	Oil	Smoked (mixed with tobacco)		

¹¹⁹ Massachusetts Department of Public Health. (1995). *Comprehensive School Health Manual* (pp. 14-17). Boston, Mass.: Author.

Major Classification	Drug	Street name	How it is taken	Effects	Health Hazards
Hallucinogens	Lysergic Acid Diethylamide	LSD, acid, cubes, microdot, Big D	Licked off paper, taken orally, gelatin or liquid put in eyes	Pupil dilation, higher body temperature, increased heart rate and blood pressure, sweating, loss of appetite illusions and hallucinations, tremors, anxiety.	<ul style="list-style-type: none"> ◆ Effects are unpredictable. ◆ Flashbacks can occur even after use has ceased. ◆ Bad trips, which may lead to suicide. ◆ Heavy users may develop brain damage.
	Mescaline and Peyote	Mesc, buttons, cactus	Taken orally, chewed, smoked		
	Psilocybin	Magic mushrooms, 'shrooms	Chewed and swallowed		
Inhalants	Solvents, nitrous oxide, aerosol sprays, paint thinner, gasoline, nail polish, model glue, cleaning fluid	Laughing gas, whippets, poppers, snappers, rush, bolt, locker room, bullet, climax	Vapors Inhaled	Nausea, sneezing, coughing, nosebleeds, fatigue, lack of coordination, bad breath, loss of appetite, exhilaration, confusion, change in heart rate (some increase and others decrease).	<ul style="list-style-type: none"> ◆ Deeply inhaling vapors or using a lot in a short period may cause disorientation, violent behavior, unconsciousness, or death. ◆ Long-term use may cause weight loss, fatigue, electrolyte imbalance, muscle fatigue, and permanent damage to nervous system, liver, kidneys, blood, and bone marrow.
Anabolic Steroids	Steroids (e.g., Dianabol, Durabolin, Winstrol)	'Roids	Taken orally, injected	Quick weight and muscle gain, acne, aggressive and hostile behavior, jaundice, swelling of feet, or lower legs, trembling, persistent unpleasant breath odor, purple or red spots on the body.	<ul style="list-style-type: none"> ◆ Long-term use can damage the liver, cardiovascular system, and reproductive system. ◆ In individuals who have not reached full growth, can arrest bone growth. ◆ Users may develop changes in sexual characteristics that may be difficult or impossible to reverse. Males: abnormal hair growth, breast enlargement, shrunken testicles, sterility. Females: shrinkage of breasts, menstrual irregularities, growth of facial hair, enlargement of the clitoris.
Phencyclidine	PCP, Semyl, Semylan	PCP, peace pill, hog, killer weed, angel dust	Taken orally, injected, smoked (on tobacco, marijuana, or parsley)	Increased heart rate and blood pressure, sweating, dizziness, slowing of time and movements, dulling of senses, poor coordination, speech blocked or incoherent	<ul style="list-style-type: none"> ◆ Large amounts may cause death from convulsions, heart or lung failure, or ruptured blood vessels in the brain. ◆ May cause violent or bizarre behavior or paranoia. ◆ Regular use affects memory, perception, concentration and judgment. ◆ If injected with shared needle, user may contract AIDS or other diseases.

Early Sexual Activity

Authorization

Code of Virginia, Section 22.1-207, Physical and Health Education.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-207.

Code of Virginia, Section 22.1-207.1, Family Life Education.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-207.1.

Recommendation

Early sexual behavior may lead to teen pregnancy, sexually transmitted infections, and HIV infection/AIDS. At the present time, there are no national guidelines related to early sexual behavior for school and community health programs from the Centers for Disease Control and Prevention. However, other nonprofit national organizations have developed guidelines and suggested instructional procedures to address prevention of sexual behaviors that lead to teen pregnancy or sexually transmitted diseases or infections, including HIV infection. These organizations include but are not limited to the following:

NATIONAL ORGANIZATIONS

- ◆ Advocates for Youth Advocates for Children and Youth
1025 Vermont Avenue, NW, Suite 200
Washington, D.C.
Telephone: (202) 347-5700
E-mail: info@advocatesforyouth.org
Web site: <http://www.advocatesforyouth.org/>
- ◆ American Red Cross
Contact your local chapter of the American Red Cross.
To find your local American Red Cross:
Telephone: 1-800-667-2968
E-mail: internet@usa.redcross.org
Web search: <http://www.crossnet.org/where/where> or call the number below.
Telephone 1-800-MOSBY-n-U (1-800-667-2968)
- ◆ American School Health Association
P.O. Box 708
Kent, OH 44240
Telephone: (330) 678-1601
E-mail: asha@ashaweb.org
Web site: <http://www.ashaweb.org/>

- ◆ Centers for Disease Control and Prevention
Guidelines for Effective School Health Education to Prevent the Spread of AIDS.
Web site: <http://www.cdc.gov/nccdphp/dash/aids.htm>
- ◆ March of Dimes
Birth Defects Foundation National Office
1275 Mamaroneck Avenue
White Plains, NY 10605
Telephone: 1-888-MODIMES (663-4637)
E-mail publiceducation@modimes.org.
- ◆ National Campaign to Prevent Teen Pregnancy
2100 M Street NW
Suite 300
Washington, D.C. 20037
Telephone: (202) 261-5655
Web site: <http://www.teenpregnancy.org>
- ◆ Institute for Youth Development
P.O. Box 16560
Washington, D.C. 20041
Telephone: (703) 471-8750
Web site: <http://www.youthdevelopment.org/>

STATE ORGANIZATIONS

- ◆ Abstinence Education Coordinator
Virginia Department of Health
Division of Child and Adolescent Health
P. O. Box 2448
Richmond, VA 23218-2448
Telephone: (804) 225-3697
- ◆ Teen Pregnancy Coordinator
Virginia Department of Health
Division of Child and Adolescent Health
P. O. Box 2448
Richmond, VA 23218-2448
Telephone: (804) 371-2409

LOCAL ORGANIZATIONS

- ◆ Contact the health educator at the local health department.

CHAPTER 5

Healthful Environment

This chapter presents general guidelines for use in planning and implementing a *healthful school environment*, a component of a school health program. It focuses on the physical environment, including related codes, standards, and recommendations for addressing the physical climate of the school.

In This Chapter

Healthful Environment

Building and Environmental Standards

- ◆ Safety and Security
- ◆ Hazard Communication
- ◆ School Food Service
- ◆ Indoor Air Quality
- ◆ Asbestos
- ◆ Radon
- ◆ Lead
- ◆ Underground Storage Tanks in Schools
- ◆ Pesticides
- ◆ Toxic Art Supplies

Laboratory, Industrial, and Vocational Hazards

- ◆ Facilities
- ◆ Ventilation
- ◆ Equipment and Supplies
- ◆ Storage and Handling of Toxic or Hazardous Materials.

Health and Safety Recommendations

- ◆ Playground Safety
- ◆ Toilets, Lavatories, Drinking Fountains, and Bathing Facilities
- ◆ Animals in School
- ◆ Lighting
- ◆ Swimming Pools/Therapy Pools
- ◆ School Maintenance and Sanitation
- ◆ Sewage Disposal
- ◆ Refuse Disposal
- ◆ Recycling

Informational

- ◆ Electromagnetic Fields
- ◆ Hazards From Video Display Terminals
- ◆ Photocopiers, Mimeograph, Equipment, and Other Machines
- ◆ X-Ray Machines

Healthful Environment

Authorization

The following governmental agencies are associated with the school health environment:

Virginia Department of Education. Within the Virginia Department of Education, School Nutritional Services, requires compliance with its regulations governing the operation of food service programs.

Virginia Department of Health. The Virginia Board of Health has established standards for food service establishments, which are administered by the local health department. The operation of a food service facility in a school requires a permit from the local health department. Its issuance is dependent on the facility meeting the requirements of the rules and regulations governing restaurants. These minimum standards cover all aspects of food sanitation, sources of food, food protection, health and cleanliness of personnel, design and construction, installation and cleanliness of equipment and utensils, water supply, plumbing and sewage disposal, toilet and hand-washing facilities, vermin control, garbage and rubbish handling and disposal, lighting and ventilation, dressing rooms, and housekeeping. A minimum of one inspection by the local health department per year is required.

Overview

Definition. Although a universally accepted definition of the term “healthful school environment” has not been adopted, *Health Is Academic: A Guide to Coordinated School Health Programs* presents the following definition:¹²⁰

***Healthy School Environment:** The physical, emotional, and social climate of the school. Designed to provide a safe physical plant, as well as a healthy and supportive environment that fosters learning.*

A safe and healthful school environment includes a safe physical plant, safe equipment, a safe school area, appropriate physical learning conditions, and an environment that meets privacy needs. Through a safe and healthful school environment, students and staff are protected from injury, disease, or adverse conditions that are associated with known risk factors. A positive school environment is considered key to healthy relationships in the school.

¹²⁰ Marx, E., and Wooley, S.F. (Eds.). (1998). *Health Is Academic: A Guide to Coordinated Health Programs* (p. 4). New York, N.Y.: Teachers College Press.

The following section provides an outline to begin an assessment of the school environment. When assessing the school environment, local, state, and federal codes, and appropriate standards should be reviewed, along with any applicable Superintendent's Memorandum issued by the Superintendent of Public Instruction. This section includes codes, standards, references, resources, and some assessment tools that may help in gathering information about a school's environment. The section is not comprehensive; however, it provides the tools necessary to begin the process.

Note. When appropriate, topic-specific resources are listed at the end of each of the following subsections. For additional information about school health environment policies, procedures, and related student/staff training, please contact the school division's maintenance and operation unit or contact the following state agencies:

- ◆ Virginia Department of Education
Facilities
P.O. Box 2120
Richmond, VA 23218-2120
Telephone: (804) 225-2035

- ◆ Virginia Department of Education
School Safety Resource Center
P.O. Box 2120
Richmond, VA 23218-2120
Telephone: (804) 225-2928
Web site: <http://www.pen.k12.va.us/VDOE/Instruction/safety.html>

- ◆ Virginia Department of Health
Office of Environmental Health Services
P. O. Box 2448
Richmond, VA 23218-2448
Telephone: (804) 786-1750
Web site: <http://www.vdh.state.va.us/oehs/03htm>

Building and Environmental Standards

Authorization

In Virginia, the responsibility for establishing and enforcing minimal building and environmental standards for school buildings is shared by two state agencies: the Virginia Board of Housing and Community Development and Virginia Department of Education. These departments depend on local health, fire, and building inspection staff to approve school facilities as being in conformance with applicable state codes and regulations.

Virginia Board of Housing and Community Development. The Virginia Board of Housing and Community Development is responsible for the *Uniform Statewide Building Code* explained in the *Code of Virginia*.

Virginia Department of Education. The Virginia Department of Education is responsible for ensuring that the building meets functional standards.

Fire Marshal. The local or state fire marshal establishes regulations requiring local inspections with regard to fire hazards. Local building inspectors are responsible for the local inspections and for approving school buildings within their municipality.

Building Requirements. The school plant and accessory buildings should be maintained in good repair and in a clean sanitary condition. In the absence of more stringent applicable construction codes or related standards, the most current edition of the *Virginia Uniform Statewide Building Code: Volume I New Construction Codes* should be used as a guideline for the construction or alteration of school buildings. (Note: For information on maintenance standards, see Volume II of the statewide building code. It is important to note that although these guidelines are voluntary, they may be adopted by the local school division.)

Subsections

The following subsections highlight building and environmental standards that may be of particular interest to schools.

- ◆ Safety and Security
- ◆ Hazard Communication Standards
- ◆ School Food Service
- ◆ Indoor Air Quality
- ◆ Asbestos
- ◆ Radon
- ◆ Lead
- ◆ Underground Storage Tanks in Schools
- ◆ Pesticides
- ◆ Toxic Art Supplies

Safety and Security

Authorization

Code of Virginia, Section 22.1-278.1, School Safety Audits Required.

Excerpt: See Appendix A for *Code of Virginia*, § 22.1-278.1.

Overview

As crime rates rise, an increasing number of school divisions are incorporating environmental crime prevention features in the design of new buildings. In addition, school divisions are trying to redesign existing architecture to reflect the principles of environmental crime prevention.

Traditionally, security concerns have been given a low priority in the building process. Until the late 1960s, when the federal government took an interest in crime prevention in urban housing, few serious attempts were made to develop a workable philosophy for controlling crime through architectural planning and design. In the early 1970s, several studies financed through the Law Enforcement Assistance Administration and the Department of Housing and Urban Development demonstrated that architectural design could be used effectively to influence crime rates in housing developments. These studies showed that by combining security hardware, psychology, and site design, a physical environment could be developed that would, by its very nature, discourage crime.

Crime Prevention Through Environmental Design. Crime Prevention Through Environmental Design,¹²¹ or CPTED (pronounced “sep-ted”), is a relatively new concept. CPTED creates a defensive environment both from a physical and a psychological aspect. The goal of CPTED is the reduction of opportunities for crime to occur. This reduction is achieved by employing physical design features that discourage crime, while at the same time encouraging legitimate use of the environment. The features include defensible space, surveillance, lighting, and landscaping, which offer protection without resorting to the prison camp approach to security.

School Safety Audit. The principles from CPTED have been incorporated into the “School Safety Audit” developed by the Virginia Department of Education.

¹²¹ Gardner, Robert A. CEPTED. *Security Management Magazine*. April 1981.

Implications

Every school should conduct a school safety audit every three years. For information on the audit procedure and checklists to complete the audit, refer to the following.

- ◆ Virginia Department of Education, School Safety Resource Center. (1997). *School Safety Audit: Protocol, Procedures and Checklists*. Richmond, Va.: Author.

Listed below are the minimum ten components that should be assessed in the audit process:¹²²

1. Safety and security of buildings and grounds.
2. Development and reinforcement of policies.
3. Procedures for data collection.
4. Development of intervention and prevention plans.
5. Level of staff development
6. Opportunities for student involvement.
7. Level of parent and community involvement.
8. Role of law enforcement.
9. Development of crisis management plans.
10. Standards for safety and security personnel.

Resources

For more information, contact the Virginia Department of Education, School Safety Resource Center, at (804) 225-2020 or (800) 292-3820.

¹²²Virginia Department of Education, School Safety Resource Center. (1997). *School Safety Audit: Protocol, Procedures and Checklists*. Richmond, Va.: Author.

Hazard Communication

Authorization

Virginia Occupational Safety and Health (VOSH) Standards for Hazard Communication, 1910.1200. The VOSH Standards for Hazard Communication requires employers to maintain and implement a written hazard communications policy if hazardous chemicals are used or stored. This standard was adopted from the Federal OSHA Standard (29 CFR part 1910) as Virginia Law.

Overview

The purpose of the hazard communications standards is to ensure that the hazards of all chemicals produced or imported are evaluated and that information concerning their hazards is transmitted to employers and employees so they can recognize the hazards of chemicals used and stored and undertake appropriate protective measures. Such chemicals may include, but are not limited to, those used in science laboratories and vocational educational centers.

Recommendation

1. Employers must provide a written hazard communications policy in each work site that includes:
 - ◆ A list of all hazardous chemicals used or stored in the workplace.
 - ◆ A description of how the employer will implement the requirements of the standard, including procedures for assuring the proper labeling of chemical containers, procedures for procuring and maintaining material safety data sheets, and procedures for providing training and information to employees.
 - ◆ A statement of policy about how employees will be trained concerning hazards of nonroutine tasks and hazards of chemicals in unlabeled pipes.
 - ◆ A statement about how outside employers who might work in the school will be informed of the presence and availability of material safety data sheets (MSDS), any precautions that might be necessary to protect their employees, and the labeling requirements of the school hazard communications policy. (Note: The outside employer has the same obligation toward the school.)
2. Employers must assure that there is an MSDS available for each chemical stored or used in the school and that it is readily available on site for use by all employees.

3. Employers must ensure that all containers of hazardous chemicals are properly labeled with a label that is in English, legible, and contains the appropriate information required by the standard.
 - ◆ Labels must indicate the identity of the chemical and the appropriate hazard warning. The identity of the chemical must be consistent with the identities provided on the list of hazardous chemicals and the MSDS.
 - ◆ For chemicals that pose a health hazard, the hazard warning must include the effect and target organ of the chemical (e.g., eye irritant or central nervous system depressant, or respiratory irritant, corrosive).
 - ◆ For chemicals that pose physical hazards, the hazard warning must indicate the nature of the hazards (e.g., flammable, explosive, corrosive).
 - ◆ Warnings may be by wording or by symbolic description. Symbolic or other means of providing this information on labels may be used if documented in written hazard communications program and if there is provision of adequate training and information so that employees can interpret them.
4. Employers must assure that employees are trained on the requirements of the hazard communication standard, provisions of the employer's written hazard communications policy, use and interpretation of MSDS, and the hazards of the chemicals to which they are or might be exposed.

Resources

For more information, contact the Virginia Department of Labor and Industry.

Web site: <http://www.dli.state.va.us/home.htm>

- ◆ Abington (540) 676-5465
- ◆ Fairfax (703) 359-1164
- ◆ Lynchburg (804) 385-0806
- ◆ Norfolk (757) 858-6700
- ◆ Richmond (804) 786-2377
- ◆ Roanoke (540) 562-3580
- ◆ Stuarts Draft (540) 337-3225

School Food Service

Authorization

Regulations. All food operations must be conducted in accordance with the requirements of the *Virginia Rules and Regulations Governing Restaurants*, which are promulgated by the Virginia Department of Health.

Health Department. The local health department provides oversight through periodic, unannounced inspections.

Overview

Food service operations in the schools of the Commonwealth must be carried out in a manner that will prevent the occurrence of food-borne illness, a major public health problem. The incidence of such illness can be reduced by using basic principles of food protection, suitable equipment, and sanitary food practices. Food may be prepared at the school or off-site and transported to the school.

Many foods are ideal media for the growth of microorganisms, including pathogenic bacteria. Contamination with pathogenic bacteria combined with mishandling or temperature abuse will result in infectious levels of bacteria or toxin production and subsequent foodborne illness outbreaks. Food sanitation is particularly important in a school food service program since the food is usually prepared to be served to a large number of students at one time, all of whom would be subject to illness if the food were not safe.

Guidelines for Food Service Personnel

Food Service Personnel. Food service personnel must be in good physical health and be free of symptoms of communicable diseases (see “List of Reportable Diseases” in Appendix A), open or infected cuts, burns, sores, or skin conditions that may contribute to the contamination of food. The food service manager should be able to recognize such conditions in the staff and exclude them from working in direct contact with food. (Note: A person with AIDS who does not have open or infected cuts, burns, or sores should not be excluded from working in a food service facility.)

Training. Training of food service personnel is not required but is offered by the local health department and local cooperative extension agencies.

Handwashing. Food service personnel must have clean hands at all times and should not wear rings. Hands must be washed with soap and hot running water after using the toilet,

coughing, sneezing, using a handkerchief, handling any object that may contaminate food, and between other operational functions and before returning to food preparation or handling functions.

Guidelines for Food Handling.

- ◆ Fingers should be kept out of the mouth and away from the hair, face, and nose.
- ◆ Workers must not eat or drink or use tobacco products in food areas.
- ◆ Plastic gloves are primarily suited for a continual food handling function. If used, workers must change them when switching from one operation to another. The use of gloves is not a substitute for proper hand washing.
- ◆ When food service workers change from a nonfood handling function to a food-handling function or from handling raw foods, they must still wash their hands before using gloves.
- ◆ Foodservice workers must also wear clean clothes and keep their hair secured with a hairnet, hat, or fastener.

Food Preparation and Storage

Ensuring Proper Food Temperature. Adequate equipment must be provided and maintained to ensure proper temperatures for food during storage, preparation, and service, as well as for the sanitation of dishware, tableware, and utensils. There must be a sufficient number of thermometers to monitor these temperatures constantly, and there must be test kits for monitoring the strength of the required sanitizing agents.

Food Transportation and Storage. If food is transported from one facility to another, adequate holding temperatures must be maintained at all times. Potentially hazardous foods must be either below 45°F or above 140° F at all times. The schools must have the facilities to maintain appropriate temperatures during storage, transportation, and service. It is important that the food and the food establishment be protected from contamination by insects and rodents, by the use of screens and other protective devices.

Indoor Air Quality

Authorization

Code of Virginia, Section 15.2-2801, Statewide Regulation of Smoking.

Excerpt: Statewide Regulation of Smoking prohibits smoking as follows:

...public school buses; the interior of any public elementary, intermediate, and secondary school; however, smoking may be allowed by a local school division in a designated area which is not a common area, including, but not limited to a classroom, library, hallway, restroom, cafeteria, gymnasium, or auditorium after regular school hours so long as all student activities in the building have been concluded...

See Appendix A for *Code of Virginia*, § 15.2-2801.

Overview

Most people are aware that outdoor air pollution can damage their health, but many do not know that indoor air pollution can also cause harm. Environmental Protection Agency (EPA) studies of human exposure to air pollutants indicate that indoor levels of pollutants may be 2 to 5 times, and occasionally more than 100 times, higher than outdoor levels. These levels of indoor air pollutants are of particular concern because it is estimated that most people spend about 90 percent of their time indoors. Comparative risk studies performed by EPA and its Science Advisory Board have consistently ranked indoor air pollution among the top four environmental risks to the public

Consequences of Indoor Air Problems. Failure to prevent indoor air problems, or failure to act promptly, can have such consequences as:

- ◆ Increasing the chances for long-term and short-term health problems for students and staff.
- ◆ Impacting the student learning environment, comfort, and attendance.
- ◆ Reducing productivity of teachers and staff due to discomfort, sickness, or absenteeism.
- ◆ Faster deterioration and reduced efficiency of the school physical plant and equipment.

- ◆ Increasing the chance that schools will have to be closed or occupants temporarily moved.
- ◆ Straining relationships among school administration and parents and staff.
- ◆ Creating negative publicity that could damage a school's or administration's image and effectiveness.
- ◆ Creating potential liability problems.

Indoor air problems can be subtle and do not always produce easily recognized impacts on health, well-being, or the physical plant. Children are especially susceptible to air pollution. For this and the reasons noted above, air quality in schools is of particular concern. Proper maintenance of indoor air is more than a quality issue—it includes safety and good management of our investment in the students, staff, and facilities.

Factors Affecting Indoor Air Quality (IAQ)

Over the past 40 or 50 years, exposure to indoor air pollutants has increased due to a variety of factors, including the construction of more tightly sealed buildings, reduced ventilation rates to save energy, the use of synthetic building materials and furnishings, and the use of chemically-formulated personal care products, pesticides, and housekeeping supplies. In addition, such decisions as delaying maintenance to save money can lead to problems from sources and ventilation. There are three factors that should be considered with respect to indoor air quality:

1. Temperature and humidity.
2. Sources of indoor air pollutants.
3. Airflow patterns.

Temperature and Humidity. Dry, hot air in winter removes moisture from skin and mucous membranes. In summer, hot and humid air prevents a person's body from cooling off—the body tends to react by overheating. Although specific temperatures are not mandated by regulation in Virginia, it is recommended that heating and cooling systems be properly maintained and capable of providing room temperatures recommended by the local school division.

Sources of Indoor Air Pollutants. Indoor air contaminants can begin within the building or be drawn in from outdoors. If pollutant sources are not controlled, IAQ problems can occur, even if the HVAC system is working properly. Air pollutants consist of numerous particles, fibers, mists, molds, bacteria, and gases. In addition to the number of potential pollutants, indoor air pollutant levels can vary within the school building or even a single classroom. Pollutants can also vary with time, such as only once each week when floor stripping is done, or be continuous, such as when fungi are

growing in the HVAC system. Four major factors, which are described in the following table, affect the quality of air in schools: (1) microbial contamination, (2) contaminated indoor air, (3) indoor chemical sources, and (4) ventilation.

Four Major Factors That Affect Air Quality in Schools

Factor	Description
Microbial Contamination	<ul style="list-style-type: none"> <li data-bbox="537 443 1425 562">◆ Microbial contamination in buildings can become a serious indoor air quality problem. Microbial contaminants—such as fungi, bacteria, viruses, and dust mites—can result in allergic or infectious diseases, and some microbial contaminants or agents can produce toxic substances. <li data-bbox="537 575 1425 730">◆ Microbial agents proliferate in warm, moist environments, often found in humidification systems, water-damaged buildings, furnishings and carpets, contaminated central air handling systems, improperly cleaned and maintained ventilation systems, and moist or wet areas where organic matter (such as paper, books, or dirt) is present. <li data-bbox="537 743 1425 1010">◆ Some biological contaminants trigger allergic reactions, including hypersensitivity pneumonitis, allergic rhinitis, and some types of asthma. Some transmit infectious illnesses, such as influenza, measles, and chicken pox. And some biologicals, such as certain molds and mildews, release disease-causing toxins. Symptoms of health problems caused by biological pollutants include sneezing, watery eyes, coughing, shortness of breath, dizziness, lethargy, fever, and digestive problems. The number of children with asthma has increased, and these children are particularly vulnerable to biological contaminants in the school. <li data-bbox="537 1022 1425 1178">◆ Carpets that have had water damage are a potential source of airborne contaminants. Shortly after installation, carpets become “dirty” with dead skin cells, food debris, dust, and tracked-in dirt that provides a good growth medium for fungi, spores of which are present everywhere. Moisture is a necessary ingredient for this fungal growth. <li data-bbox="537 1190 1425 1394">◆ If a wet carpet cannot be cleaned and dried within 12 to 24 hours, fungal growth will occur, releasing spores that in an indoor environment can reach airborne levels high enough to cause sensitivity and allergic reaction. It is also believed that even after the carpet dries out, the dead shells of the spores and fungus can cause allergic reaction. The most common health problems are asthma and respiratory congestion, of which a significant number of adults and an even higher number of children are susceptible. <li data-bbox="537 1407 1425 1686">◆ Routine cleaning of carpets is essential and includes daily vacuuming with an appropriate vacuum and regular shampooing with a nontoxic shampoo. Removal of water damaged wall-to-wall carpet is recommended. In-place cleaning is rarely successful because carpets do not dry completely. Removable carpets and rugs may be successfully cleaned if dried within 12 to 24 hours. Commercial cleaners who pick up rugs for cleaning are recommended. For those areas where moisture can be a periodic problem, smooth flooring is recommended. If carpeting is necessary, it should be readily removable (e.g., carpet tiles, throw rugs).

Four Major Factors That Affect Air Quality in Schools

Factor	Description
Contaminated Outdoor Air	<ul style="list-style-type: none"> ◆ At times the outside ambient air, particularly in urban areas, may be sufficiently contaminated to warrant treatment before it is delivered to occupied areas of the school building. As a result, air intake vents located close to or downwind from outdoor sources may cause building-related problems. Such outdoor sources of pollution as school bus and other loading areas, trash areas, oil fill areas, exhaust vents from rest rooms, street traffic, or parking lots are common.
Indoor Chemical Sources	<ul style="list-style-type: none"> ◆ Chemical sources in schools include building materials, furniture, carpets, paints, pesticides, cleaning agents, sewer gases, and combustion appliances. Such special activities as those occurring in science laboratories, photo labs, industrial/vocational shops, art and craft rooms, and duplicating devices can result in a buildup of harmful pollutants if they are not properly ventilated. ◆ If carpeting is used, it should be made of cotton or polypropylene. Nylon, orlon, wool, and silk produce toxic fumes when they become ignited. There is scientific controversy regarding the impact of carpets on indoor air quality, with the EPA concerned about emissions of volatile organic compounds (VOCs) from new carpets and related installation materials, such as carpet cushion and adhesives. Until the debate is resolved and a final determination is made by the appropriate authorities, schools purchasing and installing new carpeting should: <ol style="list-style-type: none"> 1. Talk to the carpet retailer/installer about the carpet industry's voluntary "green label." This label tells the consumer that the carpet type has been tested and passed voluntary emissions criteria. 2. Ask the retailer to unroll and air out the carpet in a well-ventilated area before installation. 3. Require low emitting adhesives if adhesives are needed. 4. Open doors and windows to increase the amount of fresh air into the building. 5. During and after installation, use window fans and room air-conditioners to exhaust fumes to the exterior. 6. Leave the building during and for several hours after carpet installation.
HVAC System	<ul style="list-style-type: none"> ◆ The heating, ventilation, and air-conditioning (HVAC) system includes all heating, cooling, and ventilating equipment serving a school. A properly designed and functioning HVAC system controls temperature and humidity to provide thermal comfort, distributes adequate amounts of outdoor air to meet ventilation needs of school occupants, and isolates and removes odors and pollutants through pressure control, filtration, and exhaust fans. ◆ Not all HVAC systems are designed to do all of these things. Some buildings rely only on natural ventilation. Others lack cooling, and many have little or no humidity control. ◆ Potential sources of pollutants from HVAC equipment include microbiological growth in drip pans, ductwork, coils, and humidifiers, improper venting of combustion products, and dust or debris in ductwork.

Pollutant Pathways and Driving Forces. Airflow patterns in buildings are caused by mechanical ventilation systems, human activity, and natural effects, such as wind. Air pressure differences created by these forces move airborne pollutants from areas of higher

pressure to areas of lower pressure through any available openings in building walls, ceilings, floors, doors, windows, and HVAC systems. An inflated balloon is an example of this driving force. As long as the opening to the balloon is kept shut, no air will flow, but when open, air will move from inside (area of higher pressure) to the outside (area of lower pressure). Even if the opening is small, air will move until the pressures inside and outside are equal.

Determining if There is an IAQ Problem

Diagnosing symptoms that relate to IAQ can be difficult. Acute (short-term) symptoms of IAQ problems typically are vague and similar to those from colds, allergies, fatigue, or influenza. There are clues, however, that can serve as indicators of potential indoor air problems:

- ◆ The symptoms are widespread within a class or within the school, potentially indicating a ventilation problem.
- ◆ The symptoms disappear when the students or staff leave the school building for the day.
- ◆ The onset is sudden after some change at school, such as painting or pesticide application.
- ◆ Persons with allergies, asthma, or chemical sensitivities have reactions indoors but not outdoors.
- ◆ A doctor has diagnosed a student or staff member as having an indoor air-related illness.

All of these symptoms, however, may also be caused by other factors and are not necessarily due to air quality problems. Such environmental stressors as improper lighting, noise, vibration, overcrowding, and psychosocial problems (such as job or home stress) can produce symptoms that are similar to those associated with poor air quality but require different solutions.

However, a lack of symptoms does not mean that the quality of the air within the school is acceptable. Symptoms from long-term health effects, such as lung cancer due to radon, often do not become evident for many years. For this reason, schools should establish a preventive indoor air program to minimize exposure of students and staff to indoor air pollutants.

Six Basic Control Strategies

There are six basic methods for lowering concentrations of indoor air pollutants. Specific applications of these methods are noted in the *Indoor Air Quality Tools for Schools*.¹²³

Source Management. Source management includes source removal, source substitution, and source encapsulation. Source management is the most effective control method when it can be practically applied. The best prevention method is never to bring unnecessary pollutants into the school building. Examples of source removal include not allowing buses to idle near outdoor air intakes, not placing garbage in rooms where HVAC system equipment is located, and banning smoking within the school. Source substitution includes such actions as selecting less toxic art material or interior paint than the products that are currently in use. Source encapsulation involves placing a barrier around the source so that it releases fewer pollutants into the indoor air.

Local Exhaust. Local exhaust is very effective in removing sources of pollutants before they can be dispersed into the indoor air, exhausting the contaminated air outside. Well-known examples include restrooms, kitchens, and science lab fume hoods. Other examples of pollutants that originate at specific points and that can be easily exhausted include science lab and housekeeping storage rooms, printing and duplicating rooms, and vocational/industrial areas, such as welding booths.

Ventilation. Mechanical or natural ventilation should be maintained to minimize health hazards, including excessive drafts, extreme temperature and humidity, and fluctuations in temperature. The American Society of Heating, Refrigeration and Air Conditioning Engineers' most recent edition of *Standard 62 Ventilation for Acceptable Indoor Air Quality* should be used as a guideline for proper indoor ventilation.

Some guidelines for proper ventilation are listed below.

- ◆ Ventilation system filters should be cleaned on a quarterly or 6 month schedule or replaced as needed to prevent excessive accumulation of dust or debris.
- ◆ Each room provided with an exhaust system should have fresh air supplied to the room equal to the amount discharged. Windows should not be used for the purpose of providing makeup air.
- ◆ Unvented combustion heaters, kitchen stoves, or hot plates should be prohibited for space heating purposes. Portable electric heaters with exposed elements should not be used in any student activity area. Hot plates, skillets, or similar cooking appliances should be used for food preparation only in kitchens, home economics rooms, or in rooms specifically designated and equipped for such use.

¹²³ U.S. Environmental Protection Agency. (1996). *Indoor Air Quality Tools for Schools*, Item number 055-000-00503-6. Washington, D.C.:U.S. Government Printing Office.

Exposure Control. Exposure control includes the principles of time of use and location of use. An example of time of use is to strip and wax the floor on Friday after school is dismissed, so that the floor products have a chance to release gases over the weekend, reducing the level of odors or contaminants in the air when the school is occupied. An example of location of use involves moving the contaminating source as far as possible from occupants or relocating susceptible occupants.

Air Cleaning. Air cleaning primarily involves the filtration of particles from the air as the air passes through the ventilation equipment. Gaseous contaminants can also be removed, but usually this type of system should be engineered on a case-by-case basis.

Education. Education of the school occupants is critical. If school staff are provided information about the sources and effects of contaminants under their control and about the proper operation of the ventilation system, they will better understand their indoor environment and can act to reduce their personal exposure.

Resources

For more detailed information, call (202) 512-1800 for “Indoor Air Quality Tools for Schools”, Item no. 055-000-00503-6.

Other information on IAQ is available by contacting the Regional EPA office or by calling (800) 438-4318.

Asbestos

Authorization

Asbestos Hazard Emergency Response Act. In 1986, the U.S. Congress passed the Asbestos Hazard Emergency Response Act (AHERA) to protect school children and school employees from exposure to asbestos in school buildings. The AHERA rule requires public school districts and private not-for-profit schools to inspect all school buildings for asbestos, to develop plans to manage asbestos in schools, and to carry out the rules in a timely fashion. Schools are required to inform parents and staff about the presence of asbestos in the school. A copy of the survey report must be available in each school identifying the location of asbestos containing materials in the school.

Asbestos Coordinator. In Virginia, the asbestos coordinator in each school division ensures that AHERA is properly carried out. The EPA sets standards for state accreditation of personnel involved in asbestos management or abatement in school buildings.

Asbestos Licensing and Lead Certification Board. Inspectors must be licensed by the Asbestos Licensing and Lead Certification Board within the Department of Professional and Occupational Regulation.

Overview

Description. Asbestos is a mineral found in certain types of rock formation. It takes the form of small fibers that are usually invisible to the naked eye. Because the fibers are so small and light, they can remain in the air for many hours if they are released from asbestos-containing material, increasing the danger of being inhaled.

Asbestos Containing Materials. EPA estimates there are asbestos-containing materials in many of the nation's approximately 107,000 primary and secondary schools. Asbestos has been used in thousands of products, particularly heat and electrical insulation. It has also been found in floor and ceiling tile, cement pipe, corrugated-paper pipe wrap, fireproofing, and other insulation.

Health Risk. Intact and undisturbed asbestos materials generally do not pose a health risk. However, asbestos fibers can cause serious health problems when, due to damage or deterioration over time (e.g., cracking, tearing, or crumbling), they release harmful fibers. If the fibers become airborne and are inhaled, they can cause cancer or lung disease. These diseases do not develop immediately after inhalation of asbestos fibers—it may be twenty years or more before symptoms become apparent. The more asbestos fibers a person inhales, the greater the risk is of developing an asbestos-related disease.

Resources

For more information, contact the Asbestos Coordinator in your local school division or the Director of Facilities at:

Virginia Department of Education
P.O. Box 2120
101 N. 14th Street
Richmond, VA 23218
Telephone: (804) 225-2035
Fax: (804) 225-2831.

Radon

Authorization

Code of Virginia, Section 22.1-138 B, Minimum Standards for Public School Buildings.

Excerpt: See Appendix A for *Code of Virginia*, §22.1-138 B.

Overview

Description. Radon is a naturally occurring gas that seeps into buildings from the surrounding soil. In some cases, well water may be a source of radon. A person cannot see, taste, or smell radon. In fact, the only way to discover if high levels of radon are present is through testing.

Risks Associated with Radon. Radon gas decays into radioactive particles that can be trapped in a person's lungs when a person breathes. As these particles break down, they release small bursts of energy. This can damage lung tissue and lead to lung cancer over the course of a person's lifetime. An individual's risk of getting lung cancer from radon depends mostly on three factors: (1) the level of radon, (2) the duration of exposure, and (3) their smoking habits.

EPA.¹²⁴ The U.S. Environmental Protection Agency (EPA) and other major national and international scientific organizations have concluded that radon is a human carcinogen and a serious environmental health problem. After smoking, it is the second leading cause of lung cancer in the United States, causing approximately 14,000 lung cancer deaths a year.

Early concern about indoor radon focused primarily on the hazard posed in the home. More recently, the EPA has conducted extensive research on the presence and measurement of radon in schools. Initial reports from some of those studies prompted the EPA in 1989 to recommend that schools nationwide be tested for the presence of radon. Based on more recent findings, EPA continues to advise U.S. schools to test for radon and to reduce levels to below 4 pCi/L.

¹²⁴ *Radon in Schools - Every School Should Take This Simple Test.* United States Environmental Protection Agency, Office of Air and Radiation (6604J). EPA Document #EPA-402-F-94-009.

Recommendation

School Testing for Radon. Testing for radon is simple and relatively inexpensive. The EPA has published guidance that is available free to schools throughout the country (see Resources below). The basic elements of testing are:

- ◆ Test all frequently used rooms on and below the ground level.
- ◆ Conduct tests in the cooler months of the year.

For more detailed information on school testing strategies, contact the Virginia Department of Health, Division of Radiological Health.

If a school does fail the radon test, the problem can be corrected. Proven techniques are available that will lower radon levels and lower risks of lung cancer from radon exposure. School is not the only place that students and teachers can be exposed to radon. Since children spend more time at home, high radon levels there can pose a much greater threat to their health.

Resources

For more information:

- ◆ Virginia Department of Health
Division of Health Hazards Control
Radiological Health Program
Telephone (804) 786-5932
- ◆ National Radon Information Line
1-800-SOS-RADON [1-800-767-7236]
- ◆ United States Environmental Protection Agency
Office of Air and Radiation
Radon-Specific Indoor Air Quality (IAQ) Publications
Web site: <http://www.epa.gov/iaq/radon/pubs/>
- ◆ *Radon in Schools* (Second Edition)
U.S. Environmental Protection Agency
Office of Air and Radiation (6604J)
EPA Document #EPA-402-F-94-009, October 1994
Note: To order, call Virginia Department of Health, Radiological Health Program, (804) 786-5932. Also, the publication is available online at:
<http://www.epa.gov/iaq/radon/pubs/schoolrn.html>

Lead

Authorization

No mandates for school inspections.

Overview

Risks. Lead in the school environment may pose a health threat to preschool-age children and renovation/remodeling workers. Once in the body, lead is very slow to leave the system. It can damage the brain and central nervous system of children, interfering permanently with their learning abilities and physical growth. Children under age 6 are at the most risk because their brain cells are still developing and even low levels of lead can interfere with normal brain development. Older children and adults can tolerate higher exposures to lead without harmful effects, but occupational exposures can exceed even these higher levels during renovation and remodeling of surfaces containing lead-based paint.

Sources of Lead. School officials should be concerned about the existence of lead in paint, dust, air, water, soil, and food. Some additional sources of lead are dust, such art activities as stained glass and pottery, and emissions from industrial processes.

Lead-Based Paint

Overview. Lead-based paint was banned for use in residences and child-care facilities in 1978. Since it was not banned for steel structures, some steel structural components in schools constructed after 1978 may contain lead-based paint if they were delivered to the school construction site pre-painted.

Recommendation.

- ◆ Primary concern should be to identify and remediate any lead-based paint exposure hazards from areas of the school occupied by children under age 6.
- ◆ Document all areas where lead-based paint exists so that future renovation and remodeling work can be planned with appropriate precautions to avoid scraping, burning, or open dry-sanding of lead-based paint. Only certified lead-based paint risk assessors and abatement contractors should be utilized for these activities.

Resources. For more information, contact the Virginia Department of Professional and Occupational Regulation at (804) 367-8595.

Soil

Overview. Lead occurs naturally in soil, which also collects lead from the air and other sources. Soil near roads and parking lots may be high in lead content due to a settling of particulates from the years of leaded gasoline exhaust emissions.

Recommendation.

- ◆ Steps should be taken to avoid direct exposure of children aged 6 or under to soil contaminated with lead.
- ◆ Bare soil areas of playgrounds use by preschoolers should be tested and covered if found to exceed the EPA recommended level of 400 parts per million. Appropriate coverings include mulch, sand, or a cultivated grass cover to reduce exposure to bare soil.

Playground Equipment

Overview. Testing by the U.S. Consumer Product Safety Commission and some state and local jurisdictions has shown that school, park, and community playgrounds across the country may have playground equipment that presents a potential lead-paint poisoning hazard for young children aged 6 and under. The equipment was painted with lead paint and, over time, the paint has deteriorated into chips and dust containing lead. Young children who put their hands on the equipment while playing and then put their hands in their mouths can ingest the lead paint chips and dust.

Recommendation. Please refer to the *Handbook for Public Playground Safety*,¹²⁵ page 31, item number 8.

Water

Overview. Lead is also a naturally occurring ingredient in surface and ground waters that supply drinking water to millions of Americans. Lead is no longer used in plumbing, however, it can still get into drinking water from old water pipes that contain lead.

Although drinking water is rarely the sole cause of lead poisoning, it can increase a person's total lead exposure. Lead dissolved in water cannot be seen, tasted, or smelled.

¹²⁵ CPSC's *Handbook for Public Playground Safety*. (1997). CPSC Document #325 U.S. Consumer Product Safety Commission, Washington, D.C. 20207

The only way to know if it is a problem is to test the water so that these toxins can be reduced or removed from the drinking water faucet

Recommendation. If lead is in the pipes:

- ◆ A tap that has not been used in the last 6 hours should be run for several minutes before consuming, and no one should use hot water for drinking because hot water draws lead out of pipes faster.
- ◆ If funds become available and water conservation is particularly needed in the community, the existing problem plumbing should be replaced with nonleaded pipes, fixtures, and solder.

Resources. The EPA passed tough lead rules that took effect January 1, 1993. The EPA training video *Lead in School Drinking Water* demonstrates how to carry out a successful sampling program. It can be obtained from the regional EPA office.

Lead Screening

Childhood lead poisoning is preventable and treatable. Data from the National Health and Nutrition Examination Survey (NHANES III, Phase 2, 1991-1994) show that 4.4 percent of children aged 1 to 5 had blood lead levels (BLL) of greater than or equal to 10 g /dl—the level that has been determined to affect learning and behavior problems in children. The prevalence was higher for those children living in homes built before 1946—non-Hispanic blacks (21.9%), Mexican Americans (13%), and white non-Hispanic (5.6%).

Centers for Disease Control and Prevention Guidelines. In November 1997, the Centers for Disease Control and Prevention (CDC) issued new guidelines on *Screening Young Children for Lead Poisoning*.¹²⁶ The American Academy of Pediatrics (AAP) issued congruent guidelines in June 1998.¹²⁷ The new guidelines recommend a target screening approach to increase screening and follow-up care of children who most need these services. Children in known high-risk geographic areas and children in known high-risk groups, such as the Medicaid population, are targeted for universal screening, while children from low-risk areas are evaluated on a case-by-case basis.

Centers for Disease Control and Prevention Recommendation. The objective of the 1997 CDC guidelines is to ensure screening of children who are high risk while reducing the number of children screened who are low risk. These new guidelines emphasize that

¹²⁶ Centers for Disease Control and Prevention (1997). *Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials*. Available: <http://www.cdc.gov/nceh/programs/lead/guide/1997/guide97.htm>.

¹²⁷ American Academy of Pediatrics. (1998). Screening for Elevated Blood Lead Levels. *Pediatrics*, 101(6).

decisions on populations to be screened should be made by local and state public health agencies. A cooperative effort between Virginia Department of Health, including local health departments, and local community representatives, pediatricians, and concerned citizen groups in making a complete assessment of the risk factors for the population in that area should result in a policy determination for lead testing in that geographic area. The focus is to be on primary prevention. The improved guidelines will focus increased attention and resources on children at highest risk, improve screening and follow-up care, and maximize the benefit of time, energy, and funds spent on screenings.

Screening. Screening is recommended for children aged 1 and 2, and aged 36 to 72 months who have not been screened previously if they meet at least one of the following criteria.

- ◆ Residence in areas with sufficient representative screening data to show that more than 12 percent of 1- and 2-year-olds have BLLs greater than or equal to 10 µg/dl.
- ◆ Residence in areas for which 27 percent or more of the housing was built before 1950.
- ◆ Membership in a group (e.g., Medicaid recipients) at risk for lead exposure.
- ◆ Parent/guardian answers “yes” or “don’t know” to any of the following questions:
 1. Does your child live in or regularly visit a house that was built before 1950 (include day care, baby-sitter, and relatives)?
 2. Does your child live in or regularly visit a house built before 1978 with recent or ongoing renovations or remodeling (within the last 6 months)?
 3. Does your child have a sibling or playmate who has or did have lead poisoning?

Resources

Other helpful sources of information include:

- ◆ National Lead Information Center (800) 424-LEAD.
- ◆ Lead-Safe Virginia Program (804) 225-4455. Virginia Department of Health, Division of Child and Adolescent Health, P.O. Box 2448, Richmond, VA, 23218. Web site: <http://www.vdh.state.va.us/fhs/child/lead/>.
- ◆ Centers for Disease Control and Prevention (1997). *Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials*. Available: <http://www.cdc.gov/nceh/programs/lead/guide/1997/guide97.htm>.
- ◆ American Academy of Pediatrics. (1998). Screening for Elevated Blood Lead Levels. *Pediatrics*, 101(6).
- ◆ Arvidson, C.R., and Colledge, P. (1996). Lead Screening in Children: The Role of the School Nurse. *Journal of School Nursing*, 12(3).

Underground Storage Tanks in Schools

Authorization

While there is no law specific to underground storage tanks in schools, users of this manual should contact the Virginia Department of Environmental Quality for related laws and regulations.

Overview

Underground storage tanks may become an environmental concern. Such tanks, many of which are made of steel, have rusted and are leaking their contents into the ground. Many school districts that operate school buses own underground storage tanks for gasoline. Therefore, any leak or spill can create a serious problem and become an environmental hazard.

Recommendation

The safety of these underground storage tanks is dependent on their age and condition. The Virginia Department of Environmental Quality (1-804-698-4000 or 1-800-592-5482) should be called if tanks become an environmental problem.

Pesticides

Authorization

U.S. Environmental Protection Agency (EPA). All pesticides legally sold in the United States must bear an EPA registration number on the front of the product label to show that they are registered. There are very few exceptions to this rule.

Virginia Department of Agriculture and Consumer Services. Only a certified pest-control operator who is licensed through the Virginia Department of Agriculture and Consumer Services, Office of Pesticide Services is allowed to apply any pesticide, even those sold over the counter.

Overview

Pests may be managed or controlled by various means. Preventive measures include reducing or excluding hiding and nesting places and food available to pests. If pests increase, they may threaten the health of people or damage property. In this situation, pesticides are usually required. Pesticides are toxic tools used to control pests and are placed into the environment or a site with the purpose of controlling a specific pest.

Recommendation

Pest Control/Management. Pest control in schools should be done as part of an integrated pest management (IPM) program. This includes the coordinated use of pest and environmental information with available pest control methods to prevent unacceptable levels of pest damage by the most economical means and with the least possible hazard to people, property, and the environment. A successful IPM program requires not only a skilled and knowledgeable pest control operator, but the cooperation of building managers and occupants. The EPA, as well as the state, encourages the IPM approach and is working with school officials and others to develop guidance for IPM in schools.

Note. For information on rabies, see “Selected Infectious Diseases” in Appendix C.

Storage and Use.

- ◆ Insecticides and rodenticides must be stored in locked storage areas that are accessible only to authorized personnel.
- ◆ All pesticides and rodenticides must be used in accordance with registered label directions.
- ◆ Instructions on the safe and proper use of these chemicals should be clearly posted.

Toxic Art Supplies

Authorization

Code of Virginia, Section 22.1-274.1 Criteria to Identify Toxic Art Materials; Labeling; Use in Certain Grades Prohibited.

Excerpt:

The State Department of Education, in cooperation with the State Department of Health, shall develop criteria to identify toxic art materials.

After these criteria have been developed, the Department of Education shall require school divisions to evaluate all art materials used in schools and identify those which are toxic. All materials used in the public schools which meet the criteria as toxic shall be so labeled and the use of such materials shall be prohibited in kindergarten through grade five.

See Appendix A for Code of Virginia, §22.1-274.1.

Regulation. Virginia Administrative Code, Title 8 – Education, Agency 20 - State Board of Education, Chapter 530 - Regulations Governing Criteria to Identify Toxic Art Materials; Labeling; Use in Elementary Grades Prohibited.

Excerpt: 8VAC20-530-10. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

“Art material” means any raw or processed material or manufactured product marketed or represented by the manufacturer or repackager, as suitable for use in demonstration or the creation of any work of visual or graphic art of any medium.

Visual or graphic art techniques employing art mediums may include, but should not be limited to, ceramics, drawing, enamels, glass, jewelry, leather, painting, photography, plastic sculpture, sculpture, stained glass, and textile goods.

Art materials shall include, but not be limited to acrylic paints, adhesives, chalks, charcoal, clays, crayons, drawing inks, drawing pencils, enamel colors, fabric dyes, felt tip markers, finger paints, fixatives, glazes, glues, lacquers, modeling materials, oils, oil paints, oil pastels, pastes, pastels, printing inks, screen printing inks,

shellacs, silver solder, solvents, spray paints, tempera paints, varnishes, and watercolors.

The term does not include economic poisons subject to the Federal Insecticide, Fungicide and Rodenticide Act (7 USC §136 et seq.), or drugs, devices, or cosmetic subject to the Federal Food, Drug, and Cosmetic Act (21 USC §301 et seq.).

Art Materials Labeling Act. In October 1988, the U.S. Congress passed § 1277. Labeling of Hazardous Materials Act (Use with Children Under Age 12 Prohibited) Public Law 100-695, 15 U.S.C. that requires warning labels on art materials with chronic long-term health hazards. The law mandates a voluntary standard, ASTM D-4236¹²⁸ as a mandatory labeling standard for art and craft materials.

Summary. The ASTM D-4236 standard requires labels for all art and craft materials determined to present a chronic health hazard. These products include solvents, spray paints, silk-screen inks, adhesives, and any other substance marked or represented as suitable for use in any phase of the creation of any work of visual or graphic art of any medium. The labels must provide:

1. A warning statement of the hazard.
2. Identification of the hazard.
3. Guidelines for safe use.

Under this standard, art material producers or repackers, including importers, must submit to the U.S. Consumer Product Safety Commission a written description of the criteria used to determine whether products can produce long-term health effects. While only hazardous art materials are required to have safety labeling, all art materials will have the statement “Conforms to ASTM D-4236,” “Conforms to ASTM Practice D-4236,” or “Conforms to health requirements of ASTM D-4236.” Products must be evaluated by a toxicologist at least every five years.

Note: Art educators are responsible for the art materials they order and the safe use thereof. Although there is no legislation prohibiting students older than age 12 from using toxic agents, there is the Hazard Communication Standard, VOSH 1910.1200, which addresses potentially hazardous materials in the workplace. (See previous section on Hazard Communication Standard.) All art educators in the field should have training in the usage, storage and disposal of each toxic agent they come in contact with while working.

¹²⁸ D4236-94 Standard Practice for Labeling Art Materials for Chronic Health Hazards. (1997). *American Society for Testing and Materials*, West Conshohocken, Pa.

Overview

According to the Environmental and Occupational Health Sciences Institute (1989),¹²⁹ children between the ages of 3 and 12 attending elementary school or participating in arts and crafts may be using harmful art supplies. These materials can include rubber cement, permanent felt tip markers, pottery glazes, enamels, spray fixatives, wheat wallpaper paste, and other possible hazardous materials.

Health Issues Related to Children Using Art Supplies

These toxic materials can be more harmful to children than adults. Since children are still growing and developing, their bodies can more readily absorb toxic materials that can cause more damage than in adults. Since children are smaller, an amount of a toxic material would be more concentrated than in an adult's body.

Children are also at higher risk because of their behavior. Children may not understand why it is important to be careful when using harmful materials. Also, some young children put things in their mouths and/or swallow them.

Toxic or poisonous materials can enter the body in three different ways:

1. Inhalation.
2. Ingestion (especially for young children who bite their nails or suck their thumbs).
3. Skin contact.

If toxic material does enter the child's body, it can result in an acute illness, chronic illness, cancer, allergic reaction, or death.

Recommendation

Safe Guidelines for Using Art Supplies. Safe guidelines for using art supplies are listed below.

1. Avoid certain materials from children's art supplies. The Center for Safety in the Arts suggests general rules of thumb about choosing art materials for children. The rules are listed below.
 - ◆ No dust or powders.
 - ◆ No chemical solvents or solvent-containing products.

¹²⁹ Environmental and Occupational Health Sciences Institute. (1989). *INFO Sheet: Children's Art Supplies, Report by the Center for Safety in the Arts.*

- ◆ No aerosol spray cans, air brushes, and so forth.
 - ◆ Nothing that stains the skin or clothing (or cannot be washed out of clothing).
 - ◆ No acids, alkalis, bleaches, or other corrosive chemicals.
 - ◆ No donated or found materials unless ingredients known.
 - ◆ No old materials—they may be more toxic and have inadequate labeling.
 - ◆ No lead, metals, or cadmium products—these can be found in paints, glazes, metal work, and stained glass.
2. Treat high-risk children with special care and attention. Children who are physically or mentally disabled are at greater than normal risk from toxic materials. High-risk children include those who have visual or hearing problems, physical disabilities, asthma, take medications, or are emotionally disturbed. These high-risk children need special attention of their use of possibly harmful art supplies.
 3. Make sure products are adequately labeled. Do not use any product that does not have a label or has a label that gives little or no information. In general, the more the label describes the product, the easier it will be to use safely. The label should state how the product is to be used. It should also state what to do in case of an accident. Even if the label says “nontoxic,” do not assume that it is completely safe. If containers are changed, be sure to label the new container.
 4. Purchase products in small containers. Smaller amounts of a product mean less exposure to the product. Also, larger amounts often are not readily used up. Leftover products need to be stored. Accidental poisonings often occur when stored products are left unattended. In the event of a poisoning, call the local poison control center.

Resources

For further information, contact the following:

- ◆ Cheryle C. Gardner
Principal Specialist of Fine Arts
Virginia Department of Education
P.O. Box 2120
Richmond, VA 23218-2120
Telephone: (804) 225-2881
E-mail: cgardner@pen.k12.va.us

Laboratory, Industrial, and Vocational Hazards

Overview

Provisions should be made for the protection of students engaging in industrial arts, physical sciences, vocational education, or in any activities where hazardous chemicals, hazardous devices, or hazardous equipment are used. These provisions should include:

- ◆ The development and posting of operating instructions.
- ◆ The development and posting of regulations.
- ◆ The development and posting of procedures.
- ◆ A comprehensive safety program addressing issues that range from dangerous exposure to hot water and broken glassware to toxic exposures and fire.

Subsections

The following subsections provide information on specific safety regulations and recommendations associated with educational courses involving industrial, vocational, or laboratory activities.

- ◆ Facilities
- ◆ Ventilation
- ◆ Equipment and Supplies
- ◆ Storage and Handling of Toxic or Hazardous Materials

Facilities

Authorization

Code of Virginia, Section 22.1-275, Protective Eye Devices.

Excerpt: See Appendix A for *Code of Virginia, §22.1-275.*

Recommendation

Safety rules specific to the activities conducted in each laboratory classroom (academic and vocational), including proper attire and the use of personal safety equipment, should be posted and enforced. A list of possible issues to consider is listed below.

- ◆ Adequate bench space with necessary utilities should be provided. Class size should be small enough to allow proper supervision.
- ◆ Protective eye devices must be worn by all students participating in, observing, or in close proximity to any experiment or activity that could result in eye injury. Eye-protection glasses, goggles, face shields, and similar eye-protection devices should be issued clean and properly sanitized and stored in a protected place.
- ◆ An easily accessible, fire blanket should be provided in each laboratory or other areas where an open flame is used.
- ◆ Where there is exposure to skin contamination with poisonous, infectious or irritating materials, a hand washing facility should be available.
- ◆ An easily accessible, operational eye-wash fountain should be provided in each laboratory or other areas where corrosives or irritating chemicals are used. The eye-wash fountain should be clean and must be tested annually. The use of portable eye-wash bottles as substitutes should not be permitted.
- ◆ An easily accessible, operational safety shower, capable of providing continuous flowing water, should be provided for each laboratory or other areas where corrosive or irritating chemicals are used. The safety shower can be centrally located to serve more than one area if doors are not locked and prompt access is available.
- ◆ Electrical equipment should be properly grounded and inspected regularly.
- ◆ Master gas valves and electrical shut-off switches should be provided in each laboratory or areas where power equipment is used. Electrical shut-off switches are not permitted to be located in fuse boxes.

Ventilation

Authorization

Threshold Limit Values and Biological Exposures Indices. All areas should be adequately ventilated so that exposures to hazardous or toxic materials are maintained at a safe level. In absence of more stringent guidelines, the most recent edition of the American Conference of Governmental Industrial Hygienists' publication *Threshold Limit Values and Biological Exposures Indices* should be used as a guide to determine safe levels.

Standards. Discharges from any exhaust hood should meet applicable *Virginia Air Pollution Standards*.

Recommendation

- ◆ Local exhaust ventilation should be provided so that contaminants are carried away from the students and not through the breathing zone.
- ◆ Sufficient fume hood capacity ventilation should be used for any activity producing hazardous toxic or noxious gases, mists, vapors, or dusts.
- ◆ Hoods should exhaust directly to the outside and should be located a minimum of 10 feet from any building air-intakes or building openings.
- ◆ Fume hoods should be kept free of storage and routinely inspected and maintained.
- ◆ A minimum face velocity of 100 feet/minute for general laboratory hoods should be provided.
- ◆ Air flow of fume hoods should be tested at least once a school year.

Equipment and Supplies

Authorization

No specific regulations.

Recommendation

- ◆ Instructional, athletic, recreational, or other equipment used in or out of the classroom should be maintained in a clean, safe condition.
- ◆ Toys and equipment should meet applicable state and local regulations.
- ◆ Gym equipment should be kept clean and in good repair. Body contact equipment surfaces should be routinely cleaned with a sanitizer approved by the local school division.
- ◆ Equipment used in physical therapy and special education should be cleaned after it is used.
- ◆ Facilities should be available for the proper storage of clean clothing and athletic, instructional, and recreational equipment and supplies to minimize health hazards and to facilitate cleaning.
- ◆ Cleaning materials, tools, and maintenance equipment should be provided and should be stored safely and secured in a locked area.
- ◆ Glassware should be properly constructed and designed for its intended use and should be handled and stored safely.
- ◆ Aspirators or suction bulbs should be used for drawing liquids into pipettes. The mouth should not be used directly on the pipettes.

Storage and Handling of Toxic or Hazardous Materials

Authorization

National Fire Protection Association Codes. National Fire Protection Association Codes should be used as guidelines for the proper storage, handling, and use of chemicals in the school. Where refrigerators are used to store flammable compounds, they must be explosion proof.

Note. National Fire Protection Association Codes are available from the National Fire Protection Association listed in this section under “Resources.”

Recommendation

- ◆ Toxic or hazardous materials should be stored in approved laboratory containers, separated by reactive group, and stored in a ventilated, locked, fire-resistant area or cabinet. (Note: The ventilation recommendations listed in the previous subsection, “Ventilation,” may not be called for where minimum quantities of such materials are stored for daily use.)
- ◆ Containers of chemicals, poisons, corrosive substances, and flammable liquids should be clearly labeled with the name of the material and the date the material entered the school. Exposure to noise or toxic liquids, dusts, gases, mists, vapors, or other hazards should be controlled to avoid health hazards.
- ◆ All chemicals, solvents, and hazardous substances should be inventoried by the school a minimum of once a year. The inventory should include the name of the compound, the amount, and the date it entered the school. Chemicals should be ordered in quantities only large enough for short-term needs.
- ◆ A current material safety data sheet should be provided for all poisonous, toxic, or hazardous substances and should be available for review upon request.
- ◆ A written plan for response to and cleanup of chemical spills should be provided by the school.
- ◆ A written plan that explains the proper storage, handling, and disposal procedures for all poisonous, toxic, or hazardous substances should be on file in each school and should be available for review upon request.
- ◆ A list of first aid procedures for accidental poisoning should be posted. The telephone number and location of the nearest poison control center should be posted near each telephone and written on the front cover of the flipbook, *First Aid Guide for School*

Emergencies, Virginia Department of Health (the flipbook should be kept in the school nurse's office or school health room). (Please refer to Appendix B for a copy of *First Aid Guide for School Emergencies*.) All incidents should be reported according to local policy.

- ◆ Pesticides and toxic or hazardous cleaning and maintenance chemicals and materials should be stored separately in a ventilated and locked cabinet or in an area accessible only to authorized personnel. The ventilation recommendation of this section may not be recommended in areas where minimum quantities of the above mentioned materials are stored for daily use. Flammable or combustible materials should be stored in accordance with the most recent edition of the *National Fire Protection Association 30 Flammable and Combustible Liquids Code* (available from the National Fire Protection Association listed below).
- ◆ The storage, preparation, and consumption of food and drink are prohibited in any area where there are poisonous, toxic, or hazardous substances.

Resources

For more information, contact the National Fire Protection Association.

National Fire Protection Association

1 Batterymarch Park

P.O. Box 9101

Quincy, MA 02269-9101

Main telephone: (617) 770-3000.

Customer sales department telephone: (800) 344-3555 (On-line catalog available).

Web site: <http://www.nfpa.org>

Health and Safety Recommendations

Overview

This section presents information on possible environmental concerns or risk areas in the school environment. Material is presented on guidelines for assessing or reducing the environmental risks in the identified areas.

Subsections

The following subsections highlight areas identified as high risk areas or areas of concern:

- ◆ Playground Safety
- ◆ Toilets, Lavatories, Drinking Fountains, and Bathing Facilities
- ◆ Animals in School
- ◆ Lighting
- ◆ Swimming Pools/Therapy Pools
- ◆ School Maintenance and Sanitation
- ◆ Sewage Disposal
- ◆ Refuse Disposal
- ◆ Recycling

Playground Safety

Authorization

See local regulations.

Overview

The United States Consumer Product Safety Commission (1997)¹³⁰ reported that each year about 200,000 children are treated in U.S. hospital emergency rooms for playground equipment-related injuries. Approximately 148,000 of these injuries involve public playground equipment. About 15 children die each year as a result of playground equipment-related incidents. Most of the injuries are the result of falls. Most of these are primarily falls to the ground below the equipment, but falls from one piece of equipment to another are also reported. Most of the deaths are due to strangulation or falls.

Recommendation

Because of the injuries noted above, the Consumer Product Safety Commission made specific recommendations in their *Handbook for Public Playground Safety*.¹³¹ The following content is included in the handbook:

- ◆ Overview of playground injuries.
- ◆ Types of surfaces for playgrounds.
- ◆ Layout and design of playgrounds.
- ◆ Use zones for playground equipment.
- ◆ Installation and maintenance of equipment.
- ◆ General hazards.
- ◆ Guidelines for platforms, guardrails, and protective barriers.
- ◆ Guidelines for specific playground equipment, such as see saws and slides.

¹³⁰ CPSC's *Handbook for Public Playground Safety*. (1997). CPSC Document #325 U.S. Consumer Product Safety Commission, Washington, D.C. 20207

¹³¹ Ibid.

Resources

For more information, contact the following agencies.

- ◆ U.S. Consumer Product Safety Commission
 - Office of Information and Public Affairs
 - Washington, DC 20207
 - Telephone number (301) 504-0580
 - Web site: <http://www.cpsc.gov/>
- Consumer Product Safety Hotline (800) 638-2772 or (800) 638-8270 (TTY)

Note: CPSC's Internet Subscription List – Agency press releases (which include product recalls and other safety information, and the agency's public calendar) can be automatically sent by e-mail. Instructions for how to subscribe to this service are available at the following

Web site:

<http://www.cpsc.gov/about/subscribe.html>.

- ◆ U.S. Consumer Gateway
 - Web site: <http://www.consumer.gov/index.htm>

Note. The *CPSC's Handbook for Public Playground Safety* is available from either of the above agencies.

Toilets, Lavatories, Drinking Fountains, and Bathing Facilities

Authorization

No specific mandate. The *Virginia Uniform Statewide Building Code, Volume II Maintenance Code*, which is a voluntary maintenance code, can be used as a guide to develop local policies.

Recommendation

General.

- ◆ Toilet, lavatory, bathing facilities, and drinking fountains should be provided and should be accessible for use by individuals with disabilities.
- ◆ Functional water outlets should be available, where necessary, at designated refuse storage areas and at high-density student common use areas where heavy accumulations of refuse are generated, to minimize hazards and to maintain such areas in a clean, safe condition.
- ◆ Plans and specifications for the installation of sanitary facilities in schools that are being remodeled to increase the occupant load should be submitted for review and approval in accordance with Virginia Department of Health regulations prior to construction (see “Resources” at the end of this subsection).
- ◆ Floors, walls, and ceilings of all toilet, shower, and locker rooms should be smooth, easily cleanable, non-absorbent and should be maintained in good repair and in a clean, sanitary condition.

Drinking Water Fountains.

- ◆ The fountains must be at appropriate heights for the users and should be easily accessible to all school program activities.
- ◆ Drinking fountains should not be installed on sinks in bathrooms used for hand washing or arts and crafts or on sinks in toilet, science, or art areas.
- ◆ Drinking fountain spouts should be of angle jet construction, with water pressure maintained so that it extends at least 1 inch beyond the mouth guard.

Note: Use of common drinking cups or vessels should be prohibited.

Toilets and Lavatories.

- ◆ Toilets and washrooms must be available for use at all times and monitored if necessary. Rooms must be unlocked and fully accessible. Toilet rooms should be conveniently located at a travel distance of not more than 500 feet from any room to be served. All toilet rooms should be provided with adequate lavatory facilities.
- ◆ Sound public health practice dictates that soap (preferably liquid), paper towels, and toilet paper be provided. Soap and single service towels should be available for all lavatory facilities; however, mechanical warm air dryers may be used in place of towels.
- ◆ All toilet facilities must be ventilated directly to the outside, either by windows that open or by mechanical exhaust systems.
- ◆ Toilet bowls should be equipped with nonabsorbent, sanitary toilet seats. Toilet paper should be available at each toilet mounted in an appropriate dispenser.
- ◆ Hot and cold water or tempered water under operating pressures (20 PSI minimum) should be available for bathing and washing. Hot water delivered to showers and lavatories should not exceed 110°F. The temperature of hot water at other fixtures should not exceed 120°F, except where necessary for sanitizing purposes.

Showers.

- ◆ New facilities should have 12-square feet of floor area per showerhead. Centralized showerheads should be located at least 3 feet apart.
- ◆ Private showers should have one soap dispenser and one towel hook for each shower.
- ◆ Gang showers should have one soap dispenser for every two showerheads and one towel hook for each shower.
- ◆ Shower floors should have a nonskid surface.

Resources

For more information, contact the Virginia Department of Health, Division of Onsite Sewage and Water Services, or local health department's Office of Environmental Health Services.

Virginia Department of Health
Office of Environmental Health Services
Division of Onsite Sewage and Water Services
P.O. Box 2448
Richmond, VA 23218
Telephone: (804) 225-4030
Fax: (804) 225-4003
Web site: <http://www.vdh.state.va.us/onsite/ehmgrs.htm>

Animals in School

Authorization

No specific regulations

Recommendation

- ◆ Animals used for instructional purposes should be maintained in a sanitary condition and in a manner to prevent health hazards or nuisance conditions and to conform to local school policy.
- ◆ The practice of keeping animals in schools is discouraged because of potential allergies, bites, and spread of disease.
- ◆ Animals kept at school must be adequately immunized, fed, sheltered, and kept clean. They are prohibited from food storage, preparation, service, and dining areas.
- ◆ Do not permit turtles, parrots, raccoons, bats, or wildlife known to carry rabies or other diseases.
- ◆ Be sure that no child in a class is allergic to animals.
- ◆ Animal areas must be cleaned frequently.
- ◆ Wash hands after handling or cleaning. Children who assist with pet cleaning and maintenance must learn proper hand washing procedures.
- ◆ An exemption has been provided to allow guide dogs in dining areas when accompanying blind, deaf, or other disabled persons.
- ◆ Pest control/management should be a part of an integrated pest management program to maintain the facility free from vermin. (See previous section in this chapter on “Pesticides.”)

Note. For information on rabies, see “Selected Infectious Diseases” in Appendix C. For information on animal bites, see “*First Aid Guide for School Emergencies*” in Appendix B.

Lighting

Authorization

No specific regulations.

Overview

The provision of adequate interior and exterior school lighting is primarily the responsibility of illuminating engineers and architects. However, the administrator, classroom teachers, and the health staff must understand the basic principles of lighting in order to use available facilities properly and recommend change when needed. The administrator should not permit the standards to decline in the name of economics or energy savings.

Recommendation

While quantity of light is important, the quality of light is even more significant, as demonstrated in extensive research. In order to supply suitable light to all working surfaces for efficiency and comfort, the following items should be considered.

Control of Bright and Dark Areas. There should be control of both bright and dark areas to avoid glare. This is best accomplished by diffusion or light coming from many directions rather than a single source, whether artificial or natural. In addition, the reflective surfaces of desks, walls, woodwork, and so forth should be considered. The adverse effects of glare are cumulative. For a short time glare is annoying—with prolonged exposure, a person becomes progressively fatigued and may develop eyestrain and headaches.

Room Colors. Room colors greatly influence the effectiveness of a lighting system. Color and texture determine how much light is reflected. Room colors also contribute to a variety of psychological reactions and have been described as, for example, warm, cool, neutral, or depressing.

Lighting Recommendations. The electrical lighting system should be capable of the following light level intensities: 70-foot candle for classroom, libraries, offices, laboratories, and shops; 100-foot candles for drafting, typing, sewing rooms, and other rooms where close eye task activities are routinely conducted; 30-foot candles for reception rooms, rest rooms, gymnasiums, service rooms, swimming areas, and dining areas; 15-foot candles for auditoriums, locker rooms, and stairways; and 20-foot candles for corridors, hallways, storage, and utility areas. Light level intensities should be measured at the work surface or 30 inches from the floor.

Determination of Appropriate Lighting. Illumination deteriorates rapidly unless windows are kept clean and wall and ceiling surfaces are well maintained. As light bulbs are used, they blacken and give off less light. Dirt and dust reduce the reflecting and transmitting qualities of lighting units. To help determine whether a classroom is appropriately lighted, the following questions should be answered.

- ◆ Is the room free from sharp shadows?
- ◆ Is it possible to exclude sunlight by adjustment of shades or blinds?
- ◆ Are walls, desktops, and chalkboards free from bright reflections?
- ◆ Are all lamps shielded so that bright light does not shine in the eyes?

Swimming Pools/Therapy Pools

Authorization

No specific regulations.

Recommendation

Swimming pools should be constructed, operated, and maintained in accordance with:

- ◆ Local regulations.
- ◆ Manufacturer's maintenance recommendations.

Resources

For more information, contact the local health department's Office of Environmental Health Services or Virginia Department of Health, Division of Onsite Sewage and Water Services.

Virginia Department of Health
Office of Environmental Health Services
Division of Onsite Sewage and Water Systems
P.O. Box 2448
Richmond, VA 23218
Telephone: (804) 225-4030
Fax: (804) 225-4003
Web site: <http://www.vdh.state.va.us/onsite/ehmgrs.htm>

School Maintenance and Sanitation

Authorization

No specific regulations.

Overview

Cleanliness is an extremely important aspect of a healthful school environment. Proper sanitation consists of maintaining the building free of those conditions that could lead to the transmission of disease. Each area of the school has its own particular cleaning and disinfectant needs.

Recommendation

- ◆ Each school should develop a written policy and plan for the cleaning and sanitizing of each area and assign the responsibility for carrying out the plan to a specific person in the school.
- ◆ The least expensive and highly effective sanitizing agent is chlorine bleach. Deodorizers should not be used—they only mask the problem. Chlorine bleach used to sanitize food contact surfaces, equipment, and utensils must be EPA approved for food service sanitation. The container of approved chlorine will have specific labeling for food establishment use and an EPA registration number.
- ◆ There must be adequate housekeeping and maintenance equipment and cleaning supplies, and equipment should be appropriate for the task it is intended to do. For instance, a vacuum cleaner should have adequate capacity and be powerful enough to clean rugs. Vacuum cleaners must also have proper filters to eliminate the dust and other small particles from being expelled from the equipment. The equipment must be kept clean, in good working condition, and be stored safely. All cleaning supplies and toxic materials must be kept in containers that are properly labeled with their contents. In food areas, cleaners, sanitizers and toxic materials must be stored away from food items.

Sewage Disposal

Authorization

Regulations. In all new schools and schools modifying existing sewage disposal systems or expanding their usage beyond the design capacity of the sewage disposal system, plans should be submitted to the Virginia Department of Health for review and approval in accordance with provisions of the most current edition of the *Sewage Handling and Disposal Regulations* or *Sewage Collection and Treatment Regulations*—whichever is more appropriate (available from the Virginia Department of Health, Division of Onsite Sewage and Water Services listed below) .

Recommendation

Facilities. Facilities approved by the Virginia Department of Health should be provided and maintained for the treatment and sanitary disposal of sewage. Where a public sewer system is available, all plumbing fixtures and all building sewer lines should be connected thereto. If a public sewer system is not available, a sewage disposal system meeting the requirements of the Virginia Department of Health should be provided and all plumbing fixtures and building sewer lines should be connected thereto.

Interruption of Service. Where a total interruption of sewer service occurs over an extended period of time, the school should be closed unless dismissal of the pupils would be detrimental to their physical well-being, or unless accessible approved alternatives for the sanitary disposal of sewage are available.

Resources

For more information, contact the Virginia Department of Health, Division of Onsite Sewage and Water Services or local health department's Office of Environmental Health Services.

Virginia Department of Health
Office of Environmental Health Services
Division of Onsite Sewage and Water Systems
P.O. Box 2448
Richmond, VA 23218
Telephone: (804) 225-4030
Fax: (804) 225-4003
Web site: <http://www.vdh.state.va.us/onsite/ehmgrs.htm>

Refuse Disposal

Authorization

No specific regulations.

Overview

The storage, collection, transportation, and disposal of refuse should be conducted to control odors, insects, rodents, communicable disease, accidents, or other nuisance conditions.

Recommendation

Containers. Durable, nonabsorbent, cleanable refuse containers should be provided, kept in a clean condition, and placed in readily accessible locations.

Universal Precautions. Use universal precautions when (see “Universal Precautions” in Appendix C):

- ◆ Cleaning up blood and body fluids.
- ◆ Disposing of bio-hazard wastes, such as refuse from the health clinics or from cleaning of blood and body fluids.
- ◆ Disposing of all sharp-edged instruments, such as blades from exacto knives, blades from saws, or needles from hypodermic syringes.

Exterior Refuse Storage. Exterior refuse storage areas should be kept in a clean, sanitary condition. Refuse receptacles for exterior storage of garbage or putrescible wastes should be provided with covers. Exterior refuse containers should be stored on a smooth surface on nonabsorbent material, such as concrete or asphalt. Exterior putrescible waste storage areas should be located a minimum of 25 feet from food services areas and classrooms.

Frequency of Removal. Refuse should be removed from the buildings and removed from the premises as often as necessary but not less than twice weekly when putrescible wastes are stored.

Recycling

Authorization

No specific regulations.

Overview

The average American throws away more than 1,300 pounds of trash a year. In recent years, a garbage crisis has caught the attention of the nation and the world. As this country is faced with ever-increasing amounts of garbage and no place to put it, more and more people are recognizing the need for action. Recycling is one important remedy to the garbage problems much of the nation is facing today.

Recommendation

Schools can take a leadership role in recycling. School recycling programs can help students learn to respect the environment, become aware of their impact on it, and develop positive attitudes and behaviors. United States, EPA, and the Office of Solid Waste have developed a comprehensive educational program, "Recycle Today," to promote recycling programs and waste awareness in schools.

Resources

For more information, refer to the following pamphlet:

Title:	Recycle Today!
Date:	April 1990
Document Number:	EPA 530-SW-90-025
Source:	EPA Office of Solid Waste and Emergency Response
Order Information:	EPA NCEPI, 1-800-490-9198 or order on line at http://www.epa.gov/ncepihom/orderpub.html
Description:	This pamphlet describes four publications that address recycling. Teachers can order those items, which include a curriculum for building solid waste awareness, a how-to handbook for teachers, a poster, and a comic book for grades 4 through 7. Ordering information is included.
Audience:	Elementary School to High School

Informational

Overview

This section provides information on areas of concern within the school environment. These areas are not necessarily high-risk areas but rather areas in which school personnel have historically had a lot of questions.

Subsections

The following subsections include environmental areas in which school personnel have frequently asked for information.

- ◆ Electromagnetic Fields
- ◆ Hazards From Video Display Terminals
- ◆ Photocopiers, Mimeograph, Equipment, and Other Machines
- ◆ X-Ray Machines

Electromagnetic Fields

Authorization

Virginia Department of Health. The Virginia Department of Health monitors research on electromagnetic fields and provides a report to the legislature each year.

Note: At the time of publication, there is no definitive research to support any health problems associated with electromagnetic fields.

Recommendation

For ongoing information, consult the annual legislative report on electromagnetic fields by the Virginia Department of Health, Division of Radiological Health.

Virginia Department of Health
Radiological Health Program
P. O. Box 2448
Richmond, VA 23218
Telephone: (804) 786-5932
Web site: <http://www.vdh.state.va.us/rad/index.htm>

Hazards From Video Display Terminals

Authorization

No specific regulations

Note: Evidence to date indicates that exposure to video display terminals (VDTs) may pose minor health problems. VDTs are not a source of dangerous radiation. Although there is some evidence that VDTs may increase physical and emotional stress, studies suggest that measures can be taken to reduce these stresses, such as relaxing, decreasing the work load, and relieving boredom in the workplace. Thus far, no information has been found that definitively rules out an effect of VDTs on reproduction.

Photocopiers, Mimeograph, Equipment, and Other Machines

Authorization

No specific regulations.

Recommendation

- ◆ The most important health consideration with photocopiers is location. Locating photocopiers in large, well-ventilated areas will reduce possible health concerns. This is especially important if workers have to share space with the photocopier or other machines.
- ◆ It is recommended that the glass-plate cover be closed while copying.
- ◆ Special attention should be given to the refilling and disposal techniques for toner in dry machines. The warnings on the additives for photocopy, mimeograph, and duplication machines should be read and followed.

X-Ray Machines

Authorization

Regulations. See *Virginia Rules and Regulations Pertaining to Radiation Control*, as amended (available from the Virginia Department of Health, Radiological Health Program listed below).

Recommendation

Use of x-ray machines and other electronic devices producing ionizing or non-ionizing radiation and radioactive materials and equipment should conform to the most recent edition of the *Virginia Rules and Regulations Pertaining to Radiation Control*, as amended and promulgated by Virginia Board of Health.

Resources

For more information, contact the Virginia Department of Health, Radiological Health Program:

Virginia Department of Health
Radiological Health Program
P. O. Box 2448
Richmond, VA 23218
Telephone: (804) 786-5932
Web site: <http://www.vdh.state.va.us/rad/index.htm>

APPENDIX A: Authorizations and Miscellaneous

- ◆ *Code of Virginia Citations*
- ◆ Superintendent Memorandums
- ◆ Definitions of Terms Associated With Special Education Programs for Children With Disabilities
- ◆ Recommended Childhood Immunization Schedule
- ◆ Minimum Immunizations Required of New Students by the State Board of Health for School Attendance
- ◆ Reportable Diseases in Virginia
- ◆ Blue Ribbon Commission on School Health Survey

Code of Virginia Citations

Note. Users of this manual are advised to consult the most recent edition of the *Code of Virginia* to make sure that the following Codes are up to date.

Searchable Database on the Internet. A searchable database of the *Code of Virginia* is available at the Internet at the Virginia General Assembly, Legislative Information System (LIS), Web site. To search for a particular law:

1. Go to the Web page <http://leg1.state.va.us/000/src.htm>
2. Enter the Code number (example: 22.1-270) or search phrase (example: comprehensive physical examination) into the screen's search window.
3. Press submit (click on the screen's "submit" button).

Additional search instructions are available on the Web site.

§ 8.01-225

Persons rendering emergency care, obstetrical services exempt from liability

A. Any person who, in good faith, renders emergency care or assistance, without compensation, to any ill or injured person at the scene of an accident, fire, or any life-threatening emergency, or en route therefrom to any hospital, medical clinic or doctor's office, shall not be liable for any civil damages for acts or omissions resulting from the rendering of such care or assistance.

Any person who, in the absence of gross negligence, renders emergency obstetrical care or assistance to a female in active labor who has not previously been cared for in connection with the pregnancy by such person or by another professionally associated with such person and whose medical records are not reasonably available to such person shall not be liable for any civil damages for acts or omissions resulting from the rendering of such emergency care or assistance. The immunity herein granted shall apply only to the emergency medical care provided.

Any person who, in good faith and without compensation, administers epinephrine to an individual for whom an insect sting treatment kit has been prescribed shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such treatment if he has reason to believe that the individual receiving the injection is suffering or is about to suffer a life-threatening anaphylactic reaction.

Any person who provides assistance upon request of any police agency, fire department, rescue or emergency squad, or any governmental agency in the event of an accident or other emergency involving the use, handling, transportation, transmission or storage of liquefied petroleum gas, liquefied natural gas, hazardous material or hazardous waste as defined in §18.2-278.1 or regulations of the Virginia Waste Management Board shall not be liable for any civil damages resulting from any act of commission or omission on his part in the course of his rendering such assistance in good faith.

Any emergency medical care attendant or technician possessing a valid certificate issued by authority of the State Board of Health who in good faith renders emergency care or assistance whether in person or by telephone or other means of communication, without compensation, to any injured or ill person, whether at the scene of an accident, fire or any other place, or while transporting such injured or ill person to, from or between any hospital, medical facility, medical clinic, doctor's office or other similar or related medical facility, shall not be liable for any civil damages for acts or omissions resulting from the rendering of such emergency care, treatment or assistance, including but in no way limited to acts or omissions which involve violations of State Department of Health regulations or any other state regulations in the rendering of such emergency care or assistance.

Any person having attended and successfully completed a course in cardiopulmonary resuscitation, which has been approved by the State Board of Health, who in good faith and without compensation renders or administers emergency cardiopulmonary resuscitation, cardiac defibrillation or other emergency life-sustaining or resuscitative treatments or procedures which have been approved by the State Board of Health to any sick or injured person, whether at the scene of a fire, an accident or any other place, or while transporting such person to or from any hospital, clinic, doctor's office or other medical facility, shall be deemed qualified to administer such emergency treatments and procedures; and such individual shall not be liable for acts or omissions resulting from the rendering of such emergency resuscitative treatments or procedures.

B. Any licensed physician serving without compensation as the operational medical director for a licensed emergency medical services agency in this Commonwealth shall not be liable for any civil damages for any act or omission resulting from the rendering of emergency medical services in good faith by the personnel of such licensed agency unless such act or omission was the result of such physician's gross negligence or willful misconduct.

Any person serving without compensation as a dispatcher for any licensed public or nonprofit emergency services agency in this Commonwealth shall not be liable for any civil damages

for any act or omission resulting from the rendering of emergency services in good faith by the personnel of such licensed agency unless such act or omission was the result of such dispatcher's gross negligence or willful misconduct.

Any individual, certified by the State Office of Emergency Medical Services as an emergency medical services instructor and pursuant to a written agreement with such office, who in good faith and in the performance of his duties, provides instruction to persons for certification or recertification as a certified basic life support or advanced life support emergency medical services technician, shall not be liable for any civil damages for acts or omissions on his part directly relating to his activities on behalf of such office unless such act or omission was the result of such emergency medical services instructor's gross negligence or willful misconduct.

B1. Any licensed physician serving without compensation as a medical advisor to an E-911 system in this Commonwealth shall not be liable for any civil damages for any act or omission resulting from rendering medical advice in good faith to establish protocols to be used by the personnel of the E-911 system, as defined in §58.1-3813, when answering emergency calls unless such act or omission was the result of such physician's gross negligence or willful misconduct.

B2. Any provider of telecommunication service as defined in §58.1-3812, including mobile service, in this Commonwealth shall not be liable for any civil damages for any act or omission resulting from rendering such service with or without charge related to emergency calls unless such act or omission was the result of such service provider's gross negligence or willful misconduct.

C. Nothing contained in this section shall be construed to provide immunity from liability arising out of the operation of a motor vehicle.

For the purposes of this section, the term "compensation" shall not be construed to include (i) the salaries of police, fire or other public officials or personnel who render such emergency assistance, nor (ii) the salaries or wages of employees of a coal producer engaging in emergency medical technician service or first aid service pursuant to the provisions of §§45.1-161.38, 45.1-161.101, 45.1-161.199 or §45.1-161.263.

Any licensed physician who directs the provision of emergency medical services, as authorized by the State Board of Health, through a communications device shall not be liable for any civil damages for any act or omission resulting from the rendering of such emergency medical services unless such act or omission was the result of such physician's gross negligence or willful misconduct.

For the purposes of this section, an emergency medical care attendant or technician shall be deemed to include a person licensed or certified as such or its equivalent by any other state when he is performing services which he is licensed or certified to perform by such other state in caring for a patient in transit in this Commonwealth, which care originated in such other state.

Any volunteer engaging in rescue or recovery work at a mine or any mine operator voluntarily providing personnel to engage in rescue or recovery work at a mine not owned or operated by such operator, shall not be liable for civil damages for acts or omissions resulting from the rendering of such rescue or recovery work in good faith unless such act or omission was the result of gross negligence or willful misconduct.

§ 15.2-2801

Statewide regulation of smoking

A. The Commonwealth or any agency thereof and every locality shall provide reasonable no-smoking areas, considering the nature of the use and the size of the building, in any building owned or leased by the Commonwealth or any agency thereof or a locality. The provisions of this chapter shall not apply to office, work or other areas of the Department of Corrections which are not entered by the general public in the normal course of business or use of the premises.

B. Smoking shall be prohibited in (i) elevators, regardless of capacity, except in any open material hoist elevator, not intended for use by the public; (ii) public school buses; (iii) the interior of any public elementary, intermediate, and secondary school; however, smoking may be allowed by a local school division in a designated area which is not a common area, including but not limited to, a classroom, library, hallway, restroom, cafeteria, gymnasium, or auditorium after regular school hours so long as all student activities in the building have been concluded; (iv) hospital emergency rooms; (v) local or district health departments; (vi) polling rooms; (vii) indoor service lines and cashier lines; (viii) public restrooms in any building owned or leased by the Commonwealth or any agency thereof; (ix) the interior of a child day center licensed pursuant to §63.1-196 that is not also used for residential purposes; however, this prohibition shall not apply to any area of a building not utilized by a child day center, unless otherwise prohibited by this chapter; and (x) public restrooms of health care facilities.

C. Any restaurant having a seating capacity of fifty or more persons shall have a designated no-smoking area sufficient to meet customer demand. In determining the extent of the no-smoking area, the following shall not be included as seating capacity: (i) seats in any bar or lounge area of a restaurant and (ii) seats in any separate room or section of a restaurant which is used exclusively for private functions.

D. The proprietor or other person in charge of an educational facility, except any public elementary, intermediate, or secondary school, health care facility, or a retail establishment of 15,000 square feet or more serving the general public, including, but not limited to, department stores, grocery stores, drug stores, clothing stores, shoe stores, and recreational facilities shall designate reasonable no-smoking areas, considering the nature of the use and the size of the building.

E. The proprietor or other person in charge of a space subject to the provisions of this chapter shall post signs conspicuous to public view stating "Smoking Permitted" or "No Smoking," and in restaurants, signs conspicuous to ordinary public view at or near each public entrance stating "No-Smoking Section Available." Any person failing to post such signs may be subject to a civil penalty of not more than twenty-five dollars.

F. No person shall smoke in a designated no-smoking area and any person who continues to smoke in such area after having been asked to refrain from smoking may be subject to a civil penalty of not more than twenty-five dollars.

G. Any law-enforcement officer may issue a summons regarding a violation of this chapter.

H. The provisions of this chapter shall not be construed to regulate smoking in retail tobacco stores, tobacco warehouses or tobacco manufacturing facilities.

§ 22.1-16

Bylaws and regulations generally

The Board of Education may adopt bylaws for its own government and promulgate such regulations as may be necessary to carry out its powers and duties and the provisions of this title.

§ 22.1-138

Minimum standards for public school buildings

A. The Board of Education shall prescribe by regulation minimum standards for the erection of or addition to public school buildings governing instructional, operational, health and maintenance facilities where these are not specifically addressed in the Uniform Statewide Building Code.

B. By July 1, 1994, every school building in operation in the Commonwealth shall be tested for radon pursuant to procedures established by the United States Environmental Protection Agency (EPA) for radon measurements in schools.

School buildings and additions opened for operation after July 1, 1994, shall be tested for radon pursuant to such EPA procedures and regulations prescribed by the Board of Education pursuant to subsection A of this section. Each school shall maintain files of its radon test results and make such files available for review. The division superintendent shall report radon test results to the Department of Health.

§ 22.1-206

Instruction concerning drugs and drug abuse

Instruction concerning drugs and drug abuse shall be provided by the public schools as prescribed by the Board of Education.

§ 22.1-207

Physical and health education

Physical and health education shall be emphasized throughout the public school curriculum by lessons, drills and physical exercises, and all pupils in the public elementary, middle, and high schools shall receive as part of the educational program such health instruction and physical training as shall be prescribed by the Board of Education and approved by the State Board of Health.

§ 22.1-207.1

Family life education

The Board of Education shall develop by December 1, 1987, standards of learning and curriculum guidelines for a comprehensive, sequential family life education curriculum in grades K through 12. Such curriculum guidelines shall include instruction as appropriate for the age of the student in family living and community relationships, the value of postponing sexual activity, human sexuality, human reproduction, and the etiology, prevention and effects of sexually transmitted diseases. All such instruction shall be designed to promote parental involvement, foster positive self concepts and provide mechanisms for coping with peer pressure and the stresses of modern living according to the students' developmental stages and abilities. The Board shall also establish by December 1, 1987, requirements for appropriate training for teachers of family life education.

By December 1, 1987, the Board of Education shall provide the House Committee on Appropriations and the Senate Committee on Finance an analysis of the state and local fiscal impact of implementing a mandatory statewide family life education program and a recommended apportionment of state and local funding for such programs if not otherwise determined by law.

§ 22.1-207.3

School breakfast programs.

A. By July 1, 1994, upon the appropriation and authorization of federal funds for the reimbursement of school breakfast programs, each school board shall establish a school breakfast program in any public school in which twenty-five percent or more of enrolled school-age children were approved eligible to receive free or reduced price meals in the federally funded lunch program during the previous school year.

B. The Board of Education shall promulgate regulations for the implementation of the program. Such regulations shall include, but not be limited to, criteria for eligibility and exemptions; a reporting system for the compilation and analysis of information concerning the number and socioeconomic characteristics of participating school-age children; standards for food services; program evaluation; the investigation of complaints; an appeals process; notification of parents and guardians of the availability of the school breakfast program; and provision to teachers, children, and their parents or guardians of nutrition information describing the relationship between good nutrition, learning, and health.

C. Each school board subject to the provisions of this section shall develop and implement a plan to ensure compliance with the provisions of subsection A and submit the plan to the

Department of Education no later than thirty days prior to the commencement of the program. Beginning by June 30, 1995, and thereafter annually, each school board shall report such information as required in subsection B to the Department of Education on such forms and in the manner to be prescribed by the Board. In the event that federal funding for school breakfast programs is reduced or eliminated, a school board may support the program with such state or local funds as may be appropriated for such purposes.

§ 22.1-213

Definitions

As used in this article:

“Children with disabilities” means those persons (i) who are aged two to twenty-one, inclusive, having reached the age of two by the date specified in §22.1-254, (ii) who are mentally retarded, physically disabled, seriously emotionally disturbed, speech impaired, hearing impaired, visually impaired, multiple disabled, other health impaired including autistic or who have a specific learning disability or who are otherwise disabled as defined by the Board of Education and (iii) who because of such impairments need special education.

“Related services” means transportation and such developmental, corrective, and other supportive services as are required to assist a disabled child to benefit from special education, including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training.

“Special education” means specially designed instruction at no cost to the parent, to meet the unique needs of a disabled child, including classroom instruction, home instruction, instruction provided in hospitals and institutions, instruction in physical education and instruction in vocational education.

“Specific learning disability” means a disorder in one or more of the basic psychological processes involved in understanding or using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations. The term does not include children who have learning problems which are primarily the result of visual, hearing or motor handicaps, of mental retardation, or of environmental, cultural or economic disadvantage.

§ 22.1-214**Board to prepare special education program for children with disabilities**

A. The Board of Education shall prepare and supervise the implementation by each school division of a program of special education designed to educate and train children with disabilities between the ages defined in §22.1-213 and may prepare and place in operation such program for such individuals of other ages. The program developed by the Board of Education shall be designed to ensure that all children with disabilities have available to them a free and appropriate education, including specially designed instruction to meet the unique needs of such children. The program shall require (i) that the hearing of each disabled child be tested prior to placement in a special education program and (ii) that a complete audiological assessment, including tests which will assess inner and middle ear functioning, be performed on each child who is hearing impaired or who fails the test required in clause (i). The school boards of the several school divisions, the Department for the Visually Handicapped, the Department for the Deaf and Hard-of-Hearing, the Department of Health and other state and local agencies which can or may be able to assist in providing educational and related services shall assist and cooperate with the Board of Education in the development of such program.

B. The Board of Education shall prescribe procedures to afford due process to children with disabilities and their parents or guardians and to school divisions in resolving disputes as to program placements, individualized education programs, tuition eligibility and other matters as defined in state or federal statutes or regulations. These procedures shall encourage the use of mediation as an informal means of resolving such disputes. Mediation shall not, however, be used to deny or delay the due process rights of parents or guardians.

C. The Board of Education may provide for final decisions to be made by a hearing officer. The parents and the school division shall have the right to be represented by legal counsel or other representative before such hearing officer without being in violation of the provisions of §54.1-3904.

D. Any party aggrieved by the findings and decision made pursuant to the procedures prescribed pursuant to subsections B and C of this section may bring a civil action in the circuit court for the jurisdiction in which the school division is located. In any such action the court shall receive the records of the administrative proceedings, shall hear additional evidence at the request of a party, and basing its decision on the preponderance of the evidence, shall grant such relief as the court determines appropriate.

E. Whenever the Board of Education, in its discretion, determines that a school division fails to establish and maintain programs of free and appropriate public education which comply with regulations established by the Board, the Board may withhold all special education moneys from the school division and may use the payments which would have been available to such school division to provide special education, directly or by contract, to eligible children with disabilities in such manner as the Board considers appropriate.

F. The Board of Education shall supervise educational programs for children with disabilities by other public agencies and shall ensure that the identification, evaluation and placement of children with disabilities and youth in education programs by other public agencies, as

appropriate, are consistent with the provisions of the Board of Education's special education regulations.

G. The Board of Education shall prescribe regulations to provide a range of assessment procedures for the evaluation of children with disabilities. These regulations shall include provision for parents to participate, if they so request, in the consideration of the assessment components to be used. However, such regulations shall not require any local school board to exceed the requirements of federal law or regulations for the identification and evaluation of children with disabilities.

§ 22.1-253.13:2

Standard 2. Support services

A. The General Assembly and the Board of Education believe that effective schools must provide and maintain efficient and cost-effective support services to ensure quality education. The General Assembly and the Board of Education further believe that in order to ensure the goal of quality education, local school divisions must have efficient administrative, supervisory, and support services.

B. The Department of Education shall provide to the local school divisions technical assistance in the delivery of those support services which are necessary for the operation and maintenance of the public schools. Such technical assistance services shall include, but not be limited to, in-service training of staff, development of appropriate facility plans, specifications for equipment, technology updates, design of summer school programs and other forms of remediation, and inspections of school buses.

C. Each local school board shall provide those support services which are necessary for the efficient and cost-effective operation and maintenance of its public schools including, but not limited to, administration, instructional support, pupil personnel services, student attendance and health, operation and maintenance of the buildings and management information systems.

D. Each local school board shall also provide a program of pupil personnel services for grades K through 12 which shall be designed to aid students in their educational, social and career development.

E. Pursuant to the appropriations act, support services shall be funded from basic school aid on the basis of prevailing statewide costs.

§ 22.1-270**Preschool physical examinations**

A. No pupil shall be admitted for the first time to any public kindergarten or elementary school in a school division unless such pupil shall furnish, prior to admission, (i) a report from a qualified licensed physician of a comprehensive physical examination of a scope prescribed by the State Health Commissioner performed no earlier than twelve months prior to the date such pupil first enters such public kindergarten or elementary school or (ii) records establishing that such pupil furnished such report upon prior admission to another school or school division and providing the information contained in such report.

B. The physician making a report of a physical examination required by this section shall, at the end of such report, summarize the abnormal physical findings, if any, and shall specifically state what, if any, conditions are found that would identify the child as handicapped.

C. Such physical examination report shall be placed in the child's health record at the school and shall be made available for review by any employee or official of the State Department of Health or any local health department at the request of such employee or official.

D. Such physical examination shall not be required of any child whose parent or guardian shall object on religious grounds and who shows no visual evidence of sickness, provided that such parent or guardian shall state in writing that, to the best of his knowledge, such child is in good health and free from any communicable or contagious disease.

E. The health departments of all of the counties and cities of the Commonwealth shall conduct such physical examinations for medically indigent children without charge upon request and may provide such examinations to others on such uniform basis as such departments may establish.

F, G. [Repealed.]

H. The provisions of this section shall not apply to any child who was admitted to a public school prior to July 1, 1972.

I. Parents or guardians of entering students shall complete a health information form which shall be distributed by the local school divisions. Such forms shall be developed and provided jointly by the Department of Education and Department of Health, or developed and provided by the school division and approved by the Superintendent of Public Instruction. Such forms shall be returnable within fifteen days of receipt unless reasonable extensions have been granted by the superintendent or his designee. Upon failure of the parent or guardian to complete such form within the extended time, the superintendent may send to the parent or guardian written notice of the date he intends to exclude the child from school.

§ 22.1-271.1**Definitions**

For the purpose of §22.1-271.2:

“Admit” or “admission” means the official enrollment or reenrollment for attendance at any grade level, whether full-time or part-time, of any student by any school.

“Admitting official” means the school principal or his designated representative if a public school; if a nonpublic school or child-care center, the principal, headmaster or director of the school or center.

“Documentary proof” means written certification that a student has been immunized, such certificate to be on a form provided by the State Department of Health and signed by the licensed immunizing physician or an employee of the immunizing local health department.

“Student” means any person who seeks admission to a school, or for whom admission to a school is sought by a parent or guardian, and who will not have attained the age of twenty years by the start of the school term for which admission is sought.

“Immunized” or “immunization” means initial immunization and any boosters or reimmunizations required by §32.1-46.

“School” means (i) any public school from kindergarten through grade twelve operated under the authority of any locality within this Commonwealth, (ii) any private or parochial school that offers instruction at any level or grade from kindergarten through grade twelve, and (iii) any private or parochial nursery school or preschool, or any private or parochial child-care center required to be licensed by this Commonwealth.

§ 22.1-271.2

Immunization requirements

A. No student shall be admitted by a school unless at the time of admission the student or his parent or guardian submits documentary proof of immunization to the admitting official of the school or unless the student is exempted from immunization pursuant to subsection C. If a student does not have documentary proof of immunization, the school shall notify the student or his parent or guardian (i) that it has no documentary proof of immunization for the student; (ii) that it may not admit the student without proof unless the student is exempted pursuant to subsection C; (iii) that the student may be immunized and receive certification by a licensed physician or an employee of a local health department; and (iv) how to contact the local health department to learn where and when it performs these services. Neither this Commonwealth nor any school or admitting official shall be liable in damages to any person for complying with this section.

Any physician or local health department employee performing immunizations shall provide to any person who has been immunized or to his parent or guardian, upon request, documentary proof of immunizations conforming with the requirements of this section.

B. Any student whose immunizations are incomplete may be admitted conditionally if that

student provides documentary proof at the time of enrollment of having received at least one dose of the required immunizations accompanied by a schedule for completion of the required doses within ninety days.

The immunization record of each student admitted conditionally shall be reviewed periodically until the required immunizations have been received.

Any student admitted conditionally and who fails to comply with his schedule for completion of the required immunizations shall be excluded from school until his immunizations are resumed.

C. No certificate of immunization shall be required for the admission to school of any student if (i) the student or his parent or guardian submits an affidavit to the admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices; or (ii) the school has written certification from a licensed physician or a local health department that one or more of the required immunizations may be detrimental to the student's health, indicating the specific nature and probable duration of the medical condition or circumstance that contraindicates immunization.

D. The admitting official of a school shall exclude from the school any student for whom he does not have documentary proof of immunization or notice of exemption pursuant to subsection C.

E. Every school shall record each student's immunizations on the school immunization record. The school immunization record shall be a standardized form provided by the State Department of Health, which shall be a part of the mandatory permanent student record. Such record shall be open to inspection by officials of the State Department of Health and the local health departments.

The school immunization record shall be transferred by the school whenever the school transfers any student's permanent academic or scholastic records.

Within thirty calendar days after the beginning of each school year or entrance of a student, each admitting official shall file a report with the local health department. The report shall be filed on forms prepared by the State Department of Health and shall state the number of students admitted to school with documentary proof of immunization, the number of students who have been admitted with a medical or religious exemption and the number of students who have been conditionally admitted.

F. The requirement for mumps immunization as provided in §32.1-46 shall not apply to any child admitted for the first time to any grade level, kindergarten through grade twelve, of a school prior to August 1, 1981.

The requirement for Haemophilus Influenzae Type b immunization as provided in §32.1-46 shall not apply to any child admitted to any grade level, kindergarten through grade twelve.

G. The Board of Health shall promulgate rules and regulations for the implementation of this section in congruence with rules and regulations of the Board of Health promulgated under §32.1-46 and in cooperation with the Board of Education.

§ 22.1-271.3**Guidelines for school attendance for children infected with human immunodeficiency virus; school personnel training required; notification of school personnel in certain cases**

A. The Board of Education, in cooperation with the Board of Health, shall develop, and revise as necessary, model guidelines for school attendance for children infected with human immunodeficiency virus. The first such guidelines shall be completed by December 1, 1989. The Board shall distribute copies of these guidelines to each division superintendent and every school board member in the Commonwealth immediately following completion.

B. Each school board shall, by July 1, 1990, adopt guidelines for school attendance for children with human immunodeficiency virus. Such guidelines shall be consistent with the model guidelines for such school attendance developed by the Board of Education.

C. Every school board shall ensure that all school personnel having direct contact with students receive appropriate training in the etiology, prevention, transmission modes, and effects of blood-borne pathogens, specifically, hepatitis B and human immunodeficiency viruses or any other infections that are the subject of regulations promulgated by the Safety and Health Codes Board of the Virginia Occupational Safety and Health Program within the Department of Labor and Industry.

D. Upon request from a school employee who believes he has been involved in a possible exposure-prone incident which may have exposed the employee to the blood or body fluids of a student, the division superintendent shall contact the local health director who, upon immediate investigation of the incident, shall determine if a potentially harmful exposure has occurred and make recommendations, based upon all information available to him, regarding how the employee can reduce any risks from such exposure. The division superintendent shall share these recommendations with the school employee. The division superintendent and the school employee shall not divulge any information provided by the local health director regarding such student. The information provided by the local health director shall be subject to any applicable confidentiality requirements set forth in Chapter 2 (§32.1-35 et. seq.) of Title 32.1.

§ 22.1-272**Contagious and infectious diseases**

Persons suffering with contagious or infectious disease shall be excluded from the public schools while in that condition.

§ 22.1-273**Sight and hearing of pupil to be tested**

The Superintendent of Public Instruction shall prepare or cause to be prepared, with the advice and approval of the State Health Commissioner, suitable test cards, blanks, record books, and other appliances for testing the sight and hearing of the pupils in the public schools and necessary instructions for the use thereof. The State Department of Education shall furnish the same free of expense to all schools in a school division upon request of the school board of such division accompanied by a resolution of the school board directing the use of such test cards, blanks, record books and other appliances in the schools of the school division.

Within the time periods and at the grades provided in regulations promulgated by the Board of Education, the principal of each such school shall cause the sight and hearing of the relevant pupils in the school to be tested, unless such students are pupils admitted for the first time to a public kindergarten or elementary school who have been so tested as part of the comprehensive physical examination required by §22.1-270 or the parents or guardians of such students object on religious grounds and the students show no obvious evidence of any defect or disease of the eyes or ears. The principal shall keep a record of such examinations in accordance with instructions furnished. Whenever a pupil is found to have any defect of vision or hearing or a disease of the eyes or ears, the principal shall forthwith notify the parent or guardian, in writing, of such defect or disease. Copies of the report shall be preserved for the use of the Superintendent of Public Instruction as he may require.

§ 22.1-274**School health services**

A. A school board shall provide pupil personnel and support services, in compliance with §22.1-253.13:2. A school board may employ school nurses, physicians, physical therapists, occupational therapists and speech therapists. No such personnel shall be employed unless they meet such standards as may be determined by the Board of Education. Subject to the approval of the appropriate local governing body, a local health department may provide personnel for health services for the school division.

B. In implementing subsection C of §22.1-253.13:2, relating to providing support services which are necessary for the efficient and cost-effective operation and maintenance of its public schools, each school board may strive to employ, or contract with local health departments for, nursing services consistent with a ratio of at least one nurse (i) per 2,500 students by July 1, 1996; (ii) per 2,000 students by July 1, 1997; (iii) per 1,500 students by July 1, 1998; and (iv) per 1,000 students by July 1, 1999. In those school divisions in which there are more than 1,000 students in average daily membership in school buildings, this section shall not be construed to encourage the employment of more than one nurse per school building. Further, this section shall not be construed to mandate the aspired-to ratios.

C. The Board of Education shall monitor the progress in achieving the ratios set forth in subsection B of this section and any subsequent increase in prevailing statewide costs, and the mechanism for funding health services, pursuant to subsection E of §22.1-253.13:2 and

the appropriation act. The Board shall also determine how school health funds are used and school health services are delivered in each locality and shall provide, by December 1, 1994, a detailed analysis of school health expenditures to the House Committee on Education, the House Committee on Appropriations, the Senate Committee on Education and Health, and the Senate Committee on Finance.

D. Effective July 1, 1998, no licensed instructional employee shall be disciplined, placed on probation or dismissed because of the instructional employee's refusal to perform nonemergency health-related services for students.

For the purposes of this subsection, "health-related services" means those activities which, when performed in a health care facility, must be delivered by or under the supervision of a licensed or certified professional.

E. Each school board shall ensure that, in school buildings with an instructional and administrative staff of ten or more, at least two instructional or administrative employees have current certification in cardiopulmonary resuscitation or have received training, within the last two years, in emergency first aid and cardiopulmonary resuscitation. In school buildings with an instructional and administrative staff of fewer than ten, school boards shall ensure that at least one instructional or administrative employee has current certification in cardiopulmonary resuscitation or has received training, within the last two years, in emergency first aid and cardiopulmonary resuscitation.

§ 22.1-274.1

Criteria to identify toxic art materials; labeling; use in certain grades prohibited

The State Department of Education, in cooperation with the State Department of Health, shall develop criteria to identify toxic art materials.

After these criteria have been developed, the Department of Education shall require school divisions to evaluate all art materials used in schools and identify those which are toxic. All materials used in the public schools which meet the criteria as toxic shall be so labeled and the use of such art materials shall be prohibited in kindergarten through grade five.

§ 22.1-275

Protective eye devices

Every student and teacher in any school, college, or university shall be required to wear industrial quality eye protective devices while participating in any of the following courses or laboratories:

1. Vocational or industrial arts shops or laboratories involving experience with:
 - a. Hot molten metals,
 - b. Milling, sawing, turning, shaping, cutting, grinding, or stamping of any solid materials,

- c. Heat treatment, tempering, or kiln firing of any metal or other materials,
 - d. Gas or electric arc welding,
 - e. Repair of any vehicle,
 - f. Caustic or explosive materials;
2. Chemical or combined chemical-physical laboratories involving caustic or explosive chemicals or hot liquids or solids.

The governing board or authority of any public or private school or the governing body of each institution of higher learning shall furnish the eye protective devices prescribed in this section free of charge or at cost to the students and teachers of the school participating in such courses or laboratories; provided, however, that such devices may be furnished by parents or guardians of such students. Eye protective devices shall be furnished to all visitors to such courses.

“Industrial quality eye protective devices,” as used in this section, means devices providing side protection and meeting the standards of the American Standards Association Safety Code for Head, Eye, and Respiratory Protection, Z2.1-1959, promulgated by the American Standards Association, Inc.

§ 22.1-275.1

School health advisory board

Each school board shall establish a school health advisory board of no more than twenty members which shall consist of broad-based community representation including, but not limited to, parents, students, health professionals, educators, and others. The school health advisory board shall assist with the development of health policy in the school division and the evaluation of the status of school health, health education, the school environment, and health services.

The school health advisory board shall hold meetings at least semi-annually and shall annually report on the status and needs of student health in the school division to any relevant school, the school board, the Virginia Department of Health, and the Virginia Department of Education.

§ 22.1-278.1

School safety audits required

A. For the purposes of this section, "school safety audit" means an assessment of the safety conditions in each public school to (i) identify and, if necessary, develop solutions for physical safety concerns, including building security issues and (ii) identify and evaluate any patterns of student safety concerns occurring on school property or at school-sponsored events. Solutions and responses may include recommendations for

structural adjustments, changes in school safety procedures, and revisions to the school board's standards for student conduct.

B. The Superintendent of Public Instruction shall develop a list of items to be reviewed and evaluated in the school safety audits required by this section. Each local school board shall require all schools under its supervisory control to conduct school safety audits as defined in this section and consistent with such list.

C. The school board may establish a school safety audit committee to consist of representatives of parents, teachers, local law-enforcement agencies, judicial and public safety personnel, and the community-at-large. The school safety audit committee shall evaluate, in accordance with the directions of the local school board, the safety of each school and submit a plan for improving school safety at a public meeting of the local school board.

§ 22.1-280.1

Reports of certain acts to school authorities

A. Reports shall be made to the principal or his designee on all incidents involving (i) the assault, assault and battery, sexual assault, death, shooting, stabbing, cutting, or wounding of any person on a school bus, on school property, or at a school-sponsored activity; (ii) any conduct involving alcohol, marijuana, a controlled substance, imitation controlled substance, or an anabolic steroid on a school bus, on school property, or at a school-sponsored activity; (iii) any threats against school personnel while on a school bus, on school property or at a school-sponsored activity; or (iv) the illegal carrying of a firearm onto school property. The principal or his designee shall submit a report of all such incidents to the superintendent of the school division. The division superintendent shall annually report all such incidents to the Department of Education for the purpose of recording the frequency of such incidents on forms which shall be provided by the Department and shall make such information available to the public. A division superintendent who knowingly fails to comply or secure compliance with the reporting requirements of this subsection shall be subject to the sanctions authorized in §22.1-65.

B. The principal or his designee shall notify the parent of any student involved in an incident required by subsection A to be reported, regardless of whether disciplinary action is taken against such student or the nature of the disciplinary action. Such notice shall relate to only the relevant student's involvement and shall not include information concerning other students.

Whenever any student commits any reportable incident as set forth in this section, such student shall be required to participate in such prevention and intervention activities as deemed appropriate by the superintendent or his designee. Prevention and intervention activities shall be identified in the local school division's drug and violence prevention plans developed pursuant to the federal Improving America's Schools Act of 1994 (Title IV - "Safe and Drug-Free Schools and Communities Act").

C. The principal shall report to the local law-enforcement agency any act enumerated in subsection A which may constitute a criminal offense.

D. All school boards shall develop, in cooperation with the local law-enforcement agencies, juvenile and domestic relations court judges and personnel, parents, and the community at large, programs to prevent violence and crime on school property and at school-sponsored events. Activities designed to prevent the recurrence of violence and crime may include such interventions as school crime lines, peer mediation, conflict resolution, community service requirements, and any program focused on demonstrating the consequences of violence and crime.

E. A statement providing a procedure and the purpose for the requirements of this section shall be included in the policy manual of all school divisions.

The Board of Education shall promulgate regulations to implement this section including, but not limited to, establishing reporting dates and report formats.

F. School boards are encouraged to develop and use a network of volunteer services in implementing the prevention activities required by subsection D.

G. For the purposes of this section, "parent" or "parents" means any parent, guardian or other person having control or charge of a child.

H. This section shall not be construed to diminish the authority of the Board of Education or the Governor concerning decisions on whether, or the extent to which, Virginia shall participate in the federal Improving America's Schools Act of 1994, or to diminish the Governor's authority to coordinate and provide policy direction on official communications between the Commonwealth and the United States government.

§ 32.1-36

Reports by physicians and laboratory directors

A. Every physician practicing in this Commonwealth who shall diagnose or reasonably suspect that any patient of his has any disease required by the Board to be reported and every director of any laboratory doing business in this Commonwealth which performs any test whose results indicate the presence of any such disease shall make a report within such time and in such manner as may be prescribed by regulations of the Board.

B. Any physician who diagnoses a venereal disease in a child twelve years of age or under shall, in addition to the requirements of subsection A hereof, report the matter, in accordance with the provisions of §63.1-248.3, unless the physician reasonably believes that the infection was acquired congenitally or by a means other than sexual abuse.

C. Any physician practicing in this Commonwealth shall report to the local health department the identity of any patient of his who has tested positive for exposure to human immunodeficiency virus as demonstrated by such test or tests as are approved by the Board for this purpose. However, there is no duty on the part of the physician to notify any third

party other than the local health department of such test result, and a cause of action shall not arise from any failure to notify any other third party.

D. Upon investigation by the local health department of a patient reported pursuant to subsection A, the Commissioner may, to the extent permitted by law, disclose the patient's identity and disease to the patient's employer if the Commissioner determines that (i) the patient's employment responsibilities require contact with the public and (ii) the nature of the patient's disease and nature of contact with the public constitutes a threat to the public health.

The patient's identity and disease state shall be confidential as provided in §32.1-36.1 and §32.1-41. Any unauthorized disclosure of reports made pursuant to this section shall be subject to the penalties of §32.1-27.

E. Physicians and laboratory directors may voluntarily report additional information at the request of the Department of Health for special surveillance or other epidemiological studies.

§ 32.1-39

Surveillance and investigation

The Board shall provide for the surveillance of and investigation into all preventable diseases and epidemics in this Commonwealth and into the means for the prevention of such diseases and epidemics. Surveillance and investigation may include contact tracing in accordance with the regulations of the Board. When any outbreak or unusual occurrence of a preventable disease shall be identified through reports required pursuant to Article 1 (§ 32.1-35 et seq.) of this chapter, the Commissioner or his designee shall investigate the disease in cooperation with the local health director or directors in the area of the disease. If in the judgment of the Commissioner the resources of the locality are insufficient to provide for adequate investigation, he may assume direct responsibility and exclusive control of the investigation, applying such resources as he may have at his disposal. The Board may issue emergency regulations and orders to accomplish the investigation.

§ 32.1-46

Immunization of children against certain diseases; authority to share immunization records

A. The parent, guardian or person standing in loco parentis of each child within this Commonwealth shall cause such child to be immunized by vaccine against diphtheria, tetanus, whooping cough and poliomyelitis before such child attains the age of one year, against *Haemophilus influenzae* type b before he attains the age of thirty months, and against

measles (rubeola), German measles (rubella) and mumps before such child attains the age of two years. All children born on or after January 1, 1994, shall be required to receive immunization against hepatitis B before their first birthday. All children shall also be required to receive a second dose of measles (rubeola) vaccine in accordance with the regulations of the Board. The Board's regulations shall require that all children receive a second dose of measles (rubeola) vaccine prior to first entering kindergarten or first grade and that all children who have not yet received a second dose of measles (rubeola) vaccine receive such second dose prior to entering the sixth grade. The parent, guardian or person standing in loco parentis may have such child immunized by a physician or may present the child to the appropriate local health department which shall administer the required vaccines without charge.

B. A physician or local health department administering a vaccine required by this section shall provide to the person who presents the child for immunizations a certificate which shall state the diseases for which the child has been immunized, the numbers of doses given, the dates when administered and any further immunizations indicated.

C. The vaccines required by this section shall meet the standards prescribed in, and be administered in accordance with, regulations of the Board.

D. The provisions of this section shall not apply if:

1. The parent or guardian of the child objects thereto on the grounds that the administration of immunizing agents conflicts with his religious tenets or practices, unless an emergency or epidemic of disease has been declared by the Board, or
2. The parent or guardian presents a statement from a physician licensed to practice medicine in Virginia which states that the physical condition of the child is such that the administration of one or more of the required immunizing agents would be detrimental to the health of the child.

E. For the purpose of protecting the public health by ensuring that each child receives age-appropriate immunizations, any physician, licensed institutional health care provider, local or district health department, and the Department of Health may share immunization and child locator information, including, but not limited to, the month, day, and year of each administered immunization; the child's name, address, telephone number, birth date, and social security number; and the parents' names. The immunization information; the child's name, address, telephone number, birth date, and social security number; and the parents' names shall be confidential and shall only be shared for the purposes set out in this subsection.

§ 32.1-47

Exclusion from school of children not immunized

Upon the identification of an outbreak, potential epidemic or epidemic of a vaccine-preventable disease in a public or private school, the Commissioner shall have the authority to require the exclusion from such school of all children who are not immunized against that disease.

§ 54.1-2969**Authority to consent to surgical and medical treatment of certain minors**

A. Whenever any minor who has been separated from the custody of his parent or guardian is in need of surgical or medical treatment, authority commensurate with that of a parent in like cases is conferred, for the purpose of giving consent to such surgical or medical treatment, as follows:

1. Upon judges with respect to minors whose custody is within the control of their respective courts.
2. Upon local superintendents of public welfare or social services or their designees with respect to (i) minors who are committed to the care and custody of the local board by courts of competent jurisdiction, (ii) minors who are taken into custody pursuant to §63.1-248.9 and (iii) minors who are entrusted to the local board by the parent, parents or guardian, when the consent of the parent or guardian cannot be obtained immediately and, in the absence of such consent, a court order for such treatment cannot be obtained immediately.
3. Upon the Director of the Department of Corrections or the Director of the Department of Juvenile Justice or his designees with respect to any minor who is sentenced or committed to his custody.
4. Upon the principal executive officers of state institutions with respect to the wards of such institutions.
5. Upon the principal executive officer of any other institution or agency legally qualified to receive minors for care and maintenance separated from their parents or guardians, with respect to any minor whose custody is within the control of such institution or agency.
6. Upon any person standing in loco parentis, or upon a conservator or custodian for his ward or other charge under disability.

B. Whenever the consent of the parent or guardian of any minor who is in need of surgical or medical treatment is unobtainable because such parent or guardian is not a resident of this Commonwealth or his whereabouts is unknown or he cannot be consulted with promptness reasonable under the circumstances, authority commensurate with that of a parent in like cases is conferred, for the purpose of giving consent to such surgical or medical treatment, upon judges of family courts.

C. Whenever delay in providing medical or surgical treatment to a minor may adversely affect such minor's recovery and no person authorized in this section to consent to such treatment for such minor is available within a reasonable time under the circumstances, no liability shall be imposed upon a licensed health professional or licensed hospital by reason of lack of consent to such medical or surgical treatment. However, in the case of a minor fourteen years of age or older who is physically capable of giving consent, such consent shall be obtained first.

D. A minor shall be deemed an adult for the purpose of consenting to:

1. Medical or health services needed to determine the presence of or to treat venereal disease or any infectious or contagious disease which the State Board of Health requires to be reported;
2. Medical or health services required in case of birth control, pregnancy or family planning except for the purposes of sexual sterilization;
3. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for substance abuse as defined in § 37.1-203;
4. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance.

E. Except for the purposes of sexual sterilization, any minor who is or has been married shall be deemed an adult for the purpose of giving consent to surgical and medical treatment.

F. Any minor seventeen years of age may, with the consent of a parent or legal guardian, consent to donate blood and may donate blood if such minor meets donor eligibility requirements. However, parental consent to donate blood by any minor seventeen years of age shall not be required if such minor receives no consideration for his blood donation and the procurer of the blood is a nonprofit, voluntary organization.

G. Any judge, local superintendent of public welfare or social services, Director of the Department of Corrections, Director of the Department of Juvenile Justice, or principal executive officer of any state or other institution or agency who consents to surgical or medical treatment of a minor in accordance with this section shall make a reasonable effort to notify the minor's parent or guardian of such action as soon as practicable.

§ 54.1-3000

Definitions

As used in this chapter, unless the context requires a different meaning:

“Board” means the Board of Nursing.

“Certified nurse aide” means a person who meets the qualifications specified in this article and who is currently certified by the Board.

“Clinical nurse specialist” means a person who is registered by the Board in addition to holding a license under the provisions of this chapter to practice professional nursing as defined in this section. Such a person shall be recognized as being able to provide advanced services according to the specialized training received from a program approved by the Board, but shall not be entitled to perform any act that is not within the scope of practice of professional nursing.

“Certified massage therapist” means a person who meets the qualifications specified in this chapter and who is currently certified by the Board.

“Massage therapy” means the treatment of soft tissues for therapeutic purposes by the application of massage and bodywork techniques based on the manipulation or application of pressure to the muscular structure or soft tissues of the human body. The terms “massage therapy” and “therapeutic massage” do not include the diagnosis or treatment of illness or disease or any service or procedure for which a license to practice medicine, nursing, chiropractic therapy, physical therapy, occupational therapy, acupuncture, or podiatry is required by law.

“Practical nurse” or “licensed practical nurse” means a person who is licensed under the provisions of this chapter to practice practical nursing as defined in this section. Such a licensee shall be empowered to provide nursing services without compensation. The abbreviation “L.P.N.” shall stand for such terms.

“Practical nursing” or “licensed practical nursing” means the performance for compensation of selected nursing acts in the care of individuals or groups who are ill, injured, or experiencing changes in normal health processes; in the maintenance of health; in the prevention of illness or disease; or, subject to such regulations as the Board may promulgate, in the teaching of those who are or will be nurse aides. Practical nursing or licensed practical nursing requires knowledge, judgment and skill in nursing procedures gained through prescribed education. Practical nursing or licensed practical nursing is performed under the direction or supervision of a licensed medical practitioner, a professional nurse, registered nurse or registered professional nurse or other licensed health professional authorized by regulations of the Board.

“Practice of a nurse aide” or “nurse aide practice” means the performance of services requiring the education, training, and skills specified in this chapter for certification as a nurse aide. Such services are performed under the supervision of a dentist, physician, podiatrist, professional nurse, licensed practical nurse, or other licensed health care professional acting within the scope of the requirements of his profession.

“Professional nurse,” “registered nurse” or “registered professional nurse” means a person who is licensed under the provisions of this chapter to practice professional nursing as defined in this section. Such a licensee shall be empowered to provide professional services without compensation, to promote health and to teach health to individuals and groups. The abbreviation “R.N.” shall stand for such terms.

“Professional nursing,” “registered nursing” or “registered professional nursing” means the performance for compensation of any nursing acts in the observation, care and counsel of individuals or groups who are ill, injured or experiencing changes in normal health processes or the maintenance of health; in the prevention of illness or disease; in the supervision and teaching of those who are or will be involved in nursing care; in the delegation of selected nursing tasks and procedures to appropriately trained unlicensed persons as determined by the Board; or the administration of medications and treatments as prescribed by any person authorized by law to prescribe such medications and treatment. Professional nursing, registered nursing and registered professional nursing require specialized education,

judgment, and skill based upon knowledge and application of principles from the biological, physical, social, behavioral and nursing sciences.

§ 54.1-3005

Specific powers and duties of Board

In addition to the general powers and duties conferred in this title, the Board shall have the following specific powers and duties:

1. To prescribe minimum standards and approve curricula for educational programs preparing persons for licensure or certification under this chapter;
2. To approve programs that meet the requirements of this chapter and of the Board;
3. To provide consultation service for educational programs as requested;
4. To provide for periodic surveys of educational programs;
5. To deny or withdraw approval from educational programs for failure to meet prescribed standards;
6. To provide consultation regarding nursing practice for institutions and agencies as requested and investigate illegal nursing practices;
7. To keep a record of all its proceedings;
8. To certify and maintain a registry of all certified nurse aides and to promulgate regulations consistent with federal law and regulation. Such regulations may include standards for the authority of licensed practical nurses to teach nurse aides;
9. To approve programs that entitle professional nurses to be registered as clinical nurse specialists and to prescribe minimum standards for such programs;
10. To maintain a registry of clinical nurse specialists and to promulgate regulations governing clinical nurse specialists;
11. (Effective until July 1, 1999) To promulgate regulations for the voluntary certification of licensees as sex offender treatment providers. In promulgating such regulations, the Board shall consider the standards recommended by the Advisory Committee on Certified Practices pursuant to §54.1-3610. The provisions of this subdivision shall expire on July 1, 1999;
12. To certify and maintain a registry of all certified massage therapists and to promulgate regulations governing the criteria for certification as a massage therapist and the standards of professional conduct for certified massage therapists; and
13. To promulgate regulations for the delegation of certain nursing tasks and procedures not involving assessment, evaluation or nursing judgment to an appropriately trained unlicensed person by and under the supervision of a registered nurse, who retains responsibility and accountability for such delegation.

§ 63.1-248.2**Definitions**

As used in this chapter unless the context requires a different meaning:

“Abused or neglected child” means any child less than eighteen years of age:

1. Whose parents or other person responsible for his care creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon such child a physical or mental injury by other than accidental means, or creates a substantial risk of death, disfigurement, or impairment of bodily or mental functions;
2. Whose parents or other person responsible for his care neglects or refuses to provide care necessary for his health. However, no child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall for that reason alone be considered to be an abused or neglected child;
3. Whose parents or other person responsible for his care abandons such child;
4. Whose parents or other person responsible for his care commits or allows to be committed any act of sexual exploitation or any sexual act upon a child in violation of the law; or
5. Who is without parental care or guardianship caused by the unreasonable absence or the mental or physical incapacity of the child’s parent, guardian, legal custodian or other person standing in loco parentis.

“Complaint” means any information or allegation of abuse or neglect made orally or in writing other than the reports referred to below.

“Department” means the State Department of Social Services.

“Local department” means the department of public welfare or social services of any county or city in this Commonwealth.

“Prevention” means efforts that (i) promote health and competence in people and (ii) create, promote and strengthen environments that nurture people in their development.

“Report” means an official document on which information is given concerning abuse and neglect and which is required to be made by persons designated herein and by local departments in those situations in which investigation of a complaint from the general public reveals suspected abuse or neglect.

“The court” means the family court of the county or city.

Nothing in this section shall relieve any person specified in §63.1-248.3 from making reports required in that section, regardless of the identity of the person suspected to have caused such abuse or neglect.

§ 63.1-248.3**Physicians, nurses, teachers, etc., to report certain injuries to children; penalty for failure to report**

Physicians, nurses, teachers, etc., to report certain injuries to children; penalty for failure to report

A. The following persons who, in their professional or official capacity, have reason to suspect that a child is an abused or neglected child, shall report the matter immediately, except as hereinafter provided, to the local department of the county or city wherein the child resides or wherein the abuse or neglect is believed to have occurred or to the Department of Social Services' toll-free child abuse and neglect hotline:

1. Any person licensed to practice medicine or any of the healing arts,
2. Any hospital resident or intern, and any person employed in the nursing profession,
3. Any person employed as a social worker,
4. Any probation officer,
5. Any teacher or other person employed in a public or private school, kindergarten or nursery school,
6. Any person providing full-time or part-time child care for pay on a regularly planned basis,
7. Any duly accredited Christian Science practitioner,
8. Any mental health professional,
9. Any law-enforcement officer,
10. Any mediator eligible to receive court referrals pursuant to § 8.01-576.8,
11. Any professional staff person, not previously enumerated, employed by a private or state-operated hospital, institution or facility to which children have been committed or where children have been placed for care and treatment, and
12. Any person associated with or employed by any private organization responsible for the care, custody or control of children.

If neither the locality in which the child resides or where the abuse or neglect is believed to have occurred is known, then such report shall be made to the local department of the county or city where the abuse or neglect was discovered or to the Department of Social Services' toll-free child abuse and neglect hotline.

If an employee of the local department is suspected of abusing or neglecting a child, the report shall be made to the juvenile and domestic relations district court of the county or city where the abuse or neglect was discovered. Upon receipt of such a report by the court, the

judge of the juvenile and domestic relations district court shall assign the report to a local department of social services that is not the employer of the suspected employee for investigation; or, if the judge believes that no local department of social services within a reasonable geographic distance can be impartial in investigating the reported case, the judge shall assign the report to the court service unit of his court for investigation. The judge may consult with the State Department of Social Services in selecting a local department to conduct the investigation.

If the information is received by a teacher, staff member, resident, intern or nurse in the course of professional services in a hospital, school or similar institution, such person may, in place of said report, immediately notify the person in charge of the institution or department, or his designee, who shall make such report forthwith.

The initial report may be an oral report but such report shall be reduced to writing by the child abuse coordinator of the local department on a form prescribed by the State Board of Social Services. The person required to make the report shall disclose all information which is the basis for his suspicion of abuse or neglect of the child and, upon request, shall make available to the child-protective services coordinator and the local department investigating the reported case of child abuse or neglect any records or reports which document the basis for the report.

A1. For purposes of subsection A, “reason to suspect that a child is abused or neglected” shall include (i) a finding made by an attending physician within seven days of a child’s birth that the results of a blood or urine test conducted within forty-eight hours of the birth of the child indicate the presence of a controlled substance not prescribed for the mother by a physician, (ii) a finding by an attending physician made within forty-eight hours of a child’s birth that the child was born dependent on a controlled substance which was not prescribed by a physician for the mother and has demonstrated withdrawal symptoms, (iii) a diagnosis by an attending physician made within seven days of a child’s birth that the child has an illness, disease or condition which, to a reasonable degree of medical certainty, is attributable to in utero exposure to a controlled substance which was not prescribed by a physician for the mother or the child, or (iv) a diagnosis by an attending physician made within seven days of a child’s birth that the child has fetal alcohol syndrome attributable to in utero exposure to alcohol. When “reason to suspect” is based upon this subsection, such fact shall be included in the report along with the facts relied upon by the person making the report.

B. Any person required to file a report pursuant to this section who fails to do so within seventy-two hours of his first suspicion of child abuse or neglect shall be fined not more than \$500 for the first failure and for any subsequent failures not less than \$100 nor more than \$1,000.

§ 63.1-248.4

Complaints by others of certain injuries to children

Any person who suspects that a child is an abused or neglected child may make a complaint concerning such child, except as hereinafter provided, to the local department of the county or city wherein the child resides or wherein the abuse or neglect is believed to have occurred

or to the Department of Social Services' toll-free child abuse and neglect hotline. If an employee of the local department is suspected of abusing or neglecting a child, the complaint shall be made to the juvenile and domestic relations district court of the county or city where the abuse or neglect was discovered. Upon receipt of such a report by the court, the judge of the juvenile and domestic relations district court shall assign the report to a local department of social services that is not the employer of the suspected employee for investigation; or, if the judge believes that no local department of social services in a reasonable geographic distance can be impartial in investigating the reported case, the judge shall assign the report to the court service unit of his court for investigation. The judge may consult with the State Department of Social Services in selecting a local department to conduct the investigation. Such a complaint may be oral or in writing and shall disclose all information which is the basis for the suspicion of abuse or neglect of the child.

§ 63.1-248.5

Immunity of person making report, etc., from liability

Any person making a report pursuant to §63.1-248.3, a complaint pursuant to §63.1-248.4, or who takes a child into custody pursuant to §63.1-248.9, or who participates in a judicial proceeding resulting therefrom shall be immune from any civil or criminal liability in connection therewith, unless it is proven that such person acted in bad faith or with malicious intent.

§ 63.1-248.10

Authority to talk to child or sibling

Any person required to make a report or investigation pursuant to this chapter may talk to any child suspected of being abused or neglected or to any of his siblings without consent of and outside the presence of his parent, guardian, legal custodian, or other person standing in loco parentis, or school personnel.

§ 63.1-248.13

Photographs and X rays of child; use as evidence

In any case of suspected child abuse, photographs and X rays of said child may be taken without the consent of the parent or other person responsible for such child as a part of the medical evaluation. Photographs of said child may also be taken without the consent of the parent or other person responsible for such child as a part of the investigation of the case by the local department or the juvenile and domestic relations district court; provided, however,

that such photographs shall not be used in lieu of medical evaluation. Such photographs and X rays may be introduced into evidence in any subsequent proceeding.

The court receiving such evidence may impose such restrictions as to the confidentiality of photographs of any minor as it deems appropriate.

§ 63.1-248.17

Cooperation by state entities

All law-enforcement departments and other state and local departments, agencies, authorities and institutions shall cooperate with each child-protective services coordinator of a local department and any multi-discipline teams in the detection and prevention of child abuse.

SUPERINTENDENT MEMORANDUMS

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF EDUCATION
P.O. BOX 2120
RICHMOND, VIRGINIA 23216-2120

SUPTS. MEMO. NO. 21
January 29, 1993

INFORMATIONAL

TO: Division Superintendents

FROM: Joseph A. Spagnolo, Jr.
Superintendent of Public Instruction

Ernest W. Martin
Assistant Superintendent

SUBJECT: Legally Permissible Activities of Licensed Nurse
Practitioners

The attached letter from the Virginia Commissioner of Health contains information about legally permissible activities of licensed nurse practitioners under the regulations of the state Boards of Medicine and Nursing.

For example, LNPs may substitute for licensed physicians in such matters as the routine physical examinations required for school entrance, participation in sports, and eligibility for other services such as homebound instruction for pregnant students.

If you have questions about the contents of the Commissioner's letter, please contact Doug Cox at the Department of Education, 804/225-2871.

JASjr/EWM/ac

Attachment (1)



COMMONWEALTH of VIRGINIA

ROBERT S. STROUBE, M.D., M.P.H.
STATE HEALTH COMMISSIONER

Department of Health
P. O. BOX 2448
RICHMOND, VA 23218

December 10, 1992

Dr. Joseph A. Spagnolo, Jr.
Superintendent of Public Instruction
101 North 14th Street
Monroe Building
Richmond, Virginia 23219

Dear Dr. Spagnolo:

I would like to request your dissemination of this letter to all Division Superintendents throughout the state informing them and their staff of the legality of licensed nurse practitioners (LNPs) substituting for licensed physicians in such matters as the routine physical examinations required for school entrance, participation in sports, and eligibility for other services, such as homebound instruction for pregnant students. Local health departments employ a large number of LNPs who perform these required examinations and authorizations and sign their names in the place designated for a physician. Some local school divisions have refused to accept the LNP's signature. We have also been made aware of similar problems with LNPs working with private physicians. Those LNPs also have the authority to perform these examinations.

Regulations of the Boards of Medicine and Nursing state that "a licensed nurse practitioner shall be authorized to engage in practices constituting the practice of medicine under the supervision and direction of a licensed physician" and that the practice shall be "in accordance with written protocols" approved by the supervising physician. These protocols uniformly authorize LNPs to perform physical examinations, to report the findings in writing and to sign the report as would be done by a physician. LNPs are also authorized to make referrals for community services such as homebound instruction when indicated for medical reasons.

The Virginia Department of Health interprets the code section 22.1-270 that requires the report of a preschool physical examination signed by a "qualified licensed physician" allows the report to be signed by a LNP. The Medicaid program accepts services performed by a LNP the same as by a physician. LNPs are now authorized to write prescriptions and school may staff

VDH VIRGINIA
DEPARTMENT
OF HEALTH
Protecting You and Your Environment

Dr. Joseph Spagnolo, Jr.
December 10, 1992
Page 2

receive requests to administer medications prescribed by a LNP.

Because LNPs may legally perform all these functions that formerly required a licensed physician and because the supervising physician is frequently not available, especially in the health departments, we request that schools accept the signature of a LNP in place of the signature of a physician in all the instances mentioned and in similar situations. This will be a time saver for the schools, health departments, private physicians and parents.

Please let me know if you have any questions about this request.

Sincerely,



Robert B. Stroube, M.D., M.P.H.
State Health Commissioner

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF EDUCATION
P. O. BOX 2120
RICHMOND, VIRGINIA 23218-2120

SUPTS. MEMO NO. 22
February 5, 1999

INFORMATIONAL

TO: Division Superintendents

FROM: Paul D. Stapleton
Superintendent of Public Instruction

SUBJECT: School Health Form HPE-h12

The Department of Education distributes a number of School Health Forms to local school divisions. These School Health Forms are currently being reviewed by the Department of Health and the Department of Education.

The following form has been deleted: **FORM HPE-h12, THE SCHOOL ENTRANCE HEALTH INFORMATION FORM (DATED DECEMBER 1983)**. The information on that form is provided in Part I, Health Information Section of the School Entrance Physical Examination and Immunization Certification, (MCH 213C) dated October 1991.

Should you have any questions or comments, please contact Gwen Smith, R.N., Student Health Services Specialist at (804) 786-8671 or e-mail gpsmith@pen.k12.va.us.

PDS/gs

cc: Gwen Smith

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF EDUCATION
P. O. BOX 6Q
RICHMOND, VIRGINIA 23216-2060

SUPTS. MEMO NO. 137
June 19, 1992

INFORMATIONAL

TO: Division Superintendents

FROM: Joseph A. Spagnolo, Jr., Superintendent of Public Instruction
Edward W. Carr, Chief of Staff

SUBJECT: School Health Education Advisory Board

The 1992 General Assembly amended and reenacted § 22.1 - 275.1 to require each school division to have a school health advisory board. The advisory board should be organized to advise school divisions about the development and implementation of school health programs, including health instruction, the school environment and health services.

The school health advisory board should be organized to include no more than twenty (20) members, with a broad base of representation including parents, students, health professionals and educators. In addition, the board may be organized to include representatives from community agencies, the local school board, business and industry, child advocacy groups, volunteer health agencies, the school division staff, and institutions of higher education. Each advisory board is required to meet at least semi-annually and to provide an annual report on the status and needs of student health in the school division to any relevant school, the school board the Virginia Department of Health, and the Virginia Department of Education.

Please find attached a copy of the act to create the Iota} school health advisory boards. You will also find attached a plan which may be helpful in defining and organizing the work of the local school health advisory board. If you have any questions, please contact Mrs. Fran Meyer at 804/225-3210, Virginia Department of Education,

JASjr/EWC/ewh

Attachments



COMMONWEALTH of VIRGINIA

James W. Dyke, Jr.
Secretary of Education

Office of the Governor
Richmond 23219

(804) 786-1151
TDD (804) 786-7765

MEMORANDUM

June 9, 1992

TO: ALL LOCAL SUPERINTENDENTS
ALL LOCAL SCHOOL BOARD CHAIRS

FROM: James W. Dyke, Jr.
James P. Jones, President, Board of Education
Joseph A. Spagnolo, Jr., Superintendent of Public Instruction

SUBJECT: Student Health Issues

In all of our discussions about educational goals, we have made it clear that in order for students to take full advantage of a "world class education", they must be ready to learn when they enter school and be healthy so they can concentrate on learning while they are in school.

In that regard, the Governor's Task Force on Child Health recommended that the Secretaries of Education and Health and Human Resources work together to encourage local school divisions to increase the school's role in improving the health of our children.

Secretary Dyke and Secretary of Health and Human Resources Howard Cullum have moved to implement that recommendation by agreeing that certain actions should be taken by each school division in Virginia. The purpose of this memorandum is to request that your division work to enact the following actions by the beginning of the 1992-93 school year:

1. All school divisions should take advantage of the federally-funded school breakfast program or a comparable program. Students cannot learn if they are hungry. This program offers students an opportunity to receive needed nourishment to give them energy during the school day. The program is funded by the federal government and it should be

ALL LOCAL SUPERINTENDENTS
ALL LOCAL SCHOOL BOARD CHAIRS
Student Health Issues
June 9, 1992

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used by every school in Virginia. The Department of Education is prepared to assist localities that do not presently offer this program to have such a program in place by the start of the next school year.

2. School divisions should work towards having onsite health screening for children. Many children presently do not have access to health care. One way we are addressing this need is by our planning for pilot school-Community Health Clinics, funded through Medicaid. We encourage your individual efforts to make health screenings available, and we encourage you to work with us on our Medicaid pilot programs. In addition, consideration should be given to involvement with the federal Early end Periodic Screening, Diagnosis and Treatment Program, which supports screening and early intervention.
3. School buildings should be "smoke free" as well as "drug free." Smoking in school buildings should be banned (or at least confined to a separate designated area). Treatment alternatives for those persons making the transition from smoking to non-smoking should be publicized.
4. School divisions should make available to students and their families information about locally available health services.
5. Schools should make every effort to have a medical staff person available to each building during school hours. This can be accomplished through creative approaches, including working with local businesses and medical organizations in a public/private partnership.
6. All school divisions should have in place by December 1992 the Health Advisory Councils required by the §22.1-275.1 end revised in Senate Bill 435. Further, these councils should be fully utilized to help develop community support for the health initiatives

ALL LOCAL SUPERINTENDENTS
ALL LOCAL SCHOOL BOARD CHAIRS
Student Health Issues
June 9, 1992

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schools need to implement in order to fully serve our students.

7. Review school food policies for the purpose of eliminating unhealthy Junk food and promoting the availability of nutritious, healthy food items. This applies to school cafeteria or food sales as well as vending machines which are accessible to students.
8. Review physical education policies to ensure that each student, from preschool to secondary school, participates in an appropriate and meaningful program geared toward physical fitness.
9. In recognition of the health, injury, and developmental problems associated with contact sports, the Governor's Task Force on intercollegiate Athletics will be reviewing the appropriate age for students to begin involvement in interscholastic athletics. Superintendents should pay particular attention to the work of this task force in their review of the elementary and secondary school athletics.

We realize that school systems have full plates in terms of meeting standards and accomplishing goals, particularly in tight economic times, we also, however, agree that we cannot afford to ignore the health needs of our students. Achieving world class education requires students ready to learn and that means healthy students. We end the Department stand ready to work with you to implement these initiatives.

JWDJr/JPJ/JASJr/pfc

cc: The Honorable Howard M. Cullum



COMMONWEALTH OF VIRGINIA
DEPARTMENT OF EDUCATION
P. O. BOX 8Q
RICHMOND, VIRGINIA 23216

SUPTS. MEMO NO. 159
August 19, 1987

INFORMATIONAL

MEMO TO: Division Superintendents

FROM: S. John Davis
Superintendent of Public Instruction

E. B. Howerton, Jr., Deputy Superintendent
for Instruction and Personnel

SUBJECT: Procedures for Implementing School Law 22.1-273

At its April meeting, the Board of Education established procedures for implementing School Law 22.1-273 Sight and hearing of pupils to be tested. A copy of the procedures for implementation is attached.

Because all children are required to have a physical examination when they first enter school, it was determined that this requirement would provide adequate screening for kindergarten students. Therefore, the only health screening required to be done for pupils will be for sight and hearing defects in grades 3, 7, and 10. Schools will continue to use the current HPE-h-8 forms for recording their findings.

If you have any questions, please contact Bernard R. Taylor, director, Division of Sciences and Elementary Administration at 804/225-2865 or Jeane L. Bentley, associate director, Health, Physical Education, and Driver Education at 804/225-2866.

/tim

Attachment

IMPLEMENTATION OF SCHOOL LAW 22.1-273

PROCEDURES:

That sight and hearing of pupils in grades 3, 7, and 10 be screened within 60 administrative working days of the opening of school. Whenever a pupil is found to have any defect of vision or hearing or a disease of the eyes or ears, the principal shall notify the parent or guardian in writing, of such defect or disease.

This screening of pupils will be monitored through the administrative review process.

Practices That Are Encouraged:

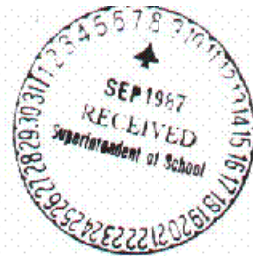
That teachers at all grade levels be observant of speech defects, postural deviations, hearing impairments, dental defects, visual problems and significant deviations in height and weight. If observed, they should be recorded on health record and reported to the school nurse for follow-up.

That scoliosis screening be done for all students in grades 5 through 9.

Adopted Virginia Board of Education
April 1987

D. Perkins - OPE
Mr. Tolson - FZI
Thompson
Bill

COMMONWEALTH OF VIRGINIA
 DEPARTMENT OF EDUCATION
 P. O. BOX 6Q
 RICHMOND, VIRGINIA 23216



SUPTS. MEMO. NO. 168
 September 2, 1987

INFORMATIONAL

MEMO TO: Division Superintendents

FROM: S. John Davis
 Superintendent of Public Instruction

E. B. Howerton, Jr., Deputy Superintendent
 for Instruction and Personnel

SUBJECT: Procedures for Implementing School Law 22.1-273

Reference is made to Superintendent's Memorandum #159 (Informational) dated August 14, 1987, which provided guidance for school division personnel when implementing section 22.1-273 of the Code of Virginia.

Existing Board of Education regulations as specified in Regulations Governing Special Education Programs in Handicapped Children and Youth in Virginia, September 1984 stipulate that:

All children, within 60 administrative working days of initial enrollment in a public school, shall be screened in the following areas to determine if formal assessment is indicated: (a) speech, voice, and language; (b) fine and gross motor functions; and (c) vision and hearing.

Additional screening for vision and hearing should now occur in grades 3, 7, and 10. Schools should continue to use the current HPE-h-8 form for recording screening results.

Questions regarding this matter should be addressed to Ms. Jeane L. Bentley, Associate Director of Health, Physical Education, and Driver Education at (804) 225-2866 or Ms. Patricia A. White, Associate Director for Visiting Teacher/School Social Work, School Psychology and School Health Services at (804) 225-2072.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF EDUCATION
P. O. BOX 60
RICHMOND, VIRGINIA 23216

SUPTS. MEMO NO. 255
November 29, 1989

INFORMATIONAL

TO: Division Superintendents

FROM: S. John Davis, Superintendent of Public Instruction
E. B. Howerton, Jr., Deputy Superintendent for
Curriculum, Instruction and Personnel Services

SUBJECT: Model Guidelines for School Attendance for
Children with Human Immunodeficiency Virus

Attached is a copy of the Model Guidelines for School Attendance for Children with Human Immunodeficiency Virus. These guidelines were developed as a result of House Joint Resolution 1974 requiring that they be completed by December 1, 1989, in cooperation with the Department of Health and distributed after approval by Board of Education

House Joint Resolution 1974 also requires that each school board shall, by July 1, 1990, adopt guidelines for school attendance of children with human immunodeficiency virus. These guidelines must be consistent with the model guidelines for school attendance developed by the Board of Education. We would like to call to your attention that the charge for the Department of Education was to address school attendance of children with the HIV virus and not confidentiality which is governed by Title 32 of the Code of Virginia. Please send copies of the attached guidelines to your school board members. If you have any questions, please contact H. Douglas Cox, Director, Division of Pupil Personnel Services, at (804) 225-2861.

SJD/EBHJr/tim

Attachment

MODEL GUIDELINES FOR SCHOOL ATTENDANCE FOR CHILDREN WITH
HUMAN IMMUNODEFICIENCY VIRUS

The _____ Public School Division will work cooperatively with the _____ Health Department to ensure compliance with Virginia Code 22.1-271.3 for school attendance of children infected with human immunodeficiency virus (HIV).

- A. Students are expected to be in compliance with an immunization schedule (Article 2, 22.1-271.2); however, some required immunizations may be harmful to the health of the student who is HIV infected or has AIDS. Students who are HIV infected or have AIDS may get an exemption from complying with the requirements (Virginia Code 22.1-27.2, C). School personnel will cooperate with public health personnel in completing and coordinating immunization data, exemptions, and exclusions, including immunization forms.
- B. Mandatory screening for HIV infection is not warranted as a condition for school entry. Upon learning a student is HIV infected or has AIDS, the superintendent will consult with the individual's family and physician or a health official from the local health department to determine whether the student is well enough to stay in school. Since it is known that HIV is not transmitted through casual contact, any student who is HIV infected will continue education in a regular classroom assignment unless the health status interferes significantly with performance. If a change in the student's program is necessary, the superintendent or designee, family, and physician or health official will develop an individual plan which is medically, legally, and educationally sound. If the HIV student is receiving special education services, the services will be in agreement with established policies.
- C. Parents/guardians may appeal decisions for restriction or exclusion as determined by the school division's established procedures.
- D. All persons privileged with any medical information about HIV infected students shall be required to treat all proceedings, discussions, and documents as confidential information. Individuals will be informed of the situation on a "Need to Know" basis with written consent of the parent/guardian.
- E. Universal precautions for handling blood will be implemented within the school setting and on buses. To ensure implementation of the proper standard operating procedures for all body fluids, the guidelines from the Virginia Department of Health will be followed. Inservice training will be provided to all school personnel. Training will include local division policies; etiology, transmission, prevention, and risk reduction of HIV; standard operating procedures for handling blood and body fluids; and community resources available for information and referral. Periodic updates will be supplied through inservice or memoranda.
- F. Comprehensive and age-appropriate instruction on the principal modes by which HIV is spread and the best methods for the reduction and prevention of AIDS are required to encourage the support and protection of the HIV infected student. To enhance school attendance, the school division will collaborate with public and private organizations in the provision of support services to HIV infected students.

Definitions of Terms Associated With Special Education Programs for Children With Disabilities

Note: The following definitions are from the *Regulations Governing Special Education Programs in Handicapped Children and Youth in Virginia* (1994), unless otherwise noted. (These regulations were under revision at the time of development of this manual.)

Special Education

Special Education. Special education means specially designed instruction, at no cost to the parent, to meet unique needs of a child with a disability, including instruction conducted in the classroom, in the home, in hospitals, and institutions and in other setting and instruction in physical education.

1. The term includes speech-language pathology or any other related service, if the service consists of specially designed instruction, at no cost to the parents, to meet the unique needs of a child with a disability, and is considered ‘special education’ rather than a ‘related service’ under state standards.
2. The term also includes vocational education if it consists of specially designed instruction at no cost to the parent, to meet the unique needs of a child with a disability.
3. The terms in this definition are defined as follows:
 - a) ‘At no cost’ means that all specially designed instruction is provided without charge, but does not preclude incidental fees which are normally charged to nondisabled students or their parents as part of the general education program.
 - b) ‘Physical education’ means:
 - ◆ The development of physical and motor fitness; fundamental motor skills and patterns; and skills in aquatics, dance, and individual and group games and sports (including intramural and lifetime sports).
 - ◆ The term includes special physical education, adaptive physical education, movement education, and motor development.

- c) ‘Vocational education’ means organized educational programs that are directly related to the preparation of individuals for paid or unpaid employment, or for additional preparation for a career requiring other than a baccalaureate or advanced degree.

The definition of special education is a particularly important one. While a child may be considered to have a disability under other laws, he does not have a disability under these regulations unless he needs special education. If a child does not need special education, there can be no related services since the provision of a related service must be necessary for a child to benefit from special education.

Disabilities

Autism. Autism means “a developmental disability significantly affecting verbal and non-verbal communication and social interaction, generally evident before age 3, that adversely affects a child’s educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences.”

Deafness. Deafness means “a hearing impairment that is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, that adversely affects educational performance.”

Deaf Blindness. Deaf Blindness means “concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational problems that they cannot be accommodated in special education programs solely for deaf or blind children.”

Developmental Delay. Developmental delay means “a significant delay in one or more of the following areas of development for a child below age 8:

1. Cognitive ability.
2. Motor skills.
3. Social/adaptive behavior.
4. Perceptual skills
5. Communication skills.

Hearing Impairment. Hearing impairment means “an impairment in hearing, whether permanent or fluctuating, that adversely affects a child’s educational performance but which is not included under the definition of ‘deafness’ in this section.”

Mental Retardation. Mental retardation means “significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period, which adversely affects a child’s educational performance.”

Orthopedic Impairment. Orthopedic impairment means “a severe orthopedic impairment that adversely affects a child’s educational performance. The term includes impairments caused by congenital anomaly (e.g., club foot, absence of some member), impairments caused by disease (e.g., poliomyelitis, bone tuberculosis), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contracture).”

Other Health Impairment. Other health impairment means “having limited strength, vitality, or alertness due to health problems, such as a heart condition, tuberculosis, rheumatic fever, arthritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, attention deficit disorder/attention deficit hyperactivity disorder, or diabetes that are chronic or acute that adversely affect a child’s educational performance.”

Serious Emotional Disturbance. Serious emotional disturbance means:

1. A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, that adversely affects a child’s educational performance.
 - ◆ An inability to learn which cannot be explained by intellectual, sensory, or health factors.
 - ◆ An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
 - ◆ Inappropriate types of behaviors or feelings under normal circumstances.
 - ◆ A general pervasive mood of unhappiness or depression.
 - ◆ A tendency to develop physical symptoms or fears associated with personal or school problems.
2. The term includes children who are schizophrenic, but does not include children who are socially maladjusted unless it is determined that they are seriously emotionally disturbed.

Severe and Profound Disability. Severe and profound disability means “individuals who have:

1. Have primary disabilities that severely impair cognitive abilities, adaptive skills, and life functioning.

2. May have associated behavior problems.
3. May have the high probability of additional and/or sensory disabilities.
4. Do require significantly more educational resources than are provided for children with mild and moderate disabilities in special education programs.”

Specific Learning Disability. Specific learning disability means “a disorder in one or more of the basic psychological processes involved in understanding or in using languages, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include children who have learning problems which are primarily the result of visual, hearing, or motor disabilities, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.”

Traumatic Brain Injury. Traumatic brain injury means “an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child’s educational performance. The term applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, or motor abilities; psychosocial behavior; physical functions; information processing; and speech. The term does not apply to brain injuries that are congenital or degenerative, or brain injuries induced by birth trauma.”

Visual Impairment. Visual impairment means “an impairment in vision that, even with correction, adversely affects a child’s educational performance. The term includes both partial sight and blindness.”

Related Services and Other Definitions

Assistive technology. “Assistive technology service means any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device.” The term includes:

1. The evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child’s customary environment;
2. Purchasing, leasing or otherwise providing for the acquisition of assistive technology devices by children with disabilities;
3. Selecting, designing, fitting, customizing, adapting, applying, retaining, repairing, or replacing assistive technology devices;

4. Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation programs;
5. Training or technical assistance for a child with a disability or, if appropriate, that child's family;
6. Training or technical assistance for professionals, employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life function of children with disabilities.

Audiology. Audiology means "services provided by a qualified audiologist and includes:

1. Identification of children with hearing loss.
2. Determination of the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the rehabilitation of hearing.
3. Provision of habilitative activities, such as language habilitation, auditory training, speech reading (lip-reading) hearing evaluation, and speech conservation.
4. Creation and administration of programs for prevention of hearing loss.
5. Counseling and guidance of pupils, parents and teachers regarding hearing loss.
6. Determination of the child's need for group and individual amplification and fitting an appropriate aid and evaluating the effectiveness of amplification."

Counseling Services. Counseling Services means "services provided by qualified visiting teachers, social workers, psychologists, guidance counselors, or other qualified personnel."

Medical Services. Medical services means "services provided by a licensed physician to determine a child's medically related disability which results in the child's need for special education and related services."

Occupational Therapy. Occupational therapy means "services provided by a qualified occupational therapist or services provided under the direction of a qualified occupational therapist and includes:

1. Improving, developing, or restoring functions impaired or lost through illness, injury or deprivation.
2. Improving ability to perform tasks for independent functioning when functions are impaired or lost.
3. Preventing, through early intervention, initial or further impairment or loss of function."

Parent Counseling and Training. Parent counseling and training means “assisting parents in understanding the special needs of their child and providing parents with information about child development.”

Physical Education. Physical education means:

1. “The development of:
 - ◆ Physical and motor fitness;
 - ◆ Fundamental motor skills and patterns; and
 - ◆ Skills in aquatics, dance, and individual and group games and sports (including intramural and lifetime sports).
2. The term includes special physical education, adaptive physical education, movement education, and motor development.”

Physical Therapy. Physical therapy means “services provided by a qualified physical therapist or under the direction or supervision of a qualified physical therapist upon medical referral and direction.”

Psychological Services. Psychological services includes “those services provided by a qualified psychologist or services provided under the direction or supervision of a qualified psychologist:

1. Administering psychological and educational tests and other assessment procedures;
2. Interpreting assessment results;
3. Obtaining, integrating, and interpreting information about child behavior and conditions relating to learning;
4. Consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological tests, interviews, and behavioral evaluations; and
5. Planning and managing a program of psychological services, including psychological counseling for children and parents.”

Recreation. Recreation includes:

1. “Assessment of leisure function.
2. Therapeutic recreation services.
3. Recreation program in schools and community agencies.

4. Leisure education.”

Rehabilitation Counseling. Rehabilitation counseling services “means services provided by qualified personnel in individual or group sessions that focus specifically on career development, employment preparation, achieving independence, and integration in the workplace and community of a student with a disability. The term also includes vocational rehabilitation services provided to students with disabilities by vocational rehabilitation programs funded under the Rehabilitation Act of 1973, as amended.”

School Health Services. School health services means “services provided by a qualified school nurse or other qualified person.”

Social Work Services. Social work services includes “those services provided by a qualified visiting teacher or social worker:

1. Preparing a social or developmental history on a child with a disability.
2. Group and individual counseling with the child and family.
3. Working with those problems in a child’s living situation (home, school, and community) that affect the child’s adjustment in school.
4. Mobilizing school and community resources to enable the child to learn as effectively as possible in his or her educational program.”

Speech/Language Pathology. Speech/language pathology “includes:

1. Identification of children with speech or language disorders.
2. Diagnosis and appraisal of specific speech or language disorders.
3. Referral for medical or other professional attention necessary for the habilitation of speech or language disorders.
4. Provisions of speech and language services for the habilitation or prevention of communicative disorders.
5. Counseling and guidance of parents, children, and teachers regarding speech and language disorders.”

Transition Services. Transition services means “a coordinated set of activities for a student, designed within an outcome-oriented process, that promotes moving from school to post-school activities, including postsecondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation. The coordinated set of activities described must:

1. Be based on the individual student's needs, taking into account the student's preferences and interests
2. Include:
 - a) The development of employment and other post-school adult living objectives.
 - b) Instruction.
 - c) Community experiences.
 - d) If appropriate, acquisition of daily living skills and functional vocational evaluation.

Transition services for students with disabilities may be special education if they are provided as specially designed instruction, or related services if they are required to assist a student with a disability to benefit from special education. The list of activities above is not intended to be exhaustive.”

Transportation. Transportation “includes:

1. Travel to and from school and between schools.
2. Travel in and around school building.
3. Specialized equipment (such as special or adapted buses, lifts, and ramps), if required to provide special transportation for a child with a disability.”

Vocational Education. Vocational education means “organized educational programs offering a sequence of courses or instruction in a sequence or aggregation of occupational competencies that are directly related to the preparation of individuals for paid or unpaid employment in current or emerging occupations requiring other than a baccalaureate or advanced degree. These programs must include competency-based applied learning that contributes to an individual's academic knowledge, higher-order reasoning, and problem-solving skills, work attitudes, general employability skills, and the occupation-specific skills necessary for economic independence as a productive and contributing member of society. This term also includes applied technology education.”

Recommended Childhood Immunization Schedule

United States, January - December 1999

NOTE. The following table is from: CDC. (1999, January 15). Notice to Readers Recommended Childhood Immunization Schedule—United States, 1999. *MMWR* 1999, 48, 8-16.

Vaccines ¹ are listed under the routinely recommended ages. Light shaded areas indicate the range of acceptable ages for vaccination. Circled areas indicate vaccines to be assessed and administered if necessary. Dark shaded area indicates the incorporation of this new vaccine into clinical practice may require additional time and resources from health-care providers.

VACCINE	AGE										
	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	4-6 years	11-12 years	14-16 years
Hepatitis B ²	← Hep B →										
		← Hep B →		← Hep B →						HepB	
Diphtheria and tetanus toxoid and pertussis ³		DTaP	DTaP	DTaP		← DTaP →		DTaP	← Td →		
<i>H. influenzae</i> type b ⁴		Hib	Hib	Hib	← Hib →						
Poliovirus ⁵		IPV	IPV	Polio				Polio			
Rotavirus ⁶		Rv	Rv	Rv							
Measles-Mumps-Rubella ⁷					← MMR →			MMR	MMR		
Varicella ⁸					← Var →				Var		

¹ This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines. Any dose not given at the recommended age should be given as a "catch-up" vaccination at any subsequent visit when indicated and feasible. Combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

² **Infants born to hepatitis B surface antigen (HBsAg) -negative mothers** should receive the second dose of hepatitis B (Hep B) vaccine at least 1 month after the first dose. The third dose should be administered at least 4 months after the first dose and at least 2 months after the second dose, but not before age 6 months. **Infants born to HBsAg-positive mothers** should receive Hep B vaccine and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate injection sites. The second dose is recommended at age 1-2 months and the third dose at age 6 months. **Infants born to mothers whose HBsAg status is unknown** should receive Hep B vaccine within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mothers HBsAg status; if the

HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). All children and adolescents (through age 18 years) who have not been vaccinated against hepatitis B may begin the series during any visit. Special efforts should be made to vaccinate children who were born in or whose parents were born in areas of the world where hepatitis virus infection is moderately or highly endemic.

³ Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP) is the preferred vaccine for all doses in the vaccination series, including completion of the series in children who have received one or more doses of whole-cell diphtheria and tetanus toxoids and pertussis vaccine (DTP). Whole-cell DTP is an acceptable alternative to DTaP. The fourth dose (DTP or DTaP) may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and if the child is unlikely to return at age 15-18 months. Tetanus and diphtheria toxoids (Td) is recommended at age 11-12 years .if at least 5 years have elapsed since the last dose of DTP, DTaP, or DT. Subsequent routine Td boosters are recommended every 10 years.

⁴ Three *Haemophilus influenzae* type B(Hib) conjugate vaccines are licensed for infant use. If Hib conjugate vaccine (PRP-OMP) (PedvaxHIB[®] or ComVax[®] [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. Because clinical studies in infants have demonstrated that using some combination products may induce a lower immune response to the Hib vaccine component, DTaP/Hib combination products should not be used for primary vaccination in infants at ages 2, 4, or 6 months unless approved by the Food and Drug Administration for these ages.

⁵ Two poliovirus vaccines are licensed in the United States: inactivated poliovirus vaccine (IPV) and oral poliovirus vaccine (OPV). The ACIP, AAFP and AAP recommend that the first two doses of poliovirus vaccine should be IPV. The ACIP continues to recommend a sequential schedule of two doses of IPV administered at ages 2 and 4 months followed by two doses of OPV at age 12-18 months and age 4-6 years. Use of IPV for all doses also is acceptable and is recommended for immunocompromised persons and their household contacts. OPV is no longer recommended for the first two doses of the schedule and is acceptable only for special circumstances (e.g., children of parents who do not accept the recommended number of injections, late initiation of vaccination that would require an unacceptable number of injections, and imminent travel to areas where poliomyelitis is endemic. OPV remains the vaccine of choice for mass vaccination campaigns to control outbreaks of wild poliovirus.

⁶ The first dose of Rv vaccine should not be administered before age 6 weeks, and the minimum interval between doses is 3 weeks. The Rv vaccine series should not be initiated at age 7 months, and all doses should be completed by the first birthday. The AAFP opinion is that the decision to use rotavirus (Rv) vaccine should be made by the parent or guardian in consultation with the physician or other health-care provider.

⁷ The second dose of measles, mumps, and rubella vaccine (MMR) is recommended routinely at age 4-6 years but may be administered during any visit provided at least 4 weeks have elapsed since receipt of the first dose and that both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule no later than the routine visit to a health-care provider at age 11-12 years.

⁸ Varicella (Var) vaccine is recommended at any visit on or after the first birthday for susceptible children (i.e., those who lack a reliable history of chickenpox [as judged by a health-care provider] and who have not been vaccinated). Susceptible persons aged ≥ 13 years should receive two doses given at least 4 weeks apart.

Use of trade names and commercial sources is for identification only and does not imply endorsement by CDC or the U.S. Department of Health and Human Services.

MINIMUM IMMUNIZATION REQUIREMENTS FOR ENTRY INTO CHILD CARE AND SCHOOL

NOTE: The following information is from the Commonwealth of Virginia, Virginia Department of Health, Division of Immunization, current as of April 1999.

For more information, please refer to the *Code of Virginia 22.1-272*, Immunization Requirements and Section 3.00 of the Rules and Regulations for the Immunization of School Children.

Upon entry or transfer into a child care or school setting, documentary proof shall be provided of adequate immunization with the prescribed number of doses of vaccine indicated below, **as appropriate for the child's age**:

DtaP, DTP, DT or Td - A minimum of 3 doses. A child must have at least one dose of diphtheria, tetanus, pertussis-containing vaccine after the fourth birthday. If the child has received six doses before the fourth birthday, additional doses are contraindicated. DT vaccine is required for children medically exempt from pertussis vaccine. Adult Td is required for children 7 years of age and older who do not meet the minimum requirements.

Polio - A minimum of 3 doses of OPV or IPV in any combination. If a child has had only 3 doses of polio vaccine, one dose must have been administered after the fourth birthday. However, a child who has received four doses before the fourth birthday, is adequately immunized and does **not** need a dose after the fourth birthday.

Hib - This vaccine is required **only** for children up to 30 months of age. A complete series consists of either 2 or 3 doses (depending on manufacturer) followed by a booster dose at age 12-15 months. However, the number of doses required is governed by the child's current age and not the number of prior doses received. Unvaccinated children between the ages of 15 and 30 months are only required to have one dose of vaccine.

Hepatitis B- A minimum of 3 doses for all children born on and after January 1, 1994 (with at least 4 months spacing between the 1st and 3rd dose).

Measles, Mumps, Rubella - A minimum of 2 measles, 1 mumps, and 1 rubella. (Most children receive 2 doses of each because the vaccine is usually given as MMR). First dose must be administered at age 12 months (365 days) or older. Second dose of measles vaccine does not have to be administered until age 4 to 6 years (at entry to kindergarten) but can be administered at any time after the minimum interval between dose 1 and dose 2. The minimum interval is one month (28 days).

*****FOR FURTHER INFORMATION, PLEASE CONSULT THE STATE BOARD OF HEALTH'S REGULATIONS FOR THE IMMUNIZATION OF SCHOOL CHILDREN, AUGUST 1,1995*****

NEW LEGISLATION EFFECTIVE JULY 1, 1999:

Varicella – All susceptible children born on and after January 1, 1997, shall be required to have a dose of chickenpox vaccine not earlier than 12 months (365 days).

Hepatitis B for 6th Graders – Beginning July 1, 2001, all children who have not received three doses of hepatitis B vaccine will be required to receive such immunization prior to entering the 6th grade.

NOTE: The following information is from: Commonwealth of Virginia State Board of Health. (1995). *Regulations for the Immunization of School Children*. Richmond, Va.: Virginia Department of Health.

CONDITIONAL ENROLLMENT: In order for a student to be CONDITIONALLY ENROLLED, the student must have proof of having received at least one (1) dose of each of the required immunizations (DTP, OPV, MEASLES, MUMPS, and RUBELLA) and have a schedule on file to receive the remainder of the required doses within 90 DAYS.

RELIGIOUS EXEMPTIONS: The student or his parent or guardian submits a CERTIFICATE OF RELIGIOUS EXEMPTION (FORM CRE-I), to the admitting official of the school to which the student is seeking admission. Form CRE-I is an affidavit stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. The CRE-1 must be signed by a NOTARY PUBLIC AND STAMPED WITH THE NOTARY'S SEAL.

MEDICAL EXEMPTIONS: The school must have written certification from a physician or a local health department on FORM MCH213C that one or more of the required immunizations may be detrimental to the student's health. Such certification of medical exemption shall specify the nature and probable duration of the medical condition or circumstance that contraindicates immunization.

If there are questions regarding immunizations please call your local health department or the Virginia Department of Health, Division of Immunization, at (804) 786-6246.

Reportable Diseases in Virginia

Disease Reporting and Control in Virginia. On January 6, 1999, a new version of the Regulations for Disease Reporting and Control went into effect. These regulations define the procedures by which disease surveillance, a critical component of the disease control process, is conducted in Virginia. Major changes to the regulations include (1) diseases added to the List of Reportable Diseases, (2) diseases removed from the List of Reportable Diseases, and (3) changes for laboratories. Among the additional notable changes to the Regulations, is the requirement for child care center directors to report outbreaks to the health department, as is required of schools.

Those Required to Report. All physicians, directors of medical care facilities, and directors of laboratories must report persons diagnosed with any of the reportable diseases (Table 1) to the local health department. Persons in charge of schools and day care centers are required to report outbreaks. Reporting is usually accomplished by completing an Epi-1 form and mailing it to the local health department, although laboratories often use their own form for reporting. The diseases listed in bold capital letters in Table 1, as well as outbreaks or any other unusual occurrence of disease, require rapid communication, such as by telephone.

Excerpts from the Regulation for Disease Reporting and Control, Commonwealth of Virginia, State Board of Health, January 1999:

12 VAC 5-90-90. Those Required to Report.

D. Person in Charge of a School or Child Care Center.

Any person in charge of a school or child care center shall report immediately to the local health department the presence or suspected presence in his school or child care center of children who have common symptoms suggesting an epidemic or outbreak situation. Any person so reporting shall be immune from liability provided by §32.1-38 of the Code of Virginia.

[Note: Please refer to the Regulations for a description of reporting requirements for physicians, directors of medical care facilities, and directors of laboratories.]

VAC 5-90-10. Definitions.

“School” means i) any public school from kindergarten through grade 12 operated under the authority of any locality within the Commonwealth; ii) any private or parochial school that offers instruction at any level or grade from kindergarten through grade 12; iii) any private or parochial nursery school or preschool, or any private or parochial child care center licensed by the Commonwealth; and iv) any preschool handicapped classes or Head Start classes.

“Child care center” means a child day center, child day center system, child day program, family day home, family day system, or registered family day home as defined by §63.1-195 of the Code of Virginia, or similar place providing day care of children by such other name as may be applied.

“Epidemic” means the occurrence in a community or region of cases of an illness clearly in excess of normal expectancy.

“Outbreak” means the occurrence of more cases of disease than expected.

“Foodborne outbreak” means two or more cases of similar illness acquired through the consumption of food contaminated with chemicals or an infectious agent or its toxic products. Such illnesses include but are not limited to heavy metal intoxications, staphylococcal food poisoning, botulism, salmonellosis, shigellosis, Clostridium perfringens food poisoning, hepatitis A, and Escherichia coli 0157:H7 illness.

Confidentiality. The health department protects the confidentiality of the information received, and anyone reporting information to the health department according to the provision of the regulations is immune from liability for so reporting.

Ordering Information. To obtain a copy of the Regulations for Disease Reporting and Control, Commonwealth of Virginia, State Board of Health, January 1999, and reporting form (Form Epi-1, 11/98), please contact:

*Virginia Department of Health
Office of Epidemiology
P.O. Box 2448
Richmond, VA 23218
Telephone: 804-786-6261
Web site: <http://www.vdh.state.va.us>*

Table 1. List of Reportable Diseases ¹³²

<i>Acquired immunodeficiency syndrome (AIDS)</i>	<i>Lyme disease</i>
<i>Amebiasis</i> *	<i>Lymphogranuloma venereum</i>
<i>ANTHRAX</i> *	<i>Malaria</i> *
<i>Arboviral infection</i> *	<i>MEASLES (Rubeola)</i> *
<i>BOTULISM</i> *	<i>MENINGOCOCCAL INFECTION</i> *
<i>Brucellosis</i> *	<i>Mumps</i> *
<i>Campylobacter infection</i> *	<i>Ophthalmia neonatorum</i>
<i>Chancroid</i> *	<i>OUTBREAKS, ALL (including foodborne, nosocomial, occupational, toxic substance-related, waterborne, and other outbreaks)</i>
<i>Chickenpox</i>	<i>PERTUSSIS (Whooping cough)</i> *
<i>Chlamydia trachomatis infection</i> *	<i>PLAGUE</i> *
<i>CHOLERA</i> *	<i>POLIOMYELITIS</i> *
<i>Cryptosporidiosis</i> *	<i>PSITTACOSIS</i>
<i>Cyclosporiasis</i> *	<i>RABIES, HUMAN AND ANIMAL</i> *
<i>DIPHTHERIA</i> *	<i>Rabies treatment, post-exposure</i>
<i>Ehrlichiosis</i>	<i>Rocky Mountain spotted fever</i>
<i>Escherichia coli O157:H7 and other enterohemorrhagic E. coli infections</i> *	<i>Rubella (German measles), including congenital rubella syndrome</i> *
<i>Giardiasis</i> *	<i>Salmonellosis</i> *
<i>Gonorrhea</i> *	<i>Shigellosis</i> *
<i>Granuloma inguinale</i>	<i>Streptococcal disease, Group A, invasive</i> *
<i>HAEMOPHILUS INFLUENZAE INFECTION, INVASIVE</i> *	<i>Syphilis (report PRIMARY and SECONDARY syphilis by rapid means)</i> *
<i>Hantavirus pulmonary syndrome</i>	<i>Tetanus</i>
<i>Hemolytic uremic syndrome (HUS)</i>	<i>Toxic shock syndrome</i>
<i>Hepatitis, Acute Viral</i>	<i>Toxic substance related illnesses</i>
<i>HEPATITIS A</i> *	<i>Trichinosis</i> *
<i>Hepatitis B</i> *	<i>TUBERCULOSIS DISEASE (MYCOBACTERIA *-)</i>
<i>Hepatitis C</i>	<i>Tuberculosis infection in children age <4 years (Mantoux skin test reaction >10 mm)</i>
<i>Other Acute Viral Hepatitis</i>	<i>Typhoid fever</i>
<i>Human immunodeficiency virus (HIV) infection</i> *	<i>Typhus</i>
<i>Influenza</i> * ¶	<i>Vancomycin-resistant Staphylococcus aureus</i> *
<i>Kawasaki syndrome</i>	<i>Vibrio infection</i> *
<i>Lead – elevated blood levels</i> *	<i>YELLOW FEVER</i>
<i>Legionellosis</i> *	
<i>Leprosy (Hansen disease)</i>	
<i>Listeriosis</i> *	

CONDITIONS LISTED IN CAPITAL AND BOLD LETTERS must be reported rapidly to the local health director or other professional employee of the department via telecommunication (e.g., telephone, telephone transmitted facsimile, telegraph, teletype, etc). Report all other diseases within seven days of diagnosis.

* These conditions are reportable by directors of laboratories. These and all other conditions are reportable by physicians and directors of medical care facilities as well.

¹³² Commonwealth of Virginia, State Board of Health. (1999, January). *Regulation for Disease Reporting and Control*, Web site: <http://www.vdh.state.va.us/epi/list.htm>

¶ Physicians and directors of medical care facilities should report influenza by number of cases only (and type of influenza, if available).

~ AFB on smear, speciation, and drug susceptibility

Blue Ribbon Commission Survey

Ratings: For your school health program, please provide success ratings for the goal items provided. Please use the following code to indicate your school's level of success: (3) High, (2) Moderate, or (1) Some to indicate your school's level of success. If your school does not have a program component to address this particular goal, check the (0) not addressed, no program, no service category

Factors: Also for each of the nine programs, consider what factors you feel contribute most to the overall success of your program and what problem factors keep you from accomplishing your goals. The following are examples of success and problem factors.

Success Factors: staff skills, excellent curriculum, excellent planning

Problem factors: not in improvement plan, low priority, inadequate materials

Item No.	I. HEALTH EDUCATION - Health Knowledge, Skill, and Behavior Improvement Areas Addressed by School's Instructional Programs	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
	The school's health instruction program...						
1	Increases physical fitness knowledge and healthful behavior						
2	Increases consumer health knowledge and healthful practices						
3	Increase community and environmental health knowledge and healthful practices						
4	Improves conflict resolution skills						
5	Improves stress management skills						
6	Increase injury prevention knowledge and safe behavior skills						
7	Increases nutrition knowledge and healthful eating behavior						
8	Increases disease prevention and control knowledge and healthful behavior						
9	Increases knowledge of substance use/abuse and healthful behavior						
10	Increases human growth and development knowledge						

Item No.	II. HEALTH SERVICES - The school's health services program...	Rate the overall success of your school health program in accomplishing the following goals in (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
11	Provides for early detection of health problems that can interfere with learning						
12	Provides information to families to facilitate access to primary health care services						
13	Provides expert handling of emergency crisis medical situations						
14	Provides record keeping needed to facilitate timely immunization of students						
15	Provides screenings for identifying student health deficits (e.g., vision, hearing, motor, and speech deficits) to ensure timely linkage to appropriate remediation services						
16	Provides monitoring of communicable diseases to prevent their spread						
17	Provides case management services to address changing health and education needs of students with chronic medical conditions and/or disabilities						

Item No.	III. HEALTHFUL SCHOOL ENVIRONMENT- School Improvement Program School maintenance and improvement efforts ensure...	Rate the overall success of your school health program in accomplishing the following goals in (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
18	Safe physical plant (e.g., toxic substance management, building meets code requirements)						
19	Safe equipment (e.g., classroom and playground equipment)						
20	Safety of school area (e.g., crime prevention efforts, safety practices)						
21	Appropriate physical learning conditions (e.g., temperature, lighting, auditory conditions)						
22	Environment for meeting privacy needs in restrooms and locker rooms						

Item No.	IV. PARENT/COMMUNITY INVOLVEMENT IN SCHOOL HEALTH PROGRAMS - Parent /Community Involvement Activities	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
	School has...						
23	Consistent, proactive approaches for involving parents/families in all student health promotion programs						
24	Effective ways of communicating with parents about student and school health issues						
25	Cooperative ventures between the community and school to ensure health problems do not interfere with learning						
26	Student participation in community projects/programs designed to promote health						
27	Health curriculum support from community agencies and/or organizations						

Item No.	V. SCHOOL COUNSELING PROGRAMS - School Counseling Service Goals	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
	School counseling program...						
28	Helps students identify their educational goals						
29	Helps students identify their career goals						
30	Helps students identify their social goals						
31	Prepares students to function more effectively in the educational communities of their choice						
32	Provides services to help students resolve their developmental problems						

Item No.	VI. PSYCHOLOGICAL AND SOCIAL SERVICES - Psychological and Social Service Linkages	Rate the overall success of your school health program in accomplishing the following goals in (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
	School staff...						
33	Ensure that students showing early signs of social/psychological services are diagnosed						
34	Ensure that special needs students (disabled) have access to appropriate psychological and social services						
35	Ensure that students <u>in crisis</u> are linked with appropriate psychological and social services						
36	Facilitate linkages with case management services for students/families with complex psychological and social health needs						

Item No.	VII. NUTRITION SERVICES - Nutrition Services	Rate the overall success of your school health program in accomplishing the following goals in (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
	The school has...						
37	Meal time long enough to accommodate healthy eating habits for all children						
38	Meal time long enough to accommodate children with special feeding problems						
39	Balanced selections of foods that enable healthy eating practices at mealtime						
40	A nutrition program that provides a variety of healthy food choices to meet individual needs and preferences						
41	Nutritional drink and snack alternatives available in school's vending machines						
42	Staff trained to obtain/provide modified meals and nutrition support for children with special needs						

Item No.	VIII. HEALTH PROMOTION FOR STAFF - Health Promotion for Staff	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
	School improves...						
43	Faculty and staff health by providing adequate smoke-free space						
44	Faculty and staff by providing access to lockers and exercise facilities						
45	Faculty and staff by providing them access to food choices						
46	Faculty and staff by providing health promotion (wellness) programs						
47	Faculty and staff health by having a staff wellness program that spans the entire school year						
48	Faculty and staff health by providing an employee assistance program (EAP) that enables early access to treatment services (e.g., financial counseling, stress reduction, and psychological services)						
17	Provides case management services to address changing health and education needs of students with chronic medical conditions and/or disabilities						

Item No.	IX. PHYSICAL EDUCATION - Physical Education Program	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
	The school's physical education program...						
49	Helps students develop life skills to promote optimal health						
50	Promotes the physical fitness of all students						
51	Promotes in-class benefits for all students						
52	Accommodates the special needs of all students						

APPENDIX B: First Aid Guide for School Emergencies

This flipbook is a quick reference guide for administering immediate and temporary care to an injured or ill individual. It contains practical, step-by-step instructions that describe what to do when caring for an injured or ill person. It replaces a previous addition published in 1991.

Who Should Use this Flipbook

This flipbook is designed for use by teachers, school nurses, clinic aides, and other staff members who are responsible for the health and safety of students and others in the school setting.

How to Use This Flipbook

This flipbook should be posted in a place that is easily accessible to all staff members. It is recommended that **all** staff become familiar with the contents of this flipbook **prior** to the necessity for handling an emergency situation.

This flipbook is designed to help the user locate procedures for handling emergency situations:

- ◆ The first section, *Topical Index*, is an alphabetical listing of all topics contained in this flipbook.
- ◆ The second section, *General Emergency Guidelines*, provides general guidance and information on the administration of emergency assistance to individuals who are ill or injured prior to the arrival of emergency medical personnel.
- ◆ The third section, *Universal Precautions*, provides an overview of handling blood and body fluids in the school setting.
- ◆ The fourth section, *First Aid Procedures*, describes specific procedures for treating an ill or injured individual.
 - ◇ This section lists each first aid procedure in alphabetical order.
 - ◇ Within each procedure, circumstances in which the first aid provider may need to refer to an additional first aid procedure and/or an emergency care procedure have been **bolded**.
 - ◇ Within each first aid procedure, the need to call the **Rescue Squad, Poison Control**, or a **parent** has been bolded. (The term “parent” refers to the student’s parent or legal guardian or the designated emergency contact person.)
- ◆ The fifth section, *Emergency Care Procedures*, describes the following procedures for the handling of emergency and life-threatening crisis medical situations:
 - ◇ Choking

- ◇ Cardiopulmonary Resuscitation (CPR)
- ◇ Rescue Breathing
- ◆ The sixth, and final section, *Poisonings*, gives the first aid provider detailed instructions for the handling of an individual who has ingested or, in some way, come into contact with a poison.

TOPICAL INDEX

- GENERAL EMERGENCY GUIDELINES**
- UNIVERSAL PRECAUTIONS**
- FIRST AID PROCEDURES**
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Protruding Wounds
- ABDOMINAL PAIN*
Non Severe/Stomach Ache
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Conscious: (Infant)
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CPR (Adult: Ages 8 & older)
CPR (Child: Ages 1-8)
CPR (INFANT)
- RESCUE BREATHING*

Rescue Breathing
(Adult: Ages 8 & older)
Rescue Breathing
(Child: Ages 1-8)
Rescue Breathing
(Infant)

POISONINGS
INGESTED/SWALLO
WED
INHALATION OF GAS
VAPORS

OCULAR (EYE)
EXPOSURE
SKIN EXPOSURE
WASP & BEE STINGS

GENERAL EMERGENCY GUIDELINES

1. Remain calm and communicate a calm, supportive attitude to the ill or injured individual.
2. Never leave an ill or injured individual unattended. Have someone else call a parent/Rescue Squad.
3. **Do not** move an injured individual or allow the person to walk (bring help and supplies to the individual). Other school staff or responsible adults should be enlisted to help clear the area of students who may congregate following an injury/altercation.
4. If trained and if necessary, institute CPR or Rescue Breathing.
5. Have Rescue Squad called immediately if there is:
 - ◆ Breathing problem
 - ◆ Bleeding-severe
 - ◆ Anaphylactic reaction (shock)
 - ◆ Burns (serious or covering large area)
 - ◆ Head, neck, or back injury
 - ◆ Concern about heart problem
 - ◆ Poisoning
 - ◆ Unconsciousness
 - ◆ Seizures (more than one convulsion)
 - ◆ Serious limb injury or amputation
 - ◆ Penetrating injury or impalement
 - ◆ Foreign object in throat
6. **Do not** become involved in using treatment methods beyond your skill. Recognize the limits of your competence. Perform procedures only within your scope of practice. When in doubt, call the Rescue Squad. All persons working with students are encouraged to obtain training in CPR/First Aid through an authorized community agency.

UNIVERSAL PRECAUTIONS: FOR HANDLING BLOOD/BODY FLUIDS IN SCHOOL

- ◆ Anticipating potential contact with infectious materials in routine and emergency situations is the most important step in preventing exposure to and transmission of infections.
- ◆ Use universal precautions and infection control techniques in **all** situations that may present the hazard of infection.
- ◆ Precautions should be observed when caring for bleeding injuries or handling other body fluids in emergency situations. Body fluids include blood, drainage from cuts, scabs, skin lesions, urine, feces, vomitus, nasal discharge, and saliva. The body fluids of all persons should be considered to be potentially hazardous.
- ◆ Avoid direct contact with body fluids. Caregivers who anticipate assisting in first aid when body fluids are present (e.g., cleaning cuts and scrapes, treating a bloody nose) should use disposable gloves.
- ◆ If unanticipated skin contact occurs, hands and all other affected skin should be washed with soap and running water as soon as possible.
- ◆ Diligent and proper hand washing, the use of barriers (e.g., gloves), appropriate disposal of waste products and needles, and proper care of spills are essential techniques of infection control.
- ◆ If it is necessary to perform rescue breathing, a one-way mask or other infection control barrier should be used. However, rescue breathing should not be delayed while such a device is located.

HAND WASHING PROCEDURE

1. Wash hands vigorously with soap under a stream of running water for at least 10 seconds.
2. Rinse hands well with running water and thoroughly dry with paper towels.
3. If soap and water are unavailable, bacteriostatic/bactericidal wet towelettes or instant hand cleaner may be used.

GLOVES

1. Gloves should be worn when direct care may involve contact with any type of body fluid.
2. Disposable single-use, waterproof gloves (e.g., latex or vinyl) should be used. (Vinyl gloves should be used with individuals who have a latex allergy or a high potential for developing a latex allergy, e.g., individuals with spina bifida.)
3. **Do not** reuse gloves.

DISPOSAL OF INFECTIOUS WASTE

1. All used or contaminated supplies (e.g., gloves and other barriers, sanitary napkins, bandages) except syringes, needles, and other sharp implements should be placed into a plastic bag and sealed. This bag can be thrown into the garbage out of reach of children or animals.
2. Needles, syringes, and other sharp objects should be placed **immediately** after use in a metal or other puncture-proof container that is leak proof on the bottom and sides. To reduce the risk of a cut or accidental puncture by a needle, **NEEDLES SHOULD NOT BE RECAPPED, BENT, OR REMOVED FROM THE SYRINGE BEFORE DISPOSAL**. Once the container is full, it should be sealed, bagged, and kept out of the reach of children or animals until it can be disposed of properly.
3. Body waste (e.g., urine, vomitus, feces) should be disposed of in the toilet. If body fluids (e.g., urine, vomitus) are spilled, the body fluids should be covered with an absorbent sanitary material, gently swept up, and discarded in plastic bags.

CLEAN-UP: Spills of blood and body fluids

1. Spills of blood and body fluids should be cleaned up immediately with an approved disinfectant cleaner.
2. Wear gloves.
3. Mop up spill with absorbent material.
4. Wash the area well, using the disinfectant cleaner supplied in the clinic or a 1:10 water/bleach solution. (Mix 1 part household bleach in 10 parts of water. Replace solution daily.)
5. Dispose of gloves, soiled towels, and other waste in sealed plastic bags and place in garbage, as already indicated.

CLEAN-UP: Routine environmental clean-up

1. When clinics and bathrooms become contaminated with blood or body fluids, use the procedures outlined above.
2. Regular cleaning of non-contaminated surfaces, (e.g., toilet seats, tabletops) can be done with standard cleaning solutions or the 1:10 water/bleach solution described above. Regular cleaning of obvious soil is more effective than extraordinary attempts to disinfect or sterilize surfaces.
3. Rooms and dustpans must be rinsed with disinfectant. Mops must be soaked in disinfectant, washed, and thoroughly rinsed. The disinfectant solution should be disposed of promptly down the drain.

Please refer to:

- ◆ The Occupational Safety and Health Administration (OSHA) Final Bloodborne Pathogens Standards for the most recent requirements.

- ◆ Keen, T., Cox, A., Ford, N., & Henry, J. (Eds.). (1996). Guidelines for Specialized Health Care Procedures, pp. IV- 1-33. Richmond, Va.: Virginia Department of Health.

FIRST AID PROCEDURES

ABDOMINAL INJURY

GENERAL WOUNDS

TREATMENT

1. Determine cause of injury.
2. Call **Rescue Squad**.
3. Carefully position individual on their back.
4. If movement of the legs does not cause pain, place a pillow under knees to help relax the abdominal muscles.
5. If movement of the legs causes pain, leave individual lying flat.
6. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
7. Control bleeding with a dressing.
8. **Do not** give food or drink.
9. **Do not** give medication.
10. Call parent.

PROTRUDING WOUNDS

NOTE: A protruding abdominal wound is an injury to the abdomen causing organs to be exposed or protrude.

TREATMENT

1. Determine cause of injury.
2. Call **Rescue Squad**.
3. Carefully position individual on their back.
4. If movement of the legs does not cause pain, place a pillow under knees to help relax the abdominal muscles.
5. If movement of the legs causes pain, leave individual lying flat.
6. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
7. **Do not** apply any pressure to the protruding organs.
8. **Do not** attempt to push protruding organs back into the abdomen.
9. Remove any clothing from around wound.
10. Cover wound with clean cloth (preferably sterile).
11. If there is a delay in medical assistance:
 - Apply moist sterile dressings or a clean cloth loosely over the wound.
 - Use warm tap water to moisten the dressings.
 - Hold dressing in place with firm bandage.
 - **Do not** allow bandage to interfere with blood flow.
12. Treat for Shock. (See **Shock**.)
13. **Do not** give food or drink.
14. **Do not** give medication.
15. Call parent.

ABDOMINAL PAINNON SEVERE/ STOMACH ACHE**TREATMENT**

1. Take temperature.
2. Have individual rest 10-30 minutes.
3. If temperature is greater than 100 °F and/or pain intensifies, call parent and recommend follow-up medical care.

SEVERE/ WITH OR WITHOUT VOMITING**TREATMENT**

1. Call **Rescue Squad**.
2. **Do not** give anything to eat or drink.
3. **Do not** give medication.
4. Take temperature.
5. Call parents and recommend follow-up medical care.

ALLERGIC REACTION

ANAPHYLACTIC

NOTE: An anaphylactic reaction (**shock**) is a rare, severe, and sudden generalized reaction that is **potentially life threatening**.

SIGNS AND SYMPTOMS

- ◆ Apprehension and flushing
- ◆ Rash (especially the face)
- ◆ Swelling of affected areas (especially the face and tongue)
- ◆ Breathing difficulty, wheezing, gurgling, high-pitched sounds
- ◆ Skin feels moist and/or appears flushed, pale, or bluish
- ◆ Absent or weak pulse

TREATMENT

1. Call **Rescue Squad**.
2. If individual is known to have allergies, consult the written action plan on file and proceed with physician's recommendations.
3. Check individual's pulse and respiration. Be alert for breathing and pulse being slower or faster than usual.
4. If necessary, cover with blankets to keep warm.
5. If necessary, certified personnel start CPR and/or Rescue Breathing. (See **CPR, Rescue Breathing, and Shock**.)
6. Call parent.

HIVES (RASH)/ITCHING

Note: Hives are eruptions of the skin caused by contact with or ingestion of an allergic substance or food. Hives appear as more or less tiny, round bumps on the skin, white in the middle, with pale, red periphery, often accompanied by itching. Hives involving mouth, eyelids and tongue are **potentially life threatening**.

TREATMENT

1. If hives involve eyelids, lips, mouth, or tongue, call **Rescue Squad** immediately.
2. Apply cold compress.
3. Give reassurance.
4. If individual is too uncomfortable to do school work, send home.
5. Call parent and recommend follow-up medical care.

SWELLING

NOTE: An allergic reaction that causes swelling is **potentially life threatening**.

TREATMENT

1. If there is face, mouth, and neck swelling, call **Rescue Squad** immediately.
2. Apply cold compresses.
3. Give reassurance.
4. Call parent and recommend follow-up medical care.

WHEEZING

NOTE: Wheezing is an abnormally high-pitched noise resulting from a partially obstructed airway. Airway obstruction is **potentially life threatening**.

TREATMENT

1. If breathing problem is severe or prolonged past 2 minutes, call **Rescue Squad**.
2. Place individual in comfortable position, usually sitting.
3. If necessary, certified personnel start Rescue Breathing. (See **Rescue Breathing**.)
4. Call parent.

AMPUTATION

NOTE: Amputation is the severing (all or part) of a limb or digit of the body.

TREATMENT

1. Call **Rescue Squad** immediately.
2. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
3. Control bleeding by placing a clean dressing (preferably sterile) over the wound and apply pressure on a nearby artery.
4. Treat for Shock. (See **Shock**.)
5. If complete amputation:
 - Place direct pressure on wound site.
 - Place indirect pressure on nearby arteries.
 - Locate severed body part.
 - **Do not** wash severed part.
 - Wrap part in moist, clean (preferably sterile) cloth.
 - Place part in plastic airtight bag and lay on ice to transport.
 - Give part to Rescue Squad personnel.
6. Call parent.

ASTHMA

NOTE: Asthma is a lung disease that causes repeated episodes of breathing problems. Symptoms of asthma can be mild, severe, or fatal. Asthma is **potentially life threatening**.

SIGNS AND SYMPTOMS

- ◆ Breathing problems
- ◆ Wheezing (high-pitched, whistling sound)
- ◆ Coughing
- ◆ Tightness in chest
- ◆ Shortness of breath

TREATMENT

1. If breathing problem is severe or prolonged past 2 minutes, call **Rescue Squad** immediately.
2. Place individual in comfortable position, usually sitting.
3. Remain calm.
4. If individual is known to school personnel as having asthma, refer to the written action plan on file and proceed with physician's recommendations.
5. If any of the following conditions exist, administration of subcutaneous epinephrine should be considered by qualified personnel:
 - Breathing rate of less than 12 or greater than 36 times a minute.
 - An anxious individual or individual with decreased consciousness.
 - Shortness of breath or inability to speak more than 3-5 word sentences.
 - Difficulty breathing (significant use of neck and chest muscles for breathing or poor air movement).
 - Bluish lips or nail beds.
 - Pale skin.
6. Call parent.

BITES

NOTE: For all bites, if there is any history of allergic reaction or if any of the following signs and symptoms are present, call **Rescue Squad**.

SIGNS AND SYMPTOMS

- ◆ Hives (tiny bumps on the skin)
- ◆ Itching and swelling involving skin, nose, or eyes
- ◆ Throat tightness, swelling inside the mouth, metallic taste, and hoarseness
- ◆ Wheezing (high-pitched, whistling sound), difficulty breathing, chest tightness
- ◆ Person appears pale
- ◆ Weakness, dizziness, headache, fainting
- ◆ Abdominal pain
- ◆ Nausea
- ◆ Vomiting
- ◆ Diarrhea

ANIMAL**TREATMENT**

1. Call **Rescue Squad**.
2. If alert, allow individual to sit up.
3. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
4. Cleanse wound thoroughly with soap and water for 5 minutes.
5. Cover wound with clean bandage (preferably sterile).
6. Determine individual's tetanus immunization status from school record.
7. Call parent and recommend follow-up medical care.
8. Call Animal Control.
9. Report all animal bites to the local health department.

HUMAN**TREATMENT**

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. Cleanse wound thoroughly with soap and water for 5 minutes.
3. Cover wound with clean bandage (preferably sterile).
4. If signs and symptoms of allergic reaction as described above (See **Bites**) occur, call **Rescue Squad**.
5. Call parent and recommend follow-up medical care.

SPIDER: BLACK WIDOW &/OR BROWN RECLUSE

NOTE: Bites from black widow spiders and brown recluse spiders can make a person sick and are **potentially life threatening**.

TREATMENT

1. Lower affected part below the level of the heart.
2. Cleanse area with soap and water.
3. If signs and symptoms of allergic reaction as described above (See **Bites**) occur, call **Rescue Squad**.
4. Call parent and recommend immediate follow-up medical care.

TICK**TREATMENT**

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. Using tweezers, remove tick as follows:
 - Grasp tick as close to the skin as possible.
 - Gently, but firmly pull tick straight out.
 - Avoid any twisting or jerking motion that may break off the mouth parts in the skin.
3. **Do not** remove tick using nail polish, petroleum jelly, alcohol, or a hot match.
4. After the tick has been removed, cleanse area thoroughly with soap and water.
5. Apply an antiseptic, (e.g., alcohol or iodine) to the bite site.
6. If signs and symptoms of allergic reaction as described above (See **Bites**) occur, call **Rescue Squad**.
7. Call parent and recommend follow-up medical care.

BLEEDING

INTERNAL

NOTE: Internal bleeding is **potentially life threatening**.

SIGNS AND SYMPTOMS

- ◆ Tender, swollen, bruised, or hard areas of the body
- ◆ Rapid, weak pulse
- ◆ Skin feels cool and moist
- ◆ Skin looks pale or bluish
- ◆ Vomiting or coughing up blood
- ◆ Excessive thirst
- ◆ Confusion, fainting, drowsiness, or unconsciousness

TREATMENT

1. Determine cause of injury.
2. Call **Rescue Squad**.
3. Maintain open airway. If necessary, certified personnel start CPR and Rescue Breathing. (See **CPR** and **Rescue Breathing**.)
4. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
5. Control bleeding by applying pressure on a nearby artery.
6. Monitor for signs and symptoms of shock. (See **Shock**.)
7. If vomiting, lay individual on side.
8. Keep individual warm, comfortable, and calm.
9. Call parent.

SEVERE BLEEDING FROM A WOUND

TREATMENT

1. Determine cause of injury.
2. Call **Rescue Squad** immediately.
3. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
4. Control bleeding by placing a clean covering (preferably sterile) over wound and applying pressure on a nearby artery.
5. If injury does not appear to involve broken bone, elevate injured area above the level of the heart.
6. If necessary, add more dressings. **Do not** remove previous dressing. Secure dressing in place.
7. In case of amputation:
 - ◆ Place direct pressure on wound site.
 - ◆ Place indirect pressure on nearby arteries.
 - ◆ Locate severed body part.
 - ◆ **Do not** wash part.
 - ◆ Wrap part in moist, clean (preferably sterile) cloth.
 - ◆ Place part in plastic airtight bag and lay on ice to transport.
 - ◆ Give part to Rescue Squad personnel.
8. Treat for shock. (See **Shock**.)
9. If necessary, certified personnel should start CPR and Rescue Breathing. (See **CPR** and **Rescue Breathing**.)
10. Call parent.

BLISTERS**TREATMENT**

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. Cleanse area with soap and water. Avoid breaking blister.
3. Apply a dry bandage.
4. If blister is broken, wash with soap and water and apply dry bandage.
5. If blistered area is red, swollen, and/or painful, call parent and recommend follow-up medical care.

BROKEN BONES

CASTS

NOTE: Swelling of extremity may occur when a cast is used. This may cause a restriction in blood flow and is **potentially life threatening**.

SIGNS AND SYMPTOMS

- ◆ Complaints of pain, tingling, and numbness
- ◆ Feelings of cold
- ◆ Swelling
- ◆ Discoloration

TREATMENT

1. Elevate casted extremity.
2. Call parent and recommend immediate follow-up medical care.

DISLOCATION

NOTE: A dislocation is the movement of a bone from its normal position.

SIGNS AND SYMPTOMS

- ◆ Inability to move the affected part normally
- ◆ A bump, ridge, or hollow that does not normally exist in a nonfunctioning joint
- ◆ Pain
- ◆ Bruising
- ◆ Swelling

TREATMENT

1. Determine cause of injury.
2. Keep individual quiet and warm
3. **Do not** attempt to put part back in place.
4. Immobilize extremity. Splint with pillows, blankets, broomstick, uninjured limb, etc.
5. Apply ice/cold pack. (**Do not** apply directly to skin.)
6. Call parent and recommend follow-up medical care.

CLOSED FRACTURE

NOTE: A closed fracture is a complete break, chip, or crack in a bone in which the skin is not broken. Fractures are **potentially life threatening** when the break involves a large bone (e.g., thigh), severs an artery, or affects breathing.

SIGNS AND SYMPTOMS

- ◆ Possible deformity
- ◆ Bruising
- ◆ Swelling

- ◆ Inability to use the affected part normally
- ◆ Pain
- ◆ Injured area is cold and numb

TREATMENT

1. Determine cause of the injury.
2. If fracture is suspected or obvious, call **Rescue Squad**.
3. Keep individual quiet, still, and warm.
4. Unless there is danger to life, **do not** move from place of accident until affected part has been properly splinted or immobilized.
5. Immobilize extremity. Splint with pillows, blankets, broomstick, uninjured limb, etc.
6. Assess for shock. (See **Shock**.)
7. If necessary, certified personnel start CPR and Rescue Breathing. (See **CPR** and **Rescue Breathing**.)
8. Apply ice/cold pack. (**Do not** apply directly to skin.)
9. Call parent immediately.

OPEN FRACTURE

NOTE: An open fracture is the complete break, crack, or chip in a bone in which the skin is broken. There is the risk of infection and severe bleeding with open fractures. Fractures may be **potentially life threatening**.

SIGNS AND SYMPTOMS

- ◆ Possible deformity
- ◆ Bone fragments sticking out of the wound
- ◆ Inability to use the affected part normally
- ◆ Bleeding
- ◆ Injured area is cold and numb

TREATMENT

1. Determine cause of injury.
2. Call **Rescue Squad**.
3. Keep individual quiet, still, and warm.
4. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
5. Control bleeding by placing a clean cloth (preferably sterile) over the wound and applying pressure on a nearby artery.
6. Assess for shock. (See **Shock**.)
7. If necessary, certified personnel start CPR and Rescue Breathing. (See **CPR** and **Rescue Breathing**.)
8. Unless there is danger to life, **do not** move from place of accident until affected limb has been properly splinted or immobilized.

9. Immobilize extremity. Splint with pillows, blankets, broomstick, uninjured limb, etc.
10. Apply ice/cold pack. (**Do not** apply directly to skin.)
11. Call parent.

BRUISES

SIGNS AND SYMPTOMS

- ◆ Skin appears deep red, purple, and/or bluish
- ◆ Swelling
- ◆ Pain

TREATMENT

1. Rest affected part.
2. Apply cold compresses or ice/cold packs immediately. (**Do not** apply directly to skin.)
3. If skin is broken, wear gloves. Use Universal Precautions. (See **Universal Precautions** and **Wounds**)
4. If there is swelling or severe pain, call parent and recommend follow-up medical care.

BURNS

CHEMICAL

NOTE: Treatment will vary with the nature of the chemical and the extent of the burn.

TREATMENT

1. Call **Rescue Squad** immediately.
2. Flush skin or eye immediately with large amounts of cool water.
3. If possible, remove outer clothing while burn is being flushed.
4. If available, follow directions on chemical container.
5. Call **Poison Control Center**.
6. If there is a burn center in the area, call immediately.
7. Call parent and recommend follow-up medical care.
8. If available, send chemical container with the individual.

ELECTRICAL

NOTE: Electrical burns, including lightning burns, may be more serious than initial appearance. The entrance wound may be small, but the electricity continues to burn as it penetrates deeper. Electrical burns are often accompanied by respiratory or cardiac arrest. Respiratory arrest usually occurs first and is later complicated by cardiac arrest.

TREATMENT

1. Call **Rescue Squad**.
2. **Do not** attempt to remove individual from the source of electricity. Never go near an individual who may have been injured by electricity until you are sure power source has been turned off.
3. If necessary, and only after contact is broken with electrical source, certified personnel start CPR and Rescue Breathing. (See **CPR** and **Rescue Breathing**.)
4. Cover the burned area with a dry (preferably sterile) dressing.
5. Look for a second burned area where the electricity left the body.
6. Treat for shock. (See **Shock**.)
7. Call parent.

FIRST DEGREE THERMAL/HEAT

NOTE: Involves only the top layer of the skin.

SIGNS AND SYMPTOMS

- ◆ Skin is red and dry
- ◆ Burn is usually painful
- ◆ Area may swell

TREATMENT

1. Maintain open airway.
2. If burned on face or smoke inhaled, anticipate need for Rescue Breathing. Call **Rescue Squad**.
3. If necessary, certified personnel start Rescue Breathing. (See **Rescue Breathing**.)
4. Cool burn area with cool compresses or water for 10-15 minutes. (**Do not** use ice.)
5. **Do not** apply any grease, salves, or lotions.
6. If necessary, bandage lightly to protect the area and to decrease pain.
7. If possible, elevate burned arm or leg.
8. If necessary, treat for shock. (See **Shock**.)
9. Call parent and recommend immediate follow-up medical care.

SECOND DEGREE THERMAL/HEAT

NOTE: Involves the top layers of skin.

SIGNS AND SYMPTOMS

- ◆ Skin is red and has blisters
- ◆ Blisters may open and weep clear fluid
- ◆ Skin may appear blotchy
- ◆ Burn is usually painful
- ◆ Area may swell

TREATMENT

1. Follow guidelines for first degree burns unless extensive area (greater than the size of palm) is involved. In this instance, follow procedure for treatment of third degree burns.
2. If difficulty breathing, call **Rescue Squad** immediately.
3. If necessary, certified personnel start Rescue Breathing. (See **Rescue Breathing**.)

THIRD DEGREE THERMAL/HEAT

Note: Destroys all layers of skin and any or all of the underlying structures—fat, muscles, bones, and nerves. Critical burns are **potentially life threatening**.

SIGNS AND SYMPTOMS

- ◆ Skin appears brown or black (charred) with tissues underneath sometimes appearing white.
- ◆ May be extremely painful or painless if burn destroys nerve endings.

TREATMENT

1. Call **Rescue Squad** immediately.
2. Maintain open airway.
3. If necessary, certified personnel start Rescue Breathing. (See **Rescue Breathing**)

4. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
5. If possible, elevate burned area.
6. **Do not** apply moist compresses, grease, salves, or lotions.
7. Keep individual quiet, comfortable and warm.
8. Cover area with clean (preferably sterile) cloth.
9. Remove clothing only if not stuck to burned area, contaminated, or on fire.
10. Treat for shock. (See **Shock**.)
11. Call parent.

DENTAL PROBLEMS

BABY TEETH/ TOOTH LOSS

(No injury) age 6-11

TREATMENT

1. Rinse mouth with warm water.
2. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
3. If bleeding, have individual bite on gauze for several minutes.
4. Send tooth home with individual in sealed container (e.g., envelope or plastic bag).
5. Call parent.

BROKEN BRACES & WIRES

TREATMENT

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. Cover ends of broken braces and wires with wax or a piece of gauze.
3. If wire becomes stuck in the cheek or gum tissues, **do not** attempt to remove it.
4. If appliance is loose or breaks, save any broken pieces.
5. Call parent and recommend follow-up dental care.

BROKEN/DISPLACED TOOTH

TREATMENT

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. Gently clean dirt from the injured area with warm water.
3. Apply ice/cold pack on the face, over the injured area. (**Do not** apply directly to skin.)
4. If tooth has a sharp edge, cover with gauze to prevent cutting lips or cheek.
5. Save any broken tooth fragments.
6. If tooth is displaced or has been pushed up into the gum, **do not** attempt to pull it into position or move it.
7. Call parent and recommend immediate dental care.

KNOCKED OUT/ PERMANENT TOOTH

TREATMENT

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. Try to locate tooth.
3. Hold tooth by its crown (white portion)—not the root.
4. Rinse tooth gently in water. **Do not** scrub.
5. If you are certain that you can replace the tooth in the correction position (consult a dentist, if necessary), gently replace tooth in the socket and hold in place. Be sure

tooth is securely held and will not be swallowed. Timing is critical—replantation within 20-30 minutes is best.

6. When insertion is not possible, place tooth in a container of cool milk or water.
7. Control bleeding by applying gentle pressure.
8. Apply ice/cold pack on the face, over the injured area. (**Do not** apply directly to skin.)
9. Call parent and recommend immediate dental care.

TOOTHACHE

TREATMENT

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. Rinse the mouth with warm water to clean it out.
3. If available, use dental floss to dislodge any trapped food.
4. If swelling is present, apply ice/cold pack on the face over the affected part. (**Do not** apply directly to skin.)
5. Use ice chips for pain caused by an incoming permanent tooth.
6. Call parent and recommend dental follow-up care.

WEDGED OBJECTS BETWEEN TEETH

TREATMENT

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. If available, try to remove the object with dental floss.
3. **Do not** try to remove the object with sharp or pointed instrument.
4. If unsuccessful, call parent and recommend follow-up dental care.

DIABETES

NOTE: The diabetic reaction may be in response to blood sugar that is too low (hypoglycemia) or blood sugar that is too high (hyperglycemia). When the first aid care provider is uncertain of the type of diabetic reaction, treat for the symptoms of hypoglycemia (low blood sugar). The immediate effects of low blood sugar can be more detrimental than those of high blood sugar. If the individual is known to the school personnel as having diabetes, **consult the written action plan** on file and proceed as directed in the physician's statement.

HYPERGLYCEMIA

NOTE: The onset of symptoms of hyperglycemia (high blood sugar) is usually gradual. If untreated, this condition is **potentially life threatening**.

SIGNS AND SYMPTOMS

- ◆ Dry, warm, and flushed skin
- ◆ Drowsiness
- ◆ Increased thirst
- ◆ Increased urination
- ◆ Hunger
- ◆ Fruity breath odor
- ◆ Nausea/vomiting
- ◆ Changes in vision
- ◆ Heavy breathing
- ◆ Eventual stupor and unconsciousness

TREATMENT

1. Determine if individual is hyperglycemic. (If available, use finger stick test.)
2. If individual is known to have diabetes, consult the written action plan on file and proceed with physician's recommendations.
3. Encourage individual to drink large quantities of sugar-free fluids.
4. If treatment is not effective and individual displays any of the symptoms listed below, call **Rescue Squad**.
 - ◆ Sunken eyes
 - ◆ Drowsiness
 - ◆ Pain
 - ◆ Vomiting
5. Call parent.

HYPOGLYCEMIA (IF THE INDIVIDUAL IS NOT UNCONSCIOUS)

NOTE: The onset of hypoglycemia (low blood sugar) is usually sudden. If left untreated, this condition **can quickly become life threatening.**

SIGNS AND SYMPTOMS

- ◆ Headache
- ◆ Shakiness
- ◆ Sweaty, pale skin
- ◆ Drowsiness
- ◆ Staggering
- ◆ Poor coordination
- ◆ Bad temper/anger
- ◆ Confusion
- ◆ Disorientation
- ◆ Eventual stupor or unconsciousness

TREATMENT

1. If individual can swallow, give one fruit exchange. One fruit exchange equals one of the following:
 - ◆ 3 teaspoons of sugar.
 - ◆ ½ cup orange juice.
 - ◆ 1/3 cup apple juice.
 - ◆ 1/3 cup soda, preferably lemon-lime (not diet).
2. If low blood sugar is the problem, recovery will usually occur in 10-15 minutes. If symptoms persist after 10-15 minutes, administer another fruit exchange. Repeat every 10-15 minutes until symptoms subside.
3. If the individual is known to have diabetes, consult the written action plan on file and proceed with physician's recommendations.
4. If treatment is not effective and individual's condition worsens, call **Rescue Squad**.
5. Call parent.

HYPOGLYCEMIA (IF THE INDIVIDUAL BECOMES UNCONSCIOUS)

TREATMENT

1. Call **Rescue Squad** immediately.
2. Place individual on side, ensuring drainage of secretions or vomiting.
3. If the individual is known to have diabetes, consult the written action plan on file and proceed with physician's recommendations.
4. If individual awakens and is able to swallow, give sips of non-diet, lemon-lime or other soda. Give no more than 3-6 ounces.
5. Call parent and recommend follow-up medical care.

EAR**BUG/INSECT****TREATMENT**

1. Place a few drops of alcohol in the ear to quiet the insect.
2. Call parent and recommend follow-up medical care.

EARACHE**TREATMENT**

1. Wear gloves. Use Universal Precautions (See **Universal Precautions**.)
2. If discharge is present, wipe from outer ear only.
3. Allow free drainage.
4. **Do not** use cotton plugs in ear.
5. Call parent and recommend follow-up medical care.

FOREIGN OBJECT**TREATMENT**

1. **Do not** attempt removal of object at school.
2. Call parent and recommend immediate medical care.

ELECTRICAL SHOCK

NOTE: Electrical shock resulting from the passage of electric current through any part of the body is **potentially life threatening**.

SIGNS AND SYMPTOMS

- ◆ Burns
- ◆ Weak, rapid pulse
- ◆ Cold, clammy skin
- ◆ Restlessness
- ◆ Confusion
- ◆ Unresponsive/unable to answer questions
- ◆ Skin over knees, hands, and feet may appear blotchy
- ◆ Face may be pale or blue
- ◆ Mucous membranes inside mouth and eyelids may be blue
- ◆ Eyes dull, pupils dilated
- ◆ Fainting
- ◆ Sweating
- ◆ Vomiting
- ◆ Breathing may be rapid, irregular, gasping, shallow, or labored

TREATMENT

1. Call **Rescue Squad**.
2. **Do not** go near an individual who may have been injured by electricity until you are sure power source has been turned off.
3. If a power line is down, wait for the fire department/power company before approaching.
4. If applicable, turn off source of electrical current.
5. Check breathing and pulse. If necessary, certified personnel start CPR and Rescue Breathing. (See **CPR** and **Rescue Breathing**)
6. If necessary, treat for Shock. (See **Shock**.)
7. Check individual for other injuries and consult appropriate procedures.
8. **Do not** move individual.
9. Cover electrical burn with dry, sterile dressing. **Do not** cool burn. (See **Burns/Electrical**)
10. If there are no signs and symptoms of electrical shock, continue to observe individual.
11. Call parent.

EYES

CHEMICAL BURNS

TREATMENT

1. Determine cause of the injury.
2. Call **Rescue Squad**.
3. Immediately flush eye with large quantities of cool water. Turn head to the side and pour water from nose outward. **Do not** allow chemical to wash into unaffected eye.
4. Call **Poison Control Center** for further instructions.
5. Call parent.

DISCHARGE

SIGNS AND SYMPTOMS

- ◆ Red, watery, swollen eyes
- ◆ Itching
- ◆ Crusting or history of crusting of eyes in the morning

TREATMENT

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. **Do not** put a patch over a possible eye infection.
3. Exclude individual from school until condition has cleared up or individual has been authorized to return to school by a health care provider.
4. Call parent.

FOREIGN OBJECT

SIGNS AND SYMPTOMS

- ◆ Pain
- ◆ Tearing
- ◆ Redness
- ◆ Scratchy feeling in eye
- ◆ Vision changes

TREATMENT

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. Urge individual to avoid rubbing affected eye.
3. Flush with lukewarm water. Turn head to the side and pour water from nose outward.
4. If particle seems imbedded, **do not** attempt to remove.
5. If object remains, cover both eyes loosely with gauze or cloth to restrict eye movement.
6. Call parent and recommend immediate follow-up medical care.

EYE INJURIES**BRUISES/BLOWS****TREATMENT**

1. Determine the cause of the injury.
2. Apply ice/cold pack to eye. (**Do not** apply directly to skin.)
3. If iris (colored part of the eye) appears brown on blue-eyed individual or reddish on brown-eyed individual, call parent and recommend immediate medical care.

PENETRATING**TREATMENT**

1. Determine the cause of the injury.
2. Call **Rescue Squad**.
3. **Do not** attempt to remove object or wash eye.
4. Cover both eyes loosely with gauze or cloth, or use paper cup for protection of injured eye.
5. Keep individual calm and quiet.
6. Call parent.

FAINTING

SIGNS AND SYMPTOMS

- ◆ Pale, moist, clammy skin
- ◆ Weakness
- ◆ Dizziness
- ◆ Rapid, weak, irregular pulse
- ◆ Stomach discomfort

TREATMENT

1. Position individual on back on a flat surface.
2. If other injuries are present, see appropriate procedures.
3. If no injuries, elevate legs 8-12 inches.
4. Loosen clothing around neck and waist.
5. Apply cool, damp cloth to head.
6. Continue to observe carefully.
7. If recovery is not complete in less than 2 minutes, call **Rescue Squad**.
8. If breathing stops, certified personnel start Rescue Breathing. (See **Rescue Breathing**)
9. Call parent.

FEVER

NOTE: Fever may indicate a contagious illness.

SIGNS AND SYMPTOMS

- ◆ Oral temperature 100°F or greater
- ◆ Headache
- ◆ Watery, red, eyes and nose
- ◆ Cough
- ◆ Skin rash
- ◆ Sore throat
- ◆ Vomiting
- ◆ Diarrhea

TREATMENT

1. Take temperature. If fever is present (100 °F or greater), check for other symptoms of illness.
2. Allow individual to lie down.
3. Isolate individual for the benefit of others.
4. Call parent and recommend follow-up medical care.

FINGER INJURIES

GENERAL

TREATMENT

1. Determine cause of injury.
2. For finger injuries, such as being caught in a door, apply ice/cold pack. (**Do not** apply directly to skin.)
3. Call parent.

TORN FINGERNAIL/TOENAIL

TREATMENT

1. Cut off fingernail to edge of nail bed and smooth edges.
2. If torn into nail bed, clean with soap and water and apply dressing.
3. If there is bleeding, wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
4. Use gentle pressure to stop bleeding.
5. Apply ice/cold pack to reduce swelling and pain. (**Do not** apply directly to skin.)
6. Call parent and recommend follow-up medical care.

FROSTBITE

NOTE: Severity of frostbite depends on air temperature, length of exposure, and the wind. Frostbite can cause loss of fingers, hands, arms, toes, feet, and legs. If freezing is deeper than the skin, tissue damage is severe. Gangrene may result. This condition is **potentially life threatening**.

SIGNS AND SYMPTOMS

- ◆ Lack of feeling in the affected area
- ◆ Skin appears waxy
- ◆ Skin is cold to the touch
- ◆ Skin may become discolored—flushed, white, yellow or, blue

TREATMENT

1. Call **Rescue Squad** immediately.
2. Bring individual indoors quickly.
3. Warm affected part using body heat or warm water (100-105°F) until it looks normal and feels warm.
4. To warm ear, place hand over it.
5. **Do not** rub. **Do not** overheat. **Do not** use hot water bottles or heat lamps.
6. If blisters appear, **do not** break. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.) Cover blister loosely with clean dressing.
7. If possible, exercise the affected part after it has been warmed.
8. If feet are frostbitten, **do not** allow individual to walk. If toes or fingers are affected, put dry, sterile gauze between them after warming.
9. Call parent.

GENITAL INJURY

SCROTAL OR PENILE

SIGNS AND SYMPTOMS

- ◆ Bleeding
- ◆ Redness
- ◆ Pain

TREATMENT

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. If possible, when examining an individual's genital area, the first aid provider should have another adult present.
3. Ensure privacy.
4. Determine cause of the injury.
5. Apply ice/cold pack. (**Do not** apply directly to skin)
6. If symptoms persist for more than 30 minutes, call parent and recommend follow-up medical care.

VAGINAL

SIGNS AND SYMPTOMS

- ◆ Bleeding
- ◆ Itching
- ◆ Redness
- ◆ Pain
- ◆ Swelling

TREATMENT

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. If possible, when examining an individual's genital area, the first aid provider should have another adult present.
3. Ensure privacy.
4. Determine cause of the injury.
5. Apply sanitary napkin.
6. Maintain individual in a reclining position with knees and legs together.
7. Call parent and recommend follow-up medical care.

HEADACHE

NOTE: Headaches should receive emergency care if they are severe; severe with sudden onset; or accompanied by changes in vision, vomiting, seizure, or alteration in consciousness.

TREATMENT

1. If there has been a head injury, call **Rescue Squad**. (See **Head Injury**.)
2. If there has been no trauma to the head, have individual lie down for 20-30 minutes in darkened area.
3. Place a cool cloth /ice pack on the head to promote relaxation. (**Do not** apply directly to skin.)
4. If headache persists, call parent to take individual home.

HEAD INJURY

NOTE: All head injuries are **potentially life threatening** and should be referred for immediate medical care. Suspect neck injury with all serious head injuries and treat head and neck as one unit.

SIGNS AND SYMPTOMS

- ◆ Nausea or vomiting
- ◆ Drowsiness
- ◆ Disorientation, confusion
- ◆ Dizziness
- ◆ Loss of consciousness at any time
- ◆ Blood or fluid in ears
- ◆ Increasing pain
- ◆ Slurring of speech
- ◆ Numbness
- ◆ Marked swelling
- ◆ Blurred or double vision
- ◆ Unequal pupils

TREATMENT

1. Determine cause of injury.
2. If individual has any of the symptoms listed above, call **Rescue Squad**.
3. Keep individual lying down and quiet.
4. If individual is unconscious and neck injury is **not** suspected, support head and gently turn entire body to one side (log roll) so secretions drain from mouth. **Do not** turn head if neck injury is suspected.
5. Loosen clothing around neck.
6. Check for airway obstruction. If necessary, certified personnel start Rescue Breathing. (See **Rescue Breathing**.)
7. **Do not** insert anything into the individual's mouth.
8. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
9. Control extensive bleeding by applying pressure to a nearby artery.
10. **Do not** wash head wounds.
11. Small cuts on face or scalp may bleed extensively. Control bleeding of this kind by applying clean dressings (preferably sterile) directly on the wound.
12. If dressings become blood soaked, add more dressings. **Do not** remove original dressing.
13. For blows to the head not accompanied by any of the above symptoms, treat for headache. (See **Headache**)

14. If any of the above signs and symptoms occur at a later time, call parent and recommend follow-up medical care.

HEART ATTACK

GENERAL

NOTE: Any chest pain that is severe, lasts longer than 10 minutes, or persists even during rest requires immediate medical care. This is **potentially life threatening**.

SIGNS AND SYMPTOMS

- ◆ Persistent pain or pressure in the chest that is not relieved by resting, changing position, or prescribed oral medication
- ◆ Pain ranges from discomfort to unbearable crushing pain behind breastbone described as dull, penetrating, pressure, squeezing
- ◆ Pain sometimes radiating down left arm, both arms, or neck
- ◆ Feeling of choking
- ◆ Agitation and apprehension
- ◆ Breathing that is noisy, faster than normal
- ◆ Shortness of breath
- ◆ Pulse faster or slower than normal or irregular
- ◆ Skin pale or bluish
- ◆ Face, moist
- ◆ Cold sweat

TREATMENT

1. Call **Rescue Squad** immediately and request **Advanced Life Support**.
2. Remain with individual until emergency personnel arrive.
3. Place the individual in a comfortable position, usually sitting up, particularly if there is shortness of breath. Individual's preference is usually a good guide.
4. Loosen tight clothing.
5. Provide reassurance.
6. Guard against drafts and exposure to cold air.
7. If individual has "heart medicine" with them or in the clinic, assist with taking it. (For a child, consult the written action plan on file and proceed with the physician's recommendations.)
8. **Do not** give food, drink, or "pills" to an unconscious individual.
9. **Do not** attempt to transport individual. This will add additional strain.
10. If necessary, certified personnel start CPR and/or Rescue Breathing. (See **CPR** and **Rescue Breathing**)
11. Call parent (or emergency contact person for non-student).

SEVERE CARDIAC ARREST

NOTE: The absence of a pulse is the main signal of cardiac arrest. Severe cardiac emergencies are **life threatening**.

SIGNS AND SYMPTOMS

- ◆ See **Heart Attack** signs and symptoms
- ◆ No pulse
- ◆ Severe difficulty or no breathing
- ◆ Sudden, severe chest pain

TREATMENT

1. For cardiac arrest (heart stops beating/no pulse), severe respiratory distress (difficulty or no breathing), coma, or shock, call **Rescue Squad** immediately. Certified personnel start CPR and Rescue Breathing. (See **CPR** and **Rescue Breathing**)
2. Keep individual quiet and calm.
3. Call parent (or emergency contact person for non-student).

HEAT EMERGENCIES

HEAT CRAMPS

NOTE: Heat cramps are often the first signal that the body is having trouble with heat.

SIGN AND SYMPTOMS

- ◆ Painful muscle spasm, usually occurring in the legs and abdomen

TREATMENT

1. Have individual rest in a cool place.
2. Give cool water or commercial sports drink.
3. Lightly stretch muscles and gently massage.
4. **Do not** give individual salt tablets or salt water.
5. When cramps stop, have individual drink plenty of fluids.
6. Watch individual for further signals of heat-related illness.
7. Individual may resume normal activity.
8. Call parent.

HEAT EXHAUSTION

NOTE: Heat exhaustion is a more severe condition than heat cramps. Often affects athletes and those wearing heavy clothing in a hot, humid environment.

SIGNS AND SYMPTOMS

- ◆ Cool, moist, pale, or flushed skin
- ◆ Headache
- ◆ Nausea
- ◆ Dizziness
- ◆ Weakness
- ◆ Exhaustion

TREATMENT

1. Remove to cool area.
2. Keep individual lying down and elevate feet 8-12 inches.
3. Loosen clothing and remove the outer layers.
4. Cool by sponging, fanning, or immersing in cool water.
5. If fully conscious, give sips of water.
6. If individual becomes drowsy, unconscious or vomits, call **Rescue Squad**.
7. If necessary, certified personnel start CPR and Rescue Breathing. (See **CPR** and **Rescue Breathing**)
8. Call parent and recommend follow-up medical care.

HEAT STROKE

NOTE: Heat stroke is the most severe heat emergency and is **potentially life threatening**.

SIGNS AND SYMPTOMS

- ◆ Red, hot, dry skin
- ◆ Changes in consciousness
- ◆ Rapid, weak pulse
- ◆ Shallow breathing
- ◆ High body temperature (106°-110°F)
- ◆ Pupils constricted

TREATMENT

1. Remove individual to a cool area.
2. Call **Rescue Squad**.
3. Loosen clothing and remove outer layer.
4. Attempt to cool quickly. Apply cold compresses to head. (**Do not** apply directly to skin.)
5. If individual is conscious, give cool water to drink. **Do not** let individual drink too quickly. Give about 4 ounces of water every 15 minutes.
6. Let individual rest in a comfortable position.
7. Watch for changes in individual's condition.
8. If individual vomits, wear gloves. Use Universal Precautions. (See **Universal Precautions**.) Stop giving fluids and position on side.
9. If breathing difficulty develops, certified personnel start Rescue Breathing. (See **Rescue Breathing**)
10. Apply ice/cold packs to each wrist and ankle, in the groin, under each armpit, and on the neck to cool large blood vessels. (**Do not** apply directly to skin.)
11. **Do not** apply rubbing alcohol.
12. If necessary, treat individual for shock. (See **Shock**)
13. Call parent.

HYPERVENTILATION

SIGNS AND SYMPTOMS

- ◆ Rapid, shallow breathing
- ◆ Profuse sweating
- ◆ Pale skin
- ◆ Nausea
- ◆ Tingling of hands, face, and feet

TREATMENT

1. Calm and reassure individual.
2. Encourage individual to breathe slowly.
3. **Do not** have individual breathe into a paper bag.
4. If individual does not respond and their condition worsens, call **Rescue Squad**.
5. Call parent.

MOUTH/JAW INJURIES

NOTE: Bleeding and fracture injuries of the mouth, jaw, lips, tongue, teeth, or inner cheek can create breathing difficulties. These injuries are **potentially life threatening**.

SIGNS AND SYMPTOMS

- ◆ Bleeding from mouth, lip, jaw, teeth
- ◆ Difficulty breathing
- ◆ Choking
- ◆ Pain

TREATMENT

1. Determine cause of injury.
2. Call the **Rescue Squad**.
3. Maintain open airway. If necessary, certified personnel start Rescue Breathing. (See **Rescue Breathing**)
4. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
5. If individual is conscious, bleeding from the mouth, and no neck injuries are suspected, prop individual up—leaning forward—to allow blood to drain.
6. If sitting position is not possible, place individual on their side to allow blood to drain from the mouth.
7. If lip is penetrated, place a rolled dressing between the lip and gum and another dressing on the outer surface of the lip. Apply ice/cold pack to reduce swelling and decrease pain. (**Do not** apply directly to lip.)
8. If tongue is bleeding, apply a dressing with gentle pressure. Apply ice/cold pack to reduce swelling and decrease pain. (**Do not** apply directly to tongue.)
9. If tooth has been knocked out, control bleeding and save tooth or tooth fragments. (See **Dental Problems**)
10. If bleeding is external, apply dressing (preferably sterile) with gentle pressure.
11. If bleeding is not severe or injury is not extreme, call parent and recommend follow-up medical care.

NOSE**NOSE BLEEDS****SIGNS AND SYMPTOMS**

- ◆ Bleeding
- ◆ Swelling
- ◆ Bruising
- ◆ Choking

TREATMENT

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. If bleeding is from trauma, see **Head Injury**.
3. If bleeding is not related to trauma, keep individual slightly leaning forward and breathing through the mouth.
4. Loosen anything tight around the neck.
5. Pinch the sides of the nose against the septum (bone in center of nose) for at least 5-10 minutes to allow a clot to form.
6. Apply ice/cold packs to forehead, over bridge of nose and back of neck. (**Do not** apply directly to skin.)
7. Tell individual not to blow nose or sniff for 1-2 hours in order to prevent dislodging the clot.
8. If bleeding does not stop in 5-10 minutes or individual has frequent episodes, call parent and recommend follow-up medical care.
9. If individual vomits blood or starts spitting up blood, call parent and recommend immediate medical care.

FOREIGN OBJECTS**SIGNS AND SYMPTOMS**

- ◆ Pain
- ◆ Swelling
- ◆ Foul odor

TREATMENT

1. **Do not** attempt to remove object.
2. Call parent and recommend immediate follow-up medical care.

SEIZURE/CONVULSION

NOTE: Remain calm. A seizure cannot be stopped once it starts. Call **Rescue Squad** unless individual is known to have a seizure disorder (epilepsy) **and** there is a written action plan on file at the school. Parent should be called immediately.

SIGNS AND SYMPTOMS

May experience an aura (unusual sensation) or feeling immediately preceding seizure, such as:

- ◆ Visual hallucination
- ◆ Strange sound
- ◆ Lack of smell
- ◆ Urgent need to get to safety
- ◆ Mild blackout
- ◆ Daydreaming
- ◆ Rhythmic jerking or stiffening of all or some of the extremities and face
- ◆ Unresponsive during and for some time after the seizure episode

TREATMENT

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. **Do not** place anything in individual's mouth. Place on side to prevent choking on secretions and blockage of airway by the tongue.
3. If individual is standing or sitting, gently lower to ground to avoid a fall.
4. If possible, place a cushion or blanket under individual's head.
5. **Do not** hold or restrain individual.
6. Clear area around the individual to prevent injury from sharp objects.
7. **Do not** give food, drink, or medications during a seizure.
8. Remain with individual during the seizure to monitor progress.
9. Observe all of the individual's activity during the seizure, including:
 - ◆ Time the seizure began.
 - ◆ Area of the body where seizure began.
 - ◆ Any movement of the seizure from one area of the body to the other.
 - ◆ Type of movements of the head, face, and arms that occur during the seizure.
10. When the seizure is over:
 - ◆ If necessary, clear secretions from mouth with a bulb syringe or suction catheter. If this equipment is not available, turn individual onto their side to allow for drainage of secretions.
 - ◆ Monitor breathing.
 - ◆ Determine level of awareness.
 - ◆ Determine individual's ability to move arms and legs.
 - ◆ Provide privacy.
 - ◆ Check for loss of control of urine and stool.
 - ◆ Check for injuries. See appropriate procedures for treatment.
 - ◆ If individual remains unconscious after seizure is over, maintain open airway and continue to assess breathing. If necessary, certified personnel start Rescue Breathing. (See **Rescue Breathing**.)

- ◆ Keep individual comfortable.
- ◆ Allow individual to sleep as needed. (May last from 30 minutes to several hours.)
- ◆ Record the length of the seizure and activity during and after the seizure.
- ◆ Call parent and recommend follow-up medical care.

SHOCK

NOTE: Shock is **life-threatening**.

SIGNS AND SYMPTOMS

- ◆ Restlessness
- ◆ Irritability
- ◆ Altered consciousness (weakness, confusion, drowsiness)
- ◆ Pale skin
- ◆ Moist extremities
- ◆ Rapid breathing
- ◆ Rapid pulse (greater than 100 beats per minute)
- ◆ Late stage: skin, lips, and area around eyes appear blue

TREATMENT

1. Call **Rescue Squad** immediately.
2. If necessary, certified personnel start CPR or Rescue Breathing. (See **CPR** and **Rescue Breathing**)
3. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
4. If vomiting occurs, turn individual onto one side, rolling body and head as one. Clear material from the mouth. **If neck injury is suspected, do not turn individual.**
5. Control all obvious bleeding by placing firm pressure on a nearby artery.
6. Unless injuries make this inadvisable, lay individual flat with legs elevated 12 inches. **Do not** elevate legs in case of head and neck injuries.
7. An individual in shock because of heart attack or with lung disease, may find it easier to breathe sitting up or in a semi-sitting position.
8. Darken room. Avoid rough and excessive handling of individual.
9. Prevent loss of body heat by putting blankets over the individual. **Do not** add extra heat.
10. **Do not** give anything to eat or drink.
11. Give first aid for any identified cause of shock (e.g., bleeding, burns) See appropriate procedure.
12. Call parent.

SPINE INJURY

BACK INJURY/NECK INJURY

NOTE: Injuries to the head and spine can cause paralysis, speech or memory problems, or other disabling conditions. This is **potentially life threatening**.

SIGNS AND SYMPTOMS

- ◆ Changes in consciousness
- ◆ Severe pain in head, neck, or back
- ◆ Tingling or loss of sensation in hands, fingers, feet, and toes
- ◆ Partial or complete loss of movement of any body part
- ◆ Unusual bumps or depressions on head or spine
- ◆ Blood or other fluids draining from ears or nose
- ◆ Heavy external bleeding of head, neck, or back
- ◆ Seizures
- ◆ Difficulty breathing
- ◆ Vision problems
- ◆ Nausea or vomiting
- ◆ Loss of balance
- ◆ Bruising of head, especially around the eyes and behind the ears

TREATMENT

1. Determine cause of injury. Spinal injuries should be suspected in all falls, collisions, and impact injuries (e.g., contact sports).
2. Call **Rescue Squad** immediately.
3. **Do not** move individual.
4. If it is necessary to move the individual due to an immediate danger, support the head and move in the direction of the long axis without bending the spine. **Do not** drag sideways.
5. Keep individual warm and comfortable.
6. If bleeding or drainage, wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
7. If necessary, treat for shock. (See **Shock**)
8. If an individual cannot move their arms and legs, they may need Rescue Breathing. If necessary, certified personnel start Rescue Breathing (See **Rescue Breathing**)
9. Call parent.

SPLINTERS**SIGNS AND SYMPTOMS**

- ◆ Redness or other discoloration
- ◆ Swelling
- ◆ Pain

TREATMENT

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. Cleanse thoroughly with soap and water.
3. Inspect to determine depth.
4. If superficially lodged under the skin, grasp portion protruding above the skin and attempt to gently remove with tweezers. **Do not** probe under the skin with tweezers or other object.
5. Determine individual's tetanus immunization status from school record.
6. If lodged beyond superficial layer of skin, call parent and recommend immediate follow-up medical care.

SPRAINS

NOTE: A sprain is the tearing of ligaments at a joint. It is distinguished from a fracture only by x-ray.

SIGNS AND SYMPTOMS

- ◆ Swelling
- ◆ Tenderness
- ◆ Pain upon motion
- ◆ Discoloration

TREATMENT

1. Determine cause of injury.
2. Keep individual warm and comfortable.
3. Immobilize extremity. Splint with pillows, blankets, broomstick, uninjured limb, etc.
4. Apply ice/cold pack to the area. (**Do not** apply directly to skin.)
5. If movement does not cause pain, elevate affected part.
6. Call parent and recommend follow-up medical care.

VOMITING**TREATMENT**

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. **Do not** give anything to eat or drink.
3. When vomiting stops, position individual comfortably.
4. Call parent and recommend follow-up medical care.

WOUNDS

CUTS/SUPERFICIAL

TREATMENT

1. Determine cause of injury.
2. Wear gloves. Use Universal precautions. (See **Universal Precautions**.)
3. Cleanse thoroughly with soap and water. **Do not** use hydrogen peroxide, alcohol, or other disinfectant.
4. If necessary, apply dry bandage.
5. **Do not** wash head wounds. Apply dry dressing (preferably sterile).
6. Determine individual's tetanus immunization status from school record.
7. Call parent and recommend follow-up medical care.

DEEP/EXTENSIVE

TREATMENT

1. Determine cause of injury.
2. Call **Rescue Squad**.
3. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
4. Control bleeding by covering with gauze dressing (preferably sterile). Apply pressure to nearby artery.
5. If necessary, apply more dressings. **Do not** remove original dressing.
6. **Do not** move individual unnecessarily.
7. **Do not** wash head wounds. Apply dry dressing.
8. In case of amputation:
 - ◆ Place direct pressure on wound site.
 - ◆ Place indirect pressure on nearby arteries.
 - ◆ Locate severed body part.
 - ◆ Wrap the part in moist, clean (preferably sterile) cloth.
 - ◆ Place part in plastic airtight bag and lay on ice to transport.
 - ◆ Give part to Rescue Squad.
9. If no fracture is suspected, elevate the extremity above the level of the heart to help stop bleeding.
10. Determine individual's tetanus immunization status from school record.
11. Call parent.

PUNCTURE**TREATMENT**

1. Determine cause of injury.
2. Call **Rescue Squad**.
3. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
4. Unless wound is spurting blood, allow to bleed freely.
5. If wound is spurting blood, apply pressure with clean gauze to stop the bleeding.
6. Cleanse thoroughly with soap and water.
7. Apply gauze dressing (preferably sterile).
8. Determine tetanus immunization status from school record.
9. Call parent and recommend follow-up medical care.

Emergency Care Procedures

CHOKING

CONSCIOUS: Speaking, breathing coughing (Child and Adult)

Child (ages 1-8)

Adult (age 8 & older)

1. If individual can breathe, cough, or speak, do not interfere.
2. Stay with the individual. Encourage to cough out the obstruction.
3. If individual cannot clear their airway by coughing, is unable to speak, breathe, or cough, or if breathing and coughing become weaker and more difficult, call **Rescue Squad**. (See **Choking/Conscious Child and Adult**.)



CONSCIOUS: Unable to dislodge object, difficulty breathing, weak/faint cough or speech (Child and Adult)

Child (ages 1-8)

Adult (age 8 and older)

NOTE: If the individual is choking and the Heimlich Maneuver is used, abdominal injury may occur. The individual should be examined by a physician.

1. **Check to see if the individual is conscious.**

Tap or gently shake them and shout, “Are you choking?” If individual cannot, cough, speak or breathe, shout “Help!” If someone is with you, have them call the **Rescue Squad**.

2. **Perform abdominal thrusts.** (Heimlich Maneuver).

- Stand behind the individual.
- Wrap arms around waist. Make a fist with one hand. Place thumb side of fist against middle of the abdomen, just above navel and well below lower tip of breastbone.
- Grasp your fist with your other hand.
- Keeping elbows out, press fist into individual’s abdomen with a quick upward thrust. Each thrust should be a separate and distinct attempt to dislodge the object.
- Repeat thrusts until the individual coughs up the object, starts to breathe or cough, or becomes unconscious.



3. Watch the individual to make sure they continue to breathe easily.
4. If a call has not been made, call **Rescue Squad** now.
5. If individual becomes unconscious, see **Choking/Unconscious Child and Adult**.

UNCONSCIOUS (Child and Adult)**Child (ages 1-8)****Adult (age 8 and older)**

NOTE: If alone with an unconscious child, give Rescue Breathing for **1 minute** and then call **Rescue Squad**. If someone is with you, have them call **Rescue Squad**. If a mask with a one-way valve or other infection control barrier is available, it should be used during rescue breathing. **Do not** delay rescue breathing while such a device is located.

1. **Check to see if the individual is conscious.**

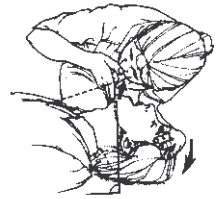
Kneel down beside the individual and tap, or gently shake them and shout, “Are you okay?” If there is no response, call **Rescue Squad**.

2. **Position the individual on back.** Support the head and neck. Roll as one unit.3. **Open the airway.** (Use head-tilt/chin-lift)

- Place hand (the one nearest the person’s ear) on the forehead.
- Place fingers of other hand under bony part of lower jaw near chin.
- Tilt head and lift jaw.
- **Avoid** closing individual’s mouth.
- **Avoid** pushing on the soft parts under the chin.

4. **Check for breathlessness.**

- Maintain open airway with head-tilt/chin-lift.
- Place ear next to mouth and nose.
- **Look, listen, and feel** for breathing for **5 seconds**.
- If no signs of breathing, give **2 slow breaths**. Pause between each breath. Watch for the chest rising to make sure breaths are going in. If not, retilt the head and try again.
- If unable to make a tight enough seal over an individual’s mouth (jaw or mouth is injured or your mouth is too small), **use mouth to nose breathing**.

5. **Check for a pulse for 5 seconds.** To check the pulse, feel at the front of the neck for the Adam’s apple and slide your fingers into the groove next to it in the side of the neck.

6. If pulse is present but individual is still not breathing, retilt the head, lift the chin, and attempt to give another breath.

7. If breaths still won’t go in:

- Straddle the legs of the individual.
- Position your hands one on top of the other on the individual’s abdomen with your fingers pointing toward the individual’s head.
- Give quick **upward thrusts**. Give up to **5 abdominal thrusts**.



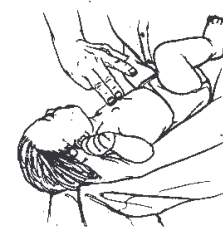
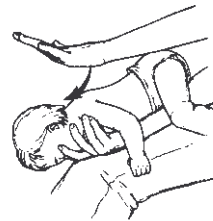
- Lift jaw and tongue. Sweep out mouth. (**For a child:** Check for object first *before* sweeping. If seen, sweep it out with finger.)
 - If object is not found and if breaths do not go in, reposition and try again.
 - Continue breaths, thrusts, and sweeps until individual coughs up the object, begins to breathe on their own, or forcefully coughs.
8. If individual resumes effective breathing, place on side in recovery position.

CONSCIOUS

Infant (up to 1 year old)

NOTE: Infants who have been treated for choking should always be examined by a physician.

1. If an infant is coughing forcefully, allow the infant to continue to cough. Watch the infant carefully.
2. If the infant does not stop coughing in a few minutes or if the infant coughs weakly, makes a high pitched sound while coughing, or cannot cry, cough, or breathe, call **Rescue Squad**.
3. **Position the infant:**
 - Place the infant face down on your arm, with hand supporting the infant's head.
 - With other hand, strike the infant between the shoulder blades **5 times (back blows)**.
 - Turn the infant over.
 - Place **two or three fingers** in the center of the breastbone.
 - Give **5 chest thrusts**. Each thrust should be about **1 inch** deep.
4. **Repeat** back blows and chest thrusts until object is coughed up, infant begins to breathe on own, or infant becomes unconscious.
5. Continue to watch the infant.
6. Call **Rescue Squad** now if a call has not been made.
7. If infant becomes unconscious, see **Choking/Unconscious Infant**.

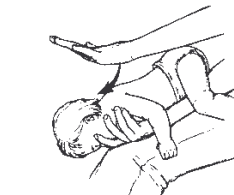
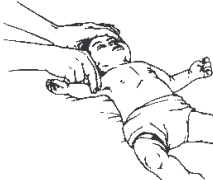
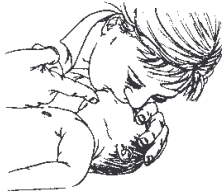
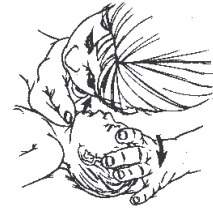


UNCONSCIOUS

Infant (up to 1 year old)

NOTE: If alone with an unconscious infant, give Rescue Breathing for **1 minute** and then call **Rescue Squad**. If someone is with you, have them call the Rescue Squad. If a mask with one-way valve or other infection control barrier is available, it should be used during rescue breathing. **Do not** delay rescue breathing while such a device is located.

1. **Check to see if the infant is conscious.** Tap or gently shake the infant. If there is no response, certified personnel start Rescue Breathing.
2. **Position the infant on their back.**
3. **Open the airway.**
 - Place hand on forehead and gently tilt head back. You do not need to tip an infant's head back very far to open the airway. Airway is open if the infant's chest rises and falls as you give breaths.
4. **Check for breathlessness.**
 - Maintain open airway with head-tilt method.
 - Place ear next to mouth and nose.
 - **Look, listen, and feel** for breathing for **5 seconds**.
5. **If no signs of breathing:**
 - Seal mouth over the infant's mouth and nose.
 - Give **2** slow breaths lasting about **1½ seconds** each. Pause between each breath. Watch for the chest rising to make sure breaths are going in. If not, retilt the head and try again.
6. **Check for a pulse for 5 seconds.** Check for a brachial pulse on the inside of the upper arm, between the infant's elbow and shoulder.
7. If pulse is present but infant is still not breathing, retilt the head. Attempt to give another breath.
8. If breaths still won't go in:
 - Place infant face down on your arm with hand supporting the infant's head.
 - With other hand strike the infant between the shoulder blades **5** times (**back blows**).
 - Turn the infant over.
 - Place **2 or 3** fingers in the center of the breastbone.
 - Give **5** chest thrusts. Each thrust should be about **1 inch** deep.
 - Lift jaw and tongue and check for the object. If the object is seen sweep it out with a finger.



- Tilt head back and give **2 breaths**. If breaths do not go in, reposition and try again.
 - If breaths still do not go in, continue the **back blows, chest thrusts, and breaths** until infant coughs up the object, begins to breathe or cough.
9. If infant resumes effective breathing, place in recovery position on side.
 10. Continue to observe until Rescue Squad arrives.

CARDIOPULMONARY RESUSCITATION

CPR

Adult/older child (ages 8 & older)

NOTE: An individual (8 & older) who is not breathing and does not have a pulse needs CPR. Call **Rescue Squad**. If someone is with you, have them call the Rescue Squad. If a mask with one-way valve or other infection control barrier is available, it should be used during rescue breathing. **Do not** delay rescue breathing while such a device is located.

1. **Check to see if the individual is conscious.**

Kneel down beside the individual and tap or gently shake them and shout, “Are you okay?” If there is no response call **Rescue Squad**.

2. **Position the individual on their back.** Support the head and neck. Roll as a unit.

3. **Open the airway.** (Use head-tilt/chin-lift)

- Place hand (the one nearest the individual’s ear) on the forehead.
- Place fingers of other hand under bony part of lower jaw and near chin.
- Tilt head and lift jaw.
- **Avoid** closing individual’s mouth.
- **Avoid** pushing on the soft parts under the chin.



4. **Check for breathlessness.**

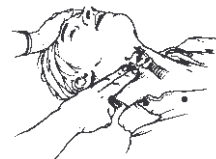
- Maintain open airway with head-tilt/chin-lift.
- Place ear next to mouth and nose.
- **Look, listen, and feel** for breathing for **5 seconds**.



5. **If no signs of breathing:**

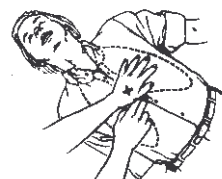
- Pinch nose shut.
- Take a deep breath, make a tight seal with your mouth around the individual’s mouth.
- Give **2** slow breaths lasting about **1 ½ seconds** each. Pause between each breath. Watch for the chest rising to make sure breaths are going in. If not, retilt the head and try again.
- If unable to make a tight enough seal over the individual’s mouth (jaw or mouth is injured or your mouth is too small), **use mouth to nose breathing**.

6. **Check for pulse for 5 seconds.** To check for the pulse in an adult, feel at the front of the neck for the Adam’s apple and slide your fingers into the groove next to it in the side of the neck. Keep head titled. If there is no breathing and no pulse, certified personnel start CPR.

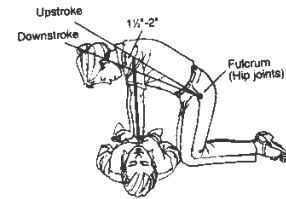


7. **Position:**

- Place the individual on their back, on a firm level surface.



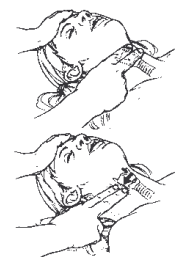
- Kneel beside the chest.
 - Find the notch where the lower ribs meet the breastbone. Place the heel of hand on the breastbone next to your index finger. Place other hand on top of the first.
 - Use the heel of bottom hand to apply pressure on the breastbone.
 - To compress the chest of an adult, keep shoulders directly over hands and elbows locked. Push straight down.
8. Perform **15 chest compressions**.
- A set of **15 compressions** should take about **10 seconds**.
 - Compress the chest about **2 inches**.
 - Retilt the head and lift the chin.
 - Give **2** slow breaths. (A cycle of **15 compressions** and **2 breaths** should take about **15 seconds**.)
 - Do **4** continuous cycles of **15 compressions** and **2 breaths** taking about **1 minute**.
9. Recheck pulse and breathing for about **5 seconds**. If there is still no pulse, continue sets of **15 compressions** and **2 breaths**. Recheck pulse and breathing every few minutes.
10. **When to stop CPR:**
- If individual is breathing and has a pulse.
 - If another trained individual takes over CPR for you.
 - If Rescue Squad arrives and takes over care of the individual.
 - If you are exhausted and unable to continue.
 - The scene becomes unsafe.



CPR**Child (ages 1-8)**

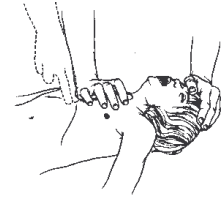
NOTE: A child who is not breathing and does not have a pulse needs CPR. Call **Rescue Squad**. If alone, give CPR for **1 minute** and then call Rescue Squad. If someone is with you, have them call the Rescue Squad. If a mask with one-way valve is available, it should be used during rescue breathing. **Do not** delay rescue breathing while such a device is located.

1. **Check to see if the child is conscious.** Kneel down beside the child and tap or gently shake them and shout, “Are you okay?” If there is no response call **Rescue Squad**.
2. **Position the child on their back.** Support the head and neck. Roll as a unit.
3. **Open the airway.** (Use head-tilt/chin-lift.)
 - Place your hand (the one nearest the child’s ear) on the forehead.
 - Place fingers of other hand under bony part of lower jaw and near chin.
 - Tilt head and lift jaw.
 - **Avoid** closing child’s mouth.
 - **Avoid** pushing on the soft parts under the chin.
4. **Check for breathlessness.**
 - Maintain open airway with head-tilt/chin-lift.
 - Place your ear next to mouth and nose.
 - **Look, listen, and feel** for breathing for **5 seconds**.
5. **If no signs of breathing:**
 - Pinch nose shut with the thumb and forefinger of the hand maintaining pressure on the child’s forehead. Lift chin with other hand.
 - Take a deep breath, make a tight seal over the child’s mouth.
 - Give **2** slow breaths lasting about **1 ½ seconds** each. Pause between each breath. Watch for the chest rising to make sure your breaths are going in. If not, retilt the head and try again.
 - If you are unable to make a tight enough seal over the child’s mouth (jaw or mouth is injured or your mouth is too small), **use mouth to nose breathing**.
6. **Check for a pulse for 5 seconds.** To check the pulse of a child, feel at the front of the neck for the Adam’s apple and slide your fingers into the groove next to it in the side of the neck. If there is no breathing and no pulse, certified personnel start CPR.



7. Position:

- Place the child on their back on a firm, level surface.
- Kneel beside the chest.
- Keep the head tilted back with one hand.
- Place the heel of the other hand on the lower half of the breastbone in the middle of the chest. When giving CPR to a child, compressions are performed with the heel of **1 hand only**.
- Position your shoulders over your hands.
- Keep elbows straight.
- Push straight down.

**8. Perform 5 chest compressions.**

- Each series of 5 chest compressions should take about **3 seconds**. Compress the chest about **1 ½ inches**. Count “one, two, three...” to help maintain a regular rhythm.
- After giving **5 compressions**, give **1** slow breath for about **1 ½ seconds**.
- Repeat cycles of **5 compressions** and **1 breath** for about **1 minute (12 cycles)**.

9. Recheck pulse and breathing for about **5 seconds**. If there is still no pulse, continue sets of **5 compressions** and **1 breath**. Recheck pulse and breathing every few minutes.

10. When to stop CPR:

- If child is breathing and has a pulse.
- If another trained individual takes over CPR for you.
- If Rescue Squad arrives and takes over care of the child.
- If you are exhausted and unable to continue.
- The scene becomes unsafe.

11. If the child is breathing on own, has a pulse, and there is no evidence of trauma, place the child in the recovery position.

12. Continue to observe until Rescue Squad arrives.

CPR**Infant (up to 1 year old)**

NOTE: An infant who is not breathing and does not have a pulse needs CPR. If alone, give CPR for **1 minute** and then call **Rescue Squad**. If someone is with you, have them call **Rescue Squad**. If a mask with one-way valve or other infection control barrier is available, it should be used during rescue breathing. **Do not** delay rescue breathing while such a device is located.

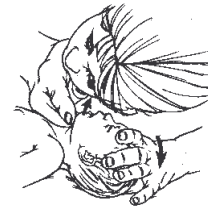
1. **Check to see if the infant is conscious.**

Kneel down beside the infant and tap or gently shake them and shout, “Are you okay”? If there is no response (noise, crying) and you are alone, certified personnel start Rescue Breathing.

2. **Place infant on back** (floor, table). Support the head and neck. Roll as a unit.

3. **Open the airway.**

- Place hand on forehead and gently tilt head back. **Do not** tip infant’s head back very far to open the airway. Airway is open if the infant’s chest rises and falls as you give breaths.



4. **Check for breathlessness.**

- Maintain open airway. Tilt head back.
- Place your ear next to mouth and nose.
- **Look, listen, and feel** for breathing for **5 seconds**.

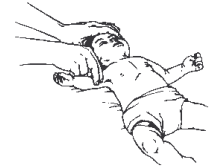


5. **If no signs of breathing:**

- Seal your mouth over the infant’s mouth and nose.
- Give **2** slow breaths lasting about **1½ seconds** each. Pause between each breath. Watch for the chest rising to make sure your breaths are going in. If not, retilt the head and try again.

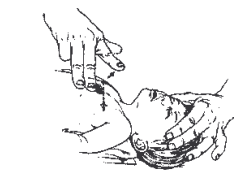


6. **Check for a pulse for 5 seconds.** Check for a brachial pulse on the inside of the upper arm, between the infant’s elbow and shoulder. If infant is not breathing and has no pulse, certified personnel start CPR.



7. **Position:**

- Place one hand on infant’s forehead.
- Place **2 fingers** on the breastbone just below an imaginary line between the nipples. Compress about **½ to 1 inch**.



8. **Perform 5 chest compressions.**

- Count “one, two three, four, five...” to help keep a regular and even rhythm, at least 100 per minute.
- After giving **5 compressions**, give **1 slow breath** (about **1 ½ seconds**).
- Do **12 cycles** of **5 compressions** and **1 breath**.



9. Recheck pulse and breathing for about **5 seconds**. If there is still no pulse, continue sets of **5 compressions** and **1 breath**. Recheck pulse and breathing every few minutes.

10. **When to stop CPR:**

- If infant is breathing and has a pulse.
- If another trained individual takes over CPR for you.
- If Rescue Squad arrives and takes over care of the infant.
- If you are exhausted and unable to continue.
- The scene becomes unsafe.

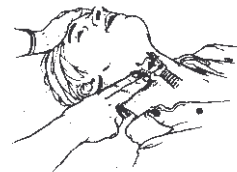
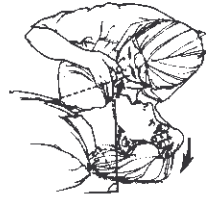
RESCUE BREATHING

Rescue Breathing

Adult: ages 8 & older

NOTE: An individual (ages 8 & older) who is not breathing needs Rescue Breathing. Call the **Rescue Squad**. If someone is with you, have them call the Rescue Squad. If a mask with one-way valve or other infection control barrier is readily available, it should be used during rescue breathing. **Do not** delay rescue breathing while such a device is located.

1. **Open the airway.** (Use head-tilt/chin-lift)
 - Place individual on hard surface.
 - Place hand (the one nearest the individual's ear) on the forehead.
 - Place fingers of other hand under bony part of lower jaw near chin.
 - Tilt head and lift jaw.
 - **Avoid** closing individual's mouth.
 - **Avoid** pushing on the soft parts under the chin.
2. **Check for breathlessness.**
 - Maintain open airway with head-tilt/chin-lift.
 - Place your ear next to mouth and nose.
 - **Look, listen, and feel** for breathing for **5 seconds**.
3. **If no signs of breathing:**
 - Pinch nose shut, make a tight seal with your mouth around the individual's mouth.
 - If you are unable to make a tight enough seal over individual's mouth (jaw or mouth is injured or your mouth is too small), **use mouth to nose breathing**.
 - Give **2 slow breaths** each lasting about **1½ seconds**. Pause between each breath. Watch for the chest rising to make sure your breaths are going in. If not, retilt the head and try again.
4. **Check for a pulse for 5 seconds.** To check for a pulse, feel at the front of the neck for the Adam's apple and slide your fingers into the groove next to it in the side of the neck.
5. If pulse is present but individual is still not breathing, certified personnel start Rescue Breathing.
 - Give **1 breath** every **5 seconds** for about **1 minute (12 breaths)**.
 - Count "one one-thousand, two one-thousand, three one-thousand." Then take a breath on "four one-thousand" and breathe into the individual on "five one-thousand."
6. Recheck pulse and breathing for about **5 seconds**.
7. Continue Rescue Breathing as long as a pulse is present but individual is not breathing.
8. **When to stop Rescue Breathing:**
 - The individual begins to breathe on own.
 - The individual has no pulse. If the individual has no pulse, certified personnel start CPR. (See **CPR**)
 - Another trained rescuer takes over for you.
 - You are too tired to continue.
 - The scene becomes unsafe.

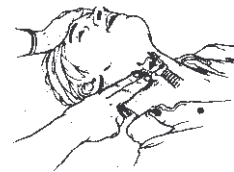


Rescue Breathing

Child: Ages 1-8

NOTE: A child who is not breathing needs Rescue Breathing. Call **Rescue Squad**. If alone, give Rescue Breathing for **1 minute** and then call Rescue Squad. If someone is with you, have them call the Rescue Squad. If a mask with one-way valve or other infection control barrier is available, it should be used during rescue breathing. **Do not** delay rescue breathing while such a device is located.

1. **Open the airway.** (Use head-tilt/chin-lift)
 - Place child on back on a hard surface (floor, table).
 - Place your hand (the one nearest the child's ear) on the forehead.
 - Place fingers of other hand under bony part of lower jaw near chin.
 - Tilt head and lift jaw.
 - **Avoid** closing child's mouth.
 - **Avoid** pushing on the soft parts under the chin.
2. **Check for breathlessness.**
 - Maintain open airway with head- tilt/chin lift.
 - Place your ear next to mouth and nose.
 - **Look, listen, and feel** for breathing for **5 seconds**.
3. **If no signs of breathing:**
 - Pinch nose shut, make a tight seal with your mouth around the child's mouth.
 - If unable to make a tight enough seal over child's mouth (jaw or mouth is injured or your mouth is too small), **use mouth to nose breathing**.
 - Give **2 slow breaths** each lasting about **1 ½ seconds**. Pause between each breath. Watch for the chest rising to make sure your breaths are going in. If not, retilt the head and try again.
4. **Check for a pulse for 5 seconds.** To check for the pulse in a child, feel at the front of the neck for the Adam's Apple and slide your fingers into the groove next to it in the side of the neck.
5. If pulse is present but child is still not breathing:
 - Give **1 breath** about every 3 seconds for about **1 minute (20 breaths)**.
 - Count "one one-thousand," take a breath on "two one-thousand," and breathe into the child on "three one-thousand."
6. Recheck pulse and breathing for about **5 seconds**.
7. Continue Rescue Breathing as long as a pulse is present but child is not breathing.
8. **When to stop Rescue Breathing:**
 - The child begins to breathe on their own.



- The child has no pulse. If the child has no pulse, certified personnel start CPR. (See **CPR**)
- Another trained rescuer takes over for you.
- You are too tired to continue.
- The scene becomes unsafe.

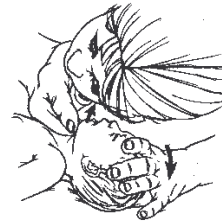
Rescue Breathing

Infant (up to 1 year)

NOTE: An infant who is not breathing needs Rescue Breathing. Call **Rescue Squad**. If alone with an infant who is not breathing, give Rescue Breathing for **1 minute** and then call the Rescue Squad. If someone is with you, have them call the Rescue Squad. If a mask with one-way valve or other infection control barrier is available, it should be used during rescue breathing. **Do not** delay rescue breathing while such a device is located.

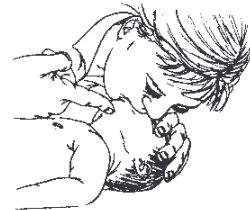
1. Open the airway:

- Place infant on back on hard surface (floor, table).
- Place hand on forehead and gently tilt head back. **Do not tilt** infant's head back very far to open the airway. The airway is open if you can see the infant's chest rise and fall as you give breaths.



2. Check for breathlessness.

- Maintain open airway with head-tilt method.
- Place your ear next to mouth and nose.
- **Look, listen, and feel** for breathing for **5 seconds**.



3. If no signs of breathing:

- Seal your mouth over the infant's mouth and nose.
- Give **2 slow breaths** lasting about **1½ seconds** each. Pause between each breath. Watch for the chest rising to make sure your breaths are going in. If not, retilt the head and try again.



4. Check for a pulse for 5 seconds. Check for a brachial pulse on the inside of the upper arm, between the infant's elbow and shoulder.

5. If pulse is present but infant is still not breathing, certified personnel start Rescue Breathing.

- Give **1 slow breath every 3 seconds**. Do this for about 1 minute (20 breaths).
- Count "one one-thousand," take a breath on "two one-thousand," and breath into the infant on "three one-thousand."

6. Recheck pulse and breathing. If the infant still has a pulse but is not breathing, continue Rescue Breathing. Check the pulse every minute.

7. Continue Rescue Breathing as long as a pulse is present but infant is not breathing.

8. When to stop Rescue Breathing:

- The infant begins to breathe on their own.
- The infant has no pulse. If the infant has no pulse certified personnel start CPR. (See CPR)
- Another trained rescuer takes over for you.
- You are too tired to continue.
- The scene becomes unsafe.

POISONINGS

In cases of poisonings, **contact the regional Poison Control Center** that serves your school division. In Virginia, your regional poison center is roughly determined by your area code:

- ◆ In area code **804** (except Charlottesville and Lynchburg schools), **call Virginia Poison Center 1-800-552-6337.**
- ◆ In area code **757**, **call Virginia Poison Center 1-800-552-6337.**
- ◆ In area code **540** (also Charlottesville and Lynchburg schools), **call Blue Ridge Poison Center 1-800-451-1428.**
- ◆ In area code **703**, **call National Capitol Poison Center 1-202-625-3333.**

The poison center's nurses will assess the situation, determine if there is any risk to the individual, and recommend the correct care to give. They can also advise the first aid provider on the need for the individual to be seen by a physician.

Most cases of accidental poisoning can be managed without referral to a health care facility.

INGESTED/SWALLOWED

NOTE: Ingested poisoning can occur from drug overdoses, medication errors, caustic and corrosive substances, and plant exposures. If a potentially caustic or corrosive liquid chemical has been swallowed, have the individual rinse their mouth with water and spit it out several times before giving them **only** 4 ounces (1/2 cup) of water to drink. This is the **only** situation in which an individual can have something to drink before calling Poison Control. **Call Poison Control.**

TREATMENT

1. If individual is unconscious or in severe respiratory distress, call **Rescue Squad** immediately.
2. If necessary, certified personnel start Rescue Breathing or CPR. (See **CPR** and **Rescue Breathing**.)
3. If necessary, treat for Shock. (**See Shock**.)

4. When medical personnel are notified provide them with:
 - ◆ All containers, food, drinking glasses, bottles, etc. found near the individual.
 - ◆ Container of known poison.
 - ◆ Any information known regarding prescription medicine the individual is taking.
5. If individual is in no apparent life threatening distress, allow them to rest.
6. **Do not** give any medication, food, or liquid until told to do so by Poison Control.
7. Call **Poison Control Center** for additional treatment. Try to have the following information when you call:
 - ◆ **What** has been swallowed.
 - ◆ **Time** it was taken.
 - ◆ **Exact Name** of the substance or medicine.
 - ◆ **How much** was swallowed. (Number of pills, milligrams per pill)
8. Call parent.

INHALATION OF GAS VAPORS

NOTE: Inhalation poisoning can result from inhalation of carbon monoxide, mace, and pepper gas.

TREATMENT

1. If individual stops breathing or is in severe respiratory distress, call **Rescue Squad**.
2. If necessary, certified personnel start Rescue Breathing. (See **Rescue Breathing**.)
3. If individual cannot be moved, the room in which the gas/vapor exposure occurred should be ventilated with open windows, fans, etc.
4. Check individual for other injuries. See appropriate procedure for treatment.
5. If there is no injury that indicates individual should not be moved, move to fresh air immediately.
6. Allow individual to rest.
7. Individuals with asthma or other respiratory disease may react to inhaled gas/vapors more severely than others. If an asthma episode occurs, see **Asthma**.
8. **Call Poison Control Center** for additional advice.
9. Call parent.

OCULAR (EYE) EXPOSURE

NOTE: Eye poisonings can result from exposure to mace, pepper gas, and other substances/chemicals.

TREATMENT

1. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
2. Immediately rinse out the eye(s) with a gentle, steady stream of tepid water for at least **15 minutes**. When only one eye is affected, position the head so that affected eye is lower than non-affected eye. Remove the poison quickly to prevent corneal injury.

3. Assist individual to keep eyes open while the rinsing is done.
4. **Call Poison Control Center** for additional treatment advice.
5. Call parent.

SKIN EXPOSURE

NOTE: Skin poisoning can result from exposure to poison ivy, chemical substances, and pencil puncture wounds.

TREATMENT

1. Remove any clothing that has become contaminated by the substance(s).
2. Wear gloves. Use Universal Precautions. (See **Universal Precautions**.)
3. If poison is a dry substance, brush off as much as possible before rinsing. Avoid getting poison on your skin.
4. Rinse skin with a steady stream of tepid water for **5-10 minutes**.
5. Cleanse skin thoroughly with soap and rinse with lots of tepid water for an **additional 5 minutes**.
6. **Call Poison Control Center** for additional treatment advice.
7. Call parent. Recommend clothing be washed when exposure has been to poison ivy.
8. For a **pencil puncture wound**:
 - If lead is superficially lodged, remove with tweezers.
 - **Do not** push tweezers beneath the skin.
 - Wash with soap and water.
 - Determine individual's tetanus immunization status from the school record.
 - Call parent and recommend immediate medical care.

WASP & BEE STINGS

SIGNS AND SYMPTOMS

- ◆ Intense pain
- ◆ A whitish bump with a red dot in its center
- ◆ Swelling **at the site** of the sting
- ◆ Rapid onset of breathing difficulty
- ◆ Vomiting
- ◆ Fainting
- ◆ An itchy, red rash distributed over the body
- ◆ Swelling **not** at the site of the sting

TREATMENT

1. If necessary, call **Rescue Squad**. (See **Allergic Reaction**.)
2. If necessary, certified personnel start Rescue Breathing. (See **Rescue Breathing**.)
3. Remove stinger. Gently scrape stinger off with the edge of a credit card or blunt edge of a table knife.
4. Apply an ice cube to sting site for **5-15 minutes** to reduce pain and swelling.
5. Apply a topical cream or lotion (e.g., calamine, caladryl, benadryl lotion) to site.
6. If the sting is on the arm or leg, raise the extremity above the level of the heart to help decrease pain and swelling.

7. **Call Poison Control Center** for additional treatment advice.
8. Call parent.

ACKNOWLEDGEMENTS

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A final word of thanks is extended to the other participants in this effort who have not received formal acknowledgment but who provided comments and suggestions that were helpful in the preparation of this edition of *First Aid Guide for School Emergencies*.

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APPENDIX C: Universal Precautions and Infectious Diseases

- ◆ Universal Precautions
- ◆ Selected Infectious Diseases

Universal Precautions for Handling Blood/Body Fluids in School

Authorization

Occupational Safety and Health Administration (OSHA) Final Bloodborne Pathogens Standard. The following guidelines are designed to protect persons who may be exposed to blood or body fluids of students or employees in a school. Please refer to the Occupational Safety and Health Administration (OSHA) Final Bloodborne Pathogens Standard for the most recent requirements.

Overview

Anticipating Potential Contact. Anticipating potential contact with infectious materials in routine and emergency situations is the most important step in preventing exposure to and transmission of infections. Use universal precautions and infection control techniques in all situations that may present the hazard of infection. Diligent and proper handwashing, the use of barriers (e.g., latex or vinyl gloves), appropriate disposal of waste products and needles, and proper care of spills are essential techniques of infection control.

Applying the Concept of Universal Precautions. When applying the concept of universal precautions to infection control, all blood and body fluids are treated as if they contain bloodborne pathogens, such as the human immunodeficiency virus (HIV) and hepatitis B virus (HBV). HIV and HBV can be found in:

- ◆ blood
- ◆ spinal fluid
- ◆ synovial fluid
- ◆ vaginal secretions
- ◆ semen
- ◆ pericardial fluid
- ◆ breast milk
- ◆ peritoneal fluid
- ◆ amniotic fluid
- ◆ pleural fluid

Hepatitis B Virus (HBV). HBV (not HIV) is also found in saliva and other body fluids such as urine, vomitus, nasal secretions, sputum, and feces. It is not possible to know whether these body fluids contain bloodborne pathogens therefore, **all body fluids should be considered potentially infectious.** Thus universal precautions should be observed by all students and staff when handling or coming into contact with any blood or body fluids.

Handwashing

Diligent and proper handwashing are essential components of infection control. Hands should be washed:

- ◆ Immediately before and after physical contact with a student (e.g., diaper changes, assisting with toileting, assisting with feeding).
- ◆ Immediately after contact with blood or body fluids or garments or objects soiled with body fluids or blood.
- ◆ After contact with used equipment (e.g., stethoscope, emesis basin, gloves).
- ◆ After removing protective equipment, such as gloves or clothing.

Procedure.

1. Remove jewelry and store in a safe place prior to initial handwashing (replace jewelry after final handwashing).
2. Wash hands vigorously with soap under a stream of running water for approximately 10 seconds.
3. Rinse hands well with running water, and thoroughly dry with paper towels.
4. If soap and water are unavailable, bacteriostatic/bactericidal wet towelettes, “handi-wipes,” or instant hand cleaner may be used.

Please see detailed instructions in Figure 5., Eight Steps to Proper Handwashing, for detailed handwashing instructions.

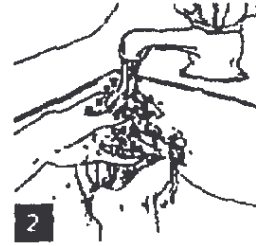
Figure 5. Eight Steps to Proper Handwashing ¹³³

¹³³ From *Resource Manual for the Prevention of HIB/HBV Viruses* by Maryland State Department of Education, 1991.



1

Open faucet



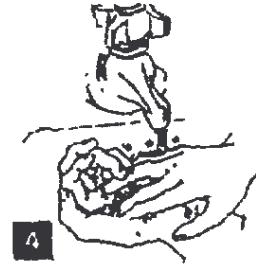
2

Wet hands thoroughly

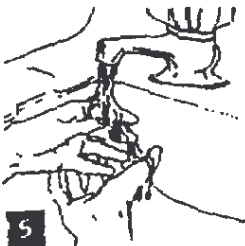


3

Apply soap

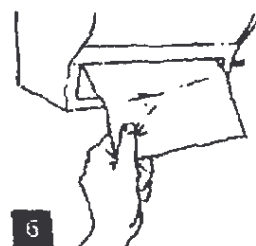


4

Rub vigorously
10 seconds or more

5

Rinse thoroughly



6

Dry hands with
disposable towel

7

Use towel to turn off faucet

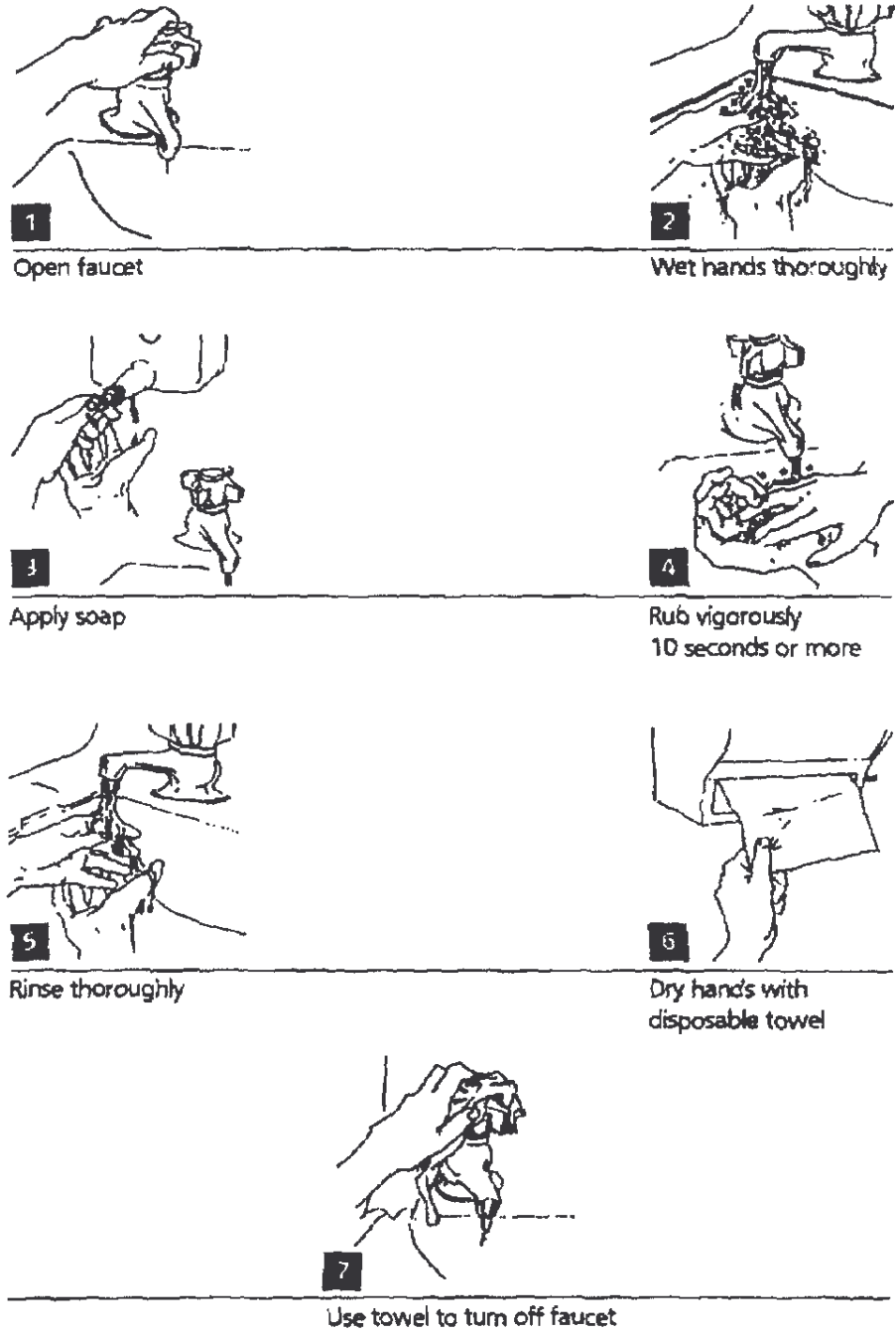
Ways to Avoid Contact with Body Fluids

Gloves. When possible, avoid direct skin contact with body fluids. Disposable single use, waterproof, latex, or vinyl gloves should be available in school clinics. Vinyl gloves should be used with students who have a latex allergy or a high potential for developing a latex allergy, such as students with spina bifida. The use of gloves is intended to reduce the risk of contact with blood and body fluids

for the caregiver as well as to control the spread of infectious agents from student to employee, employee to student, or employee to employee.

Gloves should be worn when direct care may involve contact with any type of body fluids. Incidents when gloves should be worn include (but are not limited to): caring for nose bleeds, changing a bandage or sanitary napkins, cleaning up spills or garments soiled with body fluids, disposing of supplies soiled with blood, or any procedure where blood is visible. Gloves should also be worn when changing a diaper, catheterizing a student, or providing mouth, nose or tracheal care.

Do Not Reuse Gloves. After each use, gloves should be removed without touching the outside of the glove and disposed of in a lined waste container. After removing the gloves, the hands should be washed according to the handwashing procedure. (See Figure 6., Proper Removal of Gloves.)

Figure 6. Proper Removal of Gloves ¹³⁴

¹³⁴ From *Resource Manual for the Prevention of HIB/HBV Viruses* by Maryland State Department of Education, 1991.

Protective Clothing. If spattering of body fluids is anticipated, the clothing of the caregiver should be protected with an apron or gown and the face protected with a face mask and eye goggles or face shield. The apron or gown should be laundered or disposed of after it is used and should not be used again until it is clean. The goggles and mask should be disposed of properly.

Shield for Rescue Breathing. If it is necessary to perform Rescue Breathing, a one-way mask or other infection control barrier should be used. However, Rescue Breathing should not be delayed while such a device is located.

Disposal of Infectious Waste

Contaminated Supplies. All used or contaminated supplies (e.g., gloves and other barriers, sanitary napkins, Band-Aids), except syringes, needles, and other sharp implements, should be placed into a plastic bag and sealed. This bag can be thrown into the garbage, out of reach of children or animals.

Used Needles, Syringes, And Other Sharp Objects. Make arrangements to dispose of used needles, syringes, and other sharp objects at a local medical facility or health department. Needles, syringes, and other sharp objects should be placed **immediately after use** in a metal or other puncture-proof container that is leak proof on the bottom and sides. To reduce the risk of a cut or accidental puncture by a needle, NEEDLES SHOULD NOT BE RECAPPED, BENT, OR REMOVED FROM THE SYRINGE BEFORE DISPOSAL. Once it is full, the container should be sealed, bagged, and kept out of the reach of children until it can be disposed of properly.

Body Waste. Body waste (e.g., urine, vomitus, and feces) should be disposed of in the toilet. If such body fluids as urine and vomitus are spilled, the body fluids should be covered with an absorbent sanitary material, gently swept up, and discarded in plastic bags.

Clean-Up

Spills of blood and body fluids should be cleaned up immediately with an approved disinfectant cleaner.

Procedure.

1. Wear gloves. (See “Ways to Avoid Contact with Body Fluids” on previous page.)
2. Mop up spill with absorbent material.

3. Wash the area well, using the disinfectant cleaner supplied in the clinics or a 1:10 bleach solution (mix 1 part household bleach, sodium hypochlorite, in ten parts of water). Replace solution daily.
4. Dispose of gloves, soiled towels, and other waste in sealed plastic bags and place in garbage, as already indicated.
5. WASH HANDS.

Routine Environmental Clean-Up Facilities. Routine environmental clean-up facilities (e.g., clinic and bathrooms) do not require modification unless contaminated with blood or body fluids. If so, the area should be decontaminated using the procedure outlined. Regular cleaning of non-contaminated surfaces, such as toilet seats and table tops, can be done with the standard cleaning solutions or the 1:10 bleach solution described above. Regular cleaning of obvious soil is more effective than extraordinary attempts to disinfect or sterilize surfaces.

Cleaning Tools. Rooms and dustpans must be rinsed in disinfectant. Mops must be soaked in disinfectant, washed, and thoroughly rinsed. The disinfectant solution should be disposed of promptly down the drain.

Laundry. Whenever possible, disposable barriers (e.g., disposable gloves and gowns) should be used if contamination with blood or body fluids is possible. If sheets, towels, or clothing become soiled, they should not be handled more than necessary. Wash contaminated items with hot water and detergent for at least 25 minutes. Presoaking may be required for heavily soiled clothing. The most important factor in laundering clothing contaminated in the school setting is elimination of potentially infectious agents by soap and hot water.

Soiled student clothing should be rinsed using gloves, placed in a plastic bag, and sent home with appropriate washing instructions for the parents.

Accidental Exposure

Accidental exposure to blood, body products, or body fluids places the exposed individual at risk of infection. The risk varies depending on the type of body fluid (e.g., blood vs. respiratory vs. feces), the type of infection (e.g., salmonellae vs. haemophilus influenzae virus vs. HIV), and the integrity of the skin that is contaminated.

Procedure.

- 1) Always wash the contaminated area **immediately** with soap and water.

- 2) If the mucous membranes (i.e., eye or mouth) are contaminated by a splash of potentially infectious material or contamination of broken skin occurs, irrigate or wash area thoroughly.
- 3) If a cut or needle injury occurs, wash the skin thoroughly with soap and water.

In instances where broken skin or mucous membranes, or a needle puncture occur, the caregiver should document the incident. The student's parent or guardian should also be notified. The person who was exposed to the infection should contact his/her health care provider for further care as outlined in the recommendations by the Centers for Disease Control and Prevention (CDC).

Pregnant Women

Pregnant women are at no higher risk for infection than other caregivers, as long as appropriate precautions are observed. There is, however, the possibility of in utero transmission of viral infections, such as cytomegalovirus (CMV), HIV, or HBV to unborn children.

Guidelines for Exposure Policy Development

As of 1992, all school divisions, should have an exposure policy as mandated in the Virginia Department of Labor and Industry's *Occupational Exposure to Bloodborne Pathogens; Final Rule (1992)*. For assistance concerning an exposure policy, contact the Virginia Department of Labor and Industry's Regional Office.

Department of Labor and Industry
Powers-Taylor Building
13 South Thirteenth Street
Richmond, VA 23219
Telephone: (804) 371-2327
Fax: (804) 371-2324
TDD: (804) 786-2376
E-mail: jap@doli.state.va.us

Resources

Virginia Department of Health and Virginia Department of Education. (1992). Universal Precautions for Handling Blood Body Fluids in School. In *Virginia School Health Guidelines* (pp. 195-202).

Bradley, B. (1994). *Occupational Exposure to Bloodborne Pathogens, Implementing OSHA Standards in the School Setting*. Scarborough, Maine: National Association of School Nurses, Inc.

Selected Infectious Diseases

The diseases described in the following sections are arranged alphabetically.

- ◆ Campylobacteriosis
- ◆ Chicken Pox and Shingles (Varicella Zoster)
- ◆ Cold
- ◆ Conjunctivitis (Pink Eye)
- ◆ Cytomegalovirus (CMV) Infection
- ◆ Diphtheria
- ◆ Fifth Disease (Erythema Infectiosum)
- ◆ Giardiasis
- ◆ Group A Streptococcal Infections (Strep Throat, Scarlet Fever)
- ◆ Haemophilus Influenzae Type B (Hib), Invasive
- ◆ Hand, Foot, and Mouth Disease (Coxsackievirus)
- ◆ Hepatitis A
- ◆ Hepatitis B
- ◆ Hepatitis C
- ◆ Hepatitis E
- ◆ Herpes Simplex Infection
- ◆ HIV Infection and AIDS
- ◆ Impetigo
- ◆ Influenza
- ◆ Lyme Disease
- ◆ Measles
- ◆ Meningococcal Illness
- ◆ Mononucleosis, Infectious
- ◆ Mumps
- ◆ Otitis
- ◆ Pediculosis (Head Lice)
- ◆ Pertussis (Whooping Cough)
- ◆ Pinworm Infection
- ◆ Polio
- ◆ Rabies
- ◆ Rocky Mountain Spotted Fever
- ◆ Roseola
- ◆ Rotavirus
- ◆ Rubella
- ◆ Salmonellosis
- ◆ Scabies
- ◆ Sexually Transmitted Diseases
- ◆ Shigellosis
- ◆ Sports-Related Infectious Diseases
- ◆ Tetanus
- ◆ Tinea (Ringworm)
- ◆ Tuberculosis (TB)

Each subsection contains the following information pertaining to each disease.

- ◆ A brief description of the disease and those susceptible to the disease.
- ◆ Transmission.
- ◆ Diagnosis.
- ◆ Treatment.
- ◆ School Exclusion Recommendations (including communicability, case, and contacts).
- ◆ Reporting Requirements.
- ◆ Notification Guidelines.
- ◆ Prevention Guidelines.

Resources

◆ *Additional Information and Consultation*

*Virginia Department of Health
Office of Epidemiology
P.O. Box 2448
Richmond, VA 23218
Telephone: (804) 786-6261
<http://www.vdh.state.va.us>*

Local Health Department

◆ *List of Reportable Diseases*

Please see Appendix A “Reportable Diseases in Virginia” for the list of named diseases, toxic effects, and conditions to be reported.

◆ *Persons Required to Report*

Please see Appendix A “Reportable Diseases in Virginia” for a summary of persons who are required to report named diseases, toxic effects, and conditions.

◆ *Virginia Regulations*

Regulations for Disease Reporting and Control
*Commonwealth of Virginia
State Board of Health
January 1999
To order, call (804) 786-6261.*

◆ *Wall Chart*

Communicable Disease Reference Chart for School Personnel
*Virginia Department of Health
Office of Epidemiology
To order, call (804) 786-6261.*

◆ *Reference Book*

A more complete discussion of infectious diseases, toxic effects, and conditions may be found in Control of Communicable Disease Manual (1995) published by the American Public Health Association. To order, call (301) 893-0159.

Campylobacteriosis

Campylobacteriosis is an intestinal bacterial disease caused by *Campylobacter*. Symptoms include diarrhea with fever, stomach cramps, and vomiting in adults and children. The diarrhea may be severe and bloody. Usually, symptoms disappear without treatment in 1 to 7 days, but there may still be bacteria in the stool of infected individuals for several weeks. If treatment is not received,

convulsions develop in some young children in association with high fever (febrile seizure). *Campylobacter* is the most common bacterial cause of diarrheal illness in the United States.

Transmission

Bacteria that cause campylobacteriosis are transmitted by ingestion of the organisms in undercooked chicken and pork, contaminated food, water, or raw milk; from contact with infected pets (especially puppies and kittens) or infected farm animals or infected infants. Contamination of milk most frequently occurs from fecal-carrier cattle; people and food can be contaminated from poultry, especially from cutting boards. Outbreaks of campylobacteriosis diarrhea in school children have occurred after field trips to dairy farms during which students drank unpasteurized milk. Infected children may transmit infection to puppies or kittens, which may then expose other children. The incubation period is usually 2 to 5 days, with a range of 12 to 10 days, depending on dose ingested.

School Exclusion Guidelines

Communicable: Campylobacteriosis is transmissible as long as the bacteria are excreted in the stool of infected persons. Individuals not treated with antibiotics excrete organisms for as long as 2 to 7 weeks.

Case: Exclude from school until cessation of acute diarrhea. Stress importance of proper handwashing. Infected food handlers who are asymptomatic do not pose a risk for disease transmission and do not need to be excluded from work if proper hygiene measures are maintained.

Contacts: School exclusion and stool cultures are not indicated in the absence of symptoms. Consult local health department for suspected outbreaks.

Diagnosis

A stool culture must be performed to confirm a case of campylobacteriosis.

Treatment

Persons infected with *Campylobacter* will usually recover on their own. An antibiotic (e.g., erythromycin) can be given early on and shortens the duration of the illness and prevents relapse. Treatment with erythromycin usually eradicates the organism from the stool within 2 to 3 days.

Reporting Requirements

Campylobacter infection must be reported to the local health department within seven days of diagnosis.

Notification Guidelines

When campylobacteriosis occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Refer to “Prevention Guidelines for Diseases Spread Through the Intestinal Tract” in Chapter III.
3. Family and household members in contact with a person with campylobacter diarrhea should be made aware of their possible exposure to the bacteria, especially if the individuals are involved in food preparation and handling.

Chickenpox (Varicella-Zoster)

Chickenpox (primary varicella) is an acute generalized disease caused by varicella-zoster virus, a member of the herpes virus group. The illness is characterized by a generalized, itchy, blister-like rash, with mild fever and fatigue. The rash appears as red bumps, which quickly become blistered, ooze and then crust over. New spots continue to appear for about three to four days. The spots will dry up and scab over before falling off. The disease is usually more serious in adults than in children.

A variety of complications can occur with chickenpox. These include infections ranging from impetigo to severe skin infections with toxic shock syndrome. Secondary pneumonia can occur. Less common complications can involve the blood, joints, brain, and kidney. Reyes Syndrome can follow chickenpox. Severe chickenpox can occur in newborn babies whose mothers develop chickenpox within five days before and two days after birth. Persons with weakened immune systems or who are taking drugs that suppress their immune systems are at increased risk of developing a severe form of chickenpox.

Once a person has been infected with the varicella-zoster virus and gets chickenpox, the virus remains (without symptoms) in the body's nerve cells. In some people, the virus reactivates later and is called shingles or zoster. With shingles, a red, often painful or itchy, blistering rash appears, usually in a line along one side of the body. There is no fever. The virus shed in the blisters of the rash can cause chickenpox in a person who has not had it, if that person had direct contact with the infected shingles blisters.

Transmission

Chickenpox is transmitted from person to person by direct contact, droplet, or airborne spread of vesicle fluid or secretions of the respiratory tract of chicken pox cases. Chickenpox is also transmitted by handling articles that are freshly soiled by the infected person's chickenpox lesions. The incubation period is from 2 to 3 weeks, usually 13 to 17 days; may be prolonged after passive immunization against varicella and in the immunodeficient.

School Exclusion Guidelines

Communicable: A person is communicable for as long as 5 days (usually 1 to 2 days) before an eruption of vesicles and for not more than 5 days after the appearance of the first crop of vesicles.

Case: Exclude from school for at least 5 days after eruptions first appear or until vesicles become dry. Avoid exposure of women in early pregnancy who have not had chickenpox and/or varicella vaccine. Students and staff with *shingles* carry the virus that causes chickenpox and could cause an outbreak. Therefore, unless the

shingles rash can be completely covered, it is advisable that individuals with shingles remain out of school until the rash is crusted over and dry.

Contacts: On appearance of symptoms, exclude from school.

Diagnosis

Chickenpox can be presumptively diagnosed by the signs and symptoms. The virus can be isolated from a blister-like lesion during the first three to four days of the eruption for microscopic evaluation.

Treatment

Individuals with chickenpox and shingles should discuss treatment options with their health care provider.

Reporting Requirements

Chickenpox must be reported to the local health department within seven days of diagnosis.

Notification Guidelines

When a case of chickenpox (varicella) occurs in the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Make sure all students and staff exhibiting symptoms associated with the illness are excluded from school based on guidelines described earlier.
3. Identify high risk individuals (e.g., pregnant women, immunocompromised individuals) and refer them to their health care provider immediately.
4. Watch closely for early symptoms in others for 3 weeks following the most recent case.

5. Advise parents and staff of the availability of varicella vaccine. Suggest they discuss the appropriateness of receiving this vaccine with their health care provider.

Colds (Acute Viral Rhinitis)

The common cold is a mild viral infection of the upper respiratory tract (nose and throat) caused by many different viruses. Rhinovirus infection is the most frequent cause of the common cold. (Rhinoviruses may also be involved in bronchitis, sinusitis, otitis media, and lower respiratory tract disease in children.) Cold symptoms include stuffy or runny nose, sore throat, coughing, sneezing, watery eyes, fluid in the ears, and general fatigue. (Note: Fever associated with colds is uncommon in children over 3 years old and rare in adults.)

Transmission

The viruses that cause the common cold are transmitted presumably by direct person-to-person contact or by inhalation of airborne droplet. More importantly, the viruses are transmitted indirectly by hands and articles freshly soiled by discharges of the nose and throat of an infected person. Rhinovirus and probably other similar viruses are transmitted by contaminated hands carrying viruses to the mucous membranes of the eye or nose. The virus concentration in respiratory secretions is usually highest up to 7 to 10 days before a person develops symptoms of illness. Viruses continue to be present in respiratory secretions for 2 to 3 days after symptoms begin. Students and staff have already spread viruses before they begin to feel ill.

Diagnosis

Diagnosis is generally presumptive based on symptoms. Laboratory tests are available but are expensive and generally not indicated.

Treatment

Treatment is aimed at relieving the symptoms. There is no medication to cure viral illnesses. Health care providers generally suggest rest and plenty of fluids. If a cold persists for greater than 10 to 14 days and is accompanied by high fever, persistent cough, and/or complaint of ear pain, the individual may have a secondary bacterial infection and should be advised to see their health care provider to determine if additional treatment is required. Parents should be advised that aspirin or products containing salicylate should **never** be administered to children for fever control in viral infections because of the rare association with Reyes Syndrome, a serious illness.

School Exclusion Guidelines

Communicable. The period of communicability varies, but correlates with the shedding of virus in the nose and mouth secretions, which is about 7 to 10 days (as long as 3 weeks).

Case. School exclusion is not indicated as long as a student or staff member feels well enough to attend school.

Contact. School exclusion is not indicated.

Reporting Requirements

The common cold is not a reportable disease.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Hand washing and cleanliness are essential to stop the spread of all respiratory tract diseases.
3. Refer to “Prevention Guidelines for Disease Spread Through the Respiratory Tract” in Chapter III.

Conjunctivitis (Pink-Eye)

Conjunctivitis (or pink-eye) is an inflammation of the mucous membranes that line the eyelids, most often caused by a virus but occasionally caused by bacteria or allergies. With this inflammation, the white part of the eye becomes pink and the eye produces lots of tears and discharge. In the morning, discharge may make the eyelids stick together.

Transmission

Organisms that cause conjunctivitis are transmitted by direct contact with discharge from the conjunctivae (mucous membranes that line the eyes) or upper respiratory tracts of infected people. The organisms are also transmitted from contaminated fingers, clothing, or other articles (e.g., shared eye makeup, washcloths, towels, or paper towels). Children under 5 are most often affected. The organisms may be mechanically transmitted by eye gnats or flies in some areas. The incubation period is usually 24 to 72 hours.

School Exclusion Guidelines

Communicable: Conjunctivitis is transmissible during the course of active infection.

Case: Exclude from school while symptomatic or until 24 hours of antibiotic treatment has been completed.

Contacts: School exclusion is not indicated.

Diagnosis

Conjunctivitis is diagnosed by the typical appearance of the eye(s). However, it is often difficult to tell if the cause is bacterial or viral. Occasionally, the doctor will examine the discharge under a microscope or culture it.

Treatment

Parents of students who have symptoms of conjunctivitis and staff who have symptoms of conjunctivitis should be advised to contact their health care provider to decide whether medication is needed.

Reporting Requirements

Conjunctivitis is not a reportable disease.

Notification Guidelines

When conjunctivitis occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Have affected individuals keep their eyes wiped free of discharge.
3. Teach everyone to wash their hands after wiping their eyes.
4. Be sure articles that may touch the students' eyes (e.g., prisms, binoculars, pieces of microscope, cameras) are cleaned appropriately. Consideration should be given to avoiding the use of such instruments during an outbreak.

Cytomegalovirus (CMV) Infection

While infection with cytomegalovirus (CMV) is very common, it rarely produces symptoms in children. When the manifestations of CMV infection do occur, they vary with the age and immunocompetence of the host. Occasionally, children or adults with CMV will experience infectious mononucleosis-like syndrome with prolonged fever, mild hepatitis, swollen glands, and fatigue.

Although unrecognized exposure to individuals asymptotically shedding CMV virus is likely to be frequent, concern arises when immunocompromised or pregnant women (especially in the first trimester) are exposed to children with clinically recognizable CMV infection. The fetus of the pregnant woman may become infected, and in rare cases, the fetus may suffer mental retardation, hearing loss, vision disturbances, or other serious problems.

Immunocompromised children and adults, such as those with human immunodeficiency virus (HIV) or those being treated with immunosuppressive drugs, infected with CMV virus may experience pneumonia (inflammation of the lungs) and retinitis (inflammation of the retina in the eye).

Transmission

Infection in humans is caused almost entirely by human CMV. Human CMV is everywhere and transmitted by direct person-to-person contact with virus-containing secretions and from mother to infant before or after birth. Young children can transmit CMV to their parents and other caregivers. In adolescents and adults, sexual transmission also occurs. Spread of the virus requires direct contact with infected fluids (saliva, urine, seminal and cervical fluids) that are then transferred to a mucous surface (inside the mouth, genital tract, or lining of the eye) or into the bloodstream through a break in the skin, needle stick, or blood transfusion. Spreading among children can occur by sharing mouthed objects that have infected saliva on them. The incubation period following a transplant or transfusion with infected blood begins within 3 to 8 weeks. Infection acquired during birth is first demonstrated 3 to 12 weeks after delivery.

School Exclusion Guidelines

Communicable: Transmission is person-to-person by direct contact with infected body fluids. The virus can survive several hours on surfaces outside the body.

Case: School exclusion is not indicated.

Contact: Pregnant personnel and immunocompromised staff and students who may be in contact with CMV infected persons should be urged to contact their health care providers for counseling about the potential risks of acquisition.

Diagnosis

Most individuals with CMV infection are not diagnosed because they show no symptoms. Diagnosis of CMV virus can be made from culture of infected fluids or blood tests.

Treatment

Since infection is largely asymptomatic, no treatment is offered. There is a special treatment offered for symptomatic immunocompromised patients.

Reporting Requirements

CMV infection is not a reportable disease.

Notification Guidelines

Notify pregnant personnel and immunocompromised staff and students who may be in contact with CMV infected persons so they can contact their health care providers for counseling about the potential risks of acquisition.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Refer to “Prevention Guidelines for Diseases Spread Through the Respiratory Tract” in Chapter III.
3. Make sure that everyone (especially women trying to become pregnant, pregnant women, and immunocompromised persons) use universal precautions. (See previous section on “Universal Precautions.”) If any individuals have contact with urine, saliva, stool, or blood and are not wearing gloves, they should wash their hands immediately.

4. All women who work with young children with special health care needs and who might become pregnant should be referred to their health care provider or the health department for information as to the risk of infection with CMV in that setting.

Diphtheria

Diphtheria is a rare, very serious bacterial disease, caused by *Corynebacterium diphtheriae*, involving primarily the nose and throat. Occasionally, other mucous membranes, skin, conjunctivae, or genitalia may be involved. Diphtheria causes a sore throat, swollen tonsils, with a characteristic patch or patches of an adherent grayish covering and swollen neck glands. It can lead to severe throat obstruction that can block breathing. The bacteria also produce a toxin (a type of poisonous substance) that can cause severe and permanent damage to the nervous system and heart.

Transmission

The bacteria that cause diphtheria are transmitted by contact with a patient or carrier. More rarely, the organism is transmitted by contact with articles soiled with discharges from lesions of infected people. Raw milk has served as a transmission vehicle. The incubation period is usually 2 to 5 days, occasionally longer.

School Exclusion Guidelines

Communicable: Communicability in untreated persons usually lasts for 2 weeks or less, and seldom more than 4 weeks. The rare chronic carrier may shed organisms for 6 months or more. Effective antibiotic therapy promptly terminates shedding.

Case: Exclusion from school is mandatory until documentation of two cultures—taken not less than 24 hours apart and not less than 24 hours after completion of antimicrobial therapy—fail to show presence of disease. If cultures are not possible, isolation may be ended after 14 days of appropriate antibiotic treatment.

Contacts: All close contacts (usually household members) irrespective of their immunization status should be:

1. Kept under surveillance for 7 days for evidence of disease.
2. Cultured and treated with a course of antibiotic from their health care provider. Immunization with DTaP, DT, or Td may be appropriate depending on the immunization status of the contact. (Please consult with the local health department or the patient's health care provider.)

Diagnosis

Diagnosis is made from cultures of the nose, throat, and any lesions.

Treatment

Diphtheria is treated primarily with an antitoxin, along with antibiotics. Antibiotics are given to the carriers of the diphtheria bacteria.

Reporting Requirements

Reporting of a person confirmed or suspected of having diphtheria must be made within 24 hours by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification Guidelines

When diphtheria occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § 22.1-271.1, § 22.1-271.2, and § 32.1-46. Refer to “Immunization Requirements” in Chapter III.
2. Booster doses of diphtheria toxoid, every 10 years after finishing the childhood primary immunization series, are needed to maintain protection.
3. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
4. Make sure all staff and students exhibiting symptoms associated with the illness consult a health care provider and the local health department is notified if another person develops diphtheria.

Fifth Disease (Erythema Infectiosum)

Fifth disease (erythema infectiosum) is a mild viral disease caused by human parvovirus B19. It is called “fifth disease” because it was the fifth of six similar rash-causing illnesses. The illness may begin with mild systemic symptoms (low grade fever in 15 to 30 percent of people), followed by a few days without symptoms. The next stage is the appearance of a bright red rash on the cheeks that gives a “slapped cheek” appearance, which fades and recurs. This may be followed by a “lacy” rash on the trunk, arms and legs. The rash last 3 to 7 days but may reappear over 1 to 3 weeks in response to environmental changes (e.g., sunlight, temperature, and stress).

Arthralgia (joint pain) and arthritis (inflammation of a joint) is rare in children but common in adults. The disease is usually mild with children and adults recovering without problems. People with blood disorders, such as sickle cell anemia, and other hemoglobinopathies and those with weakened immune systems may develop more severe symptoms. Women who develop fifth disease during pregnancy may pass the infection to their unborn fetus, causing miscarriages and stillbirths.

Transmission

The virus that causes fifth disease is thought to be transmitted primarily through contact with infected respiratory secretions; also from mother to fetus, and rarely by transfusion of blood products. Outbreaks frequently occur in elementary and middle schools in spring months. Secondary spread among susceptible household members—adults or children—is common, occurring in about 50 percent of contacts. The incubation period is variable; 4 to 20 days to development of rash or symptoms of aplastic crisis.

School Exclusion Guidelines

Communicable: This illness is most transmissible before the onset of symptoms. After the appearance of the rash and other symptoms the individual is unlikely to be infectious. However, people with blood disorders and immunosuppressive illnesses who are ill with fifth disease may be infectious for a longer period of time.

Case: Exclusion from school is not indicated.

Contacts: Exclusion from school is not indicated. Note: Exposed pregnant women and immunosuppressed persons should seek medical advice.

Diagnosis

The diagnosis in children can be presumptively based on symptoms and skin findings. For those at high risk, a laboratory test can detect newly formed antibodies to the parvovirus B19, documenting current or recent disease.

Treatment

There is no specific treatment for fifth disease; care is supportive.

Reporting Requirements

Fifth disease is not a reportable disease.

Notification Guidelines

When fifth disease occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Careful hand washing, especially after handling discharge from the nose and throat and before eating or handling food, is the most effective deterrent to spreading this illness.

Special Note for Pregnant Women. Although still being studied, fifth disease is not known to cause birth defects. Miscarriages and stillbirths have been reported, rarely, in women who developed fifth disease during pregnancy. Recent evidence suggests that the risk of adverse effect during pregnancy is extremely low. However, women who develop fifth disease during pregnancy should be followed closely by their obstetrician.

The decision to try to decrease any person's risk of infection by not attending a school environment where there is an outbreak should be made by the person after discussion with family members, health care providers, public health officials, and employers. A policy to routinely exclude members of high risk groups is not recommended.

Giardiasis

Giardiasis is a parasitic infection principally of the upper small intestine caused by *Giardia lamblia*. It is a fairly common cause of diarrheal illness. Infections with *giardia* may vary from no symptoms to mild, severe, or chronic diarrhea accompanied by cramping and bloating of the abdomen, pale and foul smelling stools, weight loss, and fatigue.

Transmission

The parasite that causes giardiasis is transmitted person to person by hand-to-mouth transfer of the organism from the feces of an infected individual (usually due to poor handwashing practices), especially in institutions and day-care centers; this is the principal mode of spread. Localized outbreaks may occur from ingestion of the organism in fecally contaminated water and less often from fecally contaminated food. The incubation period is usually 3 to 25 days or longer; median 7 to 10 days.

School Exclusion Guidelines

Communicable: Transmission occurs as long as the infected person excretes the *giardia* in the feces, often months.

Case: Exclude from school until cessation of acute diarrhea. Stress importance of proper handwashing.

Contacts: School exclusion and stool cultures are not indicated in the absence of symptoms. Contact local health department for advice during suspected school outbreaks.

Diagnosis

Giardiasis diagnosis can be difficult and more than one stool specimen may be needed. Special stool testing as well as stool microscopy are employed.

Treatment

Individuals with giardiasis who are ill and/or have diarrhea should receive medication prescribed by their health care provider. Infected individuals who do not have symptoms are not routinely treated. Many people recover on their own. Treatment of asymptomatic carriers is not recommended except possibly for

prevention of household transmission by toddlers to pregnant women and in patients with hypogamma-globulinemia or cystic fibrosis.

Reporting Requirements

Giardiasis must be reported to the local health department within seven days of diagnosis.

Notification Guidelines

When giardiasis occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Refer to “Prevention Guidelines for Diseases Spread Through the Intestinal Tract” in Chapter III.

Group A Streptococcal Infections (*Streptococcus Pyogenes*)

Group A *Streptococci* (GAS) are bacteria commonly found in the throat and on the skin. GAS can be present in the throat or on the skin and cause no symptoms of disease, but the organisms may also cause diseases that range from mild to severe and even life threatening. Invasive GAS infections occur when the bacteria get past the defenses of the person who is infected. A brief description of four invasive GAS diseases—impetigo, streptococcal throat, scarlet fever, and rheumatic fever—are presented below.

Impetigo. Streptococcal skin infection is a common skin infection. (See Impetigo.)

Strep Throat. Streptococcal sore throat is typically characterized by sudden onset, fever, sore, beefy red throat, and tender and swollen lymph nodes (called glands by some people). In school-age children, strep throat may be accompanied by headache, nausea, abdominal pain, and vomiting. Rheumatic fever can result when strep throat is untreated or incompletely treated.

Scarlet Fever. Scarlet fever is a form of streptococcal disease characterized by a skin rash. Clinical characteristics may include all those symptoms associated with strep throat. The rash appears 12 to 48 hours after the onset of fever. The rash begins in areas of warmth and pressure (neck, chest, groin, inner surfaces of the knees, thighs, and/or elbows), spreads rapidly to involve the entire body below the chin, and reaches its maximum in 1 to 2 days. The rash usually consists of fine red bumps with sandpaper-like texture, and fades with pressure. The rash is followed, at the beginning of the second week, by a peeling of the skin, beginning at the fingertips. The tongue appears coated at first, peeling and then beefy red.

Rheumatic Fever. Rheumatic fever may occur as a complication following infection with Group A *streptococci*. Rheumatic fever is the most common cause of symptomatic, acquired childhood heart disease (abnormalities of the heart valves and inflammation of the joints), caused by untreated Group A Beta Hemolytic Strep. Specific guidelines (Jones Criteria) have been developed for the diagnosis of this illness.

Transmission

Group A *streptococci* are transmitted person-to-person by direct contact with microscopic respiratory secretions, rarely by indirect contact through hands or objects. Nasal carriers are particularly likely to transmit disease. Casual contact rarely leads to infection. If untreated, uncomplicated cases are transmittable for 10 to 21 days; in untreated cases with runny noses, cough or other respiratory symptoms with discharge, the illness is transmittable for weeks to months. With appropriate treatment the individual is no longer infectious after 24 hours of antibiotic therapy.

Strep throat can occur at any age, but is most common among school-age children, occurring during the colder months and in crowded situations. If one person in a family develops strep throat, other family members may develop it.

School Exclusion Guidelines

Communicable: Untreated strep infections can be transmissible for weeks to months.

Case: Exclude from school until 24 hours of antibiotic treatment has been completed.

Contacts: Exclusion from school is not indicated. Observe carefully for symptoms.

Diagnosis

Throat cultures are used to diagnose strep infections. Rapid strep tests that test for the presence of the strep germ are available. The rapid tests are reliable when positive (a throat culture is not needed). A throat culture should be done when the rapid strep test is negative since the sensitivity of the rapid test is low.

Treatment

Strep infections are treated with oral antibiotics. A student should be expected to show improvement within 48 hours of antibiotics and is no longer contagious after 24 hours of antibiotic therapy if the student does not have a fever.

Reporting Requirements

Group A streptococcal infections are not reportable diseases.

Notification Requirements

When strep infections occur within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Follow the “Prevention Guidelines for Diseases Spread Through the Respiratory Tract” in Chapter III.
3. If there is a case of strep throat in school, refer students and staff with sore throats to their health care providers for evaluation.
4. Be alert to an outbreak. If there are any cases associated with rheumatic fever, kidney disease or toxic shock, consult with the local health department about having all students and staff cultured.

***Haemophilus Influenza* Type B (Hib), Invasive**

Haemophilus Influenzae Type B (Hib) bacteria are one of the most important causes of serious bacterial infection in young children. Hib bacteria may cause a variety of diseases. The incidence of Hib disease has decreased as a result of immunization with either H influenza type B conjugate vaccines and combination H influenza type-B conjugate-DTP in the United States as of December 1993. (See Appendix A for Immunization Schedule, vaccine type and dose requirements.)

Haemophilus Influenzae type B can cause:

- ◆ Meningitis (inflammation of the coverings of the brain).
- ◆ Epiglottitis (inflammation of the upper throat and entrance to the windpipe).
- ◆ Cellulitis (inflammation of the deep skin, especially of the face and neck).
- ◆ Septic arthritis (inflammation and swelling of the joints).
- ◆ Pneumonia (inflammation of the lungs).
- ◆ Pericarditis (inflammation of the sac enclosing the heart).
- ◆ Osteomyelitis (inflammation of bone, especially marrow).
- ◆ Septicemia (infection of the bloodstream).

These illnesses caused by Hib disease are primarily seen in children under 6 years old. Children in a group care setting are at a greater risk of developing these illnesses than others. Older children and adults rarely develop these illnesses; however, they can be carriers and transmit them to younger individuals.

Transmission

The bacteria that cause Hib disease are transmitted presumably person to person, by direct contact (e.g., kissing) with infected fluids, or by sharing eating utensils, drinking cups, straws, and so forth, since the bacteria may persist for hours (particularly in the cold and low humidity). Bacteria can also be passed if infected secretions are touched by people who then put their hands in their mouth, nose, or eyes. It is also spread by breathing in infected droplets of respiratory secretions containing the organisms. Airborne spread occurs predominantly among crowded populations in enclosed spaces, such as school buses. The exact period of

communicability is unknown but may be for as long as the organism is present in the upper respiratory tract. The incubation period is unknown but probably is short—2 to 4 days.

Spread is more likely among children under age 4 years. Disease is most common in children 3 months to 3 years of age. In a household or group care center where there are young children and everyone is in close contact, there is an increased risk of a second infection following a first case. Unvaccinated children, particularly those younger than 4 years of age who are in prolonged close contact (such as in a household) with a child who has developed invasive disease caused by H influenzae type B, are at increased risk for serious infection from this organism. Other factors predisposing an individual to invasive H influenzae type B include sickle cell disease, asplenia, and certain immunodeficiency syndromes, including HIV infection and malignancies.

School Exclusion Guidelines

Communicable: The exact period of communicability is unknown but may be as long as the organism is present in the respiratory tract.

Case: Students with Hib disease should not return to school until they are well and after they have finished taking the antibiotic for 1 to 2 days.

Contacts: Students who are not ill with Hib disease may return to school when antibiotic treatment has begun. Students or staff who are ill should be excluded while they are ill and until they have taken the antibiotic for 1 to 2 days. Exclude any asymptomatic students from school who do receive the antibiotic for 1 week after onset of the last case.

The school health personnel, collaborating with the local health department, should decide when students and staff should be required to take a prescribed antibiotic when one case of Hib disease occurs in school.

Diagnosis

These illnesses are diagnosed by culturing an infected person's blood, spinal fluid, middle ear fluid, or other infected fluid. It may take up to 72 hours to grow and identify the bacteria. Early diagnosis may be able to be made by examination of the infected fluid under a microscope.

Treatment

People sick with invasive Hib disease generally require hospitalization for treatment with an appropriate antimicrobial agent. The carriage of these bacteria in the nose and throat of healthy children and adults may be reduced and perhaps eliminated when a person takes an appropriate antibiotic by mouth. An antibiotic is used as a preventive treatment among household contacts and in preschool and day care environments. The antibiotic treatment can also be considered for contacts in the kindergarten setting. Preventive treatment is not generally recommended in schools where all individuals are 5 years of age or older.

Students who have been vaccinated with any *Haemophilus influenzae* vaccine as well as susceptible, unvaccinated students should receive prophylaxis. Only students who have been appropriately vaccinated should be permitted to enter the group during the time prophylactics are given and for 2 months after onset of the case. For students younger than 12 months, only those who have completed their primary vaccination series should be permitted to enroll in the group.

When antibiotic treatment is used, all students enrolled, regardless of age or Hib immunization status, should receive treatment. In multi-classroom settings, only classroom contacts need the antibiotic.

A licensed vaccine to prevent Hib infection is now required beginning at 2 months of age. The vaccine takes several doses to provide some protection. The vaccine does not prevent a child from becoming a carrier. Therefore, even immunized students need to take antibiotics as prescribed by their health care provider.

Reporting Requirements

*Reporting of a person confirmed or suspected of having **Haemophilus influenzae** infection, invasive, must be made within 24 hours by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.*

Notification Guidelines

When Hib disease occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Require all students attending school to be appropriately immunized with Hib vaccine. (For children through 30 months of age, Hib conjugate vaccine should be administered as recommended by the American Academy of Pediatrics and the U.S. Public Health Service.)
2. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
3. Inform parents and staff that antibiotics do not give 100 percent protection against disease. Therefore, any child or adult who becomes ill with fever, headache, or stiff neck, should be seen promptly by a health care provider. (Children less than 2 years old are at greatest risk of developing serious Hib disease.)
4. Monitor the situation closely for 2 to 3 weeks. Make sure all ill students—particularly those with fever, headache, stiff neck, and other symptoms associated with the illness—are seen by their health care provider and that the school is notified if another person develops Hib infection.
5. The time of greatest risk of others becoming ill is the first week following the first case. Some risk exists for up to 2 months.
6. Notify parents of any new student enrolled in the school within 2 months of the last case.

Hand, Foot, and Mouth Disease (Coxsackievirus)

Hand, foot, and mouth disease is a mild viral disease caused by coxsackievirus. Symptoms may include fever, sore throat, stomach pain and diarrhea, and a rash of tiny blisters on the palms of the hands, soles of the feet, and in the mouth (lasting 7 to 10 days). This illness is most commonly seen in the summer and fall.

Transmission

The virus that causes hand, foot, and mouth disease is transmitted by direct contact with nose and throat discharges and feces of infected people (who may be asymptomatic) and aerosol droplet spread. Adults and children are susceptible; however, incidence is highest in young children. A person can be a source of infection as long as the virus is shed in the stool, usually several weeks (as long as 8 to 12 weeks). The incubation period is 3 to 6 days.

School Exclusion Guidelines

Communicable: The virus is contagious before symptoms begin and continues to be transmissible as long as the virus is shed in the stool.

Case: School exclusion is not indicated if the person is well enough to attend school.

Contacts: School exclusion is not indicated.

Diagnosis

Diagnosis is usually presumptively made, based on symptoms. Specimens for viral isolation can be obtained from the site of clinical involvement.

Treatment

No specific anti-viral treatment is available. Care is supportive.

Reporting Requirements

Hand, foot, and mouth disease is not a reportable disease.

Notification Guidelines

When hand, foot, and mouth disease occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Particular attention should be given to handwashing and personal hygiene as well as environmental cleaning and sanitation.

Hepatitis A

Hepatitis A (formerly infectious hepatitis) is a viral infection of the liver caused by the hepatitis A virus (HAV). The disease is fairly common. The symptoms of hepatitis A may appear 2 to 6 weeks after exposure (usually within 4 weeks) and in adults include fatigue, loss of appetite, nausea, fever, and jaundice.

Urine may become darker in color, and then jaundice (a yellowing of the skin and the whites of the eyes) may appear. These symptoms usually last from 1 to 2 weeks. In infants and pre-school children, most infections are either asymptomatic or cause mild non-specific symptoms without jaundice. Not everyone who is infected with hepatitis A will have all of the symptoms. An individual who has recovered from hepatitis A is immune for life and does not continue to carry the virus.

Transmission

The hepatitis A virus is transmitted person to person by the fecal-oral route. The hepatitis A virus enters through the mouth, multiplies in the body, and is passed in the feces (stool). The virus can then be carried by an infected person's hands and can be spread by direct contact or by consuming food or drink that has been handled by the individual. Outbreaks from one common source have been related to contaminated water; food contaminated by food handlers, including sandwiches that are not cooked or are handled after cooking; raw or undercooked mollusks harvested from contaminated waters; and contaminated produce such as lettuce and strawberries. Although rare, instances have been reported of transmittal by transfusion of blood/blood products. Since most young children with hepatitis A do not become ill, the first sign of infection in a school, daycare, or baby-sitting setting is often a jaundiced parent or staff member. The incubation period is from 15 to 50 days, depending on dose; average 28 to 30 days.

School Exclusion Guidelines

Communicable: Viral shedding and probably the contagious period lasts 1 to 3 weeks. The stools of infected people are the most highly contagious 1 to 2 weeks before the onset of illness, during which time patients are most likely to transmit infections. Communicability decreases from this point.

Case: Exclude from school until health care provider advises return. Convalescence maybe prolonged.

Contacts: School exclusion is not indicated. Stress importance of handwashing. School room exposure generally does not pose a significant risk of infection, and contacts need not be excluded from school. However, IG (immune globulin) may be given to those who have close personal contact with the infected person.

Diagnosis

Hepatitis A is diagnosed by a blood test that indicates if a person has ever had the infection, regardless of presence of symptoms. Note: Anti-HAV Igm antibody positive indicates current infection.

Treatment

There is no specific anti-viral treatment for hepatitis A. Care is supportive. Administering IG (immune globulin) to household members and close contacts can minimize the chances of their becoming ill, if given within 2 weeks of exposure to the case.

Reporting Requirements

Reporting of a person confirmed or suspected of having hepatitis A must be made within 24 hours by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification Guidelines

When hepatitis A occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. If a case of hepatitis A occurs in a kindergarten, first grade, or pre-school class where hygiene may not be optimal (e.g., handwashing is poor, diapering may be needed), more stringent control measures, including the use of IG (immune globulin), may be indicated. The local health department can provide recommendations.
3. Good sanitation and personal hygiene, particularly careful handwashing and sanitary disposal of feces (stool), are important general measures.
4. For students and staff at increased risk for Hepatitis A, the Hepatitis A vaccine may be recommended.

Hepatitis B

Hepatitis B (formerly serum hepatitis) is a viral infection of the liver caused by the hepatitis B virus (HBV). The disease is fairly common. HBV infection in children is symptomatic in less than 10 percent of cases. When it is symptomatic the typical signs and symptoms include fever, loss of appetite, nausea, abdominal pain, light-colored stools, dark colored urine, and jaundice (yellowing of the skin and whites of the eyes). Pain in joints and rashes can occur early in the course of the infection. Illness can range from infection without symptoms, to mild symptoms with jaundice to severe illness with jaundice to rapid liver failure and death.

Hepatitis B virus can cause chronic infection with persistent shedding of the virus into body fluids including blood in up to 90 percent of infants who become infected by perinatal transmission (from mother to fetus during pregnancy or birth) and 6 to 10 percent of older children, adolescents, and adults who acquire HBV infection. Chronically infected persons are at increased risk for developing chronic liver disease (e.g., cirrhosis, chronic active hepatitis, and chronic persistent hepatitis) or liver cancer later in life. Persons infected as infants or young children appear to be at higher risk of death from liver disease than those infected as adults.

Transmission

The hepatitis B virus is transmitted through blood or body fluids, such as infected discharge from a wound, semen, cervical secretions, and saliva. Blood and serum contain the highest quantities of virus; saliva contains the least. HBV is spread when blood or body fluids containing the virus get into broken skin or onto mucous membranes inside the mouth, eyes, rectum, or genital tract. HBV spread requires contact with infected fluid through the skin via a needle stick, contamination of a cut, blood transfusion (now rare in the United States as the result of current donor screening practices), sharing or reusing of unsterilized needles, and sexual activities. HBV can survive in the dried state for 1 week or longer. Therefore, contact of exposed skin and mucous membranes with contaminated inanimate objects may transmit infection. HBV is not transmitted by the fecal-oral route. The incubation period is usually 45 to 180 days; average 60 to 80 days.

Most infected persons in the United States acquire their infection as adolescents or adults. Infection is associated with other sexually transmitted diseases, including syphilis. Groups at highest risk for infection with HBV include users of intravenous drugs, persons with multiple heterosexual partners, and homosexual men. Others at increased risk include those with occupational exposure to blood or body fluids, staff of institutions and nonresidential child care programs for the

developmentally disabled, persons receiving hemodialysis, and sexual or household contacts of persons with an acute or chronic infection. The incubation period is from 45 to 160 days with an average of 120 days.

Spread of HBV in schools is rare. All children born on or after January 1, 1994, are required to have 3 doses of hepatitis B vaccine prior to entering school (*Code of Virginia* § 32.1-46). In addition, the Advisory Committee on Immunization Practices (ACIP), The American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the Recommended Childhood Immunization Schedule, United States recommend children between 11 and 12 years of age receive the hepatitis B series. (See Appendix A for the Recommended Childhood Immunization Schedule, United States, January-December 1999.)

School Exclusion Guidelines

Communicable: HBV infection is transmitted by direct contact with infected body fluids, not casual contact. The virus can survive, dried up, for 1 week on inanimate objects.

Case: Persons with acute HBV infection are advised to follow the advice of their primary health care provider or local health department. Exclusion from school of HBV carriers is not indicated. The risk of HBV spread in a school setting is considered very low and does not justify exclusion of the hepatitis B carrier or routine screening of children prior to enrollment. However, in schools the risk of spread is higher from an infected person with behavior and/or medical problems, such as biting behavior that draws blood, or oozing skin sores. These behaviors may increase the possibility of transfer of infected fluid. A student or staff member with chronic HBV who has open, oozing sores that cannot be covered should remain at home until the skin sores are healed.

Contacts: School exclusion is not indicated (See the following prevention and treatment guidelines for recommendations for post-exposure treatment.)

Diagnosis

Hepatitis B infection is diagnosed with a blood test.

Treatment

No specific treatment for acute HBV infection is available. Supportive care and bed rest are advised in uncomplicated cases. Medical follow-up care is important to monitor for complications and the occurrence of chronic infection. In chronic

liver disease from adult acquired HBV infection, alpha interferon has been demonstrated to have limited results in resolving chronic infection, but the drug has been less effective for chronic infections acquired in early childhood. Hepatitis B immune globulin is indicated for persons (who have not received the full hepatitis B vaccine series) exposed to the hepatitis B virus. It helps prevent hepatitis B if given within two weeks of exposure.

Reporting Requirements

Hepatitis B must be reported to the local health department within seven days of diagnosis.

Notification Guidelines

Parents should be encouraged to notify the school nurse if their child is a known hepatitis B carrier. Parents of other students attending the school do not need to be informed. When hepatitis B occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § 22.1-271.1, § 22.1-271.2, and § 32.1-46. Refer to “Immunization Requirements” in Chapter III. (Be sure that all students born on or after January 1, 1994, have had 3 doses of hepatitis B vaccine prior to entering school in accordance with the *Code of Virginia*.)
2. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
3. Advise parents of the national vaccine recommendations and where the vaccine can be obtained. (See Appendix A.)
4. Use universal precautions. (See previous section on “Universal Precautions.”) Make sure all staff receive regular training on prevention of bloodborne disease. Age-appropriate education should be provided to students on transmission of bloodborne diseases, including sexual transmission and procedures for handwashing and cleanliness at school. (*Code of Virginia*, § 22.1-271.3, requires that “Every school board shall ensure that all school personnel having direct contact with students receive appropriate training in the etiology, prevention, transmission modes, and effects of blood-borne pathogens, specifically, hepatitis B and human immunodeficiency viruses...”)

5. Do not permit sharing of personal items that may become contaminated with blood or body fluids, such as toothbrushes, razors, eating utensils, or any other object that can be mouthed.
6. Cover skin lesions.
7. If an individual is known to have been exposed to hepatitis B (such as by a needle stick, a bite that has drawn blood, or sexual contact with an acutely infected person), hepatitis B immune globulin (HBIG) should be given. If the exposed person has not already been vaccinated, it is recommended they also receive the vaccine series after the immune globulin injection. Contact the local health department and health care provider for immediate advice.
8. Place disposable items contaminated with blood or body fluids in plastic bags in covered containers. (See previous section on “Universal Precautions.”)
9. Store clothing or other washable items stained with blood and/or body fluids separately in a plastic bag, and send them home with the owner for appropriate cleaning. Clothing stained with blood or other body fluids should be washed with hot water in a regular cycle wash.
10. Wash and sanitize surfaces of toys contaminated with blood or body fluids with a dilute solution of 1/4 cup chlorine bleach in 1 gallon of water freshly made up on a daily basis or disinfect objects by boiling them for 10 minutes.
11. Discourage aggressive behavior (e.g., biting, scratching) at the school and supervise closely to avoid these behaviors.

Hepatitis C

Hepatitis C (formerly Hepatitis Non-A Non-B) is a viral infection of the liver caused by the hepatitis C virus (HCV). It often has signs and symptoms indistinguishable from hepatitis A or B infection. In most cases the signs and symptoms are not as severe. Acute disease tends to be mild, with slow onset. In children most infections are asymptomatic. For those adults or children who do display illness, symptoms include loss of appetite, stomach pain, nausea, and vomiting. Jaundice (yellowing of the skin, whites of the eyes, mucous membranes, and other body fluids) occurs in only 25 percent of persons with HCV. Approximately 65 to 70 percent of individuals with HCV become chronic (long-term) carriers of the virus. These carriers may or may not display symptoms.

Transmission

The hepatitis C virus is spread by exposure to blood from an infected person and blood products from HCV-infected people. Other body fluids contaminated with infected blood also can be sources of infection (IV drug users, sexual contacts). Transmission of the virus from mother to fetus is 5 percent. Breastfeeding is not currently contraindicated secondary to maternal HCV infection. The incubation period ranges from 2 weeks to 6 months; most commonly 6 to 9 weeks.

School Exclusion Guidelines

Communicable: Infected persons can spread the virus beginning 1 or more weeks before the onset of symptoms and throughout the course of the disease. Chronic carriers may spread the virus indefinitely.

Case: School exclusion is not required. Persons who have hepatitis C should be educated about their carrier status and observe universal precautions.

Contacts: School exclusion is not indicated. All students and staff should adhere to universal precautions.

Diagnosis

HCV is diagnosed by screening the blood for antibodies to hepatitis C in those who have symptoms and abnormal liver function tests suggestive of hepatitis. Some individuals will test positive for hepatitis C but will not display symptoms. These individuals can still spread the disease.

Treatment

There is no specific anti-viral treatment for hepatitis C. Care is supportive. (Alpha interferon is the only treatment currently available for chronic HCV infection in adults. However, few patients have experienced a sustained response and this drug is not approved by the Food and Drug Administration [FDA] for children under 18 years of age.)

Reporting Requirements

Hepatitis C must be reported to the local health department within seven days of diagnosis.

Notification Guidelines

Parents should be encouraged to notify the school nurse if their child is a known hepatitis C carrier. Parents of other students attending the school do not need to be informed. When hepatitis C occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. All students and staff should adhere to strict universal precautions. (See previous section on “Universal Precautions.”)
3. Students and staff who have hepatitis C should be aware that their blood and possibly other body fluids may carry the virus and should take care not to expose others through sharing of needles, razors, toothbrushes, or other items that may be contaminated.
4. Students and staff who might be exposed to blood in their job need to wear gloves and follow strict universal precautions.

Hepatitis E (Enterically Transmitted Non-A, Non-B Hepatitis)

Hepatitis E virus (HEV) is the major causative organism of enterically transmitted non-A, non-B hepatitis. HEV is an acute illness, presenting with jaundice (yellowing of the skin, whites of eyes, mucous membranes, and body fluids), fatigue, anorexia, fever, abdominal pain, and arthralgia (pain in a joint).

Transmission

The hepatitis E virus is transmitted via contaminated water and probably from person to person by the fecal-oral route. HEV infection is more common in adults than children and has an unusually high case-fatality rate in pregnant women. HEV infection is not endemic to the United States, but cases have occurred in travelers from the United States to endemic areas (including Asia, Africa, and Mexico) usually related to contaminated water. The incubation period is approximately 2 to 8 weeks.

School Exclusion Guidelines

Communicable: The period of communicability after acute infection is unknown, but virus shedding in the stool and the presence of virus in the blood occurs for about 2 weeks. Chronic infection does not occur.

Case: Persons diagnosed with HEV should be excluded from school until symptoms have resolved.

Contacts: School exclusion is not indicated. Students and staff should adhere to careful sanitation and hygiene practices.

Diagnosis

Diagnosis is established by exclusion of Hepatitis A, B, C, D, and other viral causes of acute hepatitis. No diagnostic test is available.

Treatment

There is no anti-viral medication available for the treatment of HEV. Care is supportive.

Reporting Requirements

Hepatitis E must be reported to the local health department within seven days of diagnosis.

Notification Guidelines

When hepatitis E occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Promote hand washing after using the bathroom and before preparing food.
3. Ensure that bathrooms have an adequate supply of soap, running water, paper towels, and toilet paper.
4. Staff caring for students in diapers should be sure to use universal precautions. (See previous section on “Universal Precautions.”)
5. Pay attention to environmental cleaning and sanitation.
6. Refer to “Prevention Guidelines for Diseases Spread Through the Intestinal Tract” in Chapter III.

Herpes Simplex Infection

Herpes simplex viral (HSV) infections are characterized by skin blisters or sores that can be very itchy and painful. Once a person is infected, these viruses remain in nerve cells, and HSV tends to recur at the same places on the body again and again. There are two types of herpes simplex virus: HSV type 1 (usually found in the mouth) and HSV type 2 (usually found on the genitals).

HSV type 1 is extremely common. The first infection typically occurs in childhood. It is mild and often goes unnoticed. It may come in the form of gingivostomatitis—fever accompanied by wide-spread painful ulcerations (sores) in the mouth. HSV usually recurs as cold sores—single or multiple blisters around the lip. In rare cases, HSV may be spread by direct contact and cause infection on a finger (herpetic whitlow—painful, recurrent blisters of a finger) or in the eye (herpetic keratitis—recurrent ulcerations of the cornea) or other places on the skin. HSV-1 dermatitis/conjunctivitis (herpes gladiatorum) has been diagnosed in wrestlers and other contact-sport participants. (Refer to “Prevention of Sports Related Infectious Diseases” in Chapter III.)

HSV type 2 is the cause of most cases of genital herpes. It is sexually transmitted. First infection is often characterized by painful genital blisters and ulcers accompanied by fever and can last 2 weeks. Recurrence is common, usually as localized, less painful ulcers that go away in 7 to 10 days and are not accompanied by fever. Recurrence may also be asymptomatic.

Herpes of the newborn occurs when the infant passes through an infected birth canal. The resulting illnesses range in severity from skin blisters to total body disease resulting in severe brain damage or death.

Herpes infection in children is generally caused by HSV type 1, and while uncomfortable, is rarely serious. People who have severe eczema (atopic dermatitis) or immune system problems may experience more severe symptoms of herpes infection. Children should be cautious about HSV spread to hands and eyes. Touching lesions should be discouraged as much as possible. Young children with HSV lesions also need to be monitored to avoid spread to newborn infants.

Transmission

HSV type 1 is probably transmitted mostly by contact with the virus in the saliva of carriers. HSV type 1 is most common in young children. HSV type 2 is usually transmitted by sexual contact. HSV type 2 (due to its sexual transmission) is more common in adolescents and adults. HSV type 2 may be diagnosed in children in unusual circumstances or as a result of sexual abuse. Both HSV type 1 and 2 may be transmitted to various sites by oral-genital, oral-anal, or anal-genital contact. The incubation period is from 2 to 12 days.

Because herpes viruses can survive as long as 4 hours on any surface, mouthed objects contaminated by virus-containing saliva may transmit infections of the mouth.

School Exclusion Guidelines

1. Students or staff with open, oozing skin sores (including herpetic whitlow) that cannot be covered should not attend school.
2. If individuals typically put their fingers in their mouth, they should be excluded until the lesions are crusted over.
3. In the case of students who are drooling or have biting behavior, permit them to return to school settings when blisters are crusted over.
4. Students or staff with skin blisters that cannot be covered should be permitted to return when the blisters are crusted over.
5. Do not exclude students or staff with mouth sores or skin blisters that can be covered or those with genital herpes.
6. Students or staff with herpetic whitlow should be permitted to attend school if lesions are covered.

Diagnosis

Diagnosis is usually made based on the history and distinctive appearance of the blisters or sores. Microscopic exam and/or viral cultures are available.

Treatment

Anti-viral therapy for HSV infections is available. Treatment is given for genital herpes and more serious HSV disease, such as infections of the brain or eye. Anti-viral therapy may shorten the length of some less serious HSV infections (e.g., cold sores).

Reporting Requirements

There is no requirement to report HSV infections either type 1 or type 2 unless they occur in newborn babies.

Notification Guidelines

None.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Make sure that staff who may come in contact with blisters on students wear gloves and use universal precautions during diapering or changing of a dressing. (See previous section on “Universal Precautions.”)
3. Refer to “Prevention Guidelines for Diseases Spread Through Direct Skin Contact” and “Prevention Guidelines for Diseases Spread During Sexual Activity” in Chapter III.
4. To control spread of herpes gladiatorum, educate athletes and trainers about the risk, conduct routine examinations before wrestling contacts, exclude wrestlers with suspicious lesions, and refer them for diagnosis and treatment. Sanitizing of mats with a dilute bleach solution (1 tablespoon bleach to 1 quart of water) and airing of mats is also recommended as a standard precaution.

HIV Infection and AIDS

Authorization

Code of Virginia. Section 22.1-271.3 Guidelines for School Attendance for Children Infected with Human Immunodeficiency Virus. The *Code of Virginia* provides guidelines for school attendance for students who are infected with the human immunodeficiency virus (HIV). These guidelines include requirements for training of school personnel and requirements for notification of school personnel in certain cases of students with HIV infection.

Excerpt: See Appendix A for *Code of Virginia* § 22.1-271.3.

Superintendent’s Memo, No. 255, November 29, 1989. The memo provides “Model Guidelines for School Attendance for Children with Human Immunodeficiency Virus.”

Excerpt: See Appendix A for Superintendent’s Memo, No. 255, November 29, 1989.

Overview

HIV/AIDS. Human immunodeficiency virus (HIV) is the virus that causes the acquired immunodeficiency syndrome (AIDS). Human immunodeficiency virus type-1 (HIV-1) infection in children attacks the immune system, resulting in a progressive deterioration of the immune system. Ultimately, this impairment of the body’s defense system leads to opportunistic infections (any infection that results from a defective immune system that cannot defend against bacteria normally found in the environment), malignancies, and other conditions associated with acquired immunodeficiency syndrome (AIDS)—the most severe disease state caused by HIV. The incubation period is variable.

Cases of AIDS. AIDS is a severe, life-threatening clinical condition, first recognized as a distinct syndrome in 1981. By early 1995, about 500,000 cases of AIDS had been reported in the United States. Over the past decade in the United States, a shift in the distribution of AIDS cases by risk behaviors or factors has occurred with the largest rate of increase in reported AIDS cases occurring among women and minority populations, including adolescents. This shift has a significant impact on children, as the increase in the number of reported cases of AIDS in children (less than 13 years old) is tied to the increase of diagnosis of this illness in women.

Signs and Symptoms. It is not unusual for an HIV-infected person to feel healthy for a long time, without displaying signs and symptoms of illness. However, this individual can still transmit the virus to other people. The appearance of symptoms may signal deterioration of the immune system and the onset of a progressive course of HIV infection.

Signs/Symptoms of HIV. Signs/symptoms of HIV infection may include:

- ◆ Generalized lymphadenopathy (disease of the lymph nodes).
- ◆ Hepatomegaly (an enlargement of the liver).
- ◆ Splenomegaly (enlargement of the spleen).
- ◆ Failure to thrive.
- ◆ Oral candidiasis also called thrush (a yeast infection of the oral mucous membranes).
- ◆ Recurrent diarrhea.
- ◆ Parotitis (inflammation of the parotid gland).
- ◆ Nephropathy (disease of the kidney).
- ◆ Central nervous system (CNS) disease (including developmental delay, which may be progressive).
- ◆ Lymphoid interstitial pneumonia.
- ◆ Recurrent invasive bacterial infections.
- ◆ Opportunistic infections.
- ◆ Specified malignancies.

Clinical Manifestations in Children with Perinatally Acquired HIV. In children who have acquired HIV perinatally, the most common early clinical manifestations include:

- ◆ Failure to thrive or wasting.
- ◆ Chronic or recurrent diarrhea without specified cause.
- ◆ Generalized lymphadenopathy.
- ◆ Hepatosplenomegaly (enlargement of the liver and spleen);

- ◆ Persistent or recurrent oral candidiasis.
- ◆ A variety of recurrent infections, including otitis media, pneumonia, and meningitis (usually of bacterial origin but may be caused by viral, fungal, or parasitic microorganisms).

Infections in HIV-Infected Children. In older children, acute and complicating infections may be interspersed with periods during which the child functions relatively normally. As the disease progresses, involvement of multi-organ systems and the occurrence of multiple infections are as common as it is in younger children.

Pneumocystis carini pneumonia (PCP) is the most common, serious opportunistic infection in children with HIV infection and is associated with high mortality. This illness most frequently occurs in infants between 3 to 6 months who acquired the disease before or at birth, and can occur as early as 4 to 6 weeks of age. Other common opportunistic infections in children include:

- ◆ Candida esophagitis (inflammation of the esophagus caused by a fungus).
- ◆ Disseminated cytomegalovirus infection.
- ◆ Chronic disseminated herpes simplex.
- ◆ Varicella zoster virus infections.

Less common infections in children include:

- ◆ Mycobacterium tuberculosis.
- ◆ Mycobacterium avium complex (MAC) infection.
- ◆ Chronic enteritis caused by cryptosporidium or other agents.
- ◆ Cryptococcal or toxoplasma gondii infection. (Malignancies associated with HIV-infected children are relatively uncommon, affecting only 2 percent of HIV infected children developing Non-Hodgkin's Lymphoma.)

CNS Disease. The degree of CNS disease associated with HIV infection correlates with the severity of the disease. In the infant or young child CNS disease may present as developmental delay or loss of milestones. Older children may show evidence of learning disabilities or attention deficit disorders.

AIDS. Acquired immunodeficiency syndrome (AIDS) is the "late stage" of infection with the human immunodeficiency virus (HIV). Separate disease

classifications have been developed by the Centers for Disease Control and Prevention (CDC) for both children and adults that relate clinical and immunological status and describe the parameters of disease.

An understanding of HIV infection and AIDS by school health personnel can promote a comprehensive approach by various school disciplines to ensure each student receives the appropriate education testing, academic, and when necessary, mental health services to ensure an optimum educational experience.

Civil Rights Laws. Federal civil rights laws, particularly Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (ADA), protect the rights of people with disabilities and prohibit discrimination. The U.S. Congress has defined HIV infection, with or without symptoms, as a disability. Section 504 regulations mandate that every student with a disability be provided a “free, appropriate public education.” It is incumbent upon school personnel to work with families and students with HIV infection to ensure these students receive the appropriate and mandated services.

Education of Staff and Students. The *Code of Virginia*, § 22.1-271.3, requires that “Every school board shall ensure that all school personnel having direct contact with students receive appropriate training in the etiology, prevention, transmission modes, and effects of blood-borne pathogens, specifically, hepatitis B and human immunodeficiency viruses...” In addition, education of staff and students about HIV infection and AIDS can promote implementation of prevention strategies, and provide personal and professional approaches for all individuals whose lives are touched by a student or staff member with this illness.

The National Association of State Boards of Education has made available a publication entitled *Someone at School Has AIDS: A Complete Guide to Education Policies Concerning HIV Infection*. The publication provides school divisions with a variety of information including:

- ◆ Sample school policy guidelines.
- ◆ Education and prevention program ideas.
- ◆ Legal requirements and responsibilities.
- ◆ Addressing specific issues (e.g., infection control, HIV and athletics).
- ◆ Resources.

Schools are encouraged to use this publication in conjunction with the information provided in this section.

Transmission

Routine social or community contact with an HIV-infected person carries no risk of transmission; only sexual exposure and exposure to blood or tissues carries a risk. The routes of transmission of HIV are analogous to those of Hepatitis B virus (HBV).

Epidemiological evidence indicates that HIV can be transmitted person to person through sexual contact, the sharing of HIV-contaminated needles and syringes, and transfusion of infected blood or its components. While the virus has on occasion been found in saliva, tears, urine, and bronchial secretions, transmissions after contact with these secretions has not been reported.

From 15% to 30% of infants born to HIV-infected mothers are infected before, during, or shortly after birth; treatment of pregnant women results in marked reduction of infant infections. Breastfeeding by HIV-infected women can transmit infection to their infants.

After direct exposure of healthcare workers to HIV-infected blood through injury with needles and other sharp objects, the rate of seroconversion is less than 0.5%, much lower than the risk of HBV infection (about 25%) after a similar exposure.

In summary, established modes of transmission in the U.S. are via:

- ◆ Blood-to-blood contact, by use of HIV-contaminated needles during intravenous drug injection.
- ◆ A mucous membrane exposure.
- ◆ A penetrating injury with a needle or sharp object containing HIV-infected blood.
- ◆ Tissue or organ transplantation.
- ◆ Blood transfusion. (Transfusion of blood, blood components, or clotting factor concentrates is now rarely a mode of HIV transmission in the U.S. because of exclusion of infected donors, viral inactivation treatment of clotting factor concentrates, and the availability of recombinant clotting factors.)
- ◆ Unprotected sexual intercourse, including anal intercourse (regardless of the gender or sexual orientation of the partner), vaginal intercourse, or oral intercourse. HIV is transmitted through semen (including pre-ejaculatory fluid), vaginal fluids (including menstrual blood, cervical discharge, and the natural fluids that lubricate the vagina), and blood.

- ◆ Mother-to-infant, before or around the time of birth and during breast feeding.

HIV has been isolated from blood and other body fluids, such as cerebrospinal fluid, pleural fluid, human milk, semen, cervical secretions, saliva, urine, and tears. However, only blood, semen, cervical secretions, and human milk are implicated in the transmission of the infection.

HIV is **not** transmitted through:

- ◆ Casual contact, such as touching, kissing, and hugging a person with HIV.
- ◆ Animal or bug bites.
- ◆ Eating food handled, prepared, or served by a person with HIV infection.
- ◆ Sharing toilets, telephones, or clothes.
- ◆ Sharing forks, spoon, knives, or drinking glasses.
- ◆ Attending school or other public places with persons infected with HIV.

Note: Biting is a common behavior in young children. Although HIV has been isolated from saliva of some infected persons, transmission to another person from saliva is not known to have occurred.

School Exclusion Guidelines

Communicable: Transmission of HIV is by direct contact with infected blood or body fluids.

Case: Follow the advice of the student's health care provider and local health department. The need for a more restricted environment for some infected children should be evaluated on a case-by-case basis with consideration of conditions that pose an increased risk to others, such as an aggressive biting behavior or presence of exudative, weeping lesions that can not be covered. These conditions may increase the possibility of transfer of infected fluid. A student or staff member with HIV who has open, oozing sores that cannot be covered should remain at home until the skin sores are healed.

Contacts: School exclusion is not indicated.

Diagnosis

The diagnosis of symptomatic HIV and AIDS is based on the clinical, serologic (blood), and immunologic findings and exclusion of other causes of immunodeficiency (a depressed immune system). Other than infants born of infected mothers, persons infected with HIV usually develop serum antibody to HIV 6 to 12 weeks after infection. Tests for HIV include:

- ◆ Enzyme immunoassays (EIA) widely used to screen for serum HIV antibody. Although this test is highly sensitive and specific, repeat testing of the initial reactive specimens is required to reduce the likelihood of laboratory error.
- ◆ Western blot or immunofluorescent antibody tests should be used for confirmation.

A positive HIV antibody test in a child 18 months of age or older usually is indicative of infection. If an HIV antibody test is negative, no antibodies were found, and the person does not have antibodies at the time of the test, individuals should refrain from all risky behavior to be sure of their sero-negative status and be retested in 3 to 6 months. Even after a negative test, an individual who puts himself or herself at risk may become infected with HIV.

Treatment

Children with HIV infection need close medical supervision with monitoring of their clinical, neurologic, and immunologic status. The child with HIV infection should receive routine childhood care, including immunizations (exceptions below), and should be evaluated promptly if infection or fever occurs. Therapy for HIV infection includes prophylaxis against pneumocystis carinii and other infections, antiretroviral therapy, and in certain instances, intravenous gamma globulin.

The American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC) have published recommendations for immunization of children with HIV infection against other diseases. Current recommendations for immunizations and treatment of HIV-infected children, published in the *1997 Red Book*¹³⁵ should be reviewed by school personnel. Detailed information related to household members and contacts of an HIV-infected person is also available in this reference.

¹³⁵ American Academy of Pediatrics (1997). *1997 Red Book: Report of the Committee on Infectious Diseases* (24th Edition). American Academy of Pediatrics, Elk Grove Village, Ill.

Briefly symptomatic children with HIV infection or AIDS should not receive live-virus (e.g., oral polio-virus, varicella) vaccines and live bacteria (e.g., bacillus calmette-guerin) vaccines, except for measles-mumps-rubella (MMR) vaccine which should be given to these children. Other routinely recommended vaccines (DTAP /DTP, hepatitis B, Haemophilus influenza type b conjugate, and inactivated poliovirus [IPV]) should be given according to the usual immunization schedule.

In addition, pneumococcal vaccine is indicated for HIV-infected children 2 years and older and should be given every 3 to 5 years thereafter as they are at increased risk of invasive pneumococcal disease. Influenza vaccine is recommended annually for HIV-infected children 6 months and older.

HIV-infected students are expected to be in compliance with an immunization schedule (*Code of Virginia* § 22.1-271.2). Students who are HIV infected or have AIDS, may get an exemption from complying with the requirements provided for in the *Code of Virginia* § 22.1-271.2 C.

Reporting Requirements

Acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection must be reported to the local health department within seven days of diagnosis.

Disclosure and Confidentiality

No one except the student and/or student's parent(s) or guardian(s) necessarily need to know of a student's HIV or AIDS diagnosis. They are not obligated to disclose this information to anyone in the educational system. Although it is difficult for some people to accept, there is no reason school authorities must know if a student or staff member has HIV or AIDS. School policy should respect the privacy of people with HIV infection and their families to:

- ◆ Protect them from potentially hurtful stigma or hostility if the information becomes public.
- ◆ To prevent harmful distractions to learning due to misinformation and rumors.
- ◆ To promote an environment in which families, students and staff with HIV or AIDS may come forward to discuss private matters with school officials if that becomes necessary.
- ◆ To respect the decisions of parents who may have chosen to withhold information about an HIV or AIDS diagnosis from a student who they feel has not reached a level of maturity to understand their illness.

- ◆ To promote an environment in which confidentiality is the norm so that those in need of antibody testing, especially adolescents, will be more likely to be tested as they will not fear exposure.
- ◆ Because the information is not needed to promote safety.

Prevention through strict enforcement of infection guidelines, use of universal precautions, and education is a more effective policy than the need to disclose confidential information.

Disclosure. Since individuals with HIV infection and AIDS who do not engage in high-risk behavior are of no risk to others in the school, their medical information must be treated in a very confidential manner. Voluntary disclosure to the school superintendent, principal, or school health personnel can benefit the person with HIV infection. Upon learning a student is HIV infected or has AIDS, school personnel should consult with the family, their health care provider, and/or a person from the local health department to determine whether the student is well enough to attend school. These professionals are in a position to coordinate with others to provide necessary services.

Confidentiality. School physicians, school nurses, and school administrators, if made aware of a student's HIV or AIDS diagnosis, can inform others in the school of the situation on a **“Need to Know” basis with written consent of the parent/guardian.** For further information, refer to the *Code of Virginia* § 32.1-36.1, Confidentiality of test for human immunodeficiency virus, civil penalty, individual action for damages or penalty. (**Note:** A civil penalty of not more than \$5000 may be recovered if it is determined that a person willfully or through gross negligence made an unauthorized disclosure of this confidential information. In addition, any person who is the subject of the unauthorized disclosure may be entitled to recover damages and attorney's fees.)

Nationally, the Family Educational Rights Privacy Act of 1974 (FERPA), also known as the Buckley Amendment, places certain privacy restrictions on student records maintained by schools that receive federal funds. School personnel should consult this document when developing school policy.

Staff Members as Resource Person. Staff members who are well briefed on confidentiality and record keeping policies should be consulted on handling situations in which someone unexpectedly discloses HIV infection. Staff members may be approached by a student disclosing the positive HIV status of a family member, an adolescent might share results of recent HIV testing or fears related to the testing, or a special education planning team could find out about HIV infection from a medical evaluation. A staff member in this situation may be an invaluable resource to the person sharing this type of information. In this situation, a staff member may:

- ◆ Discuss the ramifications of further disclosure.

- ◆ Help locate an HIV/AIDS resource organization, teen crisis center, or hotline for the individual.
- ◆ Explain the positive health care advantages of informing school health personnel or school administrators, while stressing that disclosure is a personal decision and that confidentiality is mandatory.

The staff member who has become aware of this type of information may wish to talk to a counselor themselves, without revealing the identity of the person who has confided in them, in order to cope with their own feelings.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Use of universal precautions. (See previous section on “Universal Precautions.”)
3. Educate students, according to school policy, about preventing HIV infection and AIDS.

Resources

The Virginia Department of Education, funded by the Centers for Disease Control and Prevention, published *HIV/AIDS Prevention Education Curriculum Guide* to provide teachers with guidance in offering instruction in HIV/AIDS prevention education to students in public and non-public schools in Virginia. Students in grades K-12 can receive information designed specifically for their developmental and educational level. The curriculum provided in this publication is designed to be used in conjunction with the Standards of Learning Objectives for Health Education, Family Life Education, and “I am Always Special,” drug education programs. In addition, the publication *Someone at School Has AIDS: A Complete Guide to Education Policies Concerning HIV Infection* provides information on sample programs for HIV prevention education.

Other publications include:

Massachusetts Department of Public Health. (1995). *Comprehensive School Health Manual*. Boston, Mass.: Author.

American Academy of Pediatrics (1997). *1997 Red Book: Report of the Committee on Infectious Diseases* (24th Edition). Elk Grove Village, Ill.: American Academy of Pediatrics.

Benenson, A.S. Editor (1995). *Control of Communicable Diseases Manual* (16th Edition). Washington, D.C.: American Public Health Association.

Bogden, J. F. (1996). *Someone at School Has AIDS: A Complete Guide to Education Policies Concerning HIV Infection*. National Association of State Boards of Education.

Donowitz, L.G. (1996). *Infection Control in the Child Care Center and Preschool* (3rd Edition). Baltimore, Md.: Williams and Wilkins.

Influenza

Influenza (commonly referred to as the “flu”) is a viral disease of the respiratory tract. There are two main types of influenza virus: A and B. Each type includes many different types that change each year. Illness is usually characterized by sudden onset with symptoms of high fever or chills, headache, congestion, muscle aches, and a dry cough. Some individuals may experience stomach pain, nausea, vomiting, and conjunctivitis (inflammation of the lining of the eyes). Most people are ill with the “flu” for a week or less. Individuals with lung disease, heart disease, cancer, emphysema, diabetes, or those with weakened immune systems may have more serious illness and at times, may need to be hospitalized. Influenza occurs most often in the late fall and winter months.

Transmission

The viruses that cause influenza are highly communicable—the organisms are readily transmitted from one individual to another through contact with droplets from the nose and throat of an infected person during coughing and sneezing.

Individuals are most infectious in the 24 hours before the onset of symptoms and during the period of peak symptoms. The virus is shed in the secretions up to 7 days after the onset of symptoms, but it may last longer in young children and those with weakened immune systems. Infection with the “flu” does not make a person immune. The viruses that cause influenza frequently change, and people may be infected with a new strain. The incubation period is short, usually 1 to 3 days.

Diagnosis

Diagnosis is generally made presumptively based on symptoms. However, laboratory tests can be obtained to confirm this diagnosis.

Treatment

Health care providers generally advise individuals with influenza to drink plenty of fluids and get plenty of rest. Prescription medications are available to treat and prevent (after exposure) influenza A in children and adults. These medications are not effective against influenza B infection and are not approved for use in children less than one year of age.

School Exclusion Guidelines

Communicable. Children probably transmit influenza virus for up to 7 days. Adults probably transmit the virus for 3 to 5 days.

Case. School exclusion is not indicated as long as a student or staff member feels well enough to attend school.

Contact. School exclusion is not indicated. High risk populations (see listing below) should be advised to consult with their health care provider for possible treatment with prophylaxis antibiotics.

Reporting Requirements

Influenza (by type, if available) must be reported as number-of-cases-only to the local health department.

Notification Requirements

None.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Refer to “Prevention Guidelines for Spread of Disease Through the Respiratory Tract” in Chapter III.
3. The following groups are at increased risk for serious illness with the flu and should receive influenza vaccine yearly:
 - ◆ Adults and children with long-term heart or lung problems.
 - ◆ Individuals with kidney disease, cystic fibrosis, diabetes, anemia, severe asthma, cancer, or weak immune systems and other medical conditions for which they are under the close supervision of a health care provider.
 - ◆ All people 65 years of age and older.
 - ◆ Health care personnel and household contacts of high-risk persons.

Note. Many communities set up flu vaccine programs and encourage all residents to participate.

Impetigo

Impetigo is a common skin infection caused by streptococcal (“strep”) or staphylococcal (“staph”) bacteria. The first indication of infection may be discharge from an open, injured spot on the skin, such as an insect bite, cut or burn, where the bacteria are introduced. These bacteria can be easily spread by the individual’s hands to other areas of their skin. The skin lesions usually begin as small blisters and red, fluid filled, rounded bumps that ooze and may have a flat honey-colored crust and may be itchy. The blisters may break easily leaving raw, red “oozing” skin exposed. Secondary infection with staphylococci bacteria is common. Serious but rare complications from secondary staphylococcal infection include cellulitis (inflammation of the skin, spreading through the tissue) and kidney disease.

Transmission

The bacteria that cause impetigo are transmitted by contact with a person who has a draining lesion or who is an asymptomatic (usually nasal) carrier of a pathogenic strain of bacteria. The role of contaminated objects has been overstressed; the hands are the most important instrument for transmitting infection. Airborne spread is rare. The incubation period is variable, often 1 to 3 days.

School Exclusion Guidelines

Communicable: As long as purulent lesions continue to drain or the carrier state persists. See above under “Transmission.”

Case: Exclude from school until lesions are healed or 24 hours of antibiotic treatment has been completed

Contacts: Exclusion from school is not indicated. Observe carefully for symptoms.

Diagnosis

Impetigo is diagnosed by history and exam. Culture can be obtained to support the diagnosis.

Treatment

Impetigo treatment consists of appropriate skin care and antibiotic ointment, and/or oral antibiotic.

Reporting Requirements

Impetigo is not a reportable disease.

Notification Guidelines

When impetigo occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. When students and staff suffer an injury that causes a break in the skin, wash the area thoroughly with soap and water and dry it carefully.
3. When there is a risk of impetigo, wash the rash with soap and water and cover it loosely with gauze, a bandage, or clothing.
4. Be sure those who touch the rash wash their hands well. Dispose of any soiled tissues or bandages carefully, and keep any possibly contaminated clothing in a plastic bag.
5. Contact the student's parents and advise them to have the student examined by their health care provider.

Lyme Disease

Lyme disease is a bacterial illness that some people get after being bitten by ticks which are infected with the organism *Borrelia burgdorferi*. In most people, the first symptom of Lyme disease is a skin lesion called erythema migrans (EM) or “bull’s eye” rash—a red bump that expands to form a large red ring, with partial central clearing—at the site of a recent tick bite. The presentation of EM can vary in size and shape, appearing anywhere from 3 to 32 days after being bitten by an infected tick. Multiple secondary circular lesions, red blotches and circles, and conjunctivitis and swelling around the eye can develop. Fever, fatigue, headache, mild neck stiffness, and joint pain may occur as the illness progresses. These symptoms occur intermittently during a period of several weeks in untreated individuals. In some cases, those first symptoms do not occur. If this happens, or if the early disease is untreated, weeks to months after the tick bite other problems may develop involving joints, eyes, and the cardiac and nervous system as mentioned above.

Transmission

The bacteria that cause Lyme disease are spread by ticks. Transfer of the Lyme disease bacteria from the bite of an infected tick to a person probably does not occur until the tick has been attached for 24 hours. A person cannot get Lyme disease from animals or other persons. The incubation period for EM (erythema migrans) is from 3 to 32 days after tick exposure; however, the early stages of the illness maybe asymptomatic, and the person may present with later manifestations.

School Exclusion Guidelines

Communicable: Lyme disease is transmitted by the affected ticks that carry the *Borrelia burdorferi* bacteria. There is no evidence of natural transmission from person to person.

Case: School exclusion is not indicated

Contact: School exclusion is not indicated.

Diagnosis

Diagnosis is made clinically on the basis of history and physical examination findings. It is sometimes confirmed by laboratory tests.

Treatment

Treatment includes antibiotics and supportive measures.

Reporting Requirements

Lyme disease must be reported to the local health department within seven days of diagnosis.

Notification Guidelines

If Lyme disease has occurred, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents and staff should be notified so that they will watch for ticks as well.

If a student is bitten by a tick during the day, remove it as outlined below. Notify the parents of that student so that they can inform their health care provider. Tell them what the tick looked like. If the student develops the symptoms described, particularly a skin rash and/or flu- like symptoms, ask the parents to see a health care provider promptly for evaluation and treatment.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Advise persons who spend time outdoors in an area with ticks to (1) wear long-sleeved shirts and long pants, (2) keep shirts tucked securely into pant legs and pant legs tucked into socks, (3) wear sneakers or hiking boots instead of open sandals, and (4) wear light-colored clothing. (Ticks are dark in color and will be easier to see against a light background.)
3. Conduct a daily tick check. Ticks removed within 24 hours of attachment are unlikely to transmit Lyme disease. Ticks are most often found on the thigh, flank, arms, underarm, and legs, and are very small. Look for new “freckles.”
4. If a tick is found on a person, remove it immediately. Deer ticks are very small and hard, about the size of a pinhead. They are orange-red or black, depending on their stage of growth, and prefer to attach themselves to a human host under the hair. Dog ticks are larger, ranging from 1/10 to 1/4 inch in length. They are brown and also prefer to attach themselves under the hair or on protected parts of the body.
5. To remove a tick:

- ◆ Wear gloves. Use universal precautions. (See previous section on “Universal Precautions.”)
 - ◆ Using tweezers, grasp tick as close to the skin as possible and gently, but firmly pull tick straight out. Avoid any jerking or twisting motion that may break off the mouth parts in the skin.
6. Insect repellents containing diethyltoluamide (DEET[®], Autan[®]) applied to skin can be effective against ticks but should be used cautiously. The pesticide permethrin is available as a clothing spray; it is not to be used on the skin. A combination of diethyltoluamide applied to skin and permethrin-treated clothes may provide the best protection against tick and mosquito bites. Follow these guidelines:
- ◆ Use repellents no more than one to two times per day. Do not treat skin with permethrin under clothing.
 - ◆ Particularly with children, avoid using high concentrations of diethyltoluamide products. Never use on damaged skin.
 - ◆ Avoid inhaling the product. Keep out of eyes, and do not apply to parts of student’s hands that are likely to have contact with their eyes or mouth.
 - ◆ After returning indoors, wash treated skin with soap and water.
 - ◆ If a student is suspected to be having a reaction to an insect repellent, wash skin and call the student’s parents and advise them to contact their health care provider for follow-up care.

Measles (Rubeola)

Measles is a highly communicable viral disease. The disease is more severe in infants and adults than young children. The initial stage of the disease is characterized by fever, cough, runny nose, conjunctivitis, and small red spots with blue-white centers in the mouth in the region of the molars (Koplik spots). A characteristic red, blotchy rash appears on the third to seventh day, beginning on the face, and spreading down the body, lasting 4 to 7 days. The illness lasts 1 to 2 weeks and can be complicated by ear infections, bronchopneumonia, croup, diarrhea, encephalitis, and rarely, death. Measles can also cause miscarriages or premature delivery in pregnant women.

Transmission

The virus that causes measles is transmitted airborne by droplet spread or direct contact with nasal or throat secretions of infected people and less commonly, by utensils freshly soiled with nose and throat secretions. Measles is one of the most highly communicable infectious diseases.

The incubation period is about 10 days, varying from 7 to 18 days from exposure to onset of fever, usually 14 days until rash appears; rarely longer or shorter. IG, given for passive protection later than the third day of the incubation period, may extend the incubation instead of preventing the disease.

School Exclusion Guidelines

Communicable: The period of communicability is from 1 to 2 days before the onset of symptoms (3 to 5 days before the rash) through 4 days after the appearance of the rash.

Case: Exclude from school until at least 4 days after the appearance of the rash. (The rash should be fading and the infected person should be without fever.)

Contacts: Check immunization records. Measles vaccine, if given within 72 hours of exposure, may provide protection. Immunoglobulin may be used within 6 days of exposure for susceptible household or other contacts for whom risk of complications is very high (particularly contacts under 1 year of age, pregnant women or immunocompromised persons) or for whom measles vaccine is contraindicated. Students and staff should be excluded from school immediately with signs of initial stages of the disease.

Diagnosis

Illness can be presumptively diagnosed by the signs and symptoms; however, a blood test, to look for antibodies that are evidence of recent infection, is required in order to confirm a preliminary diagnosis of measles.

Treatment

No specific anti-viral treatment is available. Vitamin A treatment should be considered on an individual basis by person's health care provider.

Reporting Requirements

Reporting of a person confirmed or suspected of having measles (Rubeola) must be made within 24 hours by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification

When measles occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § 22.1-271.1, § 22.1-271.2, and § 32.1-46. Refer to "Immunization Requirements" in Chapter III.
2. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
3. All reports of suspected measles cases should be investigated promptly. A measles outbreak exists in a community whenever one case of measles is confirmed. Once this occurs, preventing the spread of measles depends on prompt vaccination of susceptible persons.
4. A program of re-vaccination with MMR vaccine is recommended during outbreaks in childcare centers; elementary, middle, junior, and senior high schools; and colleges and other institutions of higher education in those students without a prior documented case of measles or in those students who have received only one dose of the vaccine.

5. Make sure all students and staff exhibiting symptoms associated with the illness are seen by their health care provider and the school is notified if another person develops measles. Advise parents of the time of greatest risk of others becoming ill.

Meningococcal Infection (*Neisseria Meningitidis*)

Meningococcal infection is caused by the bacteria *Neisseria meningitidis*. Invasive meningococcal infections usually result in meningococemia (blood infection) and meningococcal meningitis (an inflammation of the covering of the brain). Many people carry the *Neisseria meningitidis* bacteria in their nose and throat without any illness, while others become seriously ill rapidly and die within hours. A rash with petechiae (fine red-purple bruising) and/or purpurae (larger red-purple splotches) is characteristic. The disease occurs most often in children less than 5 years of age; the peak is in the 3- to 5-month age group. Even today, the morbidity is significant.

Transmission

Transmission of the bacteria is person-to-person by direct contact, including respiratory droplets from nose and throat of an infected person. This occurs between people who are in close contact through coughing, sneezing, nasal discharge, saliva, and touching of infected secretions. It can be spread by sharing eating utensils, drinking cups, water bottles, and kissing. The bacteria do not survive for more than a few minutes on environmental surfaces (e.g., tables, chairs, clothing).

The bacteria are transmissible from the time a person is first infected until the organism is no longer present in the nose or throat. Symptoms may appear 2 to 10 days after exposure (usually within 5 days).

School Exclusion Guidelines

Communicable: Individuals are considered infectious for 24 hours after beginning antibiotics. The bacteria are transmissible until they are no longer present in discharges from the nose and mouth.

Case: Exclude from school during acute illness. Case is noncommunicable after 24 hours of appropriate drug therapy.

Contact: School exclusion is not indicated. Observe carefully for symptoms, especially fever. Parents of day care/nursery school contacts should be advised to check with their child's health care provider concerning prophylactic treatment with rifampin. Discuss with local health department. Certain contacts should

receive prophylactic antibiotics from their health care provider or the local health department as soon as possible—preferably within 24 hours of the diagnosis of the primary case. See the following table for more information. (Note: Contacts who develop fever and/or severe headache should be referred for prompt medical evaluation regardless of whether they have received prophylaxis.)

Disease Risk for Contacts of Index Cases of Invasive Meningococcal Disease¹³⁶

High-risk: Chemoprophylaxis recommended

- Household contact: especially young children.
- Child care or nursery school contact in previous 7 days.
- Direct exposure to index patient’s secretions through kissing or sharing toothbrushes or eating utensils.
- Mouth-to-mouth resuscitation, unprotected contact during endotracheal intubation in 7 days before onset of the illness.
- Frequently sleeps or eats in same dwelling as index patient.

Low-risk: Chemoprophylaxis is not recommended

- Casual contact: no history of direct exposure to index patient’s oral secretions (e.g., school or work mate).
- Indirect contact: only contact is with a high-risk contact, no direct contact with index patient.
- Medical personnel without direct exposure to patient’s oral secretions.

In outbreak or cluster

- Chemoprophylaxis for persons other than those at high-risk should be given only after consultation with the local public health authorities.
-

Diagnosis

Cultures of blood and cerebrospinal fluid (CSF) are indicated in persons with suspected invasive meningococcal diseases.

¹³⁶ American Academy of Pediatrics (1997). *1997 Red Book. Report of the Committee on Infectious Diseases*, 24th Edition. American Academy of Pediatrics, Elk Grove Village, Ill.

Treatment

Individuals with these infections require hospitalization for antibiotics and special care.

Reporting Requirements

Reporting of a person confirmed or suspected of having meningococcal infection must be made within 24 hours by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification Guidelines

School health personnel (e.g., school nurses or consulting physician), in consultation with the local health department and school administrators, should develop a system for immediate notification of parents, staff, and the proper health authorities, if a student or staff member becomes ill with meningococcal illness.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. The best way to prevent spread of meningococcal disease is to alert everyone that a case has occurred so that appropriate preventive measures can begin.
3. Monitor the situation closely. Make sure all ill students and staff are seen by their health care provider and that the local health department is notified if another person develops the illness.

Mononucleosis, Infectious

Infectious mononucleosis is an acute viral syndrome caused by the Epstein-Barr virus. Its symptoms include sore throat, tiredness, fever, enlarged lymph nodes, and sometimes enlargement of abdominal organs (liver and/or spleen). It occurs most frequently in adolescents or young adults. While infants and young children can be affected by the disease, they frequently have no symptoms. Individuals with this disease can experience symptoms ranging from no illness or mild illness to severe illness. Infection can occasionally be accompanied by a rash. Most cases of infectious mononucleosis go away by themselves over 2 to 3 weeks. During the course of the illness, patients often have days when they feel well, alternating with days when they feel ill.

Transmission

Both children and adults can get infectious mononucleosis. The virus is transmitted from person to person through saliva. Young children may be infected by saliva on the hands of caregivers. Spread between children can also occur by sharing mouthed objects, drinking cups, or toys that have infected saliva on them. Kissing can increase spread among young adults. Infectious mononucleosis is common in group settings of adolescents, such as in schools. Spread may also occur via blood transfusions. The disease is not seasonal, and the shedding of the virus can occur for many months after infection. The incubation period is estimated to be 4 to 6 weeks, but the time an individual is contagious is unknown.

School Exclusion Guidelines

Communicable: Spread of this virus is person-to-person through saliva. The time an individual is contagious is unknown.

Case: School exclusion is not required. However, the student or staff member may be advised to remain home while feeling ill and not able to participate in their daily routine.

Contact: School exclusion is not indicated.

Diagnosis

The diagnosis of this illness is based on symptoms and laboratory blood tests.

Treatment

More than 95 percent of patients will recover without any treatment. Individuals with this disease can be as active as they feel they are able. Students and staff may return to contact sports or heavy lifting upon the recommendation of their health care provider.

Reporting Requirements

Infectious mononucleosis is not a reportable disease.

Notification Guidelines

None.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Make sure all toys and objects that are potentially infectious due to children placing them in their mouths are properly washed.

Mumps

Mumps is a systemic viral disease, characterized by swelling of the salivary glands. (Approximately one-third of infections do not cause clinically apparent salivary gland swelling.) Complications include meningitis (inflammation of the coverings of the brain and spinal cord), encephalitis (inflammation of the brain), deafness, and particularly in adolescent or adult males, orchitis (inflammation of the testicles). Incidence rates are higher in school-age children. Mumps infection during the first trimester of pregnancy can increase the rate of spontaneous abortion (miscarriage).

Transmission

The mumps virus is transmitted by droplet spread and by direct contact with the saliva of an infected person. The period of communicability is usually 1 to 2 days but has been reported as many as 7 days before the onset of parotid swelling, and is usually 5 days (although occasionally as many as 9 days) after onset. The incubation period is about 12 to 25 days, commonly 18 days.

Most adults, particularly those born before 1957, are likely to have been infected naturally and may be considered immune, even if they did not have recognized disease. Mumps may be seen in unimmunized children or adolescents and young adults who graduated from school prior to laws requiring mumps immunizations or may have received an earlier, less effective vaccine. (The less effective vaccine, which was an inactivated mumps vaccine, was used from 1950 until its use was discontinued in the mid-1970s. The vaccine only produced short term immunity.) At risk for complications are children under the age of 12 months, pregnant women, persons who have weakened immune systems, and susceptible adolescent and adult males.

Diagnosis

The illness can be presumptively diagnosed by the signs and symptoms. However, it must be confirmed by a blood test to look for antibodies that are evidence of recent infection. Urine may be positive for as long as 14 days after onset of illness. Inapparent infections can be communicable.

Treatment

No specific anti-viral treatment is available. Care is based on symptoms and is supportive.

School Exclusion Guidelines

Communicable: The period of communicability can be as long as 7 days before onset of symptoms (usually 1 to 2 days) to 9 days after (usually 5 days).

Case: Exclude from school for 9 days after the onset of parotid swelling.

Contacts: School exclusion is not indicated. However, if a community outbreak of mumps occurs, exclusion of susceptible (non-immunized) students from both affected schools and schools judged by local health authorities to be at risk should be considered. Excluded students can be readmitted immediately after vaccination. Students who have been exempted because of medical, religious, or other reasons should be excluded until at least 26 days after the onset of gland swelling in the last person with mumps in the affected school.

Reporting Requirements

Mumps must be reported to the local health department within 7 days of diagnosis.

Notification

When mumps occur within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § 22.1-271.1, § 22.1-271.2, and § 32.1-46. Refer to “Immunization Requirements” in Chapter III.
2. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
3. Make sure all students exhibiting symptoms associated with the illness are seen by their health care provider and that the school is notified if another person develops mumps. Advise parents of the time of greatest risk of others becoming ill.

Otitis (Ear Infection)

Note. Although otitis (i.e., otitis media and otitis externa) is not contagious, a description is included here because of the frequency of occurrence among school-age children.

Otitis Media (Middle Ear Infection). Otitis media is an inflammation of the middle ear (pea-sized, air-filled cavity behind the eardrum) that occurs as the result of a middle ear infection. Otitis media is caused by bacteria or viruses that enter from the nose or throat and ascend the eustachian tube to reach the middle ear. This occurs when the eustachian tube is not functioning properly, often because it is inflamed from a cold, sinus or throat infection, or allergy attack.

Otitis media can be acute, chronic, or recurrent. Symptoms of otitis media include ear pain, frequently accompanied by systemic symptoms, including fever, a runny nose, cough, difficulty sleeping, fatigue, decreased appetite, drainage from the ear, and diarrhea. If not treated, frequent otitis media can lead to hearing loss and delay in speech development. Parents should be educated as to this possibility and encouraged to seek treatment promptly when their child complains of ear pain.

Otitis Externa (Swimmer’s Ear). Otitis externa, also known as “swimmer’s ear,” is an inflammation of the outer ear canal, which extends from the eardrum to the outside. Otitis externa is usually caused by a bacterial infection but can be fungal. It can be caused by swimming in dirty water, frequent swimming in chlorinated pools, or too much moisture in the ear from any cause. A frequent problem is related to using cotton swabs to clean the ear canal, which could result in packed earwax. (Note: If a cotton swab [e.g., Q-tip®] is used to clean ears, use only as directed—stroke swab gently around the outer surface of the ear, **without entering the ear canal**). The most common symptom is pain. Other symptoms are pain when the earlobe is pulled, itching, drainage, or slight fever.

Transmission

Both forms of otitis are not communicable (“non-contagious”)—they cannot be transmitted directly or indirectly from one individual to another. Otitis media is often associated with colds, particularly in the pre-elementary age groups.

School Exclusion Guidelines

Communicable: Otitis media is not contagious.

Case: Staff and students with otitis media and otitis externa should not be excluded from school, unless they pose a risk to others due to uncontrolled drainage from the ear canal.

Contacts: School exclusion is not indicated.

(Other systemic symptoms that have previously been defined as contagious and are present with a diagnosis of otitis media should determine the need for school exclusion for cases and contacts.)

Diagnosis

Diagnosis of otitis media and otitis externa is made by physical examination by the person's health care provider. Cultures of the particular bacterial agent are usually reserved for cases of otitis resistant to usual antibiotic treatment.

Treatment

Oral antibiotics, pain medication, and other supportive measures are given for otitis media. Recurrent or chronic otitis media may require surgical placement of ear tubes.

Otitis externa is treated by gentle cleansing of the ear canal with application of medicated ear drops and pain medication.

Reporting Requirements

Otitis is not a reportable disease.

Notification Guidelines

None.

Special Care Notes for Students With Frequent Ear Infections and/or Ear Tubes

- ◆ Never put a cotton swab and anything else into a person's ear canal. Do not allow a student to put anything in their ear(s).
- ◆ Be especially alert for any signs of hearing or speech problems. Refer the student to their health care provider or other community resource if either of these conditions are present.
- ◆ Parents should inform the school of any specific care that is needed for a student who has ear tubes in place.

Pediculosis (Head Lice)

Pediculosis. Pediculosis is an infestation of the head, the hairy parts of the body, and clothing (especially along the seams of inner surfaces) with adult lice, nymphs, and nits (eggs), which results in severe itching and excoriation

(abrasion) of the scalp or both. Secondary infection may occur with ensuing regional lymphadenitis (inflammation of the lymph nodes), especially cervical. Crab lice usually infest the pubic area; they may also infest hair of the face (including eyelashes), axillae, and body surfaces. There are three types of lice: (1) *Pediculus humanus capitis*, the head louse; (2) *Pediculus h. corporis*, the body louse; and (3) *Phthirus pubis*, the crab louse.

Head Lice. Head lice are tiny insects (about 1/10 to 1/8 of an inch long) that live in human hair and feed on human blood. They multiply rapidly, laying little silvery-colored oval-shaped eggs (called nits) which they glue to the base of the hair, close to the scalp. Although it is hard to see head lice, a person can see the nits if they look closely. Nits are most often found in the hair behind the ears and at the back of the head and neck. Nits should not be confused with dandruff. Dandruff can easily be flicked off the hair; nits cannot because they are firmly attached to individual hairs. One telltale sign of head lice is a persistent itching of the scalp, which is caused by the bite of the louse, and that is sometimes accompanied by infected scratch marks or what appears to be a rash. A secondary bacterial infection can occur, causing oozing or crusting. Swollen neck glands may also develop.

Anyone can get head lice. They are not a sign of being dirty and should not be considered a sign of an unclean house. Head lice are easily spread from person to person by direct contact and are often found in school settings. Head lice do not spread any disease.

Transmission

Head lice have no wings and do not fly or jump; they crawl. They are transmitted through direct contact with an infested person or with shared items, such as combs, brushes, towels, pillowcases, hats, headphones, other headgear, and clothing. Shared lockers and wall hooks may permit the spread of head lice. Head lice need human blood to survive. They usually do not survive for more than 2 days away from the human body. The nits (louse eggs) cannot hatch at the lower temperatures found away from the scalp.

The life cycle is composed of three stages: eggs, nymphs (3 stages), and adults. The most suitable temperature for the life cycle is 89.6°F. Eggs of head lice do not hatch at temperature less than 71.6°F. Under optimal conditions, the eggs of lice hatch in 7 to 10 days. The nymphal stages last about 7 to 13 days depending on temperatures. The egg-to-egg cycle averages about 3 weeks.

School Exclusion Guidelines

Communicable: Transmission is possible as long as lice or eggs remain alive on the infected person or on articles. Head lice live for 7 to 10 days and their eggs for about 10 days away from a host (person).

Case: Exclude from school until treated.

Note: Some schools have a “no nit” policy.

Contacts: Close contacts should be checked to determine if they are infested. School exclusion is not indicated in the absence of infestation.

Diagnosis

Diagnosis is usually made by detecting nits, which appear as tiny, pearly-gray, oval-shaped specks attached to the hair near the scalp. Use a magnifying glass and natural light when searching for nits on the hair at the back of the neck, behind the ears, and on the top of the head. The diagnosis can be confirmed by using a microscope.

Treatment

Treatment consists of getting rid of the lice from infested individuals, their surroundings, and their personal items. All household members and individuals with close physical contact should be examined for lice and if infested, treated with one of the recommended shampoos or hair rinses. (Note: Some health care providers may routinely recommend simultaneous treatment of the members of a household.)

For individuals who have head lice:

1. Treatment should be given only to people who have active lice or viable eggs present.
2. The recommended treatment is a medicated shampoo that contains either pyrethrin (such as RID[®], A-200[®], XXX[®]) or permethrin (such as Nix[®]). These products are available without a prescription, should be used as instructed on the package, and may kill the lice but not their eggs.
3. After shampooing, the remaining eggs should be removed with a special nit comb or fine-tooth metal comb.

4. Lindane, Kwell[®] may be prescribed in certain instances when other treatments have failed but should be used only with extreme caution, carefully following the label.
5. None of these treatments are 100 effective, so retreatment maybe necessary after an interval of 7 to10 days if eggs survive.
6. The hair should be carefully checked and nits removed every day for 2 weeks to be sure the infestation has been cured. Checking hair, a small section at a time, under a fluorescent light and using a magnifying glass makes the nits easier to find.
7. Kerosene, oil, or pet shampoo should NOT be used to treat a lice infestation. **Note:** More people are starting to report cases that might be resistant to treatment. Studies are underway to determine if some of the current remedies are no longer effective. In cases that do not seem to respond to treatment, manual removal of nits is the most important procedure to follow.

To Keep the Lice from Coming Back or Spreading to Others in the Household:

1. To prevent reinfestation, the hair of everyone in the household should be checked when anyone is found to have head lice.
2. Everyone with head lice in the same household should be treated on the same day.
3. Towels used to dry the hair after treatment with the lice shampoo should be washed immediately.
4. Clothing, bedding, and soft toys should be specially cleaned, such as by using hot water, hot dryers (for at least 20 minutes), or by dry cleaning. Items that cannot be washed should be sealed in a plastic bag for 2 weeks.
5. Floors, furniture, car seats and upholstery, and carpeting should be vacuumed. Insecticide sprays are not recommended.
6. Combs and brushes should be disinfected, then washed in hot water daily. Disinfecting is done by soaking them in lice shampoo for 4 minutes, soaking them in a 2% Lysol[®] solution for 1 hour, or boiling them in water for 10 minutes.
7. Hair inspection and manual removal of the nits is very important in preventing reinfestation. Nits found close to the scalp after treatment should be removed. Nits that have hatched or died, as well as empty egg casings, play no role in the spread of head lice. Nits that are seen more than 1/4 of an inch from the scalp are probably from an old infestation.

8. Children need to be told not to share headgear, coats, combs, and other articles at school.
9. Parents should routinely check their children's hair.

Reporting Requirements

Pediculosis is not a reportable disease.

Notification Guidelines

When pediculosis occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of infestation outbreaks.
2. Learn to recognize nits, and regularly check students' heads and hair when there is a case of head lice diagnosed in the classroom. Teach parents to recognize nits and to check family's hair periodically. Because outbreaks of head lice occur periodically in almost all schools and because parental concern may exceed the threat of head lice to health, this is a prime area for preventive education and information. A well-organized and prompt response to the first few cases can prevent a widespread problem and avoid the spread of misinformation.
3. If a case is identified, follow recommended treatment procedures closely. If a parent finds nits, it should be reported to the school nurse, who can check close contacts.
4. Remind students not to share combs, brushes, hair accessories, headphones, hats, helmets, towels, clothing, bedding, and so forth.

Pertussis (Whooping Cough)

Pertussis is a highly contagious bacterial disease involving the respiratory tract caused by *Bordetella pertussis*. It begins with mild cold symptoms and gradually progresses over 1 to 2 weeks into repeated attacks of severe coughing that can last 1 to 2 months or longer. The classic “whoop” sound may not occur in young infants, adolescents, and adults. Pertussis can occur at any age but is most often diagnosed in young children. The disease can be very serious in infants (less than 1 year old), where it can lead to pneumonia and, less often, seizures or inflammation of the brain. In rare cases (1 out of 200), pertussis can result in death (especially in children less than 1 year of age). In recent years in the United States, pertussis in adolescents and young adults has varied in severity. Many of these cases occur in previously immunized persons, indicating waning immunity. The total course of the disease is from 6 to 10 weeks.

Transmission

Pertussis is transmitted by direct contact with discharge from the nose or throat of an infected person or by breathing in infected droplets in the air where an infected person coughs. The incubation period is commonly 6 to 10 days.

School Exclusion Guidelines

Communicable: The period of greatest risk of spread is during the first week. Thereafter, communicability gradually decreases and becomes negligible in about 3 weeks for nonhousehold contacts.

Case: Exclude from school until a health care provider advises return (usually 5 days after initiation of erythromycin therapy). Discuss with local health department.

Contacts: Check immunization record. Exclude students or staff from school on first signs and symptoms of the illness.

Diagnosis

Diagnosis is based on identification of the pertussis germ through special tests and/or cultures obtained as early in the course as possible.

Treatment

Hospitalization may be required for supportive care and to manage complications. Antimicrobials begun in the early stage may ease the disease.

Reporting Requirements

Reporting of a person confirmed or suspected of having pertussis (Whooping cough) should be made within 24 hours by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification Guidelines

When pertussis occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § 22.1-271.1, § 22.1-271.2, and § 32.1-46. Refer to “Immunization Requirements” in Chapter III.
2. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
3. Make sure all staff and students exhibiting symptoms associated with the illness consult a health care provider and the local health department is notified if another person develops pertussis.
4. Preventive antibiotic is recommended for all household contacts and other close contacts irrespective of age and vaccination. School or classroom wide prophylaxis should be considered on a case-by-case basis with consultation from a physician and the health department.

Pinworm Infection (Enterobiasis)

Pinworm infection is caused by a small, white intestinal worm called *Enterbeasis vermicularis*, which is about the length of a staple and lives in the rectum of humans. In an infected person, female worms leave the intestine through the anus and deposit eggs on the surrounding skin. Symptoms include perianal itching (which ranges from mild to severe), disturbed sleep, irritability and sometimes secondary infection of the scratched skin. Contrary to commonly held beliefs, pinworms do not cause teeth grinding or bed-wetting and are generally not dangerous, just irritating.

Transmission

Pinworms are transmitted by direct transfer of infected eggs by hand from anus to mouth of the same person or another person, or indirectly through clothing, bedding, food, or other articles contaminated with eggs of the parasite.

The life cycle requires 2 to 6 weeks to be completed. Symptomatic disease with high worm burden results from successive reinfections occurring within months after initial exposure.

School Exclusion Guidelines

Communicable: Transmission is possible as long as gravid females are discharging eggs on perianal skin. Eggs remain infective in an indoor environment for about 2 weeks.

Case: Students and staff should be excluded from school until 24 hours after treatment is started.

Contacts: School exclusion is not indicated.

Diagnosis

The worms can sometimes be seen at night when they are laying their eggs on perianal skin. A health care provider can make the diagnosis by performing a “tape test” examination for pinworms.

Treatment

Several prescription medications are available for treatment of this infection (pyrantel pamoate or mebendazole; both given in a single dose and repeated in 2 weeks). The health care provider may choose to treat the whole family if one member of the family has pinworms. Families should be informed that recurrence is common due to a high incidence of reinfection.

Reporting Requirements

Pinworms are not a reportable disease.

Notification Guidelines

When pinworm infection occurs within the school population, school health personnel (e.g., school nurses and consulting physician), in consultation with school administrators and local health department, should determine whether some or all parents and staff should be notified so they may watch for symptoms in themselves and/or their children.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Follow hand washing and cleanliness procedures. Careful attention to good hygiene, handwashing, and environmental cleaning and sanitation is very important in reducing the spread of this infection.
3. Refer to “Prevention Guidelines for Diseases Spread Through the Intestinal Tract” in Chapter III.

Polio (Poliomyelitis)

Poliomyelitis is a highly contagious viral infection caused by three types of polio virus. It is most often recognized by the acute onset of flaccid paralysis. Most polio infections are asymptomatic. Symptoms range in severity from a mild, nonspecific illness, with low grade fever and sore throat, to aseptic meningitis (inflammation of the covering of the brain and spinal cord) to paralysis and death. There have been no cases of natural (wild-type) polio in the Western Hemisphere since 1991. Rarely, polio can occur as vaccine-associated paralytic poliomyelitis (VAPP). Eight or nine cases of VAPP per year are reported in the United States. A single case of poliomyelitis is considered a public health emergency and needs to be given top priority.

Transmission

Polio is transmitted primarily by person-to-person spread, principally through the fecal-oral route and possibly through secretions (phlegm, mucus). Transmission of polio is possible as long as the virus is excreted. Cases are most infectious during the first few days before and after onset of symptoms. Certain immunodeficient individuals are more likely to acquire VAPP from another individual who has recently received oral polio vaccine. VAPP does not occur after the inactivated polio vaccine. The incubation period is commonly 7 to 14 days for paralytic cases, with a reported range of 3 to possibly 35 days.

School Exclusion Guidelines

Communicable: Polio is most infectious during the first few days before and after onset of symptoms. Although not precisely defined, transmission is possible as long as the virus is excreted.

Case: Individuals with polio can potentially excrete the virus in stool up to 8 weeks (usually several weeks). Those with weakened immune systems may excrete virus for prolonged periods of time.

Contacts: Persons exposed to polio should have their immunization records checked by a health care provider and subsequently undertake the recommendations for polio vaccine.

Diagnosis

Polio virus can be recovered from the stool, throat, urine, and rarely, from CSF (cerebral spinal fluid).

Treatment

There is no specific anti-viral therapy. Care is supportive.

Reporting Requirements

Reporting of a person confirmed or suspected of having poliomyelitis must be made within 24 hours by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification Guidelines

When polio occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § 22.1-271.1, § 22.1-271.2, and § 32.1-46. Refer to “Immunization Requirements” in Chapter III.
2. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
3. Make sure all students and staff exhibiting symptoms of the illness consult a health care provider and the local health department is notified if another person develops polio.

Rabies

Rabies is an acute viral infectious disease of mammals, especially carnivores, caused by a neurotropic virus often in the saliva of rabid animals. Rabid animals infected with rabies virus characteristically produce an acute illness with rapidly progressive central nervous system (brain and spinal cord) symptoms, including anxiety, dysphagia (difficulty swallowing), and convulsions, and almost invariably, progresses to death.

Animals with rabies often behave strangely after the virus attacks their brains. Rabid animals may attack people or other animals for no real reason, or they may lose their fear of people and seem to be unnaturally friendly. Not all rabid animals act this way; some may become withdrawn or may even act normally.

Transmission

The virus is transmitted where virus-laden saliva of a rabid animal is introduced by a bite or scratch (or, very rarely, into a fresh break in the skin or through intact mucous membranes). Transmission from person to person is theoretically possible since the saliva of the infected person may contain virus, but this has never been documented. All mammals, including humans, can get rabies. Wild animals in the United States (particularly skunks, bats, raccoons, and foxes) harbor rabies, and in some instances these wild animals infect domestic animals (dogs, cats, ferrets, and livestock). Raccoon rabies is established in all East Coast states.

In recent years, most cases of human rabies cases in the U.S. resulted from bat bites. Most dogs, cats, and ferrets show symptoms by the time they are shedding rabies virus in their saliva. Rarely do they appear healthy for several days while shedding the virus, but no case of rabies in the U.S. has been attributed to a dog or cat that has remained healthy throughout the standard 10-day period of confinement.

The incubation period is usually 3 to 8 weeks, rarely as short as 9 days or as long as 7 years; depends on the severity of the wound site, site of the wound in relation to the richness of the nerve supply and its distance from the brain, amount and strain of virus introduced, protection provided by clotting and other factors. Prolonged incubation periods have occurred in prepubertal individuals.

School Exclusion Guidelines

Communicable: Rabies virus is transmitted through a bite of a rabid animal or by getting the saliva or brain tissue of a rabid animal in a wound or in the eye or

mouth. In dogs and cats, the period of communicability is usually for 3 to 7 days before onset of clinical signs (rarely over 4 days) and throughout the course of the disease. In one study, bats shed virus for 12 days before evidence of illness, in another study, skunks shed virus for at least 8 days before onset of clinical signs.

Case: Consult with the person's health care provider or local health department.

Contacts: School exclusion is not indicated. Casual contact with an infected person (e.g., by touching a person with rabies) or contact with non-infectious fluids or tissue (e.g., urine or feces) does not alone constitute an exposure.

Diagnosis

Rabies is diagnosed in animals through testing a sample of brain tissue after they are dead. In humans suspected of having rabies, special tests are done of the blood, spinal fluid, and brain, but the diagnosis may not be confirmed until after death.

Treatment

Once symptoms have developed, no drug or vaccine improves the prognosis. Post-exposure treatment with RIG (rabies immune globulin) and rabies vaccine (HDCV, RVA, or Rabovert) is recommended for a person bitten by a wild or domestic animal that may be infected. Make sure the exposed individual is up to date on tetanus vaccine.

Exposures other than bites rarely result in infection. However, post-exposure treatment is recommended for persons who report having an open wound or mucous membrane contaminated with saliva or other potentially infectious material (e.g., brain tissue) from a rabid animal.

Reporting Requirements

Reporting of a person or an animal confirmed or suspected of having rabies, must be made within 24 hours by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Note. All animal bites should be reported to the local health department and the local animal control office for follow up. Dogs, cats, and ferrets that bite people must be observed for 10 days for signs of rabies.

Notification Guidelines

When a student is bitten or scratched by an animal, school personnel should notify the student's parents, the local health department, and local animal control office. Parents should be advised to contact a health care provider for evaluation of the exposure.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. There is an effective vaccine for dogs and cats and certain other domestic animals to prevent them from getting rabies. All pets should be vaccinated and not allowed to roam free.
3. Avoid contact with wildlife and strays.
4. If a sick or strange-acting animal is noticed around the school, the local animal control official should be called immediately.
5. If a person is bitten or scratched by any animal, wash the wound immediately with warm soapy water for 10 minutes and contact the person's health care provider and the local health department. Use universal precautions; wear gloves. (See previous section on "Universal Precautions.")
6. Discourage wild animals from depending on humans for food and shelter. Fasten trash can lids tightly. Cap chimneys (common nest-sites for raccoons) and seal openings into houses, barns, and garages.
7. If a pet has been bitten or scratched by another animal, wash the wounds promptly with soap and water. Use universal precautions; wear gloves. (See previous section on "Universal Precautions.") A veterinarian should be contacted.
8. Teach students about preventing bites from animals.
9. Do not allow common vectors for rabies to have direct contact with students in school projects and exhibits.

Rocky Mountain Spotted Fever

Rocky Mountain spotted fever (RMSF) is a systemic, febrile disease caused by the parasite *Rickettsia rickettsii*. RMSF has a characteristic petechial (small pinhead bruises) rash usually occurring before the sixth day, resulting from a bite of a dog tick infected with the bacteria *Rickettsia rickettsii*. The rash begins on the wrists and ankles and spreads to the trunk and the other areas of the body within hours. The palms and soles are typically involved. High fever, chills, headache, and muscle pain usually appear 3 to 10 days after the tick bite. In some cases, the rash fails to develop or develops only late in the illness. The disease can last as long as 3 weeks and can affect the central nervous system (brain and spinal cord), heart, lungs, kidneys, and other organs. In severe cases, disseminated intravascular coagulation illness and shock can occur, leading to death.

Transmission

Rocky Mountain spotted fever is transmitted ordinarily by the bite of an infected tick. At least 4 to 6 hours of attachment and feeding on blood by the tick are required before the rickettsii become reactivated and infectious for people. Contamination of breaks in the skin or mucous membranes with crushed tissues or feces of the tick may also lead to infection. The incubation period is from 3 to about 14 days.

School Exclusion Guidelines

Communicable: RMSF is not transmitted from person to person. It is transmitted by ticks carrying *Rickettsia rickettsii* bacteria. The tick remains infective for life, commonly as long as 18 months.

Case: School exclusion is not indicated

Contact: School exclusion is not indicated.

Diagnosis

Diagnosis is made by history and physical examination findings. It is confirmed by laboratory tests.

Treatment

Early treatment with antibiotics and supportive measures is based on clinical findings and geography. However, treatment should not be withheld due to lack of tick bite history.

Reporting Requirements

Rocky Mountain spotted fever must be reported to the local health department within seven days of diagnosis.

Notification Guidelines

When RMSF occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

If a student is bitten by a tick during the day, remove it as outlined below. Notify the parents of that student so they can inform their health care provider. Tell them what the tick looked like. If the student develops the symptoms described, particularly a skin rash and/or flu-like symptoms, ask the parents to see a health care provider promptly for evaluation and treatment.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Advise persons who spend time outdoors in area with ticks to (1) wear long-sleeved shirts and long pants, (2) keep shirts tucked securely into pant legs and pant legs tucked into socks, (3) wear sneakers or hiking boots instead of open sandals, and (4) wear light-colored clothing. (Ticks are dark in color and will be easier to see against a light background.)
3. Conduct a daily tick check. Ticks removed within 24 hours of attachment are unlikely to transmit RMSF disease. Ticks are most often found on the thigh, flank, arms, underarm, and legs, and are very small. Look for new “freckles.”
4. If a tick is found on a person, remove it immediately. Deer ticks are very small and hard, about the size of a pinhead. They are orange-red or black depending on their stage of growth, and prefer to attach themselves to a human host under the hair. Dog ticks are larger, ranging from 1/10 to 1/4 inch

in length. They are brown and also prefer to attach themselves under the hair or on protected parts of the body.

5. To remove a tick:
 - ◆ Wear gloves. Use universal precautions. (See previous section on “Universal Precautions.”)
 - ◆ Using tweezers, grasp tick as close to the skin as possible and gently, but firmly pull tick straight out. Avoid any jerking or twisting motion that may break off the mouth parts in the skin.
6. Insect repellents containing diethyltoluamide (DEET[®], Autan[®]) applied to skin can be effective against ticks but should be used cautiously. The pesticide permethrin is available as a clothing spray; it is not to be used on the skin. A combination of diethyltoluamide applied to skin and permethrin-treated clothes may provide the best protection against tick and mosquito bites. Follow these guidelines:
 - ◆ Use repellents no more than one to two times per day. Do not treat skin with permethrin under clothing.
 - ◆ Particularly with children, avoid using high concentrations of diethyltoluamide products. Never use on damaged skin.
 - ◆ Avoid inhaling the product. Keep out of eyes, and do not apply to parts of a person’s hands that are likely to have contact with their eyes or mouth.
 - ◆ After returning indoors, wash treated skin with soap and water.
 - ◆ If a student is suspected to be having a reaction to an insect repellent, wash skin and call the student’s parents and advise them to contact their health care provider for follow-up care.

Roseola (Roseola Infantum)

Roseola infantum (exanthem subitum) is an acute viral disease, usually in children under 4 (most common before 2 years of age), caused by human herpesvirus-6 (HHV-6). The illness starts with a high fever (103 degrees F.) and irritability, lasting 1 to 5 days (average 3 days). The fever then falls to normal and a rash appears, faint red in color, with flat spots, first appearing at the nape of the neck and behind the earlobes and spreading mainly to the trunk, rarely on the face, and disappears within 24 hours. Febrile seizures are an infrequent complication and are associated with the rapidly rising temperature. The disease occurs most often in the spring.

Transmission

The mode of transmission of roseola is unknown.

Infants and preschoolers are the most susceptible, with 95 percent of the cases seen between 6 months and 3 years of life. The period of communicability is not known but is probably the greatest during the febrile period, before the appearance of the rash. The incubation period is about 10 days and unrecognized infections occur.

School Exclusion Guidelines

Communicable: The period of communicability is not known but is probably greatest during the febrile period before the appearance of the rash.

Case: Students may attend school when they feel well enough.

Contacts: School exclusion is not indicated.

Diagnosis

Diagnosis is based mainly on clinical findings, particularly if other cases are present in the community.

Treatment

There is no specific treatment for roseola, other than supportive care.

Reporting Requirements

Roseola infantum is not a reportable disease.

Notification Guidelines

When a case of roseola occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Students with roseola should not be exposed to other students while they are ill.
3. Hand washing and cleanliness are essential to stop the spread of all respiratory tract diseases.
4. Refer to “Prevention Guidelines for Diseases Spread Through the Respiratory Tract” in Chapter III.

Rotavirus (Rotavirus Enteritis)

Rotavirus enteritis is a sporadic or seasonal, often severe gastroenteritis of infants and young children, caused by rotavirus. The infection is characterized by diarrhea, often with vomiting and low-grade fever. The illness is a common cause of dehydration in young children, and can be fatal. Symptoms last for an average of 4 to 6 days.

Transmission

Rotavirus is probably transmitted by contact with infected persons through the fecal-oral route. Respiratory transmission is also thought to occur. Rotavirus is very common in young children. The incubation period is approximately 24 to 72 hours.

School Exclusion

Communicable. Person-to-person probably via fecal-oral and sometimes respiratory spread. The individual is communicable during the acute stage of disease, and later while virus shedding continues. Rotavirus is not usually detectable after about the eighth day of infection.

Case. School exclusion is appropriate during the period of diarrhea and vomiting.

Contacts. Contacts should continue in school unless they develop symptoms.

Diagnosis

Rotavirus infection can be confirmed by laboratory tests.

Treatment

No specific medication is available. Treatment includes supportive care with oral hydration techniques and sometimes hospitalization for intravenous fluids.

Reporting Requirements

Rotavirus enteritis is not a reportable disease.

Notification Guidelines

None.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Refer to “Prevention Guidelines for Diseases Spread Through the Intestinal Tract” in Chapter III.

Rubella (German Measles)

Rubella is usually a mild viral disease, caused by Rubella virus (*Rubivirus*). The illness is characterized by a flat, red rash that often begins on the face or upper trunk and extends over the rest of the body. The rash usually lasts about 3 days and is often accompanied by a slight fever and lymph gland swelling in the back of the neck. As many as half of the rubella infections may occur without rash. There can be joint pain especially in children and adolescents.

The most serious problem with rubella is when a pregnant woman becomes infected because the developing fetus can become infected. Stillbirths, miscarriages, and serious birth defects can occur.

Transmission

Rubella is transmitted chiefly through direct or droplet contact with nasal or saliva secretions of infected persons. A significant number of young adults are susceptible to rubella. This degree of susceptibility in young adults is the result of lack of vaccination, not waning immunity in immunized persons.

The period of maximal communicability appears to be the few days before, and 5 to 7 days after, onset of rash. A small number of infants with congenital rubella syndrome continue to shed virus in nasal and saliva secretions and urine for 1 year or more and can transmit infection to susceptible contacts.

The incubation period is from 16 to 18 days with a range of 14 to 23 days.

School Exclusion Guidelines

Communicable: The period of communicability appears to be a few days before, and 5 to 7 days after, onset of rash.

Case: Exclude from school for 7 days after onset of rash. Avoid exposure to women in early pregnancy. Discuss with local health department. Students with congenital rubella syndrome should be considered contagious until they are 1 year old, unless they have two negative nasal and saliva cultures and urine cultures for rubella.

Contacts: Check immunization records of all students. Those who are pregnant and not immunized should be urged to seek medical advice.

Diagnosis

The illness can be presumptively diagnosed by the signs and symptoms. Serologic testing is useful in confirming the presence of infection. Other tests are available in specific situations.

Treatment

No specific anti-viral treatment is available. Care is based on symptoms and is supportive.

Reporting Requirements

Rubella (German measles), including congenial rubella syndrome, must be reported to the local health department within seven days of diagnosis.

Notification Guidelines

When rubella occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § 22.1-271.1, § 22.1-271.2, and § 32.1-46. Refer to “Immunization Requirements” in Chapter III.
2. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
3. Make sure parents of all students who exhibit symptoms associated with the illness consult a health care provider and that the local health department is notified if another person develops rubella.
4. Pregnant staff and pregnant students should notify and seek advice from their health care provider.

Salmonellosis

Salmonellosis is an enteric (intestinal) bacterial disease caused by numerous types of *Salmonella*. It usually affects the intestinal tract and occasionally the blood stream. *Salmonella* bacteria can cause outbreaks due to food poisoning. Symptoms include mild or severe diarrhea accompanied by stomach cramps, pain, fever, headache, and occasionally vomiting. These symptoms usually develop in less than 24 hours after bacteria are ingested but may not develop until 72 hours and may disappear untreated in 2 to 5 days. Age-specific attacks of *Salmonella* infection are highest in those younger than 5 years of age and older than 70 years of age, and peak in the first years of life. Invasive infections and mortality are more frequent in infants, the elderly, and those with an underlying disease, such as sickle cell disease, cancer, and illnesses causing suppression of the immune system.

Transmission

Salmonellosis is transmitted by ingestion of the organisms in food derived from infected food animals or contaminated by feces of an infected animal or person. This includes raw or undercooked (inadequate cooking time to a given temperature) eggs and egg products, raw milk and raw milk products, poultry and poultry products. In addition, pet turtles, iguanas, and chickens, and unsterilized pharmaceuticals of animal organs are potential sources of these bacteria.

Salmonella bacteria can be transmitted person-to-person via the fecal-oral-route. Infected persons can spread this disease by not washing their hands after going to the bathroom and then handling food that other people will eat.

Salmonella can be shed in the stool for many weeks. Individuals with the illness are infectious until the bacteria are no longer present in their stool. The excretion of *Salmonella* in the stool is longer in younger children than in older children and adults. The duration of excretion can be prolonged by antimicrobial therapy.

The incubation period is from 6 to 72 hours, usually about 12 to 36 hours.

School Exclusion Guidelines

Communicable: *Salmonella* is transmittable as long as the bacteria are shed in the stool of an infected person (several days to several weeks to as long as a few months).

Case: Students and staff with salmonellosis should be excluded from school until a health care provider advises return. In high risk situations—students in daycare

and adults involved in food handling and patient or child care—cases need to be excluded until cessation of diarrhea and negative stool cultures are obtained.

Contacts: School exclusion and stool culture are not indicated in asymptomatic persons.

Diagnosis

Diagnosis is made by a stool culture. Up to 72 hours may be required to grow bacteria from a stool sample.

Treatment

Antimicrobial therapy is usually not prescribed for uncomplicated salmonellosis. In fact, medication may actually lengthen the time the bacteria are in the stool. Antimicrobial therapy is warranted for *Salmonella* infection occurring in persons with an increased risk of invasive disease and other complications, including infants younger than 3 months of age; persons with sickle cell disease, cancer, acquired immune deficiency syndrome (AIDS), or other immunosuppressive illnesses; persons on immunosuppressive therapy; and persons with chronic gastrointestinal tract disease or severe colitis.

Reporting Requirements

Salmonellosis must be reported to the local health department within seven days of diagnosis.

Notification Guidelines

When salmonellosis occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Inform family and household members in contact with a person with *Salmonella* diarrhea of their possible exposure to the bacteria, especially if the people are involved in food handling or preparation. If they develop diarrhea, they should immediately see their health care provider and get a stool culture.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Refer to “Prevention Guidelines for Diseases Spread Through the Intestinal Tract” in Chapter III.

Scabies

Scabies is a highly contagious parasitic disease of the skin caused by a mite called *Sarcoptes scabiei*, which infects only humans. The female mite burrows under the skin to lay her eggs, which hatch and start the infestation cycle. Symptoms include an intense itchy (worse at night) rash, with red bumps and characteristic mite burrows—gray or white, wavy, thread-like lines—that are generally obliterated by scratching long before the person sees the health care provider. In adults and older children, the mite burrows are typically seen between fingers and toes; in the flexor areas of the wrist; around the elbows; under the arms; and around the belt line, thighs, naval, penis, nipples, abdomen, and buttocks. In infants younger than 2 years of age, eruption is often blister-like and occurs on the head, neck, palms, and soles of feet. These areas are usually spared in older children and adults. Symptoms appear within 4 to 6 weeks of exposure in previously unexposed persons and 1 to 4 days in repeat exposures.

Transmission

Scabies is transmitted by direct skin-to-skin contact; it can be acquired during sexual contact. Transfer of parasites from undergarments and bedclothes occurs only if these have been contaminated by infested persons immediately beforehand. Mites can burrow beneath the skin in 2 ½ minutes. Scabies can be transmitted as long as the person remains infected and untreated, including the interval before symptoms develop.

The incubation period is from 2 to 6 weeks before onset of itching in people without previous exposure. People who have been previously infested develop symptoms 1 to 4 days after re-exposure.

School Exclusion Guidelines

Communicable: The mite survives only a few days off the human body. Transmission occurs most often by close personal contact. Scabies is transmittable until mites and eggs are destroyed by treatment, ordinarily after 1 or occasionally 2 courses of treatment, a week apart.

Case: Exclude from school until 24 hours of antibiotic treatment has been completed.

Contacts: Direct inspection of body. School exclusion is not indicated in the absence of infestation.

Diagnosis

Scabies is usually diagnosed by the typical appearance of the rash and accompanying symptoms and by examining skin scrapings under a microscope to detect the mite or its eggs.

Treatment

Scabies is usually treated with one of several prescriptions, mite-killing creams or lotions applied once to the skin and then washed off after a specified period of time. Medication to relieve the itching is often necessary as well. Even after effective therapy, itching may persist for up to 4 weeks. Prophylactic therapy is recommended for household members. All members of the family should be treated at the same time to prevent reinfection. Bedding and clothing worn next to the skin should be laundered in a washer with hot water and a hot dryer cycle. The parasites do not survive more than 3 to 4 days without contact with the skin. Clothing that can not be laundered should be removed from the person and stored for several days to a week or more to avoid reinfestation.

Reporting Requirements

Scabies is not a reportable disease.

Notification Guidelines

When scabies occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of infestation outbreaks.
2. Wash and rinse on the hot cycle all washable items that have come in contact with an infected individual's skin during the 72 hours prior to treatment. Use a hot dryer for at least 20 minutes.
3. Store difficult-to-wash items, such as stuffed toys and pillows, in tightly closed plastic bags for 1 to 2 weeks before using again.
4. Thoroughly vacuum all carpets and upholstered furniture.

5. Consult with the school health care personnel if there seems to be a major problem with scabies because it may be prudent and necessary to treat all students and adults in the group once.

Sexually Transmitted Diseases

The descriptions below define these illnesses and their symptoms primarily as they relate to infections in adolescents and adults. Sexual abuse must be suspected in all children diagnosed with a sexually transmitted disease. Infections are also possible in newborns due to transmission during birth from mother to newborn.

Overview

Sexually Transmitted Diseases. Sexually transmitted diseases are transmitted when an infected person has unprotected sexual intercourse or other intimate physical contact with another person. Sexual intercourse includes when a penis is inserted into a vagina, as well as oral and anal intercourse. The most common sexually transmitted diseases include syphilis, gonorrhea (GC), chlamydia, warts (condyloma), trichomonas, herpes simplex type 2 (genital herpes), HIV infection and AIDS, and hepatitis B. Symptoms may include, but are not limited to, those listed in the following chart. (For more detailed descriptions, refer to a standard infectious disease manual published by professional organizations, such as the American Academy of Pediatrics [AAP] or the Centers for Disease Control and Prevention [CDC]).

Symptoms Associated With Sexually Transmitted Diseases

Diseases	Symptoms
Chlamydia	May cause discharge or pain in males while urinating. For females, vaginal discharge, odor, or pain are common symptoms. Note: May be asymptomatic in both males and females.
Genital herpes	Painful, itchy sores on the genitals caused by the herpes simplex type 2 virus. (For additional information see Herpes Simplex Virus.)
Genital warts	These wartlike growths, caused by human papilloma virus (HPV), on the genitals are associated with cancer of the cervix in women. Some individuals complain of itching and pain accompanying genital warts.
Gonorrhea (GC)	For males, pain and discharge while urinating are common symptoms. Females may be asymptomatic or experience pain from urethritis (inflammation of the urethra), endocervicitis (inflammation of the mucous lining of the cervix uteri), and pelvic inflammatory disease (infection of the uterus, fallopian tubes, and adjacent pelvic structures), or have vaginal discharge and odor.
Hepatitis B	Weakness, abdominal pain, nausea, vomiting, dark urine, and jaundice are symptoms associated with this illness. (See Hepatitis B).

Symptoms Associated With Sexually Transmitted Diseases

Diseases	Symptoms
HIV infection and AIDS	Onset of illness includes swollen lymph nodes, weight loss, chronic diarrhea, fever, and fatigue. (See HIV Infection and AIDS.)
Syphilis (acquired)	Infection with acquired syphilis can be divided into three stages. The primary syphilis infection is accompanied by a painless sore (chancre) on or around the penis, vulva, vagina, perineum, mouth, or anus. The second stage is characterized by a generalized rash, most frequently on the palms and soles; fatigue; generalized enlargement of lymph nodes; sore throat; headache; joint pain; and a flat, gray, mucous like patch characteristic of syphilis around the external genitalia or anus (condylomata lata). The third stage may involve damage to the heart and central nervous system.
Trichomonas	Is primarily a sexually transmitted disease and frequently coexists with other infections, particularly gonorrhea. Females experience a frothy, vaginal discharge and itching. Pain when urinating and abdominal pain may occur. Infected males may experience pain while urinating, but the majority of males are asymptomatic.

Dangers Associated With Lack of Symptoms. People can be infected with an STD but be asymptomatic. Even so, the dangers of these diseases persist and the infection can still be transmitted. Anyone who thinks they may have been exposed to an STD should see a health care provider immediately. Infection with one STD may indicate the need to test for other STDs. If untreated, STDs may cause serious physical and reproductive damage or even death. STDs are particularly dangerous to infants whose infected mothers are not treated during pregnancy. Infected infants may be born mentally retarded or physically deformed, or they may die.

Transmission

Individuals who have unprotected sex, especially with many partners, are at risk of exposure to STDs. Some STDs can be transmitted directly from an infected person to another by sharing contaminated needles. Any mind-altering substance increases the chances that an individual will engage in behavior that places them at increased risk of exposure to harmful consequences.

Diagnosis

Diagnosis is made by physical examination, microscopic exam of genital secretions, cultures, and blood tests.

Treatment

Bacterial STDs (syphilis, GC, and chlamydia trichomonas) can be treated with antibiotics administered either orally or by intramuscular injections. There are several local treatments (chemical cryotherapy, laser) for treating warts. There are no cures for viral infections (such as hepatitis B, genital herpes, or AIDS), although hepatitis B may resolve itself. Hepatitis B can be prevented with a vaccine. Genital herpes may be treated with acyclovir.

An infected person may consult their health care provider or the state health department-sponsored agencies that provide comprehensive STD services. These clinics, open to all, have highly trained and sensitive staff, and there are no restrictions to access based on age, race, sex, ethnicity, ability to pay, residence, country of origin, or immigrant status. By law, minors can be treated in STD clinics without parental consent.

Reporting Requirements

Refer to “List of Reportable Diseases in Virginia” for specific sexually transmitted disease (STD), in Appendix A.

Notification Guidelines

None.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. The best way to prevent sexually transmitted diseases is to refrain from sexual intercourse and exposure to genital secretions. Students who are sexually active should be encouraged to discontinue this practice. These students should be referred to the local health department or their health care provider for evaluation, examination, and counseling.
3. Inform students who may not seek health care—for fear of information being given to their parents—of the law allowing them to be diagnosed and treated confidentially and without parental consent.
4. Educate students, according to school policy, about preventing STDs.

Shigellosis

Shigellosis is an acute bacterial disease involving the intestinal tract caused by *Shigella*. Symptoms range from mild diarrhea to diarrhea with blood and mucus. In severe cases, it can cause dehydration, high fever, severe cramps, vomiting, headache, and convulsions.

Transmission

Shigella is transmitted mainly by direct or indirect fecal-oral route from an infected person. This could unintentionally happen when diapering children. Other modes of transmission include ingestion of contaminated food or water and contact with a contaminated, inanimate object. Infection is most common in children ages 1 to 4. Persons at greatest risk for spreading the disease include food handlers, staff and attendees at child care centers or baby-sitting services, and persons providing direct patient care in hospitals, nursing homes, or institutions. As few as 10 bacteria can cause ingested shigella infection. People with this illness are infectious until the bacteria are no longer present in their stool. The incubation period is from 12 to 96 hours (usually 1 to 3 days); up to 1 week for *S.dysenteriae*.

School Exclusion Guidelines

Communicable: *Shigella* is communicable during acute illness and until the infectious agent is eliminated from the stool, usually within 4 weeks after illness.

Case: Students and staff with shigellosis should be excluded from school until the diarrhea stops.

Contacts: School exclusion is not indicated in asymptomatic persons. The stool of symptomatic (diarrheal stools) contacts who are high risk should be cultured. Exclusion from school is required until diarrhea stops.

Diagnosis

Diagnosis made by stool culture.

Treatment

Children and adults with *Shigella* in their stool are usually treated with an antimicrobial medication that shortens both the duration of the illness and length

of time that bacteria are passed in the stool. (Mild disease is often self limiting, lasting 48 to 72 hours. In these cases, treatment with an antimicrobial medication is directed toward limiting the spread.)

Reporting Requirements

Shigellosis must be reported to the local health department within seven days of diagnosis.

Notification Guidelines

When shigellosis occurs in the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Family and household members in contact with the person with shigellosis should be informed of possible exposure to the bacteria, especially if they are involved in food handling or preparation. If they develop diarrhea, they should immediately see their health care provider.

Prevention Guidelines:

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Refer to “Prevention Guidelines for Diseases Spread Through the Intestinal Tract” in Chapter III.

Shingles (Varicella-Zoster)

Note. See previous sub-section on Chickenpox.

Tetanus

Tetanus (lockjaw) is an acute infectious disease due to the toxin (poisonous substance) *Clostridium tetani* bacteria, which enters the body through a cut or wound. The toxin causes muscles to go into painful spasms. Spasm of the muscle that closes the mouth accounts for the name “lockjaw.” Paralysis and death can result.

Transmission

Tetanus is transmitted by introducing the organism into the body, usually through a puncture wound contaminated with soil, street dust, or animal or human feces; through lacerations, burns, and trivial or unnoticed wounds; or by injected contaminated street drugs. Tetanus is not transmissible from person to person.

The incubation period is usually 3 to 21 days, although it may range from 1 to several months, depending on the character, extent, and location of the wound; average 10 days. Most cases occur within 14 days. In general, shorter incubation periods are associated with more heavily contaminated wounds, more severe disease, and a worse prognosis.

School Exclusion Guidelines

Communicable: Tetanus is not directly transmitted from person to person.

Case: Infected persons should be excluded from school until they feel well.

Contacts: School exclusion is not indicated.

Diagnosis

The wound should be cultured. However, diagnosis is made clinically by excluding other possible diagnoses.

Treatment

See the following table from the *1997 Red Book*¹³⁷ for treatment recommendations:

Guide to Tetanus Prophylaxis in Routine Wound Management

History of Absorbed Tetanus Toxoid (Doses)	Clean, Minor Wounds		All Other Wounds †	
	Td ±	TIG ‡	Td ±	TIG ‡
Unknown or < 3	Yes	No	Yes	Yes
≥ 3μ	No §	No	No ¶	No

† Such as, but not limited to wounds, contaminated with dirt, feces, soil, and saliva; puncture wounds; avulsions; and wounds resulting from missiles, crushing, and frostbite.

± For children less than 7 years old, DTaP (or DTP) is recommended; if pertussis vaccine is contraindicated, DT is given. For persons 7 years of age or older, Td is recommended. Td indicates adult-use tetanus and diphtheria toxoids; TIG, tetanus immune globulin (human).

‡ Equine tetanus antitoxin should be used when TIG is not available.

μ If only 3 doses of fluid toxoid have been received, a fourth dose of toxoid, preferably an absorbed toxoid, should be given.

§ Yes, if more than 10 years since last dose.

¶ Yes, if more than 5 years since last dose. (More frequent boosters are not needed and can accentuate side effects.)

Reporting Requirements

Tetanus must be reported to the local health department within seven days of diagnosis.

Notification Guidelines

Even though tetanus is not spread person to person, if a case occurs, officials may want to use this opportunity to remind others to check their immunization records and if necessary, get boosters. After the initial immunization series (see immunization schedule in Appendix A), most persons are protected for 10 years. Boosters need to be given as soon as possible after injury, as determined by a health care provider.

¹³⁷ American Academy of Pediatrics (1997). *1997 Red Book: Report of the Committee on Infectious Diseases*, 24th Edition. American Academy of Pediatrics, Elk Grove Village, Ill.

When tetanus occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § 22.1-271.1, § 22.1-271.2, and § 32.1-46. Refer to “Immunization Requirements” in Chapter III.
2. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
3. Make sure all cuts, scrapes, and puncture wounds are cleaned well with soap and water; individuals who have sustained deep or severe wounds should be referred for medical attention.
4. Make sure all students and staff are up to date on the tetanus immunization.

Tinea (Ringworm)

Tinea and ringworm are general terms used to describe various fungal diseases that involve the scalp, body, feet, and groin. There are six types of tinea: (1) tinea capitis, ringworm of the scalp; (2) tinea corporis, ringworm of the body; (3) tinea cruris, ringworm of groin and perianal region; (4) tinea pedis, ringworm of the foot; (5) tinea barbae, ringworm of the beard; and (6) tinea unguium, ringworm of the nails.

Descriptions of tinea of the scalp, body, groin, and foot are presented on the following pages. The following school exclusion guidelines, reporting requirements, notification guidelines, and prevention guidelines are presented for all the tineaes.

School Exclusion Guidelines

Communicable: All tinea infections are transmissible as long as the fungus is present in the infected area. Viable fungus may persist on contaminated materials for long periods.

Cases: School exclusion is not indicated as long as infected area can be covered or student is being treated by a health care provider. Note: In tinea corporis, the student or staff should be excluded until 24 hours after drug therapy. During treatment, the student or staff should be excluded from the gym and swimming pools.

Contacts: Contacts should not be excluded from school. Examination of siblings and other household contacts for evidence of tinea capitis is recommended.

Reporting Requirements

Tinea infections are not reportable diseases.

Notification Guidelines

If more than one person in a class develops ringworm, school health personnel (e.g., school nurses or consulting physician), in consultation with school

administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Keep the environment as clean, dry, and cool as possible since ringworm fungi grow easily on moist, warm, surfaces.
3. Follow general cleanliness and hand washing guidelines.
4. Keep affected areas of the body loosely covered with gauze, bandage, or clothing to prevent shedding of infected scales.
5. Students and staff should be discouraged from sharing ribbons, combs, and brushes.
6. Students and staff with athlete's foot (tinea pedis) should be discouraged from using swimming pools, locker rooms, and shower rooms without wearing footwear as these areas are conducive to transmission of this infection.

Tinea Capitis (Ringworm of the Scalp)

This fungal disease occurs most commonly in children 3 to 9 years of age.

Transmission

Tinea capitis is transmitted by direct skin-to-skin contact or indirect contact especially from the backs of theater seats, shared personal items (such as combs and hairbrushes) or clothing and hats contaminated with hair from infected persons or animals. The incubation period is from 10 to 14 days.

Diagnosis

Typically, the diagnosis is made by its appearance. Tinea capitis can appear as patchy areas of dandruff-like scaling; with either subtle or extensive hair loss; discrete areas of hair loss surrounded by the stubs of broken hairs—so called “black dot ringworm;” numerous individual fluid-filled abrasions with hair loss or scaling; or a boggy, fluctuant, inflammatory, puss-filled mass, with hair loss, called a kerion, which may be accompanied by fever, swollen lymph nodes (often called glands).

Treatment

The treatment consists of oral medication prescribed by a health care provider.

Tinea Corporis (Ringworm of the Body)

This fungal disease is most common from age 2 to 20.

Transmission

Tinea corporis is transmitted by direct or indirect contact with skin and scalp lesions of infected persons; lesions of animals; contaminated floors, shower stalls, and benches; and towels, bedding, clothing, and similar objects. The incubation period is from 4 to 10 days.

Diagnosis

Typically, the diagnosis is made by its appearance. Microscopic exam is used when there is a question. The lesions start as flat and ring-shaped. The edges of the circle are usually reddish and may be raised, scaly, and itchy. The center of the circle is often clear.

Treatment

Prescription and over-the-counter antifungal creams generally are efficacious. Unresponsive cases may require oral medication.

Tinea Cruris (Ringworm of Groin “Jock Itch”)

This condition is a fungal disease that rarely occurs before puberty, except in babies. Tinea cruris occurs predominantly in adolescents and adult males. Moisture, close-fitting garments, friction, and obesity are contributing factors

Transmission

Tinea cruris is transmitted by direct or indirect contact with skin lesions of infected persons; lesions of animals; contaminated floors, shower stalls, and benches; and towels, bedding, clothing and similar objects. It is transmissible as long as the infection is present. The incubation period is from 4 to 10 days.

Diagnosis

Typically, the diagnosis is made by its appearance. Microscopic exam is used when there is a question. Itchy, reddish, and scaly lesions occur in the groin, on the adjacent thighs, and sometimes around the anus and buttocks.

Treatment

Prescription and over-the-counter antifungal creams generally are efficacious. Unresponsive cases may require oral medication.

Tinea Pedis (Ringworm of the Foot “Athlete’s Foot”)

This condition is a fungal disease that rarely occurs before puberty. There are three types: (1) interdigital (between the toes), (2) vesicular (generally affects the instep), and (3) the moccasin type (both feet are affected by a widespread, scaling rash). This infection is aggravated by heat and sweating.

Transmission

Tinea pedis is transmitted by direct or indirect contact with skin lesions of infected persons or contaminated floors, shower stalls, and other articles used by infected persons. The incubation period is unknown.

Diagnosis

Typically, the diagnosis is made by its appearance. Microscopic exam is used when there is a question.

Treatment

Prescription and over-the-counter antifungal creams generally are efficacious. Unresponsive cases may require oral medication.

Tuberculosis

Tuberculosis (TB) is a bacterial disease caused by the organism tubercle bacillus. It can affect any organ of the body—although the respiratory tract is the most commonly involved. TB infection is defined by a positive tuberculin skin test in a person who has no physical findings of disease and a chest x-ray that is either normal or reveals only granulomas or calcification in the lung or surrounding lymph nodes. TB “disease” is defined as person with infection in whom signs, symptoms, and/or x-ray changes are apparent—disease may be limited to the lung and/or outside the lung. In adults, this distinction between disease and infection is fairly clear, but it is less so in children. The most common symptom is a cough, often one that lasts for weeks and can result in coughing up mucous blood. The disease may also cause chest pain, fever, weakness, loss of appetite, and night sweating. Extrapulmonary symptoms depend on the body part that is involved with the disease.

Transmission

TB is transmitted person to person through the air when the person with infectious TB coughs, sneezes, spits, or sings, and releases infected droplets of mucous. These droplets remain viable and suspended in the air for several hours. TB is not spread by kissing, sharing utensils, or other objects, such as books or clothing. Direct invasion of the TB germ through mucous membranes or breaks in the skin may occur but is rare.

Several factors determine how the germ is transmitted. The presence of cough and of sputum that is smear and culture positive for TB increases risk. Prolonged sharing of indoor air with a person who has infectious TB increases risk. Children younger than 12 generally are not infectious because they have little cough and sputum production. Therefore, childhood disease represents transmission from an adult or adolescent. The incubation period from exposure to either findings on exam or a positive skin test is 2 to 12 weeks. The risk of developing disease is highest in the first 2 years following infection. Infected persons with suppressed immune systems (HIV) have a higher risk for disease.

The incubation period, from infection to demonstrably primary lesion or significant tuberculin reaction, is about 4 to 12 weeks.

School Exclusion Guidelines

Communicable: Theoretically, a person is communicable as long as viable tubercle bacilli are being discharged from the sputum. Some untreated or inadequately treated persons may be sputum-positive intermittently for years.

Effective antimicrobial chemotherapy usually eliminates communicability within a few weeks, at least in the household setting. Children with primary tuberculosis are generally not infectious. See above under transmission.

Case: Adolescents and adults with TB disease are considered infectious until three consecutive negative sputum smears obtained on different days are negative, and they have begun taking prescribed anti-TB medications and their health care provider states, in writing, that they are not contagious. Children with TB infection or disease can return to school as soon as effective medical treatment has been instituted, adherence to therapy has been documented, clinical symptoms have disappeared, and an acceptable plan for completing the course of treatment has been developed.

Contacts: Contacts should be evaluated for level of exposure and treated as indicated by obtaining a history and physical examination, TB skin testing, and X-ray evaluation through the health care provider and/or the local health department.

Diagnosis

TB disease is diagnosed by a positive skin test, symptoms, and other test findings including X-ray.

TB Skin Testing. A positive TB skin test indicates TB infection but not necessarily TB disease. Standardized tuberculin skin testing (the intradermal Mantoux test is recommended by the Centers for Disease Control and Prevention [CDC], the American Thoracic Society [ATS], and the American Academy of Pediatrics [AAP]) to confirm a diagnosis in the presence of one or more of the following conditions: (1) history of contact with an individual with active tuberculosis, (2) contact with immigrants from an endemic area, (3) clinical and/or x-ray findings consistent with tuberculosis. All TB skin tests must be read by a health care professional 48 to 72 hours after placement. A reaction in the first 24 hours is not significant. The *1997 Red Book*¹³⁸ defines a positive TB skin test as:

Induration \geq 5 mm

Children in close contact with known or suspected infectious cases of TB:

- Households with active or previously active cases if treatment cannot be verified as adequate before exposure, treatment was initiated after the child's contact, or reactivation is suspected.

¹³⁸ American Academy of Pediatrics (1997). *1997 Red Book: Report of the Committee on Infectious Diseases*, 24th Edition. American Academy of Pediatrics, Elk Grove Village, Ill.

Children suspected to have TB:

- Chest roetgenogram consistent with active or previously active TB.
- Clinical evidence of TB. (Evidence on physical exam or laboratory assessment that would include TB in the working diagnosis; e.g., meningitis.)

Children receiving immunosuppressive therapy (including immunosuppressive doses of corticoid steroids) or with immunosuppressive conditions, including HIV infection.

Induration \geq 10 mm

Children at increased risk of disseminated disease:

- Young age: < 4 years of age.
- Other medical risk factors, including Hodgkin's disease, lymphoma, diabetes mellitus, chronic renal failure, or malnutrition.

Children with increased environmental exposure to TB:

- Born, or whose parents were born, in high-prevalence regions of the world.
- Frequently exposed adults who are HIV-infected, homeless, users of illicit drugs, residents of nursing homes, incarcerated or institutionalized persons, and migrant farm workers.
- Travel and exposure to high prevalence regions of the world.

Induration \geq 15 mm

Children \geq 4 years of age without any risk factors.

Note: Health care providers should consult the *1997 Red Book* for more extensive guidelines for skin test interpretation.

A negative Mantoux test never excludes TB infection or disease in the presence of symptoms, contacts, and suggestive chest X-ray. Interpretation of Mantoux test results in prior recipients of Bacillus Calmette Guerin Vaccine (BCG) can be difficult. Since reliable criteria for distinguishing a positive skin test result caused by BCG from that caused by TB infection are lacking, recommendations for interpreting Mantoux skin test results are generally the same as for those who have not received BCG.

Treatment

As many as four types of medicine are used to treat TB disease. Medication is usually taken for 6 to 12 months depending on the protocol used. Preventive

treatment to high-risk contacts and those with positive TB skin tests is given using current CDC recommendations.

Reporting Requirements

Reporting of persons confirmed or suspected of having tuberculosis disease must be made within 24 hours by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Tuberculosis infection in children age <4 years (Mantoux skin test reaction \geq 10 mm) must be reported to the local health department within seven days of diagnosis.

The local health department will contact the Virginia Department of Health, Division of Tuberculosis Control ([804] 786-6251) within 24 hours. The Division of Tuberculosis Control, in conjunction with the local health department, will help determine if screening of staff and students is required.

Notification Guidelines

When TB disease occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Every effort should be made to adequately educate the community through a joint effort by the schools, local health department, and the Virginia Department of Health, Tuberculosis Control Program, when a case of TB disease occurs within the school population.

APPENDIX D: REQUIRED FORMS

- ◆ School Entrance Health Form: Health Information Form/Comprehensive Physical Examination Report/ Certificate of Immunization (MCH-213D, Rev.1/99).
- ◆ School Entrance Physical Examination and Immunization Certification Form (MCH-213C, Rev.10/91).
- ◆ Immunization Record, Virginia Department of Health (MCH-213C-Supplement).
- ◆ Certificate of Religious Exemption, Commonwealth of Virginia (CRE-1).
- ◆ Student Immunization Status Report (Form SIS-1).
- ◆ School Entrance Health Information Form (HPE-h12 12/83).
- ◆ Athletic Participation Parental Consent Physical Examination Form.
- ◆ Cumulative Health Record (Form LF.009).
- ◆ Summary of Vision and Hearing: Report to the Principal (Form LF.011, 3/95).
- ◆ Summary of Screening of Vision and Hearing: School Division Report (LF.010, 3/95).
- ◆ Scoliosis Report, Virginia Department of Education.

**COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM**
Health Information Form / Comprehensive Physical Examination Report / Certification of Immunization

Part I - HEALTH INFORMATION FORM

Part I to be completed by parents or guardians of entering students. Ref. Code of Virginia § 22.1-270, I.

Student's Name: _____

Student's Date of Birth: Sex: Male Female Number of Children in Family: State or Country of Birth: _____

Student's Social Security #: - - or I.D. #: _____

Student's Address: _____ City: _____ State: _____ Zip: _____

Name of School: _____ Grade _____

Name of Mother or Legal Guardian: _____

Home Phone: - - Work Phone: - -

Name of Father or Legal Guardian: _____

Home Phone: - - Work Phone: - -

In case of emergency—if parent or guardian cannot be contacted—contact the following:

- Name: _____ Complete Phone Number: - -
- Name: _____ Complete Phone Number: - -

Birth History (weight, premature, and any other problems at birth): _____

ALLERGIES (food, medicine, insect bites, and any other allergies): _____

Equipment Used and Specialized Health Care Needed <i>(Check all that apply and explain below. *)</i>		Chronic, Recurring, and Special Health Conditions <i>(Check all that apply and explain below. *)</i>	
Equipment Used by Child:	Catheterization	Arthritis (rheumatoid)	
Glasses / Contact Lens	Clean Intermittent Catheterization	Asthma	
Hearing Aid	External Catheter	Attention-Deficit/Hyperactivity Disorder	
Helmet	Other:	Behavioral or Developmental Problems	
Wheelchair / Walker	Medical Support Systems	Cerebral Palsy	
Other:	Hickman / Broviac / IVAC / IMED	Cystic Fibrosis	
	Mechanical Ventilator	Dental Problems	
	Oxygen	Diabetes	
Specialized Health Care Needed:	Ventricular Peritoneal Shunt	Encopresis (involuntary discharge of stool)	
Activities of Daily Living	Other:	Enuresis (involuntary discharge of urine)	
Bowel / Bladder Training	Ostomies	Head or Spinal Injury	
Diapering / Toileting	Ostomy Care	Hearing Impairment	
Lifting / Positioning	Other:	Heart Disease	
Other:	Respiratory Assistance	Kidney Disease	
Feeding	Percussion	Muscular Dystrophy	
Gastrostomy Feeding	Postural Drainage	Seizures	
Jejunostomy Tube Feeding	Suctioning	Sickle Cell Disease (not trait)	
Naso-Gastric Feeding	Other:	Spina Bifida	
Oral Feeding	Specimen Collecting / Testing	Visual Impairment	
Total Parenteral Feeding	Blood Glucose	Other:	
Other:	Other:		

*Explanation: _____

Describe any family history of chronic illnesses or genetic concerns (please list family member in relation to child [e.g., mother] and name of condition [e.g., anemia, arthritis, cancer, diabetes, heart disease, high blood pressure, kidney disease, mental illness, stroke, tuberculosis]): _____

List names of medical specialists or special clinics caring for your child: _____

Has your child ever been seen by a dentist? Yes: , No: . If yes, date of last appointment: _____ Name of dentist: _____

List all prescription and over-the-counter medications taken regularly by your child: _____

Describe your child's operations and hospitalizations, if any (reason and date): _____

Describe any other important health-related information about your child: _____

Check here if you want to discuss confidential information with school nurse or other school authority: Yes , No .

Check here if you give permission for the school nurse or other school authority to contact the examining physician to discuss any information contained on this form: Yes , No .

Signature of Parent or Legal Guardian: _____ Date (Mo., Day, Yr.): _____

Part II - COMPREHENSIVE PHYSICAL EXAMINATION REPORT

Part II to be completed by a qualified licensed physician. All components, unless otherwise indicated, are to be performed no earlier than twelve months prior to the date child enters kindergarten or elementary school. Ref. Code of Virginia § 22.1-270, A-H.

Student's Name: _____

Date of Birth: / / Height: _____ Weight: _____ Head Circumference: _____ Blood Pressure: _____

Hemoglobin: _____ gms or Hematocrit: _____%. Urine: Albumin _____, Sugar _____, Other _____

Results of Mantoux tuberculin skin test, optional (may be required in high-risk groups): _____ mm. Date of test: / /

If performed, date of most recent blood lead level: / / Results: _____ µg/dL

Vision Screening

Distance visual acuity screening results, without correction: Right Eye 20/ _____ Left Eye 20/ _____ Both Eyes 20/ _____

Distance visual acuity screening results, with correction: Right Eye 20/ _____ Left Eye 20/ _____ Both Eyes 20/ _____

If performed, stereopsis screening results: Pass _____ Fail _____

Child to be rescreened? Yes , No Child to be referred? Yes , No

Hearing

Hearing screening results: Right Ear _____ Left Ear _____ Equipment used: _____

If performed, hearing evaluation results: Right Ear _____ Left Ear _____

If indicated, Tympanogram: Normal _____ Abnormal _____

Child to be rescreened? Yes , No Child to be referred? Yes , No

Systems Examination		Examined	Not Examined	Comments About Findings
General Appearance				
Nutritional Status				
Posture / Motor Behavior				
Skin				
Head				
Eyes:	External			
	Fundi			
Ears:	External and Canal			
	Tympanic Membrane			
Nose				
Throat				
Mouth / Teeth				
Neck				
Heart				
Lungs				
Abdomen				
Genitalia (Tanner Stage)				
Bones, Joints, Muscles				
Neurological				
Estimated Developmental Level:	Cognitive Development			
	Speech / Language Development			
	Social / Emotional Development			
	Health Behaviors / Health Habits			
Other:				

Summary of abnormal physical findings, if any: _____

Medical diagnoses: _____

Describe specifically what, if any, conditions are found that would identify the child as having a disability, including conditions that might require (1) educational evaluation, (2) environmental adjustment, or (3) activity limitation: _____

Assessment: _____

Recommendations and referrals made, if any: _____

Physician's Address: _____ City: _____ State: _____ Zip: _____

Physician's Name (print): _____ Phone No. _____ - _____ - _____

Signature of Physician: _____ Date (Mo., Day, Yr.): _____

PART III - CERTIFICATION OF IMMUNIZATION

Part III to be completed by a physician or health department official.

Student's Name: _____ Date of Birth: _____
Last First Middle Mo. Day Yr.

Student's Social Security #: _____ or I.D. #: _____

Name of Parent/Guardian: _____

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
Poliomyelitis (OPV or IPV)	1	2	3	4	5
Haemophilus influenzae Type b (Hib Conjugate Vaccine)	1	2	3	4	
Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity :		
Rubella	1	2	Serological Confirmation of Rubella Immunity :		
Mumps	1	2	Other (List type and date received):		
Measles, Mumps, Rubella (MMR vaccine)	1	2			
Hepatitis B Vaccine (HBV)	1	2	3	Other:	
Varicella Vaccine	1	2	Other:	Other:	
Rotavirus Vaccine	1	2	3	Other:	

MEDICAL EXEMPTION: As specified in the Code of Virginia § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

DTP/DTaP: [] ; DT/Td: [] ; OPV/IPV: [] ; Hib: [] ; HBV: [] ; Measles: [] ; Mumps: [] ; Rubella: [] ; Varicella: []

This contraindication is permanent: [] , or temporary [] and expected to preclude immunizations until: Date (Mo., Day, Yr.): [] [] [] .

Signature of Physician or Health Department Official: _____ Date (Mo., Day, Yr.): [] [] []

RELIGIOUS EXEMPTION: The Code of Virginia allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. Code of Virginia § 22.1-271.2, C (i).

I certify that this student has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this student has a plan for the completion of his/her requirements within the next 90 days (conditional enrollment):

Signature of Physician or Health Department Official: _____ Date (Mo., Day, Yr.): [] [] []

I certify that this student is ADEQUATELY IMMUNIZED in accordance with the MINIMUM requirements for attending school prescribed by the State Board of Health's Regulations for the Immunization of School Children (For information or questions on immunization regulations, please call your local health department or the Virginia Department of Health, Division of Immunization, at 1-800-568-1929):

Signature of Physician or Health Department Official: _____ Date (Mo., Day, Yr.): [] [] []

PART II

CERTIFICATION OF SCHOOL HEALTH EXAMINATION

PART II TO BE COMPLETED BY A PHYSICIAN

(Reverses to be completed by parent/guardian)

Student's Name: _____; Birth Date: / /
LAST FIRST MI MO DAY YR

Height: _____; Weight: _____; Head Circumference: _____; BP: _____

Hemoglobin or Hematocrit: _____ gm%; Urine Albumin: _____; Sugar: _____; Other: _____

Most recent Tuberculin Test Date: / /; Results: _____; Hearing R _____; L _____
Mo Day Yr

Vision (w/out glasses) R20/ _____; L20/ _____; Hearing test performed? Audiogram _____; Voice _____

Vision (with glasses) R20/ _____; L20/ _____; Tympanogram (if indicated): normal _____; abnormal _____

Systems Examination	Exam.	Not Exam.	Comments About Findings
General Appearance, Nutrition			
Posture, Gait			
Skin			
Head			
Eyes: External			
Fundi			
Ears: External & Canal			
Tympanic Membrane			
Nose			
Throat			
Teeth			
Neck			
Heart			
Lungs			
Abdomen			
Genitalia (Tanner Stage)			
Bones, joints, muscles			
Neurological			
Other			
Est. of developmental level			
Behavioral Observations:			
Cooperation			
Emotional tone			
Activity level			

Summary of abnormal conditions which may require: (a) Educational evaluation, (b) Environmental adjustment, or (c) Activities to be limited:

Referrals made: _____

Physician (print): _____; Signature: _____; Date: / /

Address: _____; Phone: (_____) _____

PART III

CERTIFICATION OF IMMUNIZATION

Part III to be Completed by a Physician or Health Department Official

Student's Name: _____ DOB: / /
LAST FIRST MI MO DAY YR

Student's S.S. #: _____ ; I.D. #: _____

Parent/Guardian:

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES ADMINISTERED				
Diphtheria/Tetanus Pertussis (DTP)	/ /	/ /	/ /	/ /	/ /
Diphtheria/Tetanus (DT or Adult Td)	/ /	/ /	/ /	/ /	/ /
Poliomyelitis (OPV or IPV)	/ /	/ /	/ /	/ /	/ /
Measles (Rubella)	/ /	/ /	Serological Confirmation of Measles Immunity	/ /	/ /
Rubella	/ /	/ /	Serological Confirmation of Rubella Immunity	/ /	/ /
Mumps	/ /	/ /	Child Entered School Before 08/01/81	/ /	/ /
Measles, Mumps, Rubella (MMR)	/ /	/ /			
Hepatitis B Vaccine	/ /	/ /	/ /	Other	/ /

Haemophilus influenzae Type b (Hib Conjugate): PLEASE COMPLETE THE APPROPRIATE SECTION BELOW.

- Has received complete series of Hib vaccine in accordance with current recommendations of the AMERICAN ACADEMY OF PEDIATRICS OR THE U.S. PUBLIC HEALTH SERVICE.
- Has received the AGE-APPROPRIATE doses of Hib vaccine as recommended by the AMERICAN ACADEMY OF PEDIATRICS OR THE U.S. PUBLIC HEALTH SERVICE, the series will be completed on (RECORD COMPLETE DATE (month, day, year):
 Series Completion Date: / /
MO DAY YR
- Hib vaccine is not indicated because this child has had Hib disease at 24 months of age or older.
- Being over 30 months of age, this child is not required by law to have proof of immunization against Hib.

MEDICAL EXEMPTION: DTP / /; Td / /; OPV / /; Hib / /; Measles / /; Mumps / /; Rubella / /.
 As specified in 22.1-271.2.c(ii) of the Code of Virginia, I certify that administration of the vaccine(s) designated above would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify): _____

This contraindication is permanent / /, or temporary / / and expected to preclude immunization until _____

Signature of PHYSICIAN or HEALTH DEPT. OFFICIAL: _____ Date: / /

RELIGIOUS EXEMPTION: The Code of Virginia allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school for the first time after July 1, 1983, must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1) which may be obtained at any local health department, school division superintendent's office or local department of Social Services. Ref. Code 22.1-271.2, C(1), CODE OF VIRGINIA

*I certify that this student has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this student has a plan for the completion of his/her requirements within the next 90 days (conditional enrollment).

Signature of Physician or Health Dept. Official: _____ Date (mo, day, yr): / /

**I certify that this student is ADEQUATELY IMMUNIZED in accordance with the MINIMUM requirements for attending school prescribed by the State Board of Health on the reverse side of this form.

PART IV**MINIMUM IMMUNIZATIONS REQUIRED OF NEW STUDENTS BY THE
STATE BOARD OF HEALTH
FOR
*SCHOOL ATTENDANCE**

DTP: THREE (3) doses of DTP with one (1) of the three (3) administered after the fourth birthday. If any of these doses must be administered on or after the seventh birthday, ADULT Td should be used instead of DTP.

OPV: THREE (3) doses of trivalent OPV with one of the three administered after the fourth birthday or three (3) doses of eIPV with one of the three administered after the fourth birthday.

MEASLES: TWO (2) doses of live virus measles (rubeola) vaccine, one dose given at 12 months of age or older and a second dose administered prior to entering KINDERGARTEN or first grade, whichever occurs first, effective JULY 1, 1991.

RUBELLA: ONE (1) dose of rubella vaccine received at 12 months of age or older.

MUMPS: ONE (1) dose of mumps vaccine received at 12 months of age or older for students entering school on or after AUGUST 1, 1981.

***SCHOOL DEFINITION:** a) Any public school from kindergarten through grade 12 operated under the authority of any locality within this Commonwealth; b) Any private or parochial school that offers instruction at any level or grade from kindergarten through grade 12; c) Any private or parochial nursery school or preschool, or any private or parochial child care center licensed by this Commonwealth; and d) Any preschool handicapped classes or Head Start classes operated by the school divisions within this Commonwealth.

If there are questions please call your local health department.

S.S #: _____

IMMUNIZATION RECORD

VIRGINIA DEPARTMENT OF HEALTH

Name: _____ DOB: _____

	<u>DATE</u>	<u>DATE</u>	<u>DATE</u>	<u>DATE</u>	<u>DATE</u>
<u>DATE</u> Diphtheria/Tetanus/ Pertussis (DTP)	_____	_____	_____	_____	_____
Diphtheria/Tetanus (DT or Adult Td)	_____	_____	_____	_____	_____
Poliomyelitis (OPV or eIPV)	_____	_____	_____	_____	_____
Measles (Rubeola)	_____	_____	_____	_____	_____
Rubella	_____	_____	_____	_____	_____
Mumps	_____	_____	_____	_____	_____
Measles, Mumps, Rubella (MMR)	_____	_____	_____	_____	_____
Hepatitis B Vaccine	_____	_____	_____	_____	_____
Haemophilus Influenza type b (Hib)	_____	_____	_____	_____	_____
Serological Confirmation of Measles Immunity					_____
Serological Confirmation of Rubella Immunity					_____
*Child Entered School Before 08/01/81					_____
*(Mumps vaccine is not required if the child entered school before 08/01/81)					_____

This is an official replication of the vaccination record for the above patient. Dates of immunizations listed above either dates of vaccinations given or dates recorded with the Virginia Department of Health by the Patient.

Public Health Official
MCH 213C-SUPPLEMENT

_____ Date

**COMMONWEALTH OF VIRGINIA
CERTIFICATE OF RELIGIOUS EXEMPTION**

Name _____ Birth Date _____

Student I.D. Number _____

The administration of immunizing agents conflicts with the above named student's/my religious tenets or practices. I understand, that in the occurrence of an outbreak, potential epidemic or epidemic of a vaccine-preventable disease in my/my child's school, the State Health Commissioner may order my/my child's exclusion from school, for my/my child's own protection, until the danger has passed.

Signature of parent/guardian/student

Date

I hereby affirm that this affidavit was signed in my presence on

this _____ day of _____

Notary Public Seal

**COMMONWEALTH OF VIRGINIA
STUDENT IMMUNIZATION STATUS REPORT**

PLEASE TYPE OR PRINT ALL INFORMATION!

FACILITY: _____

MAILING ADDRESS: _____

CITY: _____ ZIP: _____

LOCATION: STREET: _____

COUNTY: _____ CITY: _____

PERSON PREPARING REPORT (PRINT): _____ TITLE: _____

SIGNATURE: _____ DATE: _____ PHONE: _____

TYPE OF FACILITY REPORTING

Please check one of the following:

PUBLIC SCHOOL PRIVATE SCHOOL PAROCHIAL SCHOOL HEAD START CHILD CARE CENTER

INSTRUCTIONS

- (1) Please complete this report using information in each student's school medical record.
- (2) Please refer to the back section of this form for the MINIMUM IMMUNIZATIONS REQUIRED BY THE CODE OF VIRGINIA
- (3) ALL SCHOOLS Please submit to the ADDRESS BELOW by _____

**VIRGINIA DEPARTMENT OF HEALTH
BUREAU OF IMMUNIZATION
1500 E. MAIN STREET, SUITE 120
RICHMOND, VIRGINIA 23219
PHONE (804) 786-6246**

COMPLETE THE SECTION(S) APPLICABLE TO YOUR FACILITY

Please note in each section, numbers in columns (b) through (f) should add together to equal the total number of students in column(s).

**SECTION I
CHILD CARE CENTERS, HEAD STARTS OR PRESCHOOLS**

(a) Number of Student Enrolled	(b) Number Adequately Immunized	(c) Number of Medical Exemption	(d) Number of Religious Exemptions	(e) Number of Conditionally Enrolled	(f) Number Without Records

**SECTION II
KINDERGARTEN OR FIRST GRADE IF THERE IS NO KINDERGARTEN (PUBLIC, PRIVATE,
PAROCHIAL)**

(a) Number of Students Enrolled	(b) Number Adequately Immunized	(c) Number of Medical Exemptions	(d) Number of Religious Exemptions	(e) Number Conditionally Enrolled	(f) Number Without Records

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Form SIS-2, Rev. 4/99

MINIMUM IMMUNIZATIONS REQUIRED OF NEW STUDENTS BY THE STATE BOARD OF HEALTH FOR SCHOOL ATTENDANCE

For more information, please refer to the Code of Virginia 22.1-271, Immunization Requirements and Section 3.00 of the Rules and Regulations for the Immunization of School Children.

DTP: THREE (3) doses of DTP with one (1) administered after the fourth birthday. If any of these doses must be administered on or after the seventh birthday, ADULT Td vaccine should be used instead of DTP.

OPV: THREE (3) doses of trivalent OPV or THREE (3) doses IPV (when OPV is medically contraindicated) with one administered after the fourth birthday.

MEASLES: TWO (2) doses of live virus measles (rubeola) vaccine, one (1) dose given at 12 months of age or older and a second dose administered prior to entering KINDERGARTEN or first grade, whichever occurs first, effective JULY 1, 1991. Two (2) doses of live measles vaccine shall also be required of students enrolling in grade six (6) in 1992 and thereafter. All other students should have received on (1) dose of live measles vaccine.

RUBELLA: ONE (1) dose of rubella vaccine received at 12 months of age or older.

MUMPS: ONE (1) dose of mumps vaccine received at 12 months of age or older for students entering school on or after August 1, 1981.

HEPATITIS B: For children born on or after January 1, 1994, three (3) doses of hepatitis B vaccine.

HAEMOPHILUS INFLUENZAE TYPE b (Hib): For children through 30 months of age, Hib conjugate vaccine should be administered as recommended by the American Academy of Pediatrics or the U.S. Public Health Service.

CONDITIONAL ENROLLMENT: In order for a student to be CONDITIONALLY ENROLLED, the student must have proof of having received at least one (1) dose of each of the required immunizations (DTP, OPV, MEASLES, MUMPS, and RUBELLA) and have a schedule on file to receive the remainder of the required doses within 90 DAYS.

RELIGIOUS EXEMPTIONS: The student or his parent or guardian submits a CERTIFICATE OF RELIGIOUS EXEMPTION (FORM CRE-I), to the admitting official of the school to which the student is seeking admission. Form CRE-I is an affidavit stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. The CRE-I must be signed by a NOTARY PUBLIC AND STAMPED WITH THE NOTARY'S SEAL.

MEDICAL EXEMPTIONS: The school must have written certification from a physician or a local health department on FORM MCH213C that one or more of the required immunizations may be detrimental to the

student's health. Such certification of medical exemption shall specify the nature and probable duration of the medical condition or circumstance that contraindicates immunization.

If there are questions regarding immunizations please call your local health department or the Bureau of Immunization at (804) 786-6246.

NUTRITION

- Yes No Abdominal pain
- Yes No Underweight or overweight for age
- Yes No Allergies related to foods: identify food and reaction

-
- Yes No Problems with elimination (bowel movement and/or urination)
-

OPERATIONS

- Yes No Appendectomy
 - Yes No Hernia
 - Yes No Tonsillectomy
 - Other _____
-

HANDICAPPING CONDITION

- Yes No Scoliosis
 - Yes No Spina bifida
 - Other _____
-

ORTHOPEDIC DEVICES

- Yes No Wheelchair
- Yes No Special shoes
- Yes No Crutches
- Yes No Braces
- Yes No Helmet

BLOOD DISORDERS

- Yes No Anemia
- Yes No Leukemia
- Yes No Hemophilia
- Yes No Sickle Cell Anemia

HEARING

- Yes No Frequent ear aches
- Yes No Running ear
- Yes No Hard of hearing
- Yes No Uses hearing aid

HABITS

- Yes No Sleeps/Rests well
- Yes No Exercises daily
- Yes No Eats well
- Yes No Bathes regularly
- Yes No Brushes teeth regularly

COMMUNICATION

- Yes No Speech understandable
- Yes No Stutters/stammers
- Yes No Lisps

VISION

- Yes No Wears glasses
- Yes No Rubs eyes frequently
- Yes No Squints
- Yes No Color blind

DENTAL

- Yes No Cavities
- Yes No Cleft lip or palate
- Yes No Gum disease
- Yes No Lost some or all baby teeth
- Yes No Permanent teeth appearing
- Yes No Wears dental braces

SKIN AND HAIR

- Yes No Visible scars
- Yes No Hives
- Yes No Scabies
- Yes No Body lice
- Yes No Head lice

MENTAL AND EMOTIONAL

- Yes No Bullies others
- Yes No Cries often
- Yes No Lethargic (slow/lazy)
- Yes No Short attention span
- Yes No Toilet trained
- Yes No Very sensitive
- Yes No Very shy
- Yes No Generally happy

Were there any prenatal or birth complications which affected the child?

Please indicate any other health conditions(s) your child has that is not covered on form.

Signed: _____
(Signature by parent/guardian)

Date: _____

VIRGINIA HIGH SCHOOL LEAGUE, INC.
1842 State Farm Blvd., Charlottesville, Va. 22911

Athletic Participation/Parental Consent/Physical Examination Form

Separate examination and certification required for each school year May 1 of the current year through June 30 of the succeeding year. File in the Office of the Principal.

For School _____

Part 1 - ATHLETIC PARTICIPATION

Male _____

Year _____

(To be filled in and signed by the student)

Female _____

Name _____ Social Security # _____

(Last) (First) (Middle Initial)

Home Address _____

City/Zip Code _____

Home Address of Parents _____

City/Zip Code _____

Date of Birth _____ Place of Birth _____

This is my _____ semester in _____ High School, and my _____ semester since first entering the ninth grade. Last semester I attended _____ School and passed _____ credit subjects, and I am taking _____ credit subjects this semester. I have read the condensed individual eligibility rules and risk statement of the Virginia High School League that appear below and believe I am eligible to represent my present high school in athletics.

INDIVIDUAL ELIGIBILITY RULES

Attention athlete (includes cheerleader)! To be eligible to represent your school in any VHSL interscholastic athletic contest, you—

- ◆ must be a regular bona fide student in good standing of the school you represent.
- ◆ must be enrolled in the last 4 years of high school. (Eighth-grade students may be eligible for junior varsity competition.)
- ◆ must have enrolled not later than the fifteenth day of the current semester.
- ◆ must have passed at least five credit subjects the immediately preceding year and must be currently taking not fewer than five credit subjects for participation during the first semester.
- ◆ must have passed at least five credit subjects the previous semester and must be currently taking not fewer than five credit subjects for participation during the second semester.
- ◆ must not have reached your nineteenth birthday on or before the first day of August of the current school year.
- ◆ must have been in residence at your present high school, or at a junior high school from which your high school receives its students during the entire semester immediately preceding the one in which you wish to participate.
- ◆ must not, after entering the ninth grade for the first time, have been enrolled in or been eligible for enrollment in high school more than eight consecutive semesters. [This rule also applies to a student who becomes "ungraded" for failure to earn a Literacy Passport. For this student, the eight consecutive semesters shall be counted continuously beginning with his/her first semester in the ninth grade or the first semester in which he/she become classified as "ungraded," whichever comes first.]
- ◆ must have submitted to your principal before any kind of participation, including tryouts or practice as a member of any school athletic or cheerleading team, an Athletic Participation/Parental Consent/Physical Examination Form, completely filled in and properly signed attesting that you have been examined during this school year and found to be physically fit for athletic competition and that your parents consent to your participation.
- ◆ must be an amateur as defined by the Virginia High School League: "An amateur is an athlete who engages in VHSL athletics solely for the educational, physical, mental, and social benefits he derives therefrom and to whom VHSL athletics are nothing more than an avocation.*"
- ◆ must not have received in recognition of your ability as a high school athlete any award not presented or approved by your school or the League.*
- ◆ must not be in violation of the VHSL all-star rule.*
- ◆ must not have been a member of a college team in the sport in which you wish to participate.*

*Italicized item does not apply to cheerleaders.

Eligibility to participate in interscholastic athletics is a privilege you earn by meeting not only the above-listed minimum standards, but also all other standards set by your League, district, and school. If you have any question regarding your eligibility or are in doubt about the effect an activity might have on your eligibility, check with your principal or athletic director for interpretations and exceptions provided under League rules. Meeting the intent and spirit of League standards will prevent you, your team, school, and community from being penalized.

LOCAL SCHOOL DIVISIONS AND VHSL DISTRICTS MAY REQUIRE ADDITIONAL STANDARDS TO THOSE LISTED ABOVE.

Student Signature _____

Date: _____

Providing false information will result in ineligibility for one year.

PART II – MEDICAL HISTORY

This form should be completed by parent and athlete prior to time of the physical examination and should be taken with physical examination form for review by the physician during the examination.

YES	NO	1.	Please explain any YES answers
_____	_____	Have you ever had any of the following?	_____
_____	_____	heart murmur	_____
_____	_____	high blood pressure	_____
_____	_____	other heart problems	_____
_____	_____	broken bones	_____
_____	_____	weak joints - ankles, knees	_____
_____	_____	contusion	_____
_____	_____	operation	_____
_____	_____	seizures or epilepsy	_____
_____	_____	2. Have you ever fainted or passed out?	_____
_____	_____	3. Have you ever been knocked out?	_____
_____	_____	4. Have you ever been hospitalized?	_____
_____	_____	5. Have you ever had to stop running after 1/4 to 1/2 miles for chest pain or shortness of breath?	_____
_____	_____	6. A. Have you ever had significant allergies to:	_____
_____	_____	bee stings - On medication- yes ___ no ___	_____
_____	_____	foods	_____
_____	_____	medicine	_____
_____	_____	others	_____
_____	_____	B. Do you have prescription for use of:	_____
_____	_____	Adrenalin	_____
_____	_____	Inhalers	_____
_____	_____	Other allergy medicine	_____
_____	_____	C. Do you have asthma?	_____
_____	_____	7. Do you take any medicine regularly?	_____
_____	_____	8. Have you any illnesses lasting a week or more such as mononucleosis, etc.?	_____
_____	_____	9. Have you had any blood disorders, including sickle cell trait, anemia, etc.?	_____
_____	_____	10. Has any family member had a heart attack, heart problems or sudden death before the age of 50?	_____
_____	_____	11. Do you wear contact lenses, eyeglasses or dental appliance?	_____
_____	_____	12. Do you have any missing or non-functioning organs such as testes, eye, kidney, etc.?	_____
_____	_____	13. Menstrual History: Have you begun menses yet?	_____
_____	_____	14. Do you have any other significant health problems?	_____
_____	_____	15. DATE OF LAST TETANUS IMMUNIZATION?	_____

PART III - PHYSICAL EXAMINATION

(To be completed and signed by examining physician)

NAME _____ SCHOOL _____

HEIGHT _____ SEX _____ AGE _____ GRADE _____

*Tanner Stage of Maturation Index _____ BP _____

*Percent Body Fat _____ *Pulse (rest) _____

(Exercise) _____

(Recovery) _____

*Vision: Corrected (L) _____ (R) _____ Both _____

Uncorrected (L) _____ (R) _____ Both _____

*Audiogram: _____ Cervical spine/neck _____

Back _____

Eyes _____ Shoulders _____

Ears _____ Arm/elbow/wrist/hand _____

Nose _____ Knees/hips _____

Throat _____ Ankle/feet _____

Teeth _____

Skin _____ Lab: _____

Lymphatics _____ *Urine _____

Lungs _____ *Hemoglobin or HCT _____

Heart _____ and/or Fe Stores _____

Abdomen _____

Genitalia/hernia _____

Peripheral pulses _____

***WHEN MEDICALLY INDICATED**

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics:

_____ Full Participation

_____ Limited Participation

_____ No Participation

_____ Needs Additional Evaluation

If not full participation give reasons & recommendations: _____

Any recommendations or concerns on such items as:

a. Weight loss or gain or restrictions of weight loss: _____

b. Slow and careful monitoring of conditioning because of being overweight or show an abnormal exercise testing: _____

c. Other _____

Physician Signature _____, M.D.* Date _____

Physician Name (print) _____

Address _____

City/Zip Code _____

Telephone Number _____

*Doctor of Medicine, Doctor of Osteopathy or Licensed Nurse Practitioner

PART IV -- ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT
 (To be completed and signed by parent/guardian)

I give permission for _____ to participate in any of the following sports that are
(name of child/ward)
 not crossed out: baseball, basketball, cheerleading, cross country, field hockey, football, golf, gymnastics, lacrosse, soccer, softball, swimming/diving, tennis, track, volleyball, wrestling, other (identify sports) _____

I have reviewed the individual eligibility rules and I am aware that with the participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts, or some other means. He/She has student accident insurance available through the school (yes ___ no ___); has football insurance coverage through the school (yes ___ no ___); is insured by our family policy with:

(Name of Company)
 Policy Number _____ Name of Insured _____

I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team.

I also give my consent and approval for my child/ward to receive a physical examination, as required in Part IV, Physical Examination, of this form, by _____ M.D., O.D. or LNP as recommended by the named student's school administration.

Additionally I give my consent and approval for the above named student's picture and name to be printed in any high school or VHSL athletic program.

Signature of parent/guardian _____ Date _____

PART V - EMERGENCY PERMISSION FORM*
 (To be completed and signed by parent/guardian)

STUDENT'S NAME _____ GRADE _____ AGE _____

HIGH SCHOOL _____ CITY _____

EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of _____ High School to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the person named above.

Daytime phone number (where to reach you in emergency) _____

Evening time phone number (where to reach you in emergency) _____

Signature of parent or guardian _____ Date _____

Relationship to student _____

*Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed.

Form 11 (Rev. 5-66)

CUMULATIVE HEALTH RECORD

ANNUAL PHYSICAL INSPECTION

FULL NAME _____ DATE OF BIRTH _____
 SEX _____ FIRST _____ MIDDLE _____
 SCARLET FEVER () SMALL POX () PERTUSSIS (WHOOPING COUGH) () CHICKEN POX () MUMPS () MEASLES ()
 RHEUMATIC FEVER () DIPHTHERIA ()

	CODE: NO DEFECT ○		DEFECT x		DEFECT CORRECTED ⊗		DEFECT BEING TREATED ⊕	
	YEAR	19	19	19	19	19	19	19
HEIGHT								
WEIGHT <small>(Circle if under or overweight)</small>								
VISION RIGHT								
VISION LEFT								
HEARING RIGHT								
HEARING LEFT								
TEETH								
THROAT								
SCOLIOSIS <small>(Put S on block if scoliosis is suspected. Circle if severe.)</small>								
POSTURE								
SPEECH								
PARENTS/GUARDIAN NOTIFIED ()								
EXAM (BY PHYSICIAN) ()								
EXAM (BY DENTIST) ()								

	IMMUNIZATION HISTORY *		REMARKS	
	DTaP MO, DAY, YR	MMR MO, DAY, YR	MEASLES MO, DAY, YR	Td (ADULT) MO, DAY, YR
19				
2nd				
3rd				
4th				
5th				

(Fill in no medical examination is given leave space blank)

MEDICAL AND DENTAL EXAMINATIONS

YEAR	RECOMMENDATIONS BY PHYSICIAN OR DENTIST	NAME OF PHYSICIAN OR DENTIST
19		Physician
		Dentist
19		Physician
		Dentist
19		Physician
		Dentist
19		Physician
		Dentist
19		Physician
		Dentist
19		Physician
		Dentist
19		Physician
		Dentist

COMMONWEALTH OF VIRGINIA

**Summary of Screening of Vision and Hearing
Report to Principal**

School: _____ Year: _____

Person Preparing Data: _____ Signature: _____
Principal or Designee

Check Level: _____ Elementary (Grade 3) Total student population _____
 _____ Secondary (Grade 7) Total student population _____
 _____ Secondary (Grade 10) Total student population _____

SCREENING	# SCREENED	NUMBER REFERRED FOR SUSPECTED DEFECT			NO REPORT FOLLOWING REFERRAL			NUMBER OF THOSE REFERRED THAT WERE SEEN BY HEALTH CARE PROVIDERS			NUMBER OF THOSE SEEN WITH CONDITION DIAGNOSED BY HEALTH CARE PROVIDER (Includes those seen once as well as those receiving ongoing active care)						
		BOY	GIRL	TOTAL	BOY	GIRL	TOTAL	BOY	GIRL	TOTAL	BOY	GIRL	TOTAL				
VISION																	
HEARING																	

* Screener should submit separate summaries for each designated grade level.

SUMMARY OF SCREENING OF VISION AND HEARING

School: Self explanatory

Year: School year - example: 1991-92

Person Preparing Data: The name and title of person who is collecting data.
Example: Mary Smith, RN, or Julia Brown, Teacher

Signature of Principal: Self Explanatory

Check Level: Check appropriate grade level.

Total Student Population: Total number of students in grade level checked above

Number Screened: Total number screened

Number Referred for Suspected Defect: (reported by gender and total) This is the number of suspected defects out of the total number screened.

No Report Following Referral: (reported by gender and total) This equals all those referred that no report or follow-up has been done.

Number of Those Referred That Were Seen By Health Care Providers:

This reflects those who were seen by an ophthalmologist, physician, optometrist or other health care provider for the suspected defect.

Number of Those Seen With Condition Diagnosed by Health Care Provider:

(reported by gender) This includes those seen once as well as those who may continue to receive ongoing care. This number reflects those with corrections even though it may take several visits or years to complete care. Once the child is under care for condition, the primary goal has been met.

Submit to Superintendent or Designee for compilation of the local school division's cumulative report.

COMMONWEALTH OF VIRGINIA
 Summary of Screening of Vision and Hearing
 School Division Report

School Division: _____ Year: _____

Person Preparing Data: _____

Check Level: _____ Elementary (Grade 3) Total student population _____
 _____ Secondary (Grade 7) Total student population _____
 _____ Secondary (Grade 10) Total student population _____

SCREENING	# SCREENED	NUMBER REFERRED FOR SUSPECTED DEFECT			NO REPORT FOLLOWING REFERRAL			NUMBER OF THOSE REFERRED THAT WERE SEEN BY HEALTH CARE PROVIDERS			NUMBER OF THOSE SEEN WITH CONDITION DIAGNOSED BY HEALTH CARE PROVIDER (includes those seen once as well as those receiving ongoing active care)		
		BOY	GIRL	TOTAL	BOY	GIRL	TOTAL	BOY	GIRL	TOTAL	BOY	GIRL	TOTAL
VISION													
HEARING													

Filed locally for administrative purposes.

L.F.010

3/95

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF EDUCATION
SCOLIOSIS REPORT

SCHOOL DIVISION: _____ DATE _____

NAME OF SCHOOL: _____

PERSON COMPLETING FORM: _____

TITLE OR POSITION: _____

RESULTS OF MEDICAL EXAMINATION OF REFERRED STUDENTS FROM THIS YEAR'S SCREENING PROGRAM.

GRADE LEVEL, AND SEX	NUMBER SCREENED	NUMBER SCREENED WITH SUSPECTED FINDINGS AND REFERRED THIS SCREENING	NUMBER OF RESPONSE TO REFERRAL	NUMBER SEEN BY PHYSICIAN AND REPORT INDICATES NO SIGNIFICANT FINDINGS	RESULTS OF MEDICAL EXAMINATION OF REFERRED STUDENTS								PREVIOUSLY DIAGNOSED AS SCOLIOSIS AND UNDER TREATMENT AT THIS TIME. IDENTIFY TYPE OF TREATMENT ON BACK OF FORM.	NO RESPONSE TO REFERRAL
					NUMBER SCOLIOSIS CASES DIAGNOSED	NO TREATMENT PRESCRIBED	REVIEW AS REQUESTED BY PHYSICIAN	EXERCISE AND/OR PT	BRACING	SURGERY	OTHER CONDITIONS DIAGNOSED (LIST ON BACK)			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	
5M														
5F														
6M														
6F														
7M														
7F														
8M														
8F														
9M														
9F														
TOTAL														

Numbers in columns 7, 8, 9, 10, and 11 should equal number in column 6.
Numbers in columns 5, 6, and 12 should equal the number in column 4.

COLUMN HEADING DEFINITIONS

Column 2 - The number in this column does not include those students having had surgery, braces, or undergoing treatment at this time. These should be included in column 13.

Column 3 - The number in this column are students with suspected findings and referred to a physician during this year. A student may be counted who was referred last year and did not receive treatment and was screened again this year and referred again. This includes those students whose physicians recommended no treatment last year but requested continued monitoring.

Column 6 - The number in this column includes all the students diagnosed as having scoliosis after being referred from column 3.

Column 12 - The number in this column includes all the students who have postural conditions and diagnosed as a condition other than scoliosis by the physician. List these conditions below:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Column 13 - No student in this column should have been included in any other column on this report.

_____	_____
_____	_____
_____	_____

Please compile and return to designated person within local school division.

Disposition: To be maintained and filed locally.

APPENDIX E: Sample Forms

- ◆ School Health Encounter Forms—Clinic Visits, Report to Parents, Nurse’s Notes
- ◆ Dental—Referral Form
- ◆ Scoliosis—Explanation/Parent Authorization Form
- ◆ Scoliosis—Referral Form
- ◆ Injury—Student Injury Report Form

HS-PC-7

Newport News Public Schools
Health Services
CLINIC REPORT TO PARENTS

School _____ Date _____

Name _____

To Parent or Guardian:

Your child was in the clinic today complaining of:

- stomachache earache
- headache injury
- sore throat other

If your child continues to have problems, you should have him/her checked by a physician.

Health Services Representative

The Newport News School Division does not discriminate on the basis of race, color, national origin, sex, creed, marital status, age, or disability in its programs, activities, or employment practices as required by the Title VI, Title VII, Title IX, Section 504, and ADA regulations. *Crawford Smith, Assistant Superintendent, Personnel Services at 12465 Warwick Boulevard, Newport News, VA 23606, (804-591-4550)*, is responsible for coordinating the division's efforts to meet its obligations under Section 504, Title IX, the ADA, and their implementing regulations.

**CHESTERFIELD COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES**

DATE: _____

Dear Parent/Guardian:

A dental screening was given _____ on _____.

The results of the screening indicate your child may have a dental problem that may need to be evaluated by a dentist. If your child is under the care of a private dentist, please indicate below and return this form to the school or have the dentist complete the form at your child's next visit. This information is necessary in order that your child's school health profile may be kept up-to-date.

If you do not have a family dentist, you may telephone the Dental Clinic located at Chesterfield Health Department at 748-1752 regarding dental resources.

Sincerely,

Public Health School Nurse

STUDENT: _____ SCHOOL: _____

TEACHER: _____ GRADE: _____

UNDER DENTAL CARE

Parent's Signature

Date

Dear Doctor:

Please complete the report below:

NAME: _____ SCHOOL: _____

FINDINGS RECOMMENDATIONS: _____

CORRECTED

BEING TREATED

Date

Dentist's Signature

Return this form to:
Chesterfield Health Department
P. O. Box 100
Chesterfield, VA 23832

SAMPLE

NORFOLK PUBLIC SCHOOLS
NORFOLK PUBLIC HEALTH DEPARTMENT

REFERRAL LETTER—SCOLIOSIS SCREENING

Date _____

Dear Parent:

Your child _____ participated in our school scoliosis screening program.

Although the results do not definitely mean that there is a problem or that treatment is needed, you are urged to take your child to your family physician, pediatrician or orthopedist for an examination.

The cause of scoliosis (curvature of the spine) is unknown. It becomes more apparent during adolescence and often can be corrected if discovered and treated early.

Please request the examining physician to complete this form. When your child has completed his/her examination (and you have signed the parent signature line*) please return this referral to the school nurse.

Thank you for your cooperation. Please feel free to call me if you have any questions.

	Poss. Abnorm.
1.	_____
2.	_____
3.	_____
4.	_____
5.	_____

	Ortho-team Check
1.	_____
2.	_____
3.	_____
4.	_____
5.	_____

Sincerely,

School Health Nurse
School: _____

PHYSICIAN'S FINDINGS AND RECOMMENDATION:

I have examined _____ on _____

() Standing (anterior-posterior x-ray) shows: _____

() No significant findings at this time _____

() Need for further evaluation _____

() Re-examination or treatment recommended (if so, Date _____)

Additional Comments: _____

Signed _____ M.D.

Address _____

Telephone No. _____

* _____
Parent's Signature Line

Henrico County Schools Student Injury Report Form

This form is to be completed immediately following the occurrence of any injury that is serious enough to warrant parental notification. *Additional instructions on back.*

1. Child's name _____	5. Date of birth ____/____/____ mo day yr	8. Date of injury ____/____/____ mo day yr
2. Parent's name _____	6. Grade _____	9. <input type="checkbox"/> Male <input type="checkbox"/> Female
3. School name _____	7. Time of injury ____ <input type="checkbox"/> am <input type="checkbox"/> pm	10. Fatal <input type="checkbox"/> Yes <input type="checkbox"/> No
4. School # _____		

11. Days absent: *Record letter of the DAYS absent from school related to this injury in box at left.*

<input type="checkbox"/> a) Less than 1/2	<input type="checkbox"/> b) 1/2	<input type="checkbox"/> c) 1	<input type="checkbox"/> d) 1 1/2-2	<input type="checkbox"/> e) 2 1/2-3	<input type="checkbox"/> f) If more than 3 days, then specify # _____
---	---------------------------------	-------------------------------	-------------------------------------	-------------------------------------	---

12. Action Taken: **PLEASE CHECK AND COMPLETE ALL THAT APPLY.**

	Time	By Whom (List title code.) (Title codes on back)
1. <input type="checkbox"/> First aid administered	____ <input type="checkbox"/> am <input type="checkbox"/> pm	Specify name _____
2. <input type="checkbox"/> Parent or guardian notified	____ <input type="checkbox"/> am <input type="checkbox"/> pm	Specify name _____
3. <input type="checkbox"/> Unable to contact parent/guardian	____ <input type="checkbox"/> am <input type="checkbox"/> pm	
4. <input type="checkbox"/> Remained in or returned to class		9. <input type="checkbox"/> Called 911
5. <input type="checkbox"/> Sent/taken home		10. <input type="checkbox"/> Taken to M.D., health care provider, hospital, etc. Diagnosis _____
6. <input type="checkbox"/> Parents deemed no medical action necessary		11. <input type="checkbox"/> Hospitalized. Specify length _____
7. <input type="checkbox"/> Checked by school nurse		12. <input type="checkbox"/> Restricted school activity. Specify length _____
8. <input type="checkbox"/> Checked by clinic attendant		88. <input type="checkbox"/> Other, specify _____

13. Nature of Injury: *List the injuries/symptoms incurred. (Record # in boxes at left.)*

<input type="checkbox"/> More Severe	1. Abrasion/Scrape	5. Cut/Laceration	9. No Pulse	13. Shortness of Breath
<input type="checkbox"/> Less Severe	2. Bump/Bruise/Contusion	6. Dislocation (possible)	10. Not Breathing	14. Sprain/Strain/Tear
	3. Burn/Scald	7. Fracture/Broken (possible)	11. Pain/Tenderness Only	15. Swelling/Inflammation
	4. Contusion (possible)	8. Loss of Consciousness	12. Puncture	88. Other _____

14. Area Affected: *List area affected for each injury/symptom code listed in 13 above. (Record # in boxes at left.)*

	Head	Trunk	Extremities						
<input type="checkbox"/> More Severe	1. Chin/Cheek	4. Forehead	7. Nose	10. Stomach	13. Chest/Ribs	16. Internal	19. Ankle	22. Finger/Thumb	25. Knee
<input type="checkbox"/> Less Severe	2. Ear	5. Mouth/Tongue/Lip	8. Head	11. Back	14. Collarbone	17. Pelvis/Hip	20. Arm	23. Foot	26. Leg
	3. Eye	6. Neck/Throat	9. Tooth/Teeth	12. Buttocks	15. Genitalia	18. Shoulder	21. Elbow	24. Hand/Wrist	27. Toe

15. Cause of Injury: *List main cause of the injury. (Record # in box at left.)*

<input type="checkbox"/>	1. Animal bite (dog bite, etc.)	4. Contact with sharp edge/object	7. Foreign body in eye, ear, nose	10. Struck by object	88. Other _____
	2. Collision with object/person	5. Fall	8. Jam/Crush/Pinch	11. Tripped/Slipped	99. Unknown
	3. Contact with fire, hot liquid/object	6. Fight/Roughhouse	9. Motor vehicle crash		

16. Period: *List period during which injury occurred. (Record # in box at left.)*

<input type="checkbox"/>	1. After school (authorized)	3. Athletic event	5. Before school (authorized)	7. Class time (exclude P.E.)	9. Lunch	11. Recess	99. Unknown
	2. Assembly	4. Athletic practice session	6. Class change	8. Field trip	10. P.E. class	88. Other _____	

17. Surface: *List surface on which injury occurred. (Record # in box at left.)*

<input type="checkbox"/>	1. Not applicable	3. Carpet	5. Grass/Dirt	7. Hardwood Floor	9. Mats	11. Sand	88. Other _____
	2. Blacktop	4. Concrete	6. Gravel	8. Ice/Snow	10. Mulch/Wood chips	12. Tile	99. Unknown

18. Location: *List location at which injury occurred. (Record # in box at left.)*

<input type="checkbox"/>	1. Athletic field	4. Classroom	7. Gymnasium	10. Multipurpose Room	13. Sidewalk/Stairs/Ramp	88. Other _____
	2. Blacktop	5. Corridor (exclude stairs)	8. Lab (Home Ec., Chem., etc.)	11. Playground/Playfield	14. Street/Driveway/Parking area	
	3. Bus loading area	6. Doorway	9. Lunchroom	12. School bus/Public bus	15. Restroom	99. Unknown

19. Activity: *List activity during which injury occurred. (Record # in box at left.)*

<input type="checkbox"/>	1. Baseball/Softball	6. Dodge ball	11. Jumping/Skipping	16. Roughhousing	21. Standing	27. Wrestling
	2. Basketball	7. Fighting	12. Kickball	17. Setting up/Moving equipment	22. Swinging	88. Other _____
	3. Bicycling	8. Flag/Touch football	13. Lab/Shop activities	18. Sliding	24. Tennis	99. Unknown
	4. Classroom activity	9. Football	14. Riding bus	19. Sitting	25. Volleyball	
	5. Climbing bars	10. Gymnastics/Tumbling	15. Running	20. Soccer	26. Walking	

20. Equipment: Was equipment or apparatus involved in injury? Yes No Specify equipment _____

21. Underlying medical condition(s)? Yes No Specify _____

22. Description: Describe specifically how the injury happened and treatment provided.

23. _____ 24. Title code _____ 25. _____
Signature of person making report Principal's signature

**Henrico County Schools
Student Injury Report Form Instructions**

This form is to be completed immediately following the occurrence of any injury that is serious enough to warrant parental notification.

Item #

- 1–10 Self explanatory.
- 11 If student is going to be absent for an extended period of time, use parent's estimate. If no school is missed, check less than 1/2.
- 12 **Check and complete all that apply.** List title code (from the codes that follow) and name of person(s) who perform first aid and who notify parents.

Title Codes

- | | |
|------------------------|-------------------------------|
| 1. Advisor/Counselor | 8. School Nurse |
| 2. Assistant Principal | 9. Secretary/Office Aid |
| 3. Bus Driver | 10. Substitute Teacher |
| 4. Clinic Attendant | 11. Teacher (excluding Coach) |
| 5. Coach | 12. Trainer |
| 6. Paramedics / EMT | 88. Other |
| 7. Principal | |

- 13 Of the injuries the child sustained, list whichever is the most severe in the box labeled "more severe" (even if you consider the injury to be minor). The other box is used only if there is more than one injury to the child.
- 14 List the area affected in the "more severe" box that corresponds to the injury listed in the "more severe" box in #13. Do the same for the less severe box.
- 15–16 Self explanatory. **Choose one answer only.**
- 17 Describe surface over which injury occurred (i.e. surface upon which child fell or on which child was standing, running, playing, etc. at the time of injury). **Choose one answer only.**
- 18–19 Self explanatory. **Choose one answer only.**
- 20 If yes, specify type of equipment or apparatus.
- 21 If there was some type of underlying medical condition that possibly contributed to the injury incident, please specify.
- 22 Briefly describe specifically how the incident happened and the treatment provided. If there were witnesses, please list names at the end. **If additional space is needed, continue on another sheet of paper and attach.**
- 23 Self explanatory.
- 24 Choose one of the codes listed above.
- 25 Self explanatory.

Retain original in school. Send copy to:

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