# School Health Services Guidelines

## SCHOOL HEALTH SERVICES GUIDELINES COMMITTEE

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# FOREWORD

The School Health Services Guidelines is intended to aid the school nurse in providing a comprehensive health program in the context of the requirements of New Jersey Statutes and regulations. Along with guidance from the school physician, it is the school nurse who provides most school health services. The school nursing profession is rooted in caring for others, and its mission remains to advocate for student health needs. To accomplish this mission, the school nurse draws upon knowledge from medical. educational and psychosocial disciplines.

**The terms "certified school nurse " and " school nurse" are used throughout this document. Both terms refer to school staff who hold the registered nurse license from the State Board of Nursing. Certified school nurses hold an additional credential issued by the Department of Education, State Board of Examiners. Each district board of education is required to appoint at least one full time equivalent certified school nurse to provide nursing services, and certain health services functions and duties are reserved for the certified school nurse under the provisions of administrative code (see N.J.A.C. 6A:16-2(e)). In reading the Guidelines, it is important to keep these distinctions in mind.**

The Department of Education is pleased to issue the School Health Services Guidelines with the hope that is will prove of value and support toward the goal of helping children stay healthy so that they can achieve their full potential while in school.

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# 1. School Health Services Guidelines

## Overview

### WHY DO WE NEED SCHOOL HEALTH SERVICES?

The goal of school health services is to strengthen and facilitate the educational process by improving and protecting the health status of children and staff. Parents/guardians, childcare workers, and educational professionals know that the health and intellectual development of children are inextricably related. For this reason, the need for nursing services in schools has been recognized since the early twentieth century. State mandates have accordingly required services to prevent the spread of infectious disease, to detect developmental problems, and to assist students who become ill or injured. In New Jersey, laws concerning school health services were first enacted in 1903.

Certain health services are mandated by the state because they are necessary either to protect the public health or to support the continuing participation of children in school. For instance, screening of students for current immunization helps to reduce absences due to illness. Screening for reduced vision or hearing identifies the need for equipment or accommodations to remove obstacles to learning. School health services staff provide physical and emotional support so that children can better cope with periodic illness and injury, which are commonly a part of growing up. Increasingly, schools also provide daily support to students with chronic health needs who require these services in order to participate in educational settings, whether regular or special education. Such daily services may include administration of medication, glucose blood monitoring, inhalation therapy, or maintenance of tubes and catheters. Other examples of mandated school health services are listed below, together with their function in supporting community health and student educational participation.

**Table 1.1 Educational Functions of Mandated School Health Services**

| Mandated School Health Service | Related Educational Function |
|---|---|
| immunizations for school attendance | prevention of epidemics and illness in the school and community |
| exclusion of students with infectious conditions | reduction of absenteeism for students and staff |
| athletic physicals | assurance that students are healthy to participate in athletic competition |
| vision and hearing screening | identification of potential barriers to learning |
| care for urgent illness or injury | creation of a safe, secure environment |
| care of special needs students | optimization of learning during time in school |
| administration of medication | reduction of absences |

In the modern school, health services contribute significantly to the total school climate and enhance the day-to-day functioning of students and staff. Students need to know that their physical needs will not be ignored by school staff. Parents/guardians need to understand what health services the school can (and cannot) provide, and how to coordinate care delivered at home with that provided at school. Every member of the staff must be knowledgeable regarding the general health services provided by the school, and aware of the special health needs of students in their classroom. Typically, coordination of school health services is provided by a certified school nurse, who provides direct services, maintains records, trains staff, facilitates exchange of health information, and reviews policy and programs in relation to student health needs. Even the best school nurse cannot carry the game, however, since school health is a "team sport."

## A COORDINATED SCHOOL HEALTH PROGRAM

School health services are only one component of a coordinated school health program. Diane Allensworth and Lloyd Kolbe first described a model school health program as having eight components, as shown in figure 1.1, below. This model can serve as a basis for review and evaluation of district school health programs.

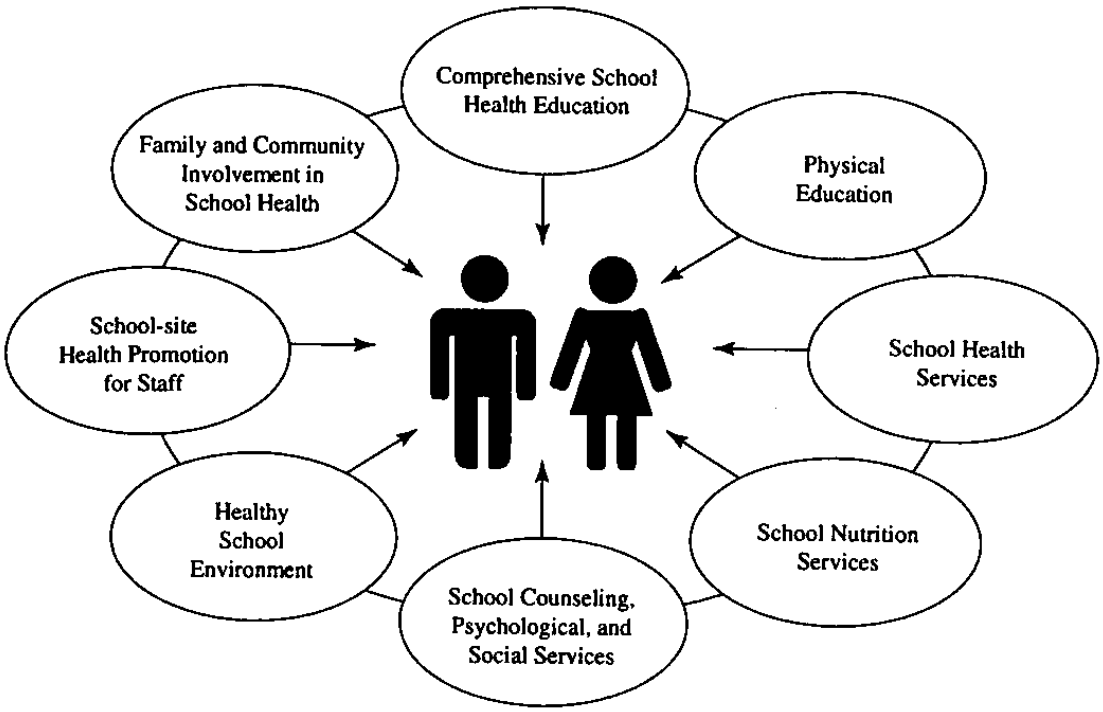


**Figure 1.1 A Coordinated School Health Program**

The National Parent Teacher Association (PTA) emphasizes the role of parent/guardian and community involvement in all school activities, overall coordination of school health programs, and integrated services. The term "coordinated school health programs" embodies an understanding that school health programs can be effectively organized in many ways, but must include a set of core functions. Approaches to coordination of the components vary. The PTA defines integrated services as:

> *... the coordinated delivery of education, health, and social services designed to improve the quality of life for individuals and families. The most ambitious efforts seek to link delivery of a full scope of services through traditional institutions including schools and human service agencies. Programs developed to integrate services vary from community to community according to local need. They may be known as school-linked services, community service centers, family resource centers, full service schools, school based youth services, integrated delivery services, or community centers.*[1]

Coordination among the components of a school's health program are not mandated in New Jersey, though more limited coordination is required through the functions of the school-based Intervention and Referral Services Team[2] (all public schools), Family Support Team[3] (Abbott district elementary schools), and health and social services coordinators[4] (Abbott secondary schools). Modest approaches to coordination make use of school-based teams, advisory groups, and assigned staff support. Many organizations, including the American Cancer Society, recommend the use of a school-community advisory group to build support and establish an ongoing exchange of information between staff involved in various aspects of the school health program.[5]

Whatever the method or means used, deliberate and ongoing coordination of the components is necessary to achieve an effective school health program, since all areas in a comprehensive school health program are either linked or overlap. The communication process established in each school should provide for clear and concise direction for all staff. As new health services issues arise, a school must be ready to address these needs, also, for the benefit of students.

New Jersey school districts are not required to duplicate services that students can obtain through their own medical homes, or their arrangements with health care providers, covered by health insurance programs. Neither are districts precluded from providing services such as administration of vaccines, conduct health screenings, or provision of athletic physicals at their own discretion. However, districts must assure that such services are conducted by qualified personnel, meet professional standards of practice, and are delivered in appropriately equipped facilities. These issues are discussed in Chapters 2 and 3. Districts can reduce the cost of delivering these services by encouraging participation in health insurance programs, including New Jersey Family Care. District staff time and effort spent on increasing household participation in New Jersey Family Care may avoid greater district costs in delivery of services at a later date. Information regarding organizing school health facilities in school buildings is available from the American Academy of Pediatrics and other organizations, summarized in brief in Chapter 10.

## SCHOOL HEALTH SERVICES PERSONNEL

The Programs to Support Student Development rules provide a framework for the establishment of the school district health services team. The following summarizes these provisions:

- N.J.A.C. 6A:16-2.1(a)-(d): Each district board of education must appoint at least one school physician pursuant to N.J.S.A. 18A:40-1. The physician must be currently

[1] http://www.pta.org/programs/intgsvc.htm
[2] N.J.A.C. 6A:16-7 Intervention and Referral Services
[3] N.J.A.C. 6A:24-4.1(i)8
[4] N.J.A.C. 6A:24-1.4(h) and N.J.A.C. 6A:24-4.1(i)8
[5] Improving School Health: A Guide to School Health Councils. American Cancer Society. 1998

licensed by the N.J. Board of Medical Examiners and have training and practice that includes child and adolescent health and development. This section clearly delineates the minimum duties of the school physician, who serves as the health services director and provides consultation to the district board of education, administrators, and staff, as well as direction for professional duties of other medical staff and the establishment of standing orders.

- N.J.A.C. 6A:16-2.1(e) & (f): Each district board of education must appoint at least one full time equivalent certified school nurse and may assign one or more noncertified school nurses to perform duties permitted under their license provided that each school nurse is assigned to the same school building or school complex as a certified school nurse. Section 2.1(e) clearly delineates the duties of the certified school nurse.
- N.J.A.C. 6A:16-2.1(f): Each district board of education must establish a school nursing services plan, in consultation with the school physician.

The school nurse is a health services specialist who assists students, families, and staff in attaining and maintaining optimal health and health attitudes. School nurses strengthen and facilitate the educational process by improving and protecting the health status of children and staff, and by identifying and assisting in the removal or modification of health-related barriers to the learning process.

It is important to keep in mind that school physicians and school nurses operate under the powers and limitations of their professional medical and nursing (N.J.S.A. 45:11-23) licenses when they function as healthcare providers in the context of an educational institution. The certified school nurse may also provide instruction under the provisions of the certificate issued by the State Board of Examiners.

**Resources**

**Centers for Disease Control and Prevention**
School Health Programs: An Investment in Our Nations Future
http://www.cdc.gov.

**National Governor's Association Center for Best Practices**
(For resources for policymakers seeking to address the link between student health and achievement. With support form the Centers for Disease Control and Prevention, the Center will continue to identify health-related issues to which policymakers should respond to improve academic performance.)
http://www.nga.org/

National Governors Association

Hall of States

444 N. Capitol St.

Washington, DC 20001-1512

Telephone: 202-642-5300

Marx, E., & Wooley, S. F. (1998). *Health is academic*. NY: Teachers College Press.

## References

Allensworth, D. (1995). *The comprehensive school health program: Essential elements* unpublished manuscript).

California Department of Education. (1999). *Healthy start works – Evaluation report: A statewide profile for healthy start sites*. Sacramento: Author. (Available at http://www.cde.ca.gov/cyfsbranch/lsp/eval/evalworks.htm)

Marx, E., & Wooley, S. F. (1998). *Health is academic*. NY: Teachers College Press.

N.J.A.C. 6A:16

Stern, B. Freehold Township Schools: "Job Description – School Nurse." Freehold, NJ: Freehold Township Schools.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. *School health programs: An investment in our nation's future*. (Available: http://www.cdc.gov)

# 2. Health Assessments

## Topic 2A: Conducting Health Assessments

The law and rules of the N.J. State Board of Education and the N.J. Department of Health and Senior Services require that each district board of education adopt policies regarding the content and procedures for the administration of student medical examinations. In order to insure that the learning potential of each student is not diminished by a remediable physical disability, that the student is able to participate in the school program, and that the school community is protected from the spread of communicable disease, certain physical examinations are required.

Each student medical examination must be conducted by a healthcare provider or advanced practice nurse chosen by the student's parent/guardian at the provider's facility (the student's "medical home"), and a full report of the examination – documented on an approved school district form, dated, and signed by the medical provider – must be presented to the school. If a student does not have a "medical home," the district may provide the examination at the school physician's office or other appropriately equipped facility.

**Authorization**

N.J.A.C. 6A:16-2.2 & N.J.S.A. 18A:40-4 require district boards of education to adopt policies regarding content of and procedures for the administration of student medical examinations.

N.J.A.C. 6A:14-3.4(a)1 requires that the child study team, the parent/guardian, and the regular education teacher who has knowledge of the student's education performance, review existing evaluation data on the student and consider the need for any health appraisal or specialized medical evaluation.

N.J.A.C. 6A:14-3.4(h) requires that upon receipt of a written referral to the child study team, the school nurse must review and summarize available health and medical information regarding the student and must transmit the summary to the child study team for the meeting according to N.J.A.C. 6A: 14-3.4(a)1 to consider the need for a health appraisal or specialized medical evaluation.

N.J.A.C. 6A:16-2.2(e) stipulates that the examination must be documented on a form approved by the Commissioner of Education.

N.J.A.C. 6A:16-2.2(e.1) & N.J.S.A.8:57-4.1 - 4.16 require that students be immunized as per the revised Chapter 14 regulations.

N.J.A.C. 6A:16-2.2(h) specifies Athletic Pre-Participation Physical Examination Requirements.

N.J.A.C. 34:2-8(3) states that students will be examined when applying for working papers.

### PROTOCOL

**Required Physical Examinations:**

**Note:** By law, information concerning a student's HIV/AIDS status cannot be required as part of the physical examination or health history.

1. Each student must be examined upon entry into the school district. This examination must be done no more than 365 days prior to entry and must state what, if any, modifications are required for full participation in the school program.

2. The district board of education must notify parents/guardians of the importance of obtaining subsequent examinations at least once during each of the student's developmental stages:
   - early childhood (pre-school through grade 3)
   - pre-adolescence (grades 4 through 6)
   - adolescence (grades 7 through 12)
3. Students who undergo comprehensive child study team evaluation may have to be examined, as per N.J.A.C. 6A:14-3.4.
4. Each candidate for a school athletic squad or team is to be examined within 365 days prior to the first practice session, with examination being made available by the school physician for those students who do not have a medical home (see **Examination Requirements for Participants on School Athletic Squads or Teams**, below).
5. Each student who applies for working papers is to be examined, as required by N.J.S.A. 34:2-8(3) (see **Examination Requirements for Working Papers Applicants**, below).
6. Every student between the ages of 10 and 18 is to be screened annually for scoliosis, as required by N.J.S.A. 18A:40-4.3.
7. Any student who is suspected of being under the influence of alcohol and/or controlled dangerous substances is to be examined, in accordance with N.J.S.A. 18A:40A-12 and 6A:16-4.3.
8. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

**Examination Requirements for Participants on School Athletic Squads or Teams**

1. The medical examination must include a health history questionnaire, completed and signed by the parent/guardian, to determine whether the student:
   - has been medically advised not to participate in any sport, and the reason for such advice
   - is under a physician's care, and the reasons for such care
   - has experienced loss of consciousness after an injury
   - has experienced a fracture or dislocation
   - has undergone any surgery
   - takes any medication on a general basis, and the names of and reasons for such medication
   - has allergies including, but not limited to; hives, asthma or reactions to bee stings
   - has experienced frequent chest pains or palpitations
   - has a recent history of fatigue and undue tiredness
   - has a history of fainting with exercise
   - has a history of a family member who died suddenly
2. The medical examination must include a physical examination that, at a minimum, includes the following:
   - measurement of weight, height, and blood pressure
   - examination of the skin to determine the presence of infection, scars from previous surgery or trauma, jaundice, and purpura
   - examination of the eyes to determine visual acuity, use of eyeglasses or contact lenses, and examination of the sclera for the presence of jaundice

**Examination Requirements for Participants on School Athletic Squads or Teams**, continued ...

- examination of the ears to determine the presence of acute or chronic infection, perforation of the eardrum, and gross hearing loss
- examination of the nose to assess the presence of deformity that may affect endurance
- assessment of the neck to determine range of motion and the presence of pain associated with such motion
- examination of chest contour
- auscultation and percussion of the lungs
- assessment of the heart with attention to the presence of murmurs, noting rhythm and rate
- assessment of the abdomen with attention to the possible presence of hepatomegaly, splenomegaly, or abnormal masses
- assessment of the back to determine range of motion or abnormal curvature of the spine
- examination of extremities to determine abnormal mobility or immobility, deformity, instability, muscle weakness or atrophy, surgical scars, and varicosities
- examination of the testes to determine the presence and descent of both testes, abnormal masses or configurations, or hernia
- assessment of physiological maturation
- neurological examination to assess balance and coordination

3. The medical report must include a recommendation concerning the student's participation from the examining healthcare provider, advanced practice nurse, or physician's assistant.

4. Each candidate whose medical examination was completed more than 60 days prior to the first practice session must provide a health history update of medical problems experienced since the last medical examination. This must be completed and signed by the parent/guardian. The health history update must include the following information:
   - hospitalization/operations
   - illnesses
   - injuries
   - care administered by a physician of medicine or osteopathy, advanced practice nurse, or physician's assistant
   - medications

5. Each district must provide written notification, signed by the district physician, to the parent/guardian, stating approval of the student's participation in athletics based upon the medical examination or the reasons for the disapproval of the student's participation. The health findings of the medical examination for participation must be made part of the student's individual health record and must be documented on a form issued by the Commissioner of Education.

6. The health findings of the medical examination must be maintained as part of the student's individual health record (A-45 New Jersey Health History and Appraisal) **Appendix 2A**.

**Examination Requirements for Working Papers Applicants**
The examination must be documented on a form approved by the Commissioner of Education (A-45) and include the following components:

1. the student's immunization record

Students must be immunized as per revised Chapter 14 regulations. **Appendix 2A**

3. results of the student's health screenings, including height, weight, hearing, blood pressure, and vision
4. the results of the student's physical examination

**Definitions**

The terms below are defined in **N.J.A.C. 6A: 16**, as follows**:**

**Health History**

The record of student's past health events obtained by school staff from the individual, a parent/guardian, or healthcare provider.

**Health Screening**

Procedures designed to detect previously unrecognized conditions as early as possible in order to provide early intervention and remediation and to limit potential disability or negative impact on scholastic performance.

**Medical Examination**

The assessment of an individual's health status.

**Medical Home**

A healthcare provider (physician or advanced practice nurse) and that provider's practice site chosen by the student's parent/guardian for the provision of healthcare.

**Medical Staff**

Employees of the district board of education serving as school physician, certified or noncertified school nurse, advanced practice nurse, registered nurse, licensed practical nurse, or certified athletic trainer.

**Physical Examination**

The examination of the body by a professional who is licensed to practice medicine or osteopathy, or an advanced practice nurse. For the purpose of this chapter, the term includes very specific procedures required by statute as stated in N.J.A.C. 6A:16-2.2.

**Other Definitions**

**Appropriately Equipped Facility**

A facility that ensures privacy for the student and is properly furnished with the necessary equipment and personnel to facilitate a physical examination.

**Documentation of Services**

1. The results of all health assessments must be reported on a district-approved form provided to the parent/guardian; these must be dated and signed by the healthcare provider.
2. Record the results of health assessments on a form approved by the Commissioner of Education (form A-45) and file the reports with the student's individual health record.
3. Share information about medical conditions that may impact upon a student's education with those who have a "need to know;" however, confidentiality issues must be taken into account (see **Chapter 7: Topic 7E**).

**Accompanying Critical Issues**

1. It is essential that district boards of education develop policies that delineate the time limit for providing entry examinations. Although kindergarten entrance physicals must be completed prior to entry, it would seem prudent to allow up to 60 days for students moving into a district. This allows the family to obtain records from their previous healthcare provider or advanced practice nurse, or to locate a new medical home.
2. The signature of the medical provider is required in order to accurately document the contents of the report.

**Resources**

Bates, B. (2000). *A guide to physical examination and history taking* (8th ed.). Philadelphia: J.B. Lippincott.

**References**

Chapter 14, NJ Sanitary Code – Immunization of Students in Schools (NJ Administrative Code Citation 8: 57-4.1 to 8:57-4.19). Adopted August 14, 2000; effective September 18, 2000.

State of New Jersey – Department of Education/Department of Health – A-45 Card.

State of New Jersey – Department of Labor forms related to working papers.

## Topic 3A: Auditory Screening

The purpose of a school auditory screening program is to identify students with any hearing loss that may impact their intellectual, emotional, social, speech, or language development. The subtlety of a hearing loss may lead to that hearing loss being overlooked. 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 educational and vocational choices

The school auditory screening program can play an important role in ensuring that no hearing loss that could result in further developmental or academic delays goes undetected and unmanaged. School screening programs generally focus on pure tone recognition. However, history, external observation of the ear, and visual inspection of the ear using an otoscope should also be used. Tympanometry – which is supported by the N.J. Department of Education in the document entitled *Technical Assistance Document for the Evaluating Students with Hearing Impairments* – is optional.

Auditory screenings are endorsed by the American Academy of Pediatrics, American Academy of Otolaryngologists, and the American Speech-Hearing-Language Association.

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|---|---|
|  | **Authorization**<br>N.J.A..C. 6A:14-3.3(g); 6A:16-2.1(f); & 6A:16-2.2(e)3; N.J.S.A. 18A:4-15 & 18A:40-4<br>Health Screenings include height, weight, hearing, blood pressure and vision. |

### PROTOCOL

**The Role of the Board of Education**
The district board of education must develop and adopt policies and procedures for the provision of audiometric screenings.

Screenings must be conducted for students who are:

- enrolled in pre-school programs
- enrolled in grades kindergarten through 4
- enrolled in grades 6, 8, and 10
- entering the district with no recent record of audiometric screening
- at risk for hearing impairments
- referred to the child study team for evaluation
- referred for screening by a teacher, a parent/guardian, or at the student's own request
- at risk for noise exposure

Screenings must be conducted by the certified school nurse, or a registered nurse under the supervision of the certified school nurse.

**The role of the school nurse:**

1. Prior to the screening, consult the **Equipment** table, below, to determine that the equipment you need is available and in good working order.
2. Explain the procedure to the student to reduce the student's anxiety;
3. Consult the **Documentation of Services** table, below, to document each screening.
4. Screen each student individually at 20dB HL in a quiet screening area at the following frequencies: 500Hz, 1000Hz, 2000Hz, 3000Hz, and 4000Hz.
5. If a student fails the first screening, use an otoscope to look into the external ear canal and identify any condition which could interfere with hearing. Tympanometry may be used at this time. If there is a possible problem, notify the student and parent/guardian and recommend a medical examination.
6. Rescreen a student who fails to respond to any one frequency in either ear in two to four weeks.
7. If a student fails to respond to the same frequency or frequencies in the same ear on the second valid screening, the student must be considered to have failed the screening and should be referred for further evaluation.
8. A student who fails to respond at a different frequency or different frequencies on the second screening must be considered to have failed the screening. Rescreen this student in two weeks.
9. A student who fails to respond at any one frequency on the third screening must be considered to have failed the screening. Refer this student for further evaluation.
10. TYMPANOMETRY REFERRAL. Students with flat tympanograms, low static compliance (Peak Y), or abnormally wide tympanogram should be rescreened in 4 to 6 weeks. If they have the same results, a referral should be made.
11. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

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|---|
| **Equipment –** Audiometric screening must be conducted with an audiometer which is calibrated annually in accordance with ANSI S3.6-1969, American National Standard Specifications for Audiometers. The examiner must decide on the proper testing equipment by realizing the limitations of the individual child:<br>• For small children, the picture audiometer may be used.<br>• For children with disabilities or special needs who cannot respond to traditional audiometric testing, otoacoustic emissions screening may be used. |

| | |
|---|---|
|  | **Documentation of Services** |
| | 1. Document services under sweep check on a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Health Record). |
| | 2. Document referral(s), follow-ups, and parent/guardian conferences on the reverse of A-45. |
| | 3. File any healthcare provider documentation with the student's individual health record. |

**Accompanying Critical Issues**

When a student fails the school's audiometric screening, notify the parent/guardian in writing – with an accompanying audiogram – of these results and of the need for additional evaluation by the family healthcare provider. Follow up on the results.

- Offer to assist parents/guardians if they need help in obtaining medical follow-up.
- Develop an Individualized Healthcare Plan or appropriate supportive measure for the student if healthcare provider input determines a positive diagnosis with implications/orders for the school setting. **Appendix 3A**
- For information on screening out-of-district students, consult **Chapter 4: Topic 4D: Out-of-District Placements**.

**Resources**

**American Academy of Pediatrics**
http://www.aap.org

**American Academy of Otolaryngology**
http://www.ent.org

**American Speech-Hearing-Language Association**
http://www.asha.org

**Audiology Information**
http://www.audiologyinfo.com

**Programs for Children and Youth Who Are Deaf or Hard of Hearing**
Division of the Deaf and Hard of Hearing
NJ Department of Human Services
P. O. Box 074
Trenton, NJ 08625-0074
Contact: Carol Grant, Acting Director
Phone: 609-984-7281 (V/TTY)
Phone: 800-792-8339 (V/TTY, in NJ only)

**References**

Cooperman ,S. (1987). *Technical assistance document for evaluating students with hearing impairments*. Trenton, NJ: Department of Education.

National Association of School Nurses. (1998). *The ear and hearing.* Scarborourgh, ME: Author.

Welch Allyn, Inc. (1996). *A guide to the use of diagnostic instruments in eye and ear examinations* [pamphlet]. Available: Welch Allyn, Inc., State Street Road, Skaneateles Falls, New York 13153-0220.

# Topic 3B: Blood Pressure Screening

High blood pressure in children can signal the possibility of serious underlying problems, such as heart or kidney disease. The American Heart Association and the American Academy of Pediatrics strongly recommend annual blood pressure checks for all children above the age of 3. Identification of children who have elevated blood pressure allows their healthcare provider to evaluate the cause and institute proper treatment to reduce their risk of cardiovascular disease as they grow into adulthood.

**Authorization**

N.J.A.C. 6A:14- 3.3(g) & 6A:16-2.2(e)3

N.J.S.A. 18A:40-4

Health Screenings include height, weight, hearing, blood pressure, and vision.

## PROTOCOL

**The role of the school nurse:**

1. Prior to the screening, consult the **Equipment** table, below, to determine that the equipment you need is available and in good working order.
2. Consult the **Documentation of Services** table, below, to document the blood pressure screening.
3. Explain the procedure to the student to reduce the student's anxiety.

Some clinicians obtain the blood pressure near the end of an examination/visit. Techniques of examination should be appropriate to age and with correct sizing of the compression cuff.

4. Consult the **Definitions** table and the **Blood Pressure Classification Charts**, below, to evaluate the blood pressure reading.

   If either the systolic or diastolic reading is higher than the levels shown on charts, allow the student to rest about 15 minutes, then take two blood pressure readings 30 to 60 seconds apart.
5. Consult the **Accompanying Critical Issues** table, below, to determine any additional actions to take.
6. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

**Equipment**

Use a mercury or aneroid manometer, a compression cuff, and a stethoscope. Note the following points about this equipment:

- Be sure the inflatable compression cuff is long enough to encircle the upper arm completely, with or without overlap.
- Be sure the cuff is wide enough to cover at least 3/4 of the upper part of the arm and impart a uniform pressure over its full width.
- Place the center of the inflatable latex bag over the brachial artery.
- Keep several inflation systems accessible to assure that the proper cuff size is available for those being assessed.
- Regularly check the stethoscope to see that the earpiece is clean and that the diaphragm is intact.
- Recalibrate the aneroid instrument periodically to prevent it from becoming inaccurate with repeated use, as is common with aneroid instruments.

**Documentation of Services**

1. Document services on a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Cumulative Health Record).
2. Document all referrals, follow-up, and parent/guardian conferences on the reverse side of form A-45.
3. File any healthcare provider documentation with the student's individual health record.

**Definitions**

See the charts that follow to determine classification of hypertension by age group, gender, and percentile height. The 1987 Task Force on Blood Pressure Control in Children defined:

**Normal BP**

Systolic and diastolic BPs <90th percentile for age and sex

**High Normal BP***

Average systolic and/or average diastolic BP between 90th and 95th percentiles for age and sex

If the BP reading is high normal for age, but can be accounted for by excess height for age or excess lean mass for age, such children are considered to have normal BP.

**High BP (hypertension)**

Average systolic and/or average diastolic BPs > 95th percentile for age and sex with measurements obtained on at least three occasions

## BLOOD PRESSURE CLASSIFICATION CHARTS

The National High Blood Pressure Education Program Working Group on Hypertension Control in Children and Adolescents published percentiles and suggested the following classification of hypertension by age group, gender, and percentile of height.[6]

**Chart 1. Blood Pressure Levels for the 90th and 95th Percentiles of Blood Pressure for Boys aged 1-17 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

[6] See **References**, below.

## Chart 2. Blood Pressure Levels for the 90th and 95th Percentiles of Blood Pressure for Girls aged 1-17 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

**Accompanying Critical Issues**

When a referral is necessary for additional evaluation by a healthcare provider, the parent/guardian should be notified in writing. The results of school screenings should be included in the notification.

- Refer student promptly for medical evaluation if blood pressure is systolic over 150/diastolic over 100.
- Take multiple blood pressure measurements on multiple occasions to provide input for the medical provider.
- Refer any student with elevated blood pressure at or above 95th percentile for age and sex on three or more consecutive occasions to medical provider as directed by school physician protocol.
- Offer to assist parents/guardians if they need help in obtaining medical follow-up.
- Rescreen all students with blood pressure referrals for follow-up annually.
- Develop an Individualized Healthcare Plan for the student if healthcare provider input determines a positive diagnosis with implications/orders for the school setting.
- Refer to **Chapter 4: Topic 4D: Out-of-District Placements** to determine actions for out-of-district students.

## Resources

**American Academy of Pediatrics**
http://www.aap.org

**American Heart Association**
http://www.aha.org

**Centers for Disease Control**
http://www.cdc.gov

## References

Bates, B. (2000). *A guide to physical examination and history taking* (8th ed.). Philadelphia: J.B. Lippincott.

Hootman, J. (1996). *Quality nursing interventions in the school setting: Procedures, models, and guidelines*. Scarborough, ME: National Association of School Nurses.

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), 649-658.

Task force on Blood Pressure Control in Children. (1987). Report of the second task force on blood pressure control in children. *Pediatrics, 79*, 1-25.

# Topic 3C: Dental and Oral Health Screenings

Tooth decay is the single most common chronic disease of childhood. The American Dental Association recommends that children visit the dentist regularly. This allows for the identification and treatment of dental problems at an early stage, before serious damage occurs. The Surgeon General has stated that oral health is essential to the general health and well-being of all Americans, and believes that there are disparities in children's oral health and access to dental care.

The members of the dental team include the dentist and the dental hygienist. A school-based dental health program may include dental screenings, a fluoride mouth-rinse program, and dental health education.

**Authorization**

N.J. statutes do not require the employment of a dentist or implementation of a dental examination program. However, there may be a need for such a program in some schools. The extent of the dental services provided should be determined jointly by the school and community, based on the identified needs of students and lack of public and/or private services.

## PROTOCOLS

### Fluoride Mouth Rinse Program

A fluoride mouth-rinse program is normally provided for children and youth ages 5 through 18 who live in fluoride-deficient areas. A school program may consist of weekly rinsing with a 0.2% solution of neutral sodium fluoride.

### Dental Screenings

Dental screenings encourage student awareness of the value of maintaining oral/dental health by promoting comfort with the dental professional and referral of defects. To arrange such a program, the school nurse schedules screening dates with the dentist, sends home permission forms, and notifies classroom teachers of the impending schedule. On the day of screening, the nurse monitors student appointments and assists the specialist.

### Dental Health Education

The school nurse provides dental health education informally as she assesses oral injuries and when other concerns are presented in the health office. Topics for review at the student's level of understanding may include dental development, oral hygiene, diet, fluoride, dental visits, and mouth protectors.

### Inspection of the Oral Cavity

The school nurse's inspection of the oral cavity can include examination of the teeth, gums, tongue, sublingual veins, frenulum, buccal mucosa, palate, and uvula.

**Documentation of Services**

1. Document services on a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Cumulative Health Record).
2. Document all referrals, follow-up, and parent/guardian conferences on the reverse side of form A-45.
3. File any healthcare provider documentation with student's individual health record.

**Accompanying Critical Issues**

Anytime screening results deviate from the normal, notify the parent/guardian in writing of these results and of the need for additional evaluation by a healthcare provider. Follow up on the results.

- Develop intervention protocols for all dental concerns. These should indicate when referrals are to be made.
- Offer to assist parents/guardians if they need help in obtaining medical follow-up.
- Share information about available community resources with families if they are not linked with a dental healthcare provider.

**Resources**

**American Dental Association**
http://www.ada.org

**American Academy of Pediatric Dentistry**
http://www.aapd.org

**American Society of Dentistry for Children**
http://www.asdc.org

**Creighton University Pediatric Dentistry**
Cudental.Creighton.edu/htm/pedo.htm

**NJ Dental Association**
http://www.njda.org

**NJ Dept. of Health and Senior Services, Division of Family Health**
P.O. Box 364, Trenton, NJ 08625-0364
Contact: Beverly Kupiec, RDH, BS
Phone: 609-292-1723

**Southern Jersey Family Medical Center**
238 East Broadway, Salem, NJ 08079
Contact: Debbie Tracey, RDH, BS, Regional Dental Consultant
Phone: 856-935-6100 ext. 5

**Resources**, continued

**Bergen County Department of Health**
327 Ridgewood Ave., Paramus, NJ 07652
Contact: Jackie Tiffinger, RDH, BA, Regional Dental Consultant
Phone: 201-599-6159 ext. 5

**Middlesex County Department of Health**
Administration Building
5th Floor, JFK Square, New Brunswick, NJ 08901-3605
Contact: Mary Ann Hanus, RDH, BS, Regional Dental Consultant
Phone: 732-745-3135/3100

**Local County Dental Society**

**References**

U.S. Surgeon General. (June 2000). U.S. Surgeon General's workshop on children and oral health: Preliminary report of findings. Washington DC: Government Printing Office.

# Topic 3D: Measurement of Height and Weight

A screening program that assesses and monitors the growth of school-age children must be implemented in each school district. If possible, each child's height and weight should be measured and recorded annually. A periodic monitoring program allows the school nurse to identify and refer, in an appropriate and timely fashion, those children who do not appear to be growing normally.

Annual height and weight measurements provide a simple, effective method of identifying significant childhood health problems. Deviation in normal growth patterns can result from any of the following:

- systemic disorders (e.g. malnutrition)
- intestinal conditions
- psychosocial conditions (e.g., eating disorders)
- congenital disorders (e.g. Turner's Syndrome, intrauterine growth retardation)
- 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/guardians, 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 an individual's sense of responsibility for his or her own growth and development

The American Academy of Family Physicians, the U.S. Preventive Task Force, and the American Academy of Pediatrics all recommend yearly screenings of height and weight. The American Medical Association recommends screening adolescents annually for eating disorders and obesity by measuring height and weight and by asking about body image and dieting patterns.

**Authorization**

N.J.A.C. 6A:16-2.2(e)3

Health Screenings include height, weight, hearing, blood pressure, and vision.

## PROTOCOL

**The role of the school nurse:**

1. Prior to the screening, consult the **Equipment** table, below, to determine that the equipment you need is available and in good working order.
2. Explain the procedure to the student to reduce the student's anxiety.
3. Ask the child to remove his/her shoes, head coverings, and any bulky clothing.
4. Situate student on the measuring device following the instructions that accompany the equipment and measure the student's height and weight.
5. Consult the **Documentation of Services** table, below, to document the student's height and weight.

6. Consult the **Definitions** table, below, to evaluate student growth.
7. Consult the **Accompanying Critical Issues** table, below, to determine any additional actions to take.
8. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

| |
|---|
| **Equipment**<br>Ideally, measurement devices and scales should be recalibrated before the start of the screening program or once a school year. |
| **Height**<br>The best way to measure height is with a stadiometer. The device has a flat vertical surface on which a measuring rule is attached. It has a movable headpiece, and either the student stands on the device's permanent surface or the entire device is mounted on the wall of a room with a level floor and the student stands on the floor. If a floppy arm device attached to a scale is used, remember there may be an error as great as 1 SD. |
| **Weight**<br>Measure weight on a standard balance beam or a digital (electronic load cell or strain gauge) scale. |

| **Documentation of Services** |
|---|
| 1. Document all services on a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Health Record). |
| 2. **Recommendation:**<br>Deviations from the norm may be plotted on National Center for Health Statistics (NCHS) Growth Charts (a sample Growth Chart is provided in **Appendix 3D**; consult the Accompanying Critical Issues table for plotting recommendations). |
| 3. **Recommendation:**<br>Body mass index (BMI) – while not required – could also be calculated at this time using the NCHS Body Mass Index for Age Percentiles Charts (sample BMI charts are provided in **Appendix 3D**). |
| 4. Document all referrals, follow-up, and parent/guardian conferences on the reverse side of form A-45. |
| 5. File any healthcare provider documentation with the student's individual health record. |

**Definitions**

**Normal Growth**

The range of normal height and weight varies for each child, but general growth remains relatively constant.

After rapid growth in the first two year of life, growth generally slows down to 2 to 2 1/2 inches per year until puberty (approximately 11 to 13).

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 normal growth curves for children of the same age and sex; they should fall between the 5th and 95th percentile on a standardized growth chart.

**Obesity**

The NCHS BMI charts (see **Documentation of Services**, above) may be helpful in determining obesity. Refer any child in the 95 percentile or above for weight for further evaluation.

**Accompanying Critical Issues**

When screening results deviate from the norm, notify the parent/guardian in writing of these results and of the need for additional evaluation by the family healthcare provider. Follow up on the results.

The following conditions warrant a referral by the certified school nurse:

- weight for age or height greater than the 95th percentile
- weight for age or height, or height for age, less than the 5th percentile
- dramatic change in student growth pattern (e.g., a student who has been consistently at the 50th percentile drops to the 10th percentile or rises to the 90th percentile)
- significant weight loss (10% or more of body weight)

- In-school growth assessment cannot confirm or rule out a growth problem. This must be done at the child's medical home with a careful evaluation.
- The certified school nurse should be knowledgeable of medical conditions that may affect proper growth, and should be aware of any medication that the child is on that may affect his/her growth rate. S/he should serve as a resource person for the family and provide in-school support for the student with a gross disorder.
- Offer to assist parents/guardians if they need help in obtaining medical follow-up.
- Develop an Individualized Healthcare Plan for the student if healthcare provider input determines a positive diagnosis with implications/orders for the school setting.
- Refer to **Chapter 4: Topic 4D: Out-of-District Placements** to determine actions for out-of-district students.

## Resources

**American Academy of Family Physicians**

http://www.aafp.org

**American Academy of Pediatrics**

http://www.aap.org

**American Medical Association**

http://www.ama-assn.org

**Center for Disease Control**

http://www.cdc.gov

**U.S. Preventive Service Taskforce**

http://www.ahcpr.gov

## References

Bates, B. (2000). *A guide to physical examination and history taking* (8th ed.). Philadelphia: J.B. Lippincott.

Kelly, K. (2000). Body mass weighs in against childhood fat. *US News and World Report* [On-line]. Available: http://www.usnews.com/usnews/issue/000612/nycu/fat.htm

Parker, S. H. (1992). Early detection of growth disorders. *Journal of School Nursing*, *8*(3), 30-41.

# Topic 3E: Medicaid Funding for School-Age Youth

A school district that provides nursing services to a student who is eligible for Medicaid may claim Medicaid funds for these needed health services. Case-finding screening activities may include vision acuity status, hearing acuity status, dental deviations, blood pressure abnormalities, and growth disorders.

The N.J. Department of Treasury administers two separate and distinct Medicaid reimbursement programs: Direct Service Claiming and Administrative Claiming. Districts must be pre-enrolled to participate in these programs.

**Authorization**

Medicaid: A federal/state medical assistance program for low income families through Title XIX of the Social Security Act.

## DIRECT SERVICE CLAIMING

### Special Education Medicaid Initiative – SEMI

This Medicaid reimbursement initiative – the Special Education Medicaid Initiative (SEMI) – provides a means of cost recovery for certain direct services provided to Medicaid-eligible special education students aged 3 to 21. SEMI is limited to services provided in educational settings under the auspices of the Commissioner of Education. Eligible SEMI services include:

- physical therapy
- occupational therapy
- speech services
- counseling
- nursing services

The State of New Jersey and its Local Education Agencies (LEAs) file claims for these services through the SEMI system. Medicaid reimburses 50% of the costs submitted. These funds are considered revenue to the State and LEAs and are classified as discretionary funds.

Prior to claims being submitted, districts must meet certain federal and state requirements to be eligible. The Department of Education and the Department of Human Services require LEAs to fulfill specific criteria prior to their registration with the State's billing vendor, DMG Maximus. The Department of Treasury's Division of Administration coordinates interactions among the Department of Education, Department of Human Services, DMG Maximus, and LEAs.

## ADMINISTRATIVE CLAIMING

### Early Periodic Screening, Diagnosis, and Treatment – EPSDT

This Medicaid reimbursement initiative – the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program – provides a means of cost recovery for a wide range of administrative activities associated with services provided to Medicaid-eligible students and their families. These services can include:

- Medicaid outreach (identifying, contracting, informing, referring, and updating Medicaid-eligible families about program benefits to which they are entitled)
- Medicaid enrollment
- program planning
- interagency collaboration
- policy development
- monitoring of Medicaid services
- training outreach staff (when these activities are related to Medicaid-covered health and mental services)

Administrative claiming can be a reliable source of funding for tasks that are normally difficult to fund. Medicaid reimburses 50% of the costs submitted. These funds are considered revenue to the State and LEAs and are classified as discretionary funds. LEAs retain 15% of the reimbursed funds.

## EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM

Children in families with low income can receive comprehensive and interim screening, diagnosis, and medically necessary treatments through the EPSDT program. Medicaid will also pay for therapeutic treatments and procedures to Medicaid-eligible children with disabling conditions or chronic illness. Components of EPSDT screening include:

- a comprehensive health and developmental history
- a comprehensive, unclothed physical examination
- appropriate immunizations
- laboratory tests
- health education (including anticipatory guidance)

## SEMI REGISTRATION

Registration procedures are usually handled by the district's Special Education Coordinator. The success of the school-based Medicaid project depends on registering all the Medicaid eligible special education students receiving health-related services.

In order for the district to receive reimbursement, the services provided – such as administration of medication – must be included in the student's Individual Education Plan (IEP). Changes to the IEP require that a meeting of the IEP team be convened.

It is recommended that consent be obtained from all parents/guardians of special education students. Consent forms are available in Spanish/English and should become a routine part of the IEP process. Providing parents/guardians with self-addressed, stamped envelopes results in a higher rate of return.

Districts may use the free-school-lunch list to identify special education students who may be Medicaid-eligible.

## CATEGORIES OF SCHOOL NURSING SERVICES FOR MEDICAID REIMBURSEMENT

Eligible case finding screening activities include:

- health history review
- developmental maturation/milestones
- vision and hearing acuity status
- speech development
- dental deviations
- spinal deviations
- blood pressure abnormalities
- growth and nutritional disorders

Eligible nursing care procedures can include:

- administration of immunizations
- assessment, monitoring, and administration of medication
- nursing assessment and intervention
- specialized care procedures (such as feeding, catheterization, ostomies, respiratory, medical support services, medications, specimen collecting, and the development of protocols)
- care coordination
- student health counseling and instruction
- emergency care

**Accompanying Critical Issues**

- For important distinctions about the care of preschool, disabled children, refer to **Appendix 4B: The Role of the School Nurse With 3- to 5-Year-Old Children With Disabilities**.

**Documentation of Services**

1. Be sure that all services for which reimbursement will be sought are specified in the student's Individualized Education Program.
2. For children who receive special services, document services as completed on a specific date, indicate the student either has a current IEP or was referred for evaluation, and specify the practitioner who provided the service.
3. Document services provided by a certified school nurse, a registered nurse licensed in New Jersey, or a licensed practical nurse.
4. All services rendered to the child must be reported to the Billing Unit on the appropriate turnaround document (see Appendix 3E).

## Resources

**MAXIMUS**
Contact: Lori Bembry, SEMI Field Team Manager
Phone: 1-800-618-SEMI ext. 200

**NJ Department of Education**
Office of Special Education Programs
Bureau of Program Review and Approval
Contact: Elaine Lerner, Education Program Development Specialist
Phone: 609-984-7902

**NJ Department of the Treasury**
Office of Administration
Contact: Nancy Kuprewicz, SEMI/EPSDT Coordinator
Phone: 609-633-9069

## References

National Association of School Nurse Consultants. (August 1993). *A position statement of the National Association of School Nurse Consultants: Medicaid reimbursement for school nursing services*. Kent, OH: Author. (Available: http://lserver.aea14.k.iaus/swp/tadkins/nassnc)

National Association of School Nurses. (1994). *School-based EPSDT program training and presentation manual for school nurses*. Scarborough, ME: Author. (Available: http://www.nasn@nasn.org,)

Maximus, NJ. Department of the Treasury, Office of Administration. (1999). *Special education Medicaid initiative (SEMI) provider handbook*. Trenton, NJ: Author. (Contact person: Nancy Kuprewicz, 609-633-9069.)

# Topic 3F: Scoliosis Screening

Revised March 2002

Scoliosis is a lateral curvature of the spine most commonly detected during the adolescent growth period. It is estimated that between 5% and 10% of school children have such a curvature to varying degrees. However, only about 2% of these curvatures are significant. If someone else in the family has scoliosis, the likelihood of incidence is much higher – approximately 20%. The effect of scoliosis depends upon its severity, how early it is detected, and how promptly it is treated.

By law, every N.J. board of education must provide scoliosis screening of every student between the ages of 10 and 18. The goal of this mass screening program is early identification, because curvatures can often be controlled if detected early. Students diagnosed with scoliosis should be under the care and supervision of a family healthcare provider or clinic. Referral to an orthopedist or orthopedic clinic may also be indicated.

**Authorization**

N.J.A.C. 6A:16-2.2(f); N.J.S.A. 18A:40-4.3 to 4.5 &. A-1183 Pamphlet Law 2000c.126 9-21-00

Every board of education must provide the biennial examination of every student between the ages of 10 and 18.

## PROTOCOL

Screenings must be conducted by a school physician, school nurse, physical education instructor, or other school personnel properly trained in the screening process.

**The role of the school nurse:**

1. Prior to the screening, inform parents/guardians in a written communication that is understandable to them that all students aged 10-18 will be screened for scoliosis.

   

   Any student must be exempt from the examination upon the written request of a parent/guardian.

2. Conduct the screening using the Scoliosis Screening Technique:
   - Explain the procedure to the student to reduce the student's anxiety.
   - Screen each student for scoliosis individually in a well-lit private area.
   - Have the student stand with his/her exposed back to screener.
   - Check for the following:
     - unequal shoulder levels
     - symmetry of scapulae
     - symmetry of flanks
     - uneven or greater crease at one side of waist
     - unequal distance between and the elbow when both arms are hanging straight down from the shoulder
   - Have the student face the screener and bend 90 degrees at the waist, feet together, knees straight, and arms hanging in front with palms together.
   - The screener may sit facing student to check the following:
     - a rib hump (one side of upper back higher than the other)
     - hump in both upper and lower back
     - levels of the back on both sides of the spine

- Have the student turn to the side and bend; check symmetry of both sides of the spine and look for a smooth continuous curve of spine.

Optional: If available, a scoliometer may be used. The scoliometer is placed over thoracic and lumbar regions, with the middle of the meter over the spinal column. Degrees should be noted.

3. Consult the **Documentation of Services** table, below, to document the scoliosis screening.
4. Consult the **Accompanying Critical Issues** table, below, to determine any additional actions to take.
5. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

**Documentation of Services**

1. Document all screenings on a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Cumulative Health Record).
2. Document all referrals, follow-up, and parent/guardian conferences on the reverse side of form A-45.
3. File any healthcare provider documentation with the student's individual health record.

**Accompanying Critical Issues**

When screening results deviate from norm, notify the parent/guardian in writing of these results and of the need for additional evaluation by the family healthcare provider. Follow up on the results.

- Refer students with clearly identified abnormalities to the healthcare provider immediately; referral to an orthopedist or orthopedic clinic may also be indicated.
- Questionable curvatures should be rescreened by the school nurse and may be examined by the school physician before any referral is made to the parent/guardian.
- Notify the parent/guardian of each student suspected of a problem in writing; explain the significance of the findings and the need for further evaluation by the appropriate healthcare provider. **Appendix 3F**
- When notifying parents/guardians, include a form on which the examining healthcare provider can record findings and recommendations. This form should be returned to the school nurse.
- Offer to assist parents/guardians if they need help in obtaining medical follow-up.
- Develop an Individualized Healthcare Plan for the student if healthcare provider input determines a positive diagnosis with implications/orders for the school setting.
- Refer to **Chapter 4: Topic 4D: Out-of-District Placements** to determine actions for out-of-district students.

## Resources

**American Academy of Orthopedic Surgeons**
http://orthoinfo.assos.org

**Alfred I. duPont Hospital for Children**
1600 Rockland Road, P.O. Box 269, Wilmington, DE 19899
Phone: 302-651-4000
http://www.kidshealth.org

**Children's Hospital of Philadelphia**
34th Street & Civic Center Blvd., Philadelphia, PA 19104-4399
Phone: 215-590-1100
http://www.chop.edu

**Shriner's Hospital For Children – Philadelphia**
3551 North Broad St., Philadelphia, PA 19140
Phone: 215-430-4000
Fax: 215-430-426
http://www.shrinersshq.org

**UMDNJ Robert Wood Johnson Medical School**
671 Hoes Lane, Piscataway, NJ 08854
Phone: 908-235-4557
http://rwjmsumdnj.edu

**UMDNJ Medical School**
185 South Orange Ave., Newark, NJ 07103
Phone: 201-982-4539
http://njms.umdnj.edu

**Scoliosis Research Society**
http://srs.org

## References

Bates, B. (2000). *A guide to physical examination and history taking* (8th ed.). Philadelphia: J.B. Lippincott.

Block, C. E. (1998). Scoliosis: School screening specifics. *School Nurse, March/April*, 6-7.

Keim, H. (1978). Scoliosis: Clinical symposia. Summit, NJ: CIBA.

National Association of School Nurses. (1995). Postural screening guidelines for school nurses [under revision]. Scarborough, ME: Author.

# Topic 3G: Vision Screening

In order to detect visual impairment, the vision screening process is essential for all children enrolled in the school. Vision problems affect the development, adjustment, and achievement of the child. Children with vision problems are often not aware of their difficulty, nor do they seek help or complain. Impaired vision in children can:

- seriously affect their learning abilities, leading to educational problems and limited academic success
- lead to poor self esteem and social isolation
- result in emotional and behavioral problems
- negatively impact on the child's educational and vocational choices

National studies indicate that 20% to 25% of children aged 5-14 have vision problems that require professional eye care. Among 15-19 year olds, this ratio increases to 30%. Ideally, vision screening should be done annually throughout the child's school years. School screening programs generally focus on visual acuity and color discrimination and are designed **only** to identify students who may need further evaluation.

To standardize the vision screening process and to facilitate the detection of vision impairments, the American Academy of Pediatrics, the American Association of Pediatric Ophthalmology on Strabismus, and the American Academy of Ophthalmology have endorsed vision screening guidelines for use by all pediatric vision screening professionals (including physicians, nurses, educational institutions, and public health departments).

**Authorization**
N.J.A.C. 6A:14-3.3(h) & 6A:16-2.2(e)3
N.J.S.A. 18A:4-15 & 18A:40-4
Health Screenings include height, weight, hearing, blood pressure, and vision.

## PROTOCOL

**The Role of the Board of Education**
The district board of education must develop and adopt policies and procedures for the provision of vision screenings.

Vision screening should be conducted, at a minimum, at the following grade/age levels:

- preschool (3 to 4 years)
- kindergarten ( 5 to 6 years)
- 2nd grade (7 to 8 years)
- 4th grade (8 to 9 years)
- 6th grade (10 to 11 years)
- 8th grade (13 to 14 years)
- 10th grade (15 to 17 years)

The following students also should be screened for vision problems:

- all new students
- all students registering for driver education
- all teacher-referred children who show signs or symptoms of visual problems, experience scholastic failure, or have reading difficulties or other learning problems (e.g., dyslexia)
- all children at high risk of having vision disorders (i.e., children with disabilities and special needs)
- all children referred to child study team for evaluation

**The Role of the School Nurse:**

Vision screenings must be conducted by the certified school nurse, or a registered nurse under the supervision of the certified school nurse.

1. Prior to the screening, consult the **Equipment** table, below, to determine that the equipment you need is available and in good working order.
2. Consult the **Documentation of Services** table, below, to document the vision screening.
3. Explain the procedure to the student to reduce the student's anxiety.
4. **First screening.** Screen each student individually for visual acuity.

   

   Visual acuity may be tested at 10, 15, or 20 feet, using the appropriate chart for the distance. For young children, the distance of 10 feet may result in better compliance due to closer interaction with the examiner.
5. Check each student's eyes for the absence of disease or anomaly.
6. Ideally, screening for color deficiency is recommended in the second semester of first grade because of educational implications. The Ishihara test is recommended and comes with instructions with which the nurse should become familiar before beginning the test.
7. **Optional.** Perform any of the following optional tests:
   - **Hirschberg Test** (muscle balance test). This test estimates the corneal light reflex from the center of the pupil of the eye.
   - **Alternative Cover Test** (muscle balance test). This test observes the eye movements when each eye is alternately covered and uncovered.
   - **Near Vision.** This test measures the ability to see at eight to 10 inches.
   - **Worth Four-Dot Test** (stereopsis). This is a clinical test for fusion or binocular cooperation.
8. Consult the **Screening Referral Criteria** table, below, to evaluate the results of visual acuity testing.
9. Notify parents/guardians of all students who did not perform satisfactorily during both the first visual acuity screening and the subsequent retest. Refer these students for further evaluation. (For more information on notification and referrals, see the **Accompanying Critical Issues** table, below.)
10. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

**Equipment**

**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
- Leah Hyvarienen (LH) Test

The Titmus tester may be used in place of charts utilizing the Michigan Preschool Series.

The MTI Photo Screener may be used in the identification of serious eye disorders and with small children who are difficult to screen.

Appropriate charts should be used for preschool screenings.

**Screening Referral Criteria**

Visual acuity of 20/20 is considered excellent for children of all ages. Although the National Society to Prevent Blindness recommends the referral criteria below, a visual acuity of 20/40 has been found to be a practical referral level.

**Screening Referral Criteria for Professional Exam Visual Acuity Test (1997):**

**Three-Year Olds**

Three-year-olds must read three of five symbols on the 20/40 line or better to pass the vision screening. Refer the student for further evaluation if s/he misses three of five symbols on or above the 20/40 line.

**Four-Year Olds and Older**

Four-year-olds must read three of five symbols on the 20/30 line or better to pass the vision screening. Refer the student for further evaluation if s/he misses three of five symbols on or above the 20/30 line.

**All Children**

Refer for further evaluation any student who displays a two-line difference in visual acuity between the right and left eye.

**Accompanying Critical Issues**

When screening results deviate from the normal, notify the parent/guardian in writing of these results and of the need for additional evaluation by the family healthcare provider. Follow up on the results.

- 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.
- Offer to assist parents/guardians if they need help in obtaining medical follow-up.
- Develop an Individualized Healthcare Plan for the student if healthcare provider input determines a positive diagnosis with implications/orders for the school setting.
- Refer to **Chapter 4: Topic 4D: Out-of-District Placements** to determine actions for out-of-district students.

| | |
|---|---|
|  | **Documentation of Services** |
| | 1. Document services on a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Cumulative Health Record). |
| | 2. Document all referrals, follow-up, and parent/guardian conferences on the reverse side of from form A-45. |
| | 3. File any healthcare provider documentation with the student's individual health record. |

**Resources**

**American Foundation for the Blind**

11 Penn Plaza, Suite 300, New York, NY 10001
Contact: Regina Genwright, Acting Director of Information Center
Phone: 212-502-7600; 212-502-7662 (TTY)
E-mail: afbinfo@afb.org
http://www.afb.org

**Blind Children's Resource Center**

23 Alexander Ave., Madison, NJ 07940
Contact: Carol Castellano, Director and President of Parents of Blind Children
Phone: 888-625-6066; 973-625-5999; 973-377-0976
E-mail: center@webspan.net

**National Federation of the Blind of NJ**

69 Prospect Place, Belleville, NJ 07109
Contact: Joe Ruffalo, President
Phone: 973-450-3030

**Commission for the Blind and Visually Impaired**

(State Agency for the Visually Impaired)
Department of Human Services
P.O. Box 47017, 153 Halsey St., Newark, NJ 07101
Contact: Jamie Casabianca Hilton, Executive Director
Phone: 973-648-2324 1-800-962-1223 (voice/ttdds)
Fax: 210-648-7364
E-mail: jhilton@dhs.state.nj.us
http://www.state.nj.us/humanservices/dhsbvi1.html

**Prevent Blindness New Jersey**

2525 Route 130, Bldg D, Cranbury, NJ 08512
Phone: 609-409-0770
Email: pblindness@aol.com
http://www.preventblindess.org/NJ

**Recording for the Blind and Dyslexic**
20 Roszel Road
Princeton, NJ 08640
Phone: 609-452-0606
http://www.rfbd.org/about_2.htm

## References


American Academy of Pediatrics. (1995). AAP policy statement: Proposed vision screening guidelines. *AAP News*, *11*(1).

American Academy of Pediatrics. (1998). Policy statement: Eye examination and vision screening in infants, children, and young adults (RE9625). *Pediatrics, 98*(1), 153-157.

American Nurses Association. (1994). *Clinician's handbook of preventive services.* Waldorf, MD: American Nursing Publishing.

American Optometric Association. (1999). *A school nurse's guide to vision screening and ocular emergencies.* St. Louis, MO: Author.

Merenstein G. B. (1997). *Handbook of pediatrics* (18th ed.). Stanford, CT: Appleton and Lange.

National Association of School Nurses. (1998*). Vision screening guidelines for school nurses.* Scarsborough, ME: Author.

Prevent Blindness New Jersey (1997). *Chart for Referrals.* (Phone: 888-605-5744; Fax: 609-409-0755; E-Mail: pblindness@aol.com).

# 4. Services to Students with Special Needs

## Overview

Enrollment of students with special healthcare needs in the school setting presents a challenge to students, families, and school staff. Development of a healthcare plan for these students provides for effective and efficient delivery of services, promotes their success in school, and reduces the liability of the school district.

### RESPONSIBILITIES

The parent/guardian is the most important source of information regarding the unique needs of the child with special healthcare needs. The parent/guardian should play a major role in the development of the healthcare plan.

The school nurse has the primary role in initiating, facilitating, and implementing procedures for the care of the student. S/he must establish relationships with the child, the family, the medical provider, and any other agencies involved in the provision of services. The school nurse is the main intermediary in interpreting what is shared with all staff members who have contact with the student.

**The role of the parent/guardian:**

1. Act as an advocate for the child.
2. Provide access to healthcare providers for the purpose of securing information and orders for necessary medications and treatments.
3. Approve the healthcare and emergency plan.
4. Notify the school nurse of changes in the student's condition, healthcare providers, or healthcare needs.

**The role of the school nurse:**

**Source**

Adapted in part from *Guidelines for Special Healthcare Procedures in Missouri Schools* (1990), published by the Missouri Department of Elementary and Secondary Education in cooperation with the Missouri Department of Health.

1. Review emergency and healthcare information for all students.
2. Determine which students will require a written healthcare plan.
3. Obtain significant health data on identified students.
4. Consult the **Nursing Assessment** table, below, to complete a nursing assessment for each identified student.
5. Secure signed, written release of confidential information for all sources of significant medical information about identified students.
6. Consult the **Development of a Healthcare Plan** table, below, to develop and implement an individual healthcare plan to be carried out at school for identified students.

7. File healthcare plans for identified students with students' individual health records.
8. Note on emergency cards of identified students that a healthcare plan is on file.
9. Ensure that a child-specific emergency plan – developed in collaboration with school administration, community emergency personnel, and family – is in place.
10. See that medication and training procedures are performed and documented.
11. Conduct general staff training to provide an overview of the student's condition and healthcare needs. Include all staff who are in contact with the student, including bus drivers, lunchroom personnel, and playground staff. Include the following topics:
    - overview of student's condition and special healthcare needs
    - overview of anatomy and physiology, when appropriate
    - detailed review of student's healthcare plan
    - roles and responsibilities of school personnel in the daily and emergency care of the student at school
    - transportation issues and personnel involved
    - emergency plan and procedures

    

    Encourage staff members to ask questions during the training sessions and assure them that they will be updated with any changes in the student's condition or placement.
12. For more information on this topic, consult the **Resources** and **References** provided later in this chapter under **Topic 4F**.

**Nursing Assessment**

To complete the Nursing Assessment, summarize the following data on identified students:

- age of student at onset of condition
- description of condition and course of illness
- summary of treatment
- other significant illnesses and allergies
- date last seen by primary healthcare provider for noted condition
- name, address, and phone numbers of healthcare provider(s)
- significant emergency information
- preferred hospital
- description of what constitutes a medical emergency for this student
- orders, supplies, or medications needed for medical emergency for this student
- healthcare procedures, orders for treatments including administration of medication
- equipment to be supplied and party responsible for supplying it

**Development of a Healthcare Plan**

When developing a healthcare plan, plan for situations that might arise while the student is in school, on a school bus or field trip, during a safety drill, and in the event of a disaster. (**Appendix 3A)** Also, include the following components:

- student identification data and date of plan
- description of the health condition and possible effects on this student (if multiple health conditions exist, list each as a separate problem in the action plan)
- general guidelines for determining action
- procedures for the following:
  - medication and equipment needs
  - medication and equipment storage
  - possible adverse effects of medication or procedure
  - carrying out signed orders, if applicable
  - obtaining parent/guardian authorizations
  - using names and phone numbers of important personnel
  - training school personnel
- identification of school personnel who are to be trained in child-specific procedures and problem management
- documentation of training of school personnel
- signatures of school nurse, parent/guardian, and school administrator

Also obtain the healthcare provider's signature if prescribed healthcare is to be provided at school.

The healthcare plan should be typed.

# Topic 4A: Provision of Section 504 Services

Students with disabilities who do not meet the criteria for eligibility under the Individuals with Disabilities Education Act (IDEA) may be eligible for services under Section 504 of the Rehabilitation Act of 1973.

Students are eligible for Section 504 protection if they have a physical or mental impairment that substantially limits one or more major life activities, or if they have a record of, or are regarded as, having such impairment. School is considered a major life activity. However, learning is not the only major life activity to be considered in determining a student's eligibility for protection under Section 504. For example, if a condition such as asthma substantially limits another major life activity of a student, s/he may be eligible for services under Section 504.

N.J. school districts are required to convene a multidisciplinary team to evaluate the student and determine eligibility for Section 504 accommodations. It is highly recommended that the school nurse be part of the team. Once the student's eligibility is determined, the team must develop and implement a Section 504 accommodation plan, which describes the nature of the student's disability and the major life activity it limits.

For more information on this topic, see **Appendix 4A: Role of the School Nurse** and **504 Plans and Accommodations**.

**Authorization**
34 C.F.R. § 104.31 et seq., Subpart D

**Accompanying Critical Issues**

If the Section 504 accommodation plan will include a nursing component, the school nurse should be a collaborative partner in both its development and implementation.

**Documentation of Services**

Every step utilized in a 504 plan must be documented.

1. School districts will determine the location of the 504 Accommodation Plan.
2. If a medical diagnosis forms the basis for the plan, record documentation from the healthcare provider on a form provided by the Commissioner of Education (form A-45) and place the report with the student's individual health record.
3. Document all nursing services provided under the plan with the student's individual health record.

## Resources

### Section 504, the ADA, and the Schools

Perry A. Zirkel and Jeanne M. Kincaid
LRP Publications
Horsham, PA
Phone: 800-341-7874 Ext. 275

**Writing a Legally Sound Section 504 Accommodation Plan**
http://www.crosswinds.net/~iep/504.html

**Student Placement in Elementary and Secondary Schools and Section 504 and Title II of the Americans with Disabilities Act**
http://www.ed.gov/offices/OCR/docs/placpub.html

**Section 504 Resources**
http://www.504idea.org/504resources.html

## References

Arnold, M., & Silkworth, C. (Eds.). (1999). *The school nurse's source book of individualized healthcare plans (vol, II). North Branch, MN: Sunrise River Press.*

Miller, L., & Newbill, C. (1998). *Section 504 in the classroom: How to design and implement accommodation plans*. Austin, TX: Pro.ED, Inc.

# Topic 4B: Provision of IDEA Services

Students who are disabled due to physical, sensory, emotional, communication, cognitive, or social difficulties may be eligible for services under the Individuals with Disabilities Education Act (IDEA).

Every N.J. school district must have written procedures for the location and referral of students with these types of difficulties. Among other things, these procedures must provide the means through which instructional, administrative, and other professional school staff, parents/guardians, and agencies concerned with the welfare of students may refer such students for possible evaluation by the local child study team.

Upon receipt of a written referral for evaluation, the local child study team is required to hold an identification meeting within 20 calendar days (excluding school holidays, but not summer vacation) to identify the need for an evaluation of the student's eligibility for special education and related services. Health and medical information provided by the school nurse is critical to this process. The group assembled at the identification meeting – the child study team, the parent/guardian, and the student's regular education teacher (who is knowledgeable about the student's educational performance) or a teacher who is knowledgeable about the district's programs (if there is no teacher who is knowledgeable of the student) – will determine whether an evaluation is warranted. If a need for evaluation is identified, this group will also determine the nature and scope of the evaluation.

The nurse may be asked to act as a consultant in the evaluation process.

For more information on this topic, see the following documents in **Appendix 4B**:

- Entrance Process
- Role of the School Nurse with Three- to Five-Year-Old Children With Disabilities
- Criteria for Selection of Health Problems to be Included in the Health Component of the Individual Educational Plan
- Guidelines for Healthcare Planning for Students With Special Healthcare Needs
- Role of the School Nurse in Implementing IDEA in the Assessment and Placement Process

**Authorization**

N.J.A.C. 6A:14- 3.3(a, e, g-h); 6A:14- 3.4(a)1; 6A:14- 3.4(h)

## PROTOCOL

**The role of the school nurse:**

1. Upon receipt of a written referral for evaluation by the local child study team, review available health and medical information on the referred student.
2. Consult the **Documentation of Services** table, below, to prepare a written summary report of the referred student's health and medical information.
3. Transmit the summary report to the child study team for the identification meeting, so that any need for a health appraisal or specialized medical evaluation may be considered.

   If there is no existing health and medical information on the referred student, communicate that to the child study team.

**Identification Meeting**

Within 20 calendar days (excluding school holidays, but not summer vacation) of receipt of a written request for evaluation by the local child study team, the team must convene a meeting to identify any need for evaluation. The child study team, the parent/guardian, and the student's regular education teacher (who is knowledgeable about the student's educational performance) or a teacher who is knowledgeable about the district's programs (if there is no teacher who is knowledgeable of the student) should all be present at the meeting.

Because the child study team must schedule the identification meeting within 20 days of receiving the referral, it is important to submit this information promptly.

4. Consult **Chapter 3: Topic 3A** and **Chapter 3: Topic 3G** to conduct audiometric and vision screening of the referred student.
5. Be prepared to act as a consultant in the evaluation process.
6. For more information on this topic, consult the **Resources** and **References** provided later in this chapter under **Topic 4F**.

| | |
|---|---|
|  | **Documentation of Services**<br>The summary report must be made in writing. |
| | 1. Complete the written summary report using a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Cumulative Health Record). |
| | 2. File a copy of your written summary report with the student's individual health record. |

**Resources**

See the resources provided in **Chapter 4: Topic 4F**.

**References**

See the references provided in **Chapter 4: Topic 4F**.

# Topic 4C: Out-of-District Placements

Students identified as eligible for services under the Individuals with Disabilities Education Act (IDEA) may be enrolled in a special class or program in another school district, or in a special education program in a receiving school (including educational services commissions, jointure commissions, regional day schools, county special services school districts, the Marie H. Katzenbach School for the Deaf, approved private schools for the disabled that may or may not provide residential services, and public college operated programs for the disabled).

**Authorization**

N.J.A.C. 6A:14-4.3 & 6A:14-7

**Accompanying Critical Issues**

Out-of-district educational programs provided through contractual arrangements are considered educational programs of the resident-district board of education. When placing students in out-of district programs, resident-districts must consider how the health needs of these students will be met. Areas of consideration include, but are not limited to:

- mandatory screenings
- provision of medication

In many instances, receiving schools have appropriately certified staff to address these issues, but this is not always the case.

**Documentation of Services**

Records of all out-of-district placements must be retained by the resident school district.

1. Upon admission to an out-of-district program, send a copy of form A-45, Health History and Appraisal Health Record, to the receiving school.
2. When the out-of-district placement is terminated, form A-45, Health History and Appraisal Cumulative Health Record, must be returned to the resident school district.

**Resources**

See the resources provided in **Chapter 4: Topic 4F**.

**References**

See the references provided in **Chapter 4: Topic 4F**.

# Topic 4D: Participation in the Special Education Medicaid Initiative

The Special Education Medicaid Initiative (SEMI) – provides a means of cost recovery for certain direct services provided to Medicaid-eligible special education students aged 3 to 21.

For more information on this topic, see **Chapter 3: Topic 3E**.

**Accompanying Critical Issues**

In order for the district to receive reimbursement for provided services through SEMI, these services must be included in the student's IEP.

Changes to the student's IEP require a meeting of the child study team.

**Documentation of Services**

Records of cost recovery requests must be retained by the school district.

1. Document all attempts at cost recovery through SEMI on a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Health Record) and on SEMI turnaround documents.

**Resources**

**SEMI Handbook**

Available through Maximus or the Department of the Treasury

**Maximus**

Contact: Lori Bembry, SEMI Field Team Manager
Phone: 800-618-7364 Ext. 200

**Department of the Treasury**

Division of Administration
Contact: Nancy M. Kuprewicz, SEMI/EPSDT Coordinator
Phone: 609-633-9069

**Department of the Education**

Office of Special Education Programs
Contact: Elaine Lerner, Education Program Specialist 1/SEMI Coordinator
Phone: 609-984-7902

**References**

See the references provided at the end of Chapter 4.

# Topic 4E: Transportation as a Related Service

As part of the mandate of a free and appropriate public education, "related services" are required when they are deemed necessary for a child with a disability to benefit from special education.

Transportation is defined as a related service under the Individuals with Disabilities Education Act (IDEA). Transportation may include:

- travel to and from school
- travel between schools
- travel in and around school buildings
- specialized equipment (such as special or adaptive buses, lifts, and ramps), if required to provide transportation to special education for a child with a disability

It is possible for a school district to be required to provide specialized transportation services to a student with disabilities who is not in special education.

The reauthorization of the Education of the Handicapped Act as the Individuals with Disabilities Education Act (IDEA) in 1990 did not change the original definitions of transportation.

**Authorization**

Rehabilitation Act of 1973 P.L. 93-112, § 504, states in part:

> "No otherwise qualified handicapped individual in the United States must, solely by reason of his handicap, be excluded from participating in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." It is possible for a school district to be required to provide specialized transportation services to a student with disabilities who is not in special education.

Individuals with Disabilities Education Act P.L. 105-17; Of note for transporters: The "non-Academic Services" section, under the Free Appropriate Public Education component of IDEA, requires the public agency to "provide nonacademic and extracurricular services and activities in such manner necessary to afford children with disabilities an equal opportunity for participation in those services." One of those services is transportation.

N.J.A.C. 13:37-6.2

N.J.A.C. 18A:40-12.5 to 40-12.6.

N.J.S.A. 45:11-23 & 45: 11-45

N.J.S.A. 18A:46

State of New Jersey Nurse Practice Act PL1947, c. 262 as amended, c. 45 § 11-23

N.J. Department of Law and Public Safety PL1997, c. 368

N.J.A.C. 6A:14-3.9(a)7iii requires that, when necessary for a student classified eligible for special education receiving transportation a related service, the case manager must provide the transportation coordinator and the bus driver with specific information including safety concerns, mode of communication, health and behavioral characteristics of the student.

## PROTOCOL

**The Role of the Case Manager**

When transportation as a related service is necessary for a student who is eligible for special education, the student's case manager must provide the transportation coordinator and bus driver with specific information, including any safety concerns, the student's mode of communication, and relevant health and behavioral characteristics of the student.

**The Role of the School Nurse in Implementing the Individualized Healthcare Plan**

When appropriate, an Individualized Healthcare Plan (IHP) should specify the type and frequency of care required or expected for the student who is to be transported, as well as the skill level of the person who is expected to give that care. The IHP should also include a recommendation as to when general observation of the student by the driver is adequate during transportation, and when a staff person independent of the vehicle driver is needed.

**Procedures**

The school district should develop procedures to provide consistent direction to transportation staff. See the **Accompanying Critical Issues** table, below, for procedure considerations.

**The role of the IEP team:**

1. In the course of evaluating a student for a suspected disability, also determine:
   - whether the student will need transportation as a related service
   - the type of specialized transportation service the student will require
   - whether specialized care, intervention, or staff trained in blood borne pathogens and Universal/Standard Precautions will be required during transportation due to the student's medical or health problem, a chronic, contagious, or communicable disease, or another reason

   

   If appropriate, invite transportation staff to participate on the IEP team if the student who needs transportation as a related service requires care or intervention that exceeds that required for a nondisabled student, or if the student would require adaptive or assistive equipment in order to be transported.

   

   The school nurse, in consultation with the student's parents/guardians and healthcare providers, should use information from a thorough health assessment to determine the level of care, equipment, and qualified personnel needed during transportation.

   

   According to the N.J. Board of Nursing Nurse Practice Act, only the school nurse can delegate healthcare procedures, including care provided while a student is in transit. Consult the **Delegation of Healthcare Procedures**, below, for important information directing this process.

2. Consider the following concerns:
   - Can the student be safely transported, given the transportation environment (including the length of the ride) without undue risk to the student or others?
   - Are there any medical, health, physical, or behavioral concerns that may expose the student to unreasonable risk, given the anticipated transportation environment?
   - Can assistive or adaptive equipment identified as necessary to accommodate the student during the transportation process be safely secured and transported, and are adequate instructions available regarding its use?

- Will the necessary transportation services (such as the length of ride) impact on the student's ability to benefit from the planned program?
- Are there any questions regarding the safe and appropriate use of assistive or adaptive equipment (including mobile seating devices, ventilators, or oxygen equipment)? (Consult physical therapists, occupational therapists, rehabilitation engineers, or equipment vendors for answers to these questions).

3. Consider the following legal issues related to the student's educational program:
   - Can the student independently utilize regular transportation?
   - If not, can regular transportation be safely utilized if supplementary staff, equipment, or services are provided?
   - If not, what type of specialized transportation is required?
   - Is an attendant or other qualified personnel available?
   - Is a responsible adult available for pick-up and delivery of the student?
   - What is the maximum riding time that is considered safe for this student?
   - Are there special temperature requirements of the transportation vehicle that will need to be considered?
4. Consult the **Documentation of Services** table, below, to document the determination.
5. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

**Accompanying Critical Issues**

The school district should develop procedures to provide consistent direction to transportation staff. Topics to be considered include:

- control of student medicine transported between home and school on a vehicle
- physical intervention and management
- authority to use special harnesses, vest, and belts
- early closing of school due to inclement weather or other emergencies
- authority to operate special equipment
- actions to take when no adult is home to receive students
- when to exclude special equipment that has a different design or configuration than last used, or has tears or breaks in the fabric or metal
- actions to take when students are referred for transportation without sufficient information available to transportation staff to protect their safety
- student pick-up/drop-off location (one location specified, or unlimited alternative locations allowed)
- control and management of confidential information
- when and how to involve community emergency medical/law enforcement personnel
- when to use wheelchairs and mobility aids as student seating on school buses if the manufacturer of said device does not endorse its use as such (recognizing that in many situations the safe, economical, and prudent way to transport a child is in his/her wheelchair/mobility aid)
- district policy regarding parent/guardian Do Not Resuscitate (DNR) requests
- driver and attendant responsibilities regarding DNR requests

**Delegation of Healthcare Procedures**

By law, the school nurse must be involved in determining the drivers and attendants who will transport a student who might require nursing care in transit, and in determining any additional accommodations the student may need. The school nurse must:

- coordinate the training of all drivers and attendants – including substitutes – regarding their roles and responsibilities toward the student

Training should be provided and updated on an annual basis or when the student's health condition, equipment, and/or seating device change.

- include the following topics in the training of drivers and attendants:
  - confidentiality of information covered in training
  - availability of several inflation systems in transit (to assure that the proper cuff size is available for those being assessed)
  - overview of the student's health condition
  - signs of possible health problems
  - emergencies and action to be taken
  - student-specific healthcare procedures needed in transit
  - roles and responsibilities of the vehicle driver
  - roles and responsibilities of any other adults accompanying the student
  - cardiopulmonary resuscitation
  - first aid
  - Universal/Standard Precautions
  - equipment and supplies used in transit
  - security/storage of equipment and supplies during transit
  - obtaining community emergency assistance (fire department, ambulance, emergency department)
  - techniques and procedures for dealing with inappropriate or unacceptable behavior that creates emergency conditions or poses a risk to health and safety
- determine the need for any of the following vehicle accommodations to ensure safe transit of a student with special needs:
  - a communication system ( cellular phone, two-way radio)
  - climate control (for students with temperature instability)
  - route modifications that decrease amount of transportation time
  - a back-up power source for electrical equipment used in transit
  - the conversion of lead acid batteries on electrically powered wheelchairs and respiratory systems to gel-cell or dry-cell batteries
  - an external battery box to house and protect batteries used in transit
  - precautions for the transport of oxygen

**Delegation of Healthcare Procedures** table, continued ...

- develop an Emergency Healthcare Plan **(Appendix 4E)** that should be included in the IEP or 504 Plan and should include:
  - a brief description of the student's current medical, health, or behavioral status, as well as an emergency care card that lists emergency addresses, phone numbers, and other pertinent details
  - a description of the medical/healthcare or intervention necessary during transportation, including the frequency required
  - the names or skills of those who should provide the care or intervention
  - a description of the type and extent of training or skills necessary for the driver and/or attendant
  - instructions for the inspection, operation, use, and care of the student's adaptive/assistive equipment, including items such as oxygen containment systems, suctioning equipment, apnea monitors, ventilation equipment, and so on
  - emergency procedures to be implemented during a medical/health crisis, including directions for communication with medical staff
  - procedures to be followed in changing the care plan when conditions indicate that a change is warranted

**Documentation of Services**

Document the provision of transportation as a related service on the following:

1. the Individual Healthcare Plan (IHP)
2. the Individual Educational Plan (IEP)
3. the Emergency Healthcare Plan (EHCP), if part of IDEA services
4. the Section 504 Plan, if appropriate
5. the Delegation of Nursing Services form **Appendix 4E**
6. a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Cumulative Health Record)

**Resources**

(1995). A report from the National School Bus Standards conference. *Exceptional Parent, 25*(8), 66.

**References**

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NJ State School Nurses Association. (2000). *Position statement: Delegation of nursing care in the school setting.* Trenton, NJ: Author.

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# Topic 4F: Resources and References for Special Needs Issues

## Resources

### National Association of School Nurses

http://www.nasn.org
Phone: 207-883-2117
Fax: 207-883-2683

### NJ State Board of Nursing Decision Making Model Algorithm

Guidelines for Determining Scope of Nursing Practice and Making Delegation Decisions (June 4, 1999). Available: http://www.state.nj.us.lps/ca/nursing/algo1.htm

Guidelines for Determining Scope of Nursing Practice and Making Delegation Decisions ( July 20, 1999). Available: http://www.state.nj.us.lps/ca/nursing/algo1/htm

### NJ State School Nurses Association

http://www.njssna.org

### NJ Department of Law and Public Safety

State of New Jersey Nursing Practice Act (1979)
PL1947, c. 262 as amended; c. 45 sec. 11-23

http://www.state.nj.us/lps/ca/nursing/laws.htm

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Luckenbill, D. (1996). *The school nurse's role in delegation of care: Guidelines and compendium.* Scarborough, ME: National Association of School Nurses.

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National Association of School Nurses. (1996). *Position statement: The school nurse and specialized healthcare services.* Scarborough, ME: Author.

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Whaley, L. F., & Wong, D. L. (1994). *Nursing care of infants and children.* St. Louis, MO: Mosby-Yearbook.

Zaiger, D. S. (2001). *School nursing practice: An orientation manual* (2nd ed.). Scarborough, ME: National Association of School Nurses.

# Topic 4G: Intervention and Referral Services

The term "intervention and referral services" refers to a coordinated, building-based system for planning and delivering services to assist general education students who experience learning, behavioral, or health difficulties, and for assisting staff who have difficulties addressing students' learning, behavioral, or health needs. Planning and delivery of intervention and referral services requires a multidisciplinary team approach.

Functions of intervention and referral services include:

- identification of students' learning, behavior, and health difficulties
- collection of information on identified difficulties
- development and implementation of action plans that provide for appropriate school or community interventions or referrals to school or community resources that can address the identified difficulties
- active involvement of parents/guardians in the development and implementation of action plans
- coordination of school and community resources and services for achieving outcomes identified in action plans
- review and assessment of the effectiveness of action plans in achieving desired student outcomes
- modification of students' action plans when appropriate
- support, guidance, and professional development for school staff who identify students' learning, behavioral, and health difficulties
- support, guidance, and professional development for school staff who participate in each building's system for planning and providing intervention and referral services
- annual review of the intervention and referral services system
- recommendations to the principal for improving school programs and services

**Authorization**

N.J.A.C. 6A:16.7, "Intervention and Referral Services"

## PROTOCOL

**The Role of the Board of Education**

Each district board of education is responsible for establishing guidelines that identify the roles and responsibilities of building staff who participate in planning and providing intervention and referral services, as well as the roles and responsibilities of other district staff who aid in the development and implementation of action plans.

**The role of school nurse:**

Since school health professionals have general knowledge of common health issues that affect classroom performance, their input should be included in defining procedures, intervention, and referral services.

1. Use health histories and health assessments to identify health problems that may impact on the educational progress of students who have been referred to the intervention and referral services team (see the **Accompanying Critical Issues** table, below).
2. Interpret health information that has a significant impact on students' learning or behavior.
3. When appropriate, participate as a member of the intervention and referral services team, assist in the coordination of school and community services, and support the development, assessment, and modification of action plans.
4. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

| **Accompanying Critical Issues** |
|---|
| Health issues can affect student performance. While school staff may understand that good health enhances learning, they may not readily associate health problems with student behavior and academic performance. The intervention and referral services team should always consider health issues that may underlie academic or behavioral concerns. |
| • Include student health information in the analysis of school performance of students referred to the intervention and referral services process.<br>  Without the coordination of information on the part of the team, students' health problems may go unnoticed or be dealt with in a fragmented and ineffective manner.<br>  Consideration of important health information facilitates coordination, comprehensive planning, and support for students whose health needs are intertwined with social, educational, behavioral, and psychological issues. |

**Resources**

**American School Health Association**
P.O. Box 708, Kent, OH 44240
http://www.ashaweb.org
Phone: 330-678-1601

**National Association of School Nurses**
P.O. Box 1300, Scarborough, ME 04074
http://www.nasn@nasn.org
Phone: 207-883-2117
Fax: 207-883-2683

## References


Institute of Medicine. Alensworth, D., Lawson, E., Nicholson, L., & Wyche, J. (Eds.). (1997). *School and health: Our nation's investment.* Washington, DC: National Academy Press.

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National Health and Education Consortium. (1993). *Eat to learn, learn to eat: The link between nutrition and learning in children.* Washington, DC: Institute for Educational Leadership.

National School Boards Association. (1991). *School health: Helping children learn.* Alexandria, VA: Leadership Reports.

NJ Department of Education. (1999). *Resource manual for intervention and referral services for general education students.* Trenton, NJ: Author.

Smith, D. R. (1996). *Healthy children are prepared to learn: School health programs in action.* Austin, TX: Texas Department of Education.

World Health Organization. (1996). *Promoting health through schools.* Geneva, Switzerland: Author.

# 5. Administering Medication in Schools

The administration of prescription and over-the-counter medications during school hours is a complex issue. However, in order for many students with chronic health conditions and disabilities to remain in school, medication may have to be administered during school hours.

Herbal remedies and nutritional supplements are not considered medications and should not be administered in school.

Parents/guardians should be encouraged to administer medications at home whenever possible. Medications should be administered in school only when necessary for the health and safety of students.

The following individuals are authorized by law to administer medication to students in schools:

- a school physician
- a certified or noncertified school nurse
- a substitute school nurse (RN) employed by the district
- the student's parent/guardian
- a student who is approved to self-administer in certain life-threatening conditions as pursuant N.J.S.A. 18A: 40-12.3 and 12.4
- school employees who have been trained and designated by the certified school nurse to administer epinephrine in an emergency pursuant to N.J.S.A. 18A: 40-12.5 and 12.6

For more information on this topic, consult the following documents in **Appendix 5**:

- Questions & Answers on the Administration of Medication in Schools (from the N.J. Department of Education)
- Emergency Administration of Epinephrine
- Questions & Answers on the Emergency Administration of Epinephrine (from the N.J. Department of Education)
- Policy for Administration & Policy Development: Emergency Administration of Epinephrine (P.L. 1997, c. 368)
- Article 3. Health Measures in General. N.J.S.A. 18A:40-12.3 Self-Administration of Medication by Student

**Authorization**

N.J.S.A. 45:11-23, "Nurse Practice Act"

N.J.S.A. 18A:40-12.3, P.L. 1993, c. 308, "Self-Administration of Medication by a Student"

N.J.A.C. 6A:16-2.3, "Programs to Support Student Development"

Emergency Administration of Epinephrine: Implementation of P.L. 1997, c. 368

## PROTOCOL

**The Role of the Board of Education**
The district board of education must develop and adopt written policies and procedures in consultation with the school physician for the administration of medication to students and staff (see the **Accompanying Critical Issues** table, below).

**The role of the school nurse:**

1. Collaborate with the school physician and the district board of education in the development of policies, procedures, and forms for the administration of medication (see the **Accompanying Critical Issues** table, below).
2. Manage the medication administration program.
3. Document the medication administration program (see the **Documentation of Services** table, below).
4. Implement the district board of education policy on the administration of epinephrine as pursuant to the protocols.
5. Provide services – such as, daily, prn, and emergency medication administration, coverage for field trips, and summer school/extended year programs – as addressed under § 504.
6. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

| **Accompanying Critical Issues**<br>For important information related to policy development, consult the documents provided in Appendix 5. In general, procedures for the administration of medication should address: |
|---|
| • dissemination of policies to parents/guardians |
| • provision of a secure, locked space for the safe storage of medications |
| • medical authorization by a licensed prescriber (N.J.-licensed MDs, DOs, dentists, or advanced practice nurses) |
| • the role of the school nurse |

| **Documentation of Services**<br>Every N.J. school district should develop forms that document the following: |
|---|
| • parent/guardian permission to administer medication |
| • medication orders by licensed prescriber |
| • administration forms |
| • medication errors<br>  For more information on this topic, see **Appendix 5**. |

## Resources

**American Academy of Pediatrics**
http://www.aap.org/policy/04524.html

## References


Anderson, B. (Nov 16, 1998). *Training protocols for the implementation of emergency administration of epinephrine. Administration of medication: Questions and answers*. Trenton, NJ: NJ Department of Education.

**Board of Nursing Statutes**

N.J.S.A. 45: 11-23 et seq.
http://www.state.nj.us/lps/ca/nursing/laws.htm

N.J.A.C. 13: 37
http://www.state.nj.us/njded/code

Graff, J., Ault, M., Guess, D., Taylor, M., & Thompson, B. (1990). Medication administration. In *Healthcare for students with disabilities: An illustrated medical guide for the classroom* (pp. 29-41). Baltimore: Paul H. Brookes Publishing.

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# 6. Communicable Disease and Infection Control

## Overview

Communicable disease was the basis for the development of school nursing services. School nurses continue to be involved in many aspects of infection control today. Public perception concerning the prevention of infection and the importance of infection control is increasing. School nurses should provide leadership in developing necessary policy and procedures to prevent the spread of infections in the school setting.

An infection control program goes beyond sending home a child who has a rash or educating the child to cover his mouth and nose when sneezing. The Occupational Safety and Health Administration (OSHA) regulations provided guidance for developing a more comprehensive Communicable Disease and Infection Control Program. Universal Precautions/Standard Precautions for the handling of body fluids have implications for the entire school community – both adults and children. The school nurse must practice, teach and advocate for inclusion of basic hygiene in the school curriculum. The "fine art" of hand washing has been revived and should be actively promoted.

# Topic 6A: The Communicable Disease and Infection Control Program

|  | **Authorization** |
|---|---|
| | N.J.S.A. 18A:40-7 to 12 |
| | N.J.S.A. 18A:40-16 to 18 governs the isolation, exclusion, and readmission of any student or employee suspected as having tuberculosis. |
| | N.J.A.C. 8:57-4 to 4.19 requires the exclusion of any student from the school setting for failure to meet requirements for immunization against communicable disease. |
| | N.J.A.C. 8:61-1.1 requires the exclusion of any person from the school setting if the person has uncovered weeping skin lesions, and provides assurance that any student with HIV infection or AIDS will not be excluded from general education, transportation services, or extracurricular activities, or be assigned to home instruction or classified as eligible for special education for reason of HIV infection, as required in N.J.A.C. 8: 61-1.1. |
| | N.J.A.C. 6A:16-1.4 outlines district policies and procedures. |
| | N.J.A.C. 6A:16-2.1 outlines the duties of the certified school nurse |
| | Department of Labor, Occupational & Health Administration, 29CFR Part 11910.1030 |
| | Occupational Exposure to Bloodborne Pathogens: Final Rule, The Federal Register, December 6, 1991. Part II, pages 64175-64182. |

|  | **Definitions** |
|---|---|
| | **Standard Precautions**<br>An expanded set of universal practices, which applies to blood, all body fluids, secretions, and excretions except sweat (regardless of whether these fluids, secretions, or excretions contain visible blood), nonintact skin, and mucous membranes. |
| | **Universal Precautions**<br>A set of procedures designed to prevent transmission of human immunodeficiency virus (HIV), hepatitis B virus, and other bloodborne pathogens. Universal precautions involve the use of protective barriers such as gloves, masks or eye wear, and procedures for use of sharps and needles to prevent exposure to human blood, other body fluids containing visible blood, semen, vaginal secretions, tissue, and cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids.<br>  **Note:** Universal precautions do not apply to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus, unless they contain visible blood. Universal precautions do not apply to saliva, except in the dental setting, where blood contamination of saliva is predictable. |

## PROTOCOL

**The role of the school nurse:**

1. Review and understand state laws, regulations, and roles that apply to infection control in the school setting. State agencies such as the Department of Education and the Department of Health and Senior Services provide information concerning: (**Appendix 6A)**
   - reportable diseases and conditions
   - regulations applicable to the management of communicable disease in the schools
   - tuberculosis testing and reporting
   - PEOSHA guidelines for employees
2. Review the school district's existing policies and procedures for communicable disease control and prevention or spread of infectious conditions.
3. In cooperation with administration, revise the school district's policies and procedures to provide a safe, infection-controlled environment that is in compliance with state and federal laws and regulations (see the **Management of the Communicable Disease and Infection Control Program** table, below).
4. Monitor the student and adult population for communicable disease symptoms (see the **Accompanying Critical Issues** tables, below).
5. Monitor the school community and environment for actual or potential infection control concerns (see the **Accompanying Critical Issues** tables, below).
6. Educate students, staff, and community in basic hygiene, and on the use of Universal/Standard Precautions and PEOSHA regulations.
7. Coordinate care of the communicable disease problems and care of students or staff with immunosuppressive conditions.
8. Consult the **Documentation of Services** table, below, to document the incidence of communicable disease and infection.
9. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

| **Management of the Communicable Disease and Infection Control Program**<br>Communicable diseases are the leading cause of childhood morbidity and school absences. Students and staff with communicable diseases – which can be transmitted directly or indirectly from one individual to another – require special consideration in the school setting. The transmission of infectious disease may be prevented by ALL school staff using procedures of effective infection control. In the school setting, the risk of exposure can be unpredictable; therefore, control measures that are simple and uniform across all situations have the greatest likelihood of compliance and success. |
|---|
| Local school district policies should address:<br>• preventive measures necessary to protect the health of all students and staff<br>• procedures for the immediate care of students or staff who develop a potentially communicable illness<br>• special needs of children with chronic infectious illnesses that are determined to be |

noncontagious under normal conditions

**Management of the Communicable Disease and Infection Control Program** table, continued

The school nurse should use the following principles when developing policies and procedures related to communicable disease and infection control:

- The spread of infectious disease can be prevented or deterred if students or staff adhere to basic principles of good personal hygiene, cleanliness and recommended use of any necessary personal protective measures.
- Transmission of infectious disease is controlled by routine use of standard procedures and techniques to maintain environmental cleanliness and personal protection.
- Schools are legally authorized to prohibit the attendance of teachers or students if necessary to prevent the spread of contagious disease.
- Case management activities include the timely identification and potential exclusion of students and staff with communicable disease. Appropriate follow-up to ensure treatment and prompt readmission will prevent the spread of contagious illness in school and minimize excessive absence.
- The Department of Health and Senior Services is responsible for initiating preventive measures to suppress or prevent the spread of disease and for implementing regulations relating to quarantine, isolation and other control measures to protect the public.
- Federal and state courts have held that children with chronic infectious diseases are entitled to a free appropriate public education in the least restrictive environment.
- Persons with suppressed immune systems run a higher than normal risk of severe complications from common communicable illness.
- Students with signs and symptoms of communicable diseases are excluded from school for the period of communicability and readmitted in accordance with recommendations of the personal healthcare provider, state and local health agency guidelines and local school district policy.
- The school nurse is responsible for providing or arranging in-service education for teachers and other school staff regarding the signs and symptoms of common communicable illness, mode of transmission, and period of communicability. Information should include local school district policies governing exclusion and readmission and a mechanism for health service referrals.
- The school nurse should serve as the in-school case coordinator for the student who has a chronic infectious disease. S/he is responsible for monitoring and assessing students with infectious diseases and maintaining a liaison with home, community health agencies and the student's personal healthcare provider.
- The student with a suppressed immune system may need to be temporarily removed from school for his/her own protection during an outbreak of contagious disease among classmates. The decision to remove the student is made by the student's healthcare provider and parent/guardian in consultation with the nurse.

**Accompanying Critical Issues I**

**Guidelines for Developing a Communicable Disease and Infection Control Program**

Regardless of the specific disease, certain elements are critical to the management of a communicable disease and infection control program. Federal, state and local laws and regulations must guide school district policy development.

- Written policy should include the following:
  - written procedures for general infection control and Universal Precautions/Standard Precautions (**Appendix 6A**)
  - an Exposure Control Plan – in place, implemented, and updated at least annually
  - education and instruction for the general school community as well as that described in the Exposure Control Plan
  - professional educational training that is appropriate in content and vocabulary to the educational level, literacy, and language background of participants
  - provision of all materials necessary to ensure employee and student access to the practice of hand washing
  - continuing education/training for staff responsible for presenting and monitoring programs
  - process for reviewing the infection control program, training, standard operating standards, management, and implementation on an annual basis
- All employees – including those with infectious diseases – have a right to confidentiality and access to employment, as well as other rights, privileges, and services provided by federal and state statutes.
- All children – including those with infectious diseases – have a right to a free and appropriate public education. Students with chronic infectious disease are eligible for all rights, privileges, and services provided by law.
- Extreme measures to isolate students – particularly those with chronic infectious diseases – are usually not necessary. Many irrational fears can be mitigated through planned health education programs for school staff, students, and parents/guardians. The educational program should include information regarding the mode of transmission and the methods of preventing the transmission of infectious diseases.
- The school should respect the right to privacy of the individual. If a student has an infectious disease, such knowledge should be confined to those persons with direct need to know, such as the school nurse or school physician. Those persons who are informed of the identity of an infected child should be made aware of confidentiality requirements. For reporting purposes, except as required by law, the identity of an individual with an infectious disease must NOT be revealed. Health records are confidential.
- In some instances, students who have an immunodeficiency may need to be removed from the classroom for their own protection (e.g., if there is an outbreak of a communicable disease). A student should never be discriminated against because of an infectious disease. The decision to remove the student should be made by the student's healthcare provider and parent/guardian in consultation with the professional school health personnel and local Department of Health.

**Accompanying Critical Issues I** table, continued

- If a student will be absent from school due to an infectious disease, reasonable accommodation for a home or hospital tutoring program may be appropriate. The school district should do everything possible to ensure that the student's educational progress is maintained.
- In the event of an outbreak of vaccine preventable disease, in cooperation with the local Department of Health, all susceptible students (e.g., students with medical or religious exemption from immunization) must be excluded. Depending on the disease outbreak, individuals may need to be reimmunized.
- The school health staff should routinely assess all students identified as having an infectious disease, as follows:
  - Students in school should be assessed in order to determine if their behavior or medical condition has altered in such a way as to affect transmissibility status.
  - Because students with chronic infectious diseases must be educated in the least restrictive environment, these children whose behavior or physical condition preclude school attendance must be routinely evaluated for return to the classroom.
- District policies for managing communicable disease should ensure that all school staff are instructed regarding the hygienic procedures that must be followed to maintain a safe, clean school environment.
- An Exposure Control Plan is mandated by the PEOSHA Bloodborne Pathogens Standard.

**Accompanying Critical Issues II**

**Components of a Communicable Disease and Infection Control Program**

**Prevention**

- maintenance of routine hygiene procedures, including handwashing, to assure a clean, safe, healthful school environment
- use of Universal/Standard Precautions when handling blood/body fluids and contaminated materials/surfaces
- health education and health counseling program to educate school personnel, students and parents/guardians
- immunization against preventable diseases and post-exposure prophylaxis; passive immunization when appropriate

**Identification**

- Classroom teachers are in an excellent position to detect early physical and behavioral changes by observing differences in the usual pattern for a student.
- Persons with signs and symptoms of infectious disease should be assessed by the school nurse and/or examined by an appropriate healthcare provider.
- Contacts of individuals with symptoms of infectious disease should be screened by the school nurse, as appropriate, to contain the spread of infection; referrals to the parent/guardian should be made as necessary.

**Accompanying Critical Issues II** table, continued

**Management**

- An individual with a suspected case of infectious disease should be referred to a healthcare provider for diagnosis and treatment.
- If it is determined by the school nurse that an individual's physical condition endangers the health or safety of the individual or others, that individual may be excluded from school until appropriate treatment is obtained or a healthcare provider has determined that the individual is not a risk to others. Local and state laws, as well as school district policies and procedures, must be followed.
- The school district should encourage medical follow-up and assist the individual in complying with the treatment regimen in cooperation with the healthcare provider.
- Documentation regarding infectious disease that impacts on the student's education must be recorded on the confidential cumulative health record. Any available documentation should be retained. A serial record of communicable disease outbreaks may be maintained in order to provide data for an epidemiological study if necessary.
- School nurses should notify the local Department of Health when any reportable disease occurs.

**Staff Development**

- The school nurse should be encouraged and supported in participating in continuing education activities to obtain current knowledge and upgrade skills.
- Appropriate educational programs should be provided to meet the current and anticipated needs of other school personnel (e.g., General Infection Control Standards and the PEOSHA Bloodborne Pathogens Standard).

**Accompanying Critical Issues III**

**Effective Management of the Communicable Disease and Infection Control Program**

An effective Communicable Disease and Infection Control program requires the participation and support of all school officials, local health department officials, healthcare providers, parents/guardians, and school staff. The school nurse is the most appropriate person to coordinate the school's infectious disease program and is responsible for instituting programs to prevent or control the spread of communicable disease. The school nurse's knowledge and judgement are essential for the collection and interpretation of data related to infectious disease. The school nurse should:

- participate in the development of infectious disease policies and procedures
- develop and review the Exposure Control Plan
- consult with local or state health department personnel as needed
- interpret infectious disease policies and procedures for school personnel, parents/guardians, and students
- provide health information, health counseling, and in-service programs regarding infectious diseases and control measures for school personnel, parents/guardians, and students
- promote positive health practices for the school community
- develop Individual Healthcare Plans for students with infectious diseases

**Accompanying Critical Issues III** table, continued

- recommend modification of the school program of infected students as needed
- monitor and assess the school environment for infection control standards
- monitor and assess students with infectious diseases
- make recommendations for proper equipment and supplies
- serve as an advocate for students with infectious diseases
- act as a liaison between the school, home, community health agencies, and private healthcare provider
- keep current regarding information, rules and regulations, policies, and procedures regarding infectious disease

**Documentation of Services**

If necessary, document services on a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Cumulative Health Record) and the District Exposure Control Plan.

**Resources**

**Harvard School of Public Health, School of Entomology: Head Lice Fact Sheet**
http://www/hsph.harvard.edu/headlice.html

**NJ Health and Senior Services: Communicable Disease Service**
http://www.state.nj.us/health/co/f

**NJ State Sanitary Code: Immunizations of Students in Schools**
http://www.state.nj.us/health/cd/chap14.htm

**References**

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Bradley, B. (1992). *HIV infection and the school setting: A guide for school nursing practice*. Kent, OH: American School Health Association.

Brogan, J. F., Fraser, K., Vega-Matos, C., & Ascroft, J. (1996). *Someone at school has AIDS.* Alexandria, VA. National Association of State Boards of Education.

**References**, continued

Center for Disease Control and Prevention. (1997). *Epidemiology and prevention of vaccine-preventable diseases* (4th ed.). Washington, DC: Department of Health, Public Health Service.

Champion, C. (1999). *Occupational exposure to bloodborne pathogens.* Scarborough, ME: National Association of School Nurses.

Chin, J. (Ed.). (2000). *Control of communicable diseases. Manual*. Washington, DC: American Public Health Association.

Haas, M., Gerber, M. J. V., Kalb, K. M., Lueher, R. E., Miller, W. R., Silkworth, C. K., & Will, S. I. S. (1992). *The school nurse's source book of individualized healthcare plans.* North Branch, MN: Sunrise River Press.

National Association of School Nurses. (2001). *Position statement: Infectious diseases.* Scarborough, ME: Author.

National Task Force on Confidential Student Health Information. (2000). *Guidelines for protecting confidential student health information.* Kent, OH: American School Health Association.

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Proctor, S. T., Lordi., S. L., & Zaiger, D. S. (1993). *School nursing practice: Roles and standards.* Scarborough, ME: National Association of School Nurses.

Schwab, N., & Gelfman, M. H. B. (Eds.). (2001). *Legal Issues in school health services.* North Branch, MN: Sunrise River Press.

Zaiger, D. S. (2001). *School Nursing Practice: An Orientation Manual* (2nd ed.). Scarborough, ME: National Association of School Nurses.

# Topic 6B: Immunization Compliance

| | |
|---|---|
|  | **Authorization**<br>N.J.A.C. 5A:16-1.6 & 5A:16-2.19(e)<br>N.J.A.C. 8:57-4.1 to 57-4.19 |

## PROTOCOL

**The role of the school nurse:**

1. Review students' immunization records to ensure compliance with state requirements for school admission.

   Documents accepted as evidence of immunization include:

   

   - official school/childcare records
   - records from any public health department
   - physician's certificate/letterhead stationery/prescription pad listing specific vaccines and administration dates signed by a licensed physician or advanced practice nurse

2. Maintain an official State of New Jersey School Immunization Record for every student that includes the dates of every immunization administered to that student (see the **Documentation of Services** table, below).
3. Recommend to the school principal the exclusion of students who have not submitted acceptable evidence of required immunizations.
4. Annually review immunization records to confirm with medical providers that the medical condition for exemption from immunization requirements is still applicable (see the **Accompanying Critical Issues** table, below).
5. Ensure that students with provisional admission are receiving required immunizations on schedule. Recommend to the school principal the exclusion of students with provisional admission who fail to comply with immunization requirements (see the **Accompanying Critical Issues** table, below).
6. Provide data for the immunization status report that each school is required to send annually to the Department of Health and Senior Services.
7. Upon request of the local or state public health officials, provide access to immunization records for purposes of audit or survey.
8. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

| | |
|---|---|
|  | **Documentation of Services** |
| | 1. Records for documentation of immunizations are provided by the N.J. Department of Education/Department of Health and Senior Services (form A-45). |

| Accompanying Critical Issues |
|---|
| **Medical Contraindication**<br>No child must be required to have any immunization that is medically contraindicated. Requests for medical exemption must state:<br>• the reason the immunization is medically contraindicated (must be a valid contraindication)<br>• the specific period of time for which immunization is medically contraindicated<br>• the signature of a licensed physician or advanced practice nurse |
| **Religious Exemption**<br>A child may be exempt from a required immunization if it conflicts with the student's religious beliefs or practices. The parent/guardian must request the religious exemption by writing a letter stating how the immunization conflicts with religious beliefs, and submit it to the school. |
| **Provisional Admission**<br>A child may be given provisional admission to school if documentation is provided that at least one dose of each required immunization has been administered. |

**Resources**

**Advisory Committee on Immunization Practices**

U.S. Public Health Services
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30333
Phone: 800-232-7468
Email: acip@cdc.gov
http://www.cdc.gov/nip/vfc/acip/htm

**American Academy of Pediatrics**

Committee on Infectious Diseases
P.O. Box 927
Elk Grove, IL 60009-0927
http://www.aap.org/

**Roll Up Both Sleeves!**

Comprehensive Guide for Nurses and Program Planners
American School Health Association
P.O. Box 708
Kent, OH 44240
http://www.asha.org

## References

Communicable Disease Service, Vaccine Preventable Disease Program. (September 18, 2000). *Chapter 14, NJ Sanitary Code: Immunization of students in schools*. Trenton, NJ: NJ Department of Health and Senior Services.

# Topic 6C: Standard Precautions/Universal Precautions

The major intent of this regulation – the Federal Bloodborne Pathogens Standard (see below) – is to prevent the transmission of bloodborne diseases within potentially exposed workplace occupations. The Standard is expected to reduce and prevent employee exposure to the Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and other bloodborne diseases. It requires that employers follow Universal Precautions – which means that all blood or other potentially infectious material must be treated as being infectious for HIV and HBV.

Each employer must determine the application of Universal Precautions by performing an employee exposure evaluation. If employee exposure is recognized, as defined by the Standard, then the Standard mandates a number of requirements. One of the major requirements is the development of an Exposure Control Plan, which mandates engineering controls, work practices, personal protective equipment, HBV vaccinations, and training. The Standard also mandates practices and procedures for housekeeping, medical evaluations, hazard communication, and record keeping.

| | **Authorization** |
|---|---|
| | N.J.A.C. 8:6.1-1.1(j) & N.J.A.C. 6A:16-2.3(e) require implementation of Universal Precautions in the handling of human blood and certain bodily fluids in the school setting. The rules are intended to protect all persons, including students. |
| | N.J.A.C. 6A:16-1.4(a)7 & 8A:61-1.1 are related rules that require anyone with an uncovered, weeping skin lesion to be excluded from school. |
| | 29 CFR Part 1910.1030, Occupational Exposure to Bloodborne Pathogens, Occupational Safety and Health Administration (OSHA), is incorporated into N.J. regulations as N.J.A.C. 12: 100-4.2, Public Employee Occupational Safety and Health (PEOSH). |
| | **Federal Bloodborne Pathogens Standard**<br>• Acquired Immunodeficiency Syndrome (AIDS) and HBV warrant serious concerns for workers who are occupationally exposed to blood and certain other body fluids that contain bloodborne pathogens. It is estimated that more than 5.6 million workers in healthcare and public safety occupations could potentially be exposed. In recognition of these potential hazards, the N.J. Public Employees Occupational Safety and Health (PEOSH), the N.J. Department of Health and Senior Services, and the N.J. Department of Labor have adopted the Federal Bloodborne Pathogens Standard (CFR 1910.1030) to help protect workers from these health hazards. The NJ Bloodborne Pathogens amendment to N.J.A.C. 12: 100-4.2 became effective in it's entirety on February 6, 1994. |

**Definitions**

**Standard Precautions**

An expanded set of universal practices, which applies to blood, all body fluids, secretions, and excretions except sweat (regardless of whether these fluids, secretions, or excretions contain visible blood), nonintact skin, and mucous membranes.

**Universal Precautions**

A set of procedures designed to prevent transmission of human immunodeficiency virus (HIV), hepatitis B virus, and other bloodborne pathogens. Universal precautions involve the use of protective barriers such as gloves, masks or eye wear, and procedures for use of sharps and needles to prevent exposure to human blood, other body fluids containing visible blood, semen, vaginal secretions, tissue, and cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids.

**Note:** Universal precautions do not apply to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus, unless they contain visible blood. Universal precautions do not apply to saliva, except in the dental setting, where blood contamination of saliva is predictable.

**Universal Precautions vs. Standard Precautions**

Universal precautions differ from guidelines for Standard Precautions, which were issued by the Centers for Disease Control in 1996 for use in hospitals. Standard precautions call for treatment of all bodily fluids and nonintact skin as potentially infectious, regardless of the presence of visible blood. While N.J. public schools are required to implement Universal Precautions in all school programs, the district board of education should encourage application of Standard Precautions in all settings.

**Exposure Control Plan**

The Exposure Control Plan is a key document for use in implementing and ensuring compliance with the Federal Bloodborne Pathogens Standard, and therefore, for protecting employees. The plan includes:

- employee exposure determination (**Appendix 6 C**)
- procedures for evaluating the circumstances surrounding an exposure incident
- the schedule and method for implementing specific sections of the standard, including:
    - methods of compliance
    - Hepatitis B vaccination and post-exposure follow-up
    - training and communication of hazards to employees
    - record keeping

Those employees who are reasonably anticipated to have contact with or exposure to blood or other potentially infected materials – such as, human blood, other body fluids containing visible blood, semen, vaginal secretions, tissue, and cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids – are required to comply with the procedures and work practices outlined in the Exposure Control Plan.

**Exposure Control Plan** table, continued

Universal precautions do not apply to feces, urine, nasal secretions, sputum, sweat, tears, or vomitus – unless they contain visible blood.

Universal precautions do not apply to saliva – except in the dental setting, where blood contamination is predictable.

**Good Samaritan Acts**

Good Samaritan acts – acts that result in exposure to blood or other potentially infectious materials from assisting a student or fellow employee – are not included in the Exposure Control Plan. However, post-exposure evaluation and follow-up in such cases is to be provided by the employer.

**Employee Training**

Employees covered by the Bloodborne Pathogens Standard will receive an explanation of the Exposure Control Plan during an initial training session. It will be reviewed in an annual refresher training.

**Accompanying Critical Issues**

- Training of staff identified under the district's Exposure Control Plan is mandatory, prior to assuming tasks which place them at risk and annually thereafter. In addition, it is advisable to train all students and staff in Standard Precautions in order to reduce the spread of infectious diseases.
- Supplies for implementation of the Exposure Control Plan must be budgeted by the district.
- Hepatitis B vaccination must be provided by the district for all employees identified in the plan who request it.
- The Exposure Control Plan must be updated by the employer annually. All employees covered by the plan are required to have these updates included in their annual training.

**Regulated Medical Waste**

In the school setting, medical waste is limited to sharps. Any school that generates regulated medical waste must:

register as a generator
utilize a red sharps-disposal container
arrange for annual transport and disposal of the container with a registered medical waste transporter

Records of the registration and of disposal must be maintained by the each facility for a minimum of 3 years.

**Documentation of Services**

Documentation of training, Hepatitis B vaccine administration, and incidents of exposure are the responsibility of the employer, as is the maintenance of records required by the District Exposure Control Plan.

## Resources

For a more complete discussion of infectious diseases and toxic effects and conditions, see:
**Control of Communicable Disease Manual**
Published by the American Public Health Association (1995)
To order: 301-893-0159

**NEA Health Information Network**

Phone: 202-822-7570 or 800-718-8387
http://www.nea.org/hin

**Center for Disease Control (CDC) Hepatitis Hotline**

Phone: 888-443-7232

**Occupational Safety and Health Administration (OSHA)**

Phone: 202-219-8151
http://www.osha.gov

**CDC Business and Labor Services**

Phone: 800-458-5231
http://www.brta-Irta.org

**CDC National AIDS Hotline**

Phone: 800-342-2437
http://www.ashastd.org/nah/nah.html

**National Association of School Nurses**

Phone: 201-883-2117
http://www.Vrmedia.com/nurses

**Coastal Video Communications Corporation**

3083 Brickhouse Court
Virginia Beach, VA 23452
Phone: 800-767-7703
Fax: 804-498-3657

## References

Friday, December 6, 1991. "Rules and regulations." *Federal Register*. Vol. 56, No. 235, pp. 64,175-64,182.

Gutter, E. (1996). *Protecting yourself against bloodborne diseases on the job.* Freehold, NJ: CentraState Healthcare System.

Stern, B. P. (1998). *Bloodborne pathogens exposure control plan.* Freehold Township, NJ: Freehold Township schools.

# Topic 6D: Tuberculosis Testing

Based upon the incidence of tuberculosis or tuberculin reactor rates in specific communities and population groups, each N.J. school district may be required to perform tuberculosis tests on students using methods specifically directed by the N.J. Department of Health and Senior Services.

| | |
|---|---|
|  | **Authorization**<br>N.J.A.C. 6A:16-2.3(a)<br>N.J.S.A. 18A:40-16 |

## PROTOCOL

**The role of the school nurse:**

1. Determine which students should be tested.

   

   Test only those students who are in the grades and schools identified and whose circumstances conform to those specified by the N.J. Department of Health and Senior Services. These requirements are based upon the high incidence of tuberculosis or tuberculin reactor rates in the communities concerned. Local Boards of Education cannot exceed these rules.

   

   Districts may require Mantoux tuberculin skin testing of any student transferring into their district from any of the areas required by the N.J. Department of Health and Senior Services to test eighth grade students, regardless of the transferring student's grade level.

2. Prior to testing, notify parents/guardians in writing about the testing of the students and obtain written permission to administer the test from the parents/guardians. (**Appendix 6 D**)

   

   The parent/guardian may elect to have the testing done by a family healthcare provider.

3. Prior to testing, consult the **Equipment** table, below, to determine that the equipment you need is available and in good working order.
4. Prior to testing, consult the **Accompanying Critical Issues** table, below, to determine whether testing may be contraindicated for any student identified to be tested.
5. Explain the procedure to the student to reduce the student's anxiety.
6. Conduct testing following the rules set forth by the NJ Department of Health and Senior Services in "School Tuberculin Testing in New Jersey."
7. Interpret and record the test results (see the **Documentation of Services** table, below).
8. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

**Equipment**

To detect evidence of tuberculosis infection in students, use only the Mantoux intradermal tuberculin skin test using five tuberculin units of Purified Protein Derivative.

- Prior to testing, ensure that an adequate supply of appropriately stored testing materials are on hand.

The school or school district is responsible for obtaining testing supplies.

- Refrigerate testing solution at all times.
- Discard remaining testing solution 30 days after opening.
- Follow Department of Environmental Protection regulations for the disposal of Regulated Medical Waste (sharps).

**Accompanying Critical Issues**

In some cases, tuberculosis testing is contraindicated, as follows.

**Medical Contraindications**

Asymptomatic individuals with a documented history of positive tuberculin skin testing, adequate treatment for disease, or adequate treatment for latent TB infection should be exempt from further testing.

**Testing Contraindications**

1. Vaccination with live-attenuated virus – including measles, mumps, rubella, oral polio, varicella, yellow fever, and oral typhoid (TY21a) – can cause suppression of the tuberculin testing response. The Advisory Committee on Immunization Practices recommends that tuberculin testing be done either on the same day as vaccination with live virus or 4-6 weeks later.

While the presence of the BCG vaccine (overseas vaccine) is not a contraindication for tuberculosis testing, students who have been given the BCG vaccine may have a significant reaction to Mantoux Testing.

2. Treatment with certain drugs – such as corticosteroids and other immunosuppressive agents – can also cause suppression of the tuberculin testing response. Contact the prescribing healthcare provider to arrange a date when testing can take place.

**Documentation of Services**

1. Record the administration, reading, and interpretation of Mantoux test results on a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Health Record).
2. Document X-rays and treatment, if any, on form A-45.
3. Complete the following annual reports:
   - Those schools in which tuberculin skin testing was not done and those schools in which testing was done, but no reactors were identified, must submit Form TB-57 to the agencies listed on the form by January 15 of the current school year.
   - Those schools in which tuberculin reactors have been identified must submit Form TB-57 and Form TB-42 to agencies listed on the form by March 1 of the current school year. These forms are supplied to school districts from the NJ Department of Health and Senior Services on an annual basis.

**Resources**

**NJ Department of Health and Senior Services**
Tuberculosis Program
Box 369, Trenton, NJ 08625-0369
Contact: Ken Shilkret, Manager
Phone: 609- 588-7522
Fax: 609-588-7562

**References**

NJ Department of Health. (1990). *School tuberculin testing in New Jersey.* Trenton, NJ: Author.

NJ Department of Health and Senior Services Division of Epidemiology. (2000). *Environmental and occupational health: Annual update of information , 2000-01*. Trenton, NJ: Author.

# 7. Other Health Services

## Topic 7A: Managing First-Aid Emergencies

By regulation, schools must provide prompt and appropriate medical attention for students, staff members, or visitors who are injured or become ill on school premises or at school sponsored events. In a collaborative effort involving the chief school administrator, the school physician, the certified school nurse, and the local emergency management agency, every N.J. school district must develop procedures for the provision of these services. District boards of education must also develop emergency and crisis management plans.

|  | **Authorization** |
|---|---|
| | N.J.A.C. 6A:16-5.2, "School Safety"<br>N.J.A.C. 6A:16-1.4, "District Policies and Procedures" |
| | N.J.A.C. 6A:16-4, "Procedures for Substance Abuse Intervention" |

### PROTOCOL

**The role of the school nurse:**

1. Maintain files of standing orders – written and signed annually by the school physician – that delineate actions to be taken by the school nurse in an emergency (see the **Accompanying Critical Issues** table, below).
2. Provide prompt and appropriate medical attention for students, staff members, or visitors who are injured or become ill on school premises or at school sponsored events.

Procedures for providing these services must be developed by every school district in a collaborative effort involving the chief school administrator, the school physician, and the school nurse(s). Procedures must provide for:

- notification of parents/legal guardians of an injured or ill student, and if necessary, the emergency contact of an injured or ill staff member or adult visitor
- transportation to a source of medical care, if indicated
- management of illness and injury at school sponsored events away from school property
- management of athletic injuries

The school nurse is responsible for assessing any injury or illness and acting in accordance with sound professional judgment. Immediate steps may be taken as necessary to remove the injured or ill person from imminent danger and/or prevent the exacerbation of the disability.

In the absence of the school nurse, the building administrator or his/her designee is responsible for obtaining emergency assistance by activating the 9-1-1 emergency service.

Student disabilities attributable to suspected substance abuse require <u>immediate</u> evaluation by the student's private healthcare provider, the school physician, or the nearest hospital emergency facility (in order of availability).

Students who make written or verbal suicide threats must be referred immediately for medical evaluation.

3. Document all injuries to and illnesses of students, staff, or visitors that occur on school property or during school-sponsored events (see the **Documentation of Services** table, below).
4. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

**Accompanying Critical Issues**

- Plans for evaluation, immediate intervention, and referral of ill and injured students, staff, and visitors must be established as district procedures.
- Individual Healthcare Plans and Individual Emergency Healthcare Plans for students and staff who have been identified with health problems should be readily available in their individual health records.
- Written emergency information should be readily available on all students and staff and should be updated at least annually. This information should include methods of contacting parents/guardians or emergency contacts, names and phone numbers of medical and dental providers, any known allergies or medical conditions, and any actions to be taken.

Provide this information to 9-1-1 responders should treatment and transportation of the student or staff member be necessary.

**Documentation of Services**

Document all injuries to and illnesses of students, staff, or visitors that occur on school property or during school sponsored events.

1. Document all referrals for illness or injury requiring immediate medical care on the "Nurse's Notes" portion of the form approved by the Commissioner of Education (form A-45, Health History and Appraisal Cumulative Health Record).
2. Complete district Incident Reports and Workers' Compensation Reports when necessary.

Record injuries to visitors on a district Incident Report and place in an appropriate file.

3. Record a referral for illness or injury requiring immediate medical care in the Nurse's Notes portion of the Student Health Record (form A-45).

**Resources**

Grabeel, J. (1997). *Nursing practice management: Compendium of individualized healthcare plans*. Scarborough, ME: National Association of School Nurses.

Haas, M. (Ed.). (1993). *The school nurse's source book of individualized healthcare plans* (Vol. 1). North Branch, MN: Sunrise River Press.

National Association of School Nurses. (1991) Guidelines for school nursing documentation: Standards, issues, and models. Scarborough, ME: Author.

Porter, S., Haynee, M., Bierle, T., Caldwell, T. H., & Palfrey, J. S. (1999). *Children and youth assisted by medical technology in educational settings: Guidelines for care* (2nd ed.). Baltimore, MD: Paul H. Brookes Publishing.

**References**

Porter, S., et al. (Eds.). (1997). *Children and youth assisted by medical technology in educational settings*. Baltimore: Paul H. Brookes Publishing.

Schwab, N., & Gelfman, M. H. B. (Eds.). (2001). *Legal issues in school health services.* North Branch, MN: Sunrise River Press.

Stern, B. (2000). *Procedure book for school nurses* (rev. ed.). Freehold, NJ: Freehold Township Schools.

# Topic 7B: Managing Disasters and Mass Casualties

| | |
|---|---|
|  | **Authorization** |
| | N.J.A.C. 6A:16-5.2, "School Safety"<br>N.J.A.C. 6A:16-1.4, "District Policies and Procedures" |

| | |
|---|---|
|  | **Definition: Disaster/Mass Casualty Incident**<br>For the purposes of this document, a disaster or mass casualty incident is any incident that requires more resources than those normally available. During a disaster or mass casualty incident, the primary focus is the health and safety of the students, staff, visitors, and responders to the school premises or school sponsored event. |

## PROTOCOL

**Disaster/Mass Casualty Incident Response Plan**

At a minimum, each district board of education shall establish plans, procedures and mechanisms for responding to emergencies and crises. The response plan to a disaster or mass casualty incident should include the following elements:

- total number of students, staff, and visitors potentially involved
- type of emergency (i.e., toxic material exposure, structural failure, natural disaster, explosion, violence, etc.)
- safety of students, staff, visitors, and responders
- emergency evacuation and assembly points
- notification mechanism (if telephone lines are adversely affected)
- availability of staff responders (staff members who may have training in emergency medical care, etc.)

**The role of the school nurse:**

1. Provide prompt and appropriate medical attention for students, staff members, or visitors who are injured or become ill on school premises or at school sponsored events.

Procedures for provision of these services must be developed by every school district in a collaborative effort involving the chief school administrator, the school physician, the certified school nurse, and local emergency management agency. Procedures must provide for:

- notification of parents/legal guardians of an injured or ill student, and if necessary, the family or emergency contact of an injured or ill staff member or adult visitor
- management of illness and injury at school sponsored events away from school property

In the absence of the school nurse, the building administrator or his/her designee is responsible for obtaining emergency assistance by activating the 9-1-1 emergency service.

2. For more information on this topic, consult the **Resources** and **References** tables

provided at the end of this section.

**Accompanying Critical Issues**

- Plans for evaluation, immediate intervention and referral of ill and/or injured students, staff and visitors must be established as district procedures.
- Individual Healthcare Plans and Individual Emergency Healthcare Plans for students who have been identified with health problems should be readily available in their individual health records.
- Written emergency information on all students and staff should be readily available and updated at least annually. This should include methods of contacting parents/guardians of students or emergency contacts of staff, names and phone numbers of medical and dental providers, any known allergies or medical conditions, and any actions to be taken.

  Provide this information to 9-1-1 responders should treatment and transportation of the student or staff member be necessary.

- Every school nurse should be familiar with the triaged system (Simple Triage and Rapid Treatment – START) that is utilized throughout the state (for more information, see **Appendix 7B**).
- Consider supplying emergency responders with a detailed map of the facility.
- Consider holding a practice drill once per school year to familiarize staff, students, and responders with established procedures.

**Resources**

**NJ State Police Office of Emergency Management**
P.O. Box 7068
West Trenton, NJ 08625-0068
Phone: 609-882-2000

**Office of Emergency Medical Services**

NJ Department of Health and Senior Services
P.O. Box 360
Trenton, NJ 08625-0360
Phone: 609-633-7777

**THE UNIFORM STATE MEMORANDUM OF AGREEMENT BETWEEN EDUCATION AND LAW ENFORCEMENT OFFICIALS**

http://www.state.nj.us/lps/dcj/index.htm

**References**

Emergency Management Act, N.J.S.A. Appendix A:9-30 et seq. (Chapter 251, P.L. 1942, as amended by Chapter 438, P.L. 1953, Chapter 504, P.L. 1985, and Chapter 222, P.L. 1989).

# Topic 7C: Managing Crises

## VIOLENCE

School districts should recognize their responsibility to be prepared to confront circumstances in which the physical and/or mental well being of students, staff, and other individuals on school grounds is threatened or overtly impacted upon by an individual or group of individuals. Situations at issue include, but are not limited to, acts of terrorism, hostage situations, and other threats or acts of a violent nature. School districts must also recognize the need to deal with the aftermath of such events and circumstances, and to contend with the psychological trauma, pain, and confusion that may ensue as a result of these events. Cooperation with local law enforcement officials is a critical part of crisis management planning. All school districts are required to establish agreements of understanding with appropriate law enforcement authorities, which must be updated annually.

## SUBSTANCE ABUSE

School districts should recognize that a student's abuse of harmful substances seriously impedes that student's education and threatens the welfare of the entire school community. Schools must make a commitment to the prevention of substance abuse and the rehabilitation of substance abusers by educational means, and they must also take necessary and appropriate steps to protect the school community from harm and from exposure to harmful substances. Intervention, prevention, and treatment referral programs must be in place in every district.

## SUICIDE

School districts should recognize that depression and self-destruction are problems of increasing severity among children and adolescents. Students under severe stress cannot benefit fully from the educational program and may pose a threat to themselves or to others. Employees of boards of education are not responsible for determining the reality of suicide threats or diagnosing or treating psychiatric illness. Every suicide threat should be treated with the utmost concern and must be referred to a source of medical care for evaluation. All personnel should be alert to students who threaten self-destruction – either verbally or in writing – or who attempt suicide. School personnel should also be alert to students who exhibit signs of potential self-destruction, but who have not made any written or verbal threat or overtly attempted to commit suicide.

## OTHER CRISIS SITUATIONS

The sudden death of a student, staff member, or community member involved with the school, as well as natural disasters, can present crises that are best handled by the district Crisis Team working collaboratively with community agencies.

| | Authorization |
|---|---|
| | N.J.A.C. 6A:16-3, "Comprehensive Substance Abuse Prevention Programs"<br>N.J.A.C. 6A:16-4, "Procedures for Substance Abuse Intervention"<br>N.J.A.C. 6A:16-5, "School Safety"<br>N.J.A.C. 6A:16-6, “Law Enforcement Operations for Substances, Weapons and Safety<br>N.J.A.C. 6A:16-7, "Intervention and Referral Services" |

## PROTOCOL

**The role of the school nurse:**

1. Provide assessment to determine if any physical action taken by a student could result in a medical emergency.
2. Secure immediate assistance from paramedics if there is any possible threat to the physical well being of the patient.
3. Keep students under the immediate supervision of certified personnel until arrangements for medical/psychiatric evaluation can be made.
4. Follow-up on referrals.

   A medical note for return-to-school should be required. This ensures that the patient has been evaluated by an appropriate agency and that return to school presents no danger to the student or others.

5. Consult the **Documentation of Services** table, below, to document the crisis.
6. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

**Accompanying Critical Issues**

**Crisis Team**

The district board of education must establish policies and procedures to deal with the crises described above. The Superintendent must designate a Crisis Team, which will act as a source of information, a vehicle through which direct services may be delivered, and as an advisory body to the superintendent or his/her designee and other agents or agencies dealing with the crisis situation.

Crisis Teams should be convened at least on an annual basis to review established policy and procedures, to orient new members as to their responsibilities, and to maintain and reinforce lines of communication between the various disciplines and specialists who make up the Crisis Team. Ideally, Crisis Teams should consist of the following members:

- the Superintendent of Schools or assigned central office administrator
- an administrator from each of the schools within the district
- school psychologists, guidance counselors, and school social workers
- school nurse

- Director of Special Services and/or Guidance
- Director of Buildings and Grounds
- a representative of local/state police
- a representative of local medical facility/hospital
- others, as deemed appropriate to the functioning of the Crisis Team (e.g., a fire department representative, EMT specialist, or other school or community representatives)

**Documentation of Services**

1. Document all referrals to outside agencies or medical providers on a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Cumulative Health Record).

State only the facts as they present to the nurse.

2. Be careful to stay within the laws governing substance abuse referrals (see **Topic 7E: Confidentiality** later in this chapter).
3. Record and file permission-to-return-to-school notes – which must be signed by the private medical provider – with the student's individual health record.

**Resources**

**District Board of Education Policies**

**Local Law Enforcement Agencies**

**Local and Regional Emergency Health Centers**

**Johnson, K. (2000) School crisis management. Alameda, CA: Hunters House Inc.**

**References**

National Task Force on Confidential Student Health Information. (2000). *Guidelines for protecting confidential student health information.* Kent, OH: American School Health Association.

Underwood, M., & Dunne-Maxim, K. (1997). *Managing sudden traumatic loss in the schools* (rev. ed.). NJ Adolescent Suicide Prevention Project.

# Topic 7D: Student Health Records

Boards of education are required to maintain health records on standardized forms provided by the NJ Department of Health and Senior Services and by the Commissioner of Education. This form, identified as form A-45, is the only form schools are permitted to use.

**Authorization**
N.J.A.C. 6A:16-1.5, "Student Health Records"

## PROTOCOL

**The role of the school nurse:**

1. Maintain an individual health folder for each student (see the **Accompanying Critical Issues** table, below).
2. Maintain the student's individual health record on a standardized form provided by the N.J. Department of Health and Senior Services and by the Commissioner of Education (form A-45, Health History and Appraisal Cumulative Health Record).

When completing the family identification at the top of form A-45, use permanent marker for everything except the address and telephone number of the family and the address and telephone number of the healthcare provider, since they may change. The address and telephone number of the family and healthcare provider should be recorded in pencil.

3. Obtain each student's health history from the parent/guardian at the time of registration. Make additions throughout the student's school career, as necessary.
4. Complete immunization records utilizing the day, month, and year of each dose as well as an indication as to the type of vaccine used for DPT and Polio immunizations.

If provisional admission or medical or religious exemptions are granted, attach those certifications.

5. Record health screenings annually.

Record only the Mantoux Test for tuberculosis screening.

6. Record dental reports as "Teeth" listed in "Physical Examination."
7. On the Nurse's Notes portion of form A-45:
   - explain entries that explain code used elsewhere on the health record
   - promptly record all medication orders – whether long-term, prn, or short-term – on the health record
   - note any physical activity restrictions
   - document referrals to outside medical and social sources – except those excluded by confidentiality regulations (see **Topic 7E: Confidentiality** later in this chapter)
   - note exclusions for communicable diseases
   - record accidents or serious injuries
   - document notifications to parents/guardians of immunization requirements
   - record transfers in or out with a note as to sending or receiving district

Every Nurse's Notes entry requires a date and a signature and must be in ink or other permanent medium.

8. Record the administration of all medication to each individual student. Place the record in that student's health file at the end of each school year.

**Record of Administration of Medication**

Records of medication administered must be kept for each individual student and must be placed in that student's health file at the end of each school year. (**Appendix 5**)

9. Keep Nurse's Notes on every student evaluated in the health office (see the **Accompanying Critical Issues** table, below).
10. Consult the **Accompanying Critical Issues** table, below, for additional record keeping information.
11. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

| **Accompanying Critical Issues** |
|---|
| **Individual Student Health Folder**<br>Every student should have an individual health folder containing the following:<br>• form A-45<br>• medication orders and records of administration<br>• healthcare provider's directives for limitation of physical activity<br>• reports of physical examinations performed in the student's medical home<br>• reports of referrals<br>• copies of health summaries for Child Study Team referrals<br>• other forms as directed by district policy<br>• individual health record of health office visits and treatment, inserted when student leaves the school<br>• copies of accident/incident reports |
| **Individual Student Record of Health Office Visits and Treatment**<br>In addition to mandated records kept on form A-45, the school nurse must keep Nurse's Notes on every student evaluated. This record should be placed in the student's health folder when the student leaves the school. Health records should be factual and understandable, using only accepted medical abbreviations, and should include clear descriptions of the following:<br>• why the person was referred or came of his/her own volition<br>• what the nurse's assessment disclosed and what treatment, if any, was provided<br>• what next step, or steps, were taken |

**Accompanying Critical Issues** table, continued ...

| |
|---|
|  Accurate descriptions of events, conditions, and actions taken minimize the danger that a student may suffer from misuse of a record in the future and maximize the protection of the nurse and the district if a record is needed later to demonstrate that appropriate procedures were followed.<br>  Descriptions of student behavior and condition, backed up by whatever objective information may be available (such as vital signs), comprise one of the most important documents in dealing with situations that may be controversial. |
| **Daily Logs**<br>If kept, daily logs may contain only the following information:<br>• the name of the student<br>• the time of the student's arrival and the time that the student left the office<br>All other information must be entered on the student's individual record of health office visits and treatment. |
| **Errors on Records**<br>Any error made on a health record should be bracketed with a line drawn through the incorrect information, and the word "error" and the initials of the nurse written across it. Under no circumstances is "white out" to be used. |
| **Disposition of Records**<br>The original form A-45 of a student transferring to another N.J. public school district must be forwarded to the new school within 10 days of receipt of a written request. (A copy of the front of form A-45 should be given to parents/guardians to present to the new school). For a student transferring to a N.J. private or parochial school, or transferring to a school outside of New Jersey, a copy of form A-45 must be sent to the receiving school. Original records remain with the last public school of attendance in New Jersey. |

**Resources**

N.J.A.C. 6A:16-1.5, "Student Records"

**References**

Hootman, J. (1996). *Quality nursing interventions in the school setting; Procedures, models, and guidelines.* Scarborough, ME: National Association of School Nurses.

Schwab, N,. & Gelfman, M. (Eds.). (2001). *Legal issues in school health services*. North Branch, MN: Sunrise River Press.

Stern, B. P. (2000). *Procedure book for school nurses* (rev. ed.). Freehold Township, NJ: Freehold Township Schools.

# Topic 7E: Confidentiality

Protecting the confidentiality of medical information must be balanced against the "need to know" certain medical conditions that significantly impact upon learning. It is essential that the student's right to confidentiality be paramount in any sharing of information, that written parent/guardian/student consent, when necessary, be obtained, and that staff with whom information is shared be made aware of the requirement for protecting the confidentiality of that information.

**Authorization**

N.J.A.C. 6A:16-1.5(c)

F.E.R.P.A. 1974 20U.S.C.(see authorization in 7F)

Protection of Family Privacy Amendment (Hatch Amendment) to GEPA, 1978, amended 1994 and updated version published in 1999.

Individuals with Disabilities Education Act (IDEA), Regulations at 34 C.F.R.

## PROTOCOL

**The role of the school nurse:**

1. Distinguish student health information from other types of school records.
2. Extend adequate protection to school health records (see the **Accompanying Critical Issues** table, below).
3. Establish uniform standards for collecting and recording student health information.
4. Require written, informed consent from the parent/guardian, and when appropriate, the student, to release medical and psychiatric diagnoses to other school personnel.
5. Limit the disclosure of confidential health information within the school to that information necessary to benefit student's health or education (see the **Accompanying Critical Issues** table, below).
6. Establish policies and standard procedures for requesting needed health information from outside sources and for releasing confidential health information, with parent/guardian consent, to outside agencies and individuals.
7. Provide regular, periodic training for all new school staff, contracted service providers, substitute teachers, and school volunteers concerning the district's policies and procedures for protecting confidentiality.
8. Consult the **Accompanying Critical Issues** table, below, for additional confidentiality concerns.
9. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

**Accompanying Critical Issues**

School district policy should ensure that health records generated within the school by school health professionals are adequately protected.

- School nurses may legally share appropriate health information with those school health professionals who are designated as having "legitimate health interest" within the district, as well as other individuals who provide direct school health and education services to students.
- School nurses must restrict direct access to health records without written, informed consent from the student, or the parent/guardian if the student is under 18 years of age.
- If other staff members have a legitimate "need to know," the information in the health record must be interpreted, either through the Individual Healthcare Plan or directly by the school nurse.
- Confidentiality of certain health information – such as HIV status and substance abuse counseling and treatment – is regulated by separate statute, which accords a greater restriction to access of information and demands that such information be kept separate from student health records.
- Schools have a responsibility to disclose some types of information – such as suspected child abuse, self injury or suicide threats, and the threat of possible harm to another person.
- School districts must establish uniform practices and policies for ensuring security during the creation, storage, transfer, and destruction of student health records.

## Resources

**District Board of Education Policy**

**Health Privacy Rules and Proposed Security Rules as a Guide**
U.S. Health and Human Services
http://aspe.os.dhhs.gov/admnsimp/

## References

Hootman, J. (1996). *Quality nursing interventions in the school setting; Procedures, models, and guidelines.* Scarborough, ME: National Association of School Nurses.

National Association of State School Nurse Consultants. (July 2000). *Position statement: Confidentiality of health information in schools*. Available: http://lserver.aea14.k12.ia.us/tadkins/nassnc/NASSNC_confid.html#CONFIDENTIALITY

National Task Force on Confidential Student Health Information. (2000). *Guidelines for protecting confidential student health information*. Kent, OH: American School Health Association.

Schwab, N,. & Gelfman, M. (Eds.). (2001). *Legal issues in school health services*. North Branch, MN: Sunrise River Press.

# Topic 7F: Access to and Disclosure of School Health Records

|  | **Authorization** |
|---|---|
| | 20 U.S.C. §1232g, Family Education Rights and Privacy Act (FERPA), & 34 C.F.R. Part 99 provide for parent/guardian and adult student access to the student record, including the health record. |
| | 42 C.F.R Part 2 establishes requirements for maintaining the confidentiality of drug and alcohol abuse patient records, which may be maintained by school staff operating school-based alcohol and other drug use programs. |
| | N.J.A.C. 6A:16-1.4(a)19 requires the adoption of district policies and procedures to assure confidentiality related to juvenile justice proceedings (pursuant to N.J.S.A. 2A:4A-60 & N.J.A.C. 6A:16-5.4), HIV identifying information (pursuant to N.J.S.A. 26:5C-5 et seq.), and drug and alcohol use information (pursuant to 42 CFR Part 2, N.J.S.A. 18A:40A-7.1 through 40A-7.2, & N.J.A.C. 6A:16-3.2). |
| | N.J.S.A. 26:5C-5 & N.J.A.C. 6A:16-1.5(c) establish rules of confidentiality and disclosure of records with HIV identifying information. School staff with knowledge of or access to information that identifies a student as having HIV infection or AIDS must be shared only with prior written informed consent of the student age 12 or greater, or of the student's parent/guardian and only for the purpose of determining an appropriate educational program for the student. |
| | N.J.S.A. 18A:40A-7.1 & 40A-7.2 protect information provided by a secondary school student (enrolled in grades 7-12) while participating in a school-based alcohol or other drug counseling program that indicates that a parent/guardian or other person residing in the student's household is dependent upon or illegally using a substance. |
| | N.J.A.C. 6A:16-3.2 & 6A:16-6.5 incorporate federal and state law by reference concerning protection of information, including information concerning illegal activity gained in course of referral for treatment or treatment for alcohol or other drug abuse. |
| | N.J.A.C. 6A:16-1.5(d) requires that the district provide access to the student health record to licensed medical personnel not holding educational certification who are working under contract with or as employees of the district only to the extent necessary to enable the licensed medical personnel to perform their duties. (This rule contrasts with access to student educational records, to which staff holding educational certification may obtain access for purposes of instruction.) |
| | N.J.A.C. 6A:16-1.5(b) requires that school immunization records be:<br>• maintained on a form provided by the N.J. Department of Health and Senior Services<br>• be maintained separately from other student health records<br>• be accessible for review by state and local health officials |
| | N.J.S.A. 9:2-4 provides for parent/guardian access to the student health record regardless of whether the student resides with that parent/guardian, but directs that the place of residence not be disclosed and that access not be provided if denied by the court. |
| | N.J.S.A. 9:6-8.9, N.J.A.C. 6A:16-1.4(a)21, & N.J.A.C. 6A:16-10.2(a)1 require that school personnel with reasonable cause to believe that a child has been subjected to child abuse or neglect must immediately report to the Division of Youth and Family Services. The report must include, when possible, a description of the child's condition, including any available information concerning current or previous injuries, abuse, or maltreatment and including any evidence of previous injuries. |

**Authorization**, continued

N.J.A.C. 6:3-6, "Student Records," establishes rules and conditions for providing access to student records in compliance with FERPA. These regulations encompass student health records as among "mandated" records. N.J.A.C 6:3-6.5(c) provides access to these records to certified school district personnel who have educational responsibility for the student and to certified educational personnel working for an agency contracted with the district to provide educational or clinical services. This rule is qualified by the more recently adopted N.J.A.C. 6A:16-1.5(d), which limits access to the student health record to licensed medical personnel. N.J.A.C. 6:3-6.5(c)10 provides rules for transfer of records to a receiving district, but do not detail mechanisms to prevent transfer of records that have special protection under federal and state rules.

## PROTOCOL

**The role of the school nurse:**

1. **Creation of records.** Conduct a periodic review of how school health records are created and maintained in order to assure that school procedures fulfill written school policies concerning confidentiality and permitted access to records. For instance:
   - Specific information concerning a student's health condition should not be collected on forms that are handled by nonmedical personnel.
   - Staff should not ask parents/guardians or students to discuss health concerns unless the setting provides privacy.
   - Information concerning HIV status or drug/alcohol assessment must not be recorded on the general health history and assessment form.
2. **Separation of records: alcohol or other drug use.** Maintain records of student alcohol or other drug use separately from other student records.

   

   School districts will find it difficult, if not impossible, to assure compliance with detailed federal and state rules specific to alcohol and other drug use programs unless records are maintained separately.

3. **Separation of records: health.** Handle student health records differently from student educational records or directory information.

   

   The American School Health Association National Task Force on Confidential Student Health Information recommends that school districts establish a classification system for student records and define "legitimate health interest" for staff access to each category. The central, or educational, record should indicate that any other records exist and where they are maintained. When specifically protected records are sent or shown together with other records (such as during student transfer with written consent), they should be packaged separately and marked as confidential material.

4. **Security.** Maintain student health records in locked file cabinets or on a secure computer.

   

   The physical layout of the health office should assure that bystanders cannot observe the content of health records. Methods for documenting daily and weekly contact with students should likewise assure the confidentiality of each student by utilizing individual health records.

5. **Routine access.** Limit routine access to student health records only to those school medical staff – employees of the district who serve as school physician, certified or noncertified school nurse, advanced practice nurse, registered nurse, licensed practical nurse, or certified athletic trainer – who require access to perform their duties.

This rule does not preclude school medical staff from delegating limited access rights to specific clerical staff, but such staff should not be granted access to records for which they do not have specific, current, assigned responsibilities. Further, clerical staff needs in-service training to assure that they understand their legal obligations concerning disclosure and re-disclosure of health information.

6. **Parent/guardian and adult student access.** Assure compliance with limitations on parent/guardian and adult student access concerning:
   - disclosure of the home address to a noncustodial parent/guardian
   - disclosure of protected alcohol or other drug use information
   - disclosure of HIV status without specific written consent

Access means the right to view, make notes, and/or have a reproduction made of the record.

The district is required to establish written policies and procedures for access to student records under FERPA, and to notify parents/guardians annually in writing of these rights.

As per FERPA, each time the record is copied or disclosed, record the name, title, and date of access, and for persons other than authorized school medical staff, include the reason for access. Attach written parent/guardian or student disclosure consent.

7. **Written consent.** Exercise vigilance in obtaining written consent prior to disclosing HIV-identifying information and information related to student or family alcohol or other drug use or treatment (see the **Accompanying Critical Issues** table, below). The form used to obtain the consent should specify:
   - approved reasons for the disclosure
   - the type of information to be disclosed
   - names and titles of specific individuals to be informed
   - the date on which the consent expires

Generally, school health record disclosure consent forms should have an effective period no greater than one year.

The standards for maintaining confidentiality of records which identify the HIV status of an individual exceed those established for district educational records or general health records. Identifying records could include the written consent form, referral letters from healthcare providers, child study team evaluations, or medication records, and could be obtained either formally or informally. Any information that identifies an individual as HIV positive can be shared only with specific written consent (see the statute for limited exceptions such as by court order) from the parent/guardian or student age 12 or greater. The information can be shared only for purposes of establishing an appropriate educational program for the student.

The standards for maintaining confidentiality of drug and alcohol patient information do not encompass information gained casually outside the context of program delivery. Because the rules are extensive, staff responsible for related records or who are privy to related information should study these rules directly.

Whenever health information is shared with a third party with the written parent/guardian or student consent, the third party should be warned concerning the protected nature of the information and the necessity to obtain written consent to disclose the information to a fourth party. If the information is shared in writing, the warning should be sent in writing.

8. **Disclosure during team problem-solving**. When participating on a team to assess the needs of specific students, or when asked by the child study team to provide information concerning the health status of a student as part of an evaluation, share general health status information that is not specifically protected by federal or state law. However, consult the health record and provide only relevant information; do not share the health record itself with other team members.

9. **Transfer of records.** Forward mandated school records to a receiving district, with written consent of the parent/guardian or adult student, within 10 days of verification of the transfer. As explained above, certain portions of the student health record may be protected; any records with HIV identifying information and those created under the school alcohol and other drug programs cannot be sent without specific written consent. If such consent has been provided, mark the protected records "confidential" and place a notice on them concerning the receiving district's legal obligations for re-disclosure.

10. **Threats to health and safety.** Report suspected child abuse or neglect to the Department of Human Services, Division of Family and Youth Services. Exercise judgement concerning the kind and extent of information that is necessary to secure care or protect the safety of a child.

Despite protections concerning certain health information, school staff must take action to protect the children they serve. State rules permit the sharing of information under emergency conditions in order to protect health and safety.

11. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

| **Accompanying Critical Issues** |
|---|
| **Training of School Staff**<br>Federal and state rules concerning confidentiality concern all school staff, not only those with official access to student health records. Some rules limit the disclosure of information, however it may have been obtained. Other rules apply specific conditions depending upon how the information was obtained or how it will be shared with other parties. For this reason, school policies and programs to assure confidentiality must include periodic training of all school staff. |
| **Annual Parent/guardian Notification**<br>N.J. school districts must maintain written policy and procedures concerning access and disclosure of student records, and must notify parents/guardians annually in writing concerning their rights to access student records. It is a district responsibility to integrate federal and state requirements governing district staffing and organization, and to fashion district policies and procedures accordingly. |

## Resources

Committee on School Health. (1993). School health: Policy and practice. Elk Grove Village, IL: American Academy of Pediatrics.

National Task Force on Confidential Student Health Information. (2000). *Guidelines for protecting confidential student health information*. Kent, OH: American School Health Association.

U.S. Department of Health and Human Services, Public Health Service, Office of Substance Abuse Prevention. (1990). OSAP technical report 2: Legal issues for alcohol and other drug use prevention and treatment programs serving high-risk youth (DHHS Publication No. ADM 90-1774). Washington, DC: U.S. Government Printing Office.

## References

National Task Force on Confidential Student Health Information. (2000). *Guidelines for protecting confidential student health information*. Kent, OH: American School Health Association.

# Topic 7G: Child Abuse and Referrals to Protective Services

| | Authorization |
|---|---|
| | N.J.A.C. 6A:16-10.1 establishes uniform statewide policies and procedures for public school personnel to report allegations of child abuse and neglect to the Division of Youth and Family Services (DYFS) and to cooperate with the investigation of such allegations. |
| | N.J.A.C. 6A:16-10.2 states that district boards of education must adopt and implement policies and procedures for reporting to and cooperating with DYFS in investigations of child abuse and neglect. District policies and procedures developed pursuant to this subchapter must be reviewed and approved by the country superintendent. |
| | N.J.S.A. 18A:36-19 & N.J.A.C. 6:3-6 govern the release of records to DYFS. |
| | N.J.S.A. 9:6-8.40 governs the maintenance, security, and release of confidential information about child abuse or neglect cases. |

## PROTOCOL

**The role of the district and all school personnel:**

1. School personnel – including professional staff members, support staff members, and unpaid volunteers – who have reasonable cause to believe that a child has been subjected to child abuse or neglect or acts of child abuse or neglect as defined under N.J.S.A. 9:6-8.9 must immediately report to the Division of Youth and Family Services.

   The suspicion of child abuse and/or neglect may be based on the complaints of the student, on the direct observations of the employee over a period of time, or both.

   Although abuse is more easily recognizable, neglect can take more subtle forms. Neglect includes failure of the caregiver to provide food, shelter, adequate supervision, or medical care. Failure to send a child to school and to keep a child reasonably clean may also be considered neglect.

2. School districts are mandated to cooperate with DYFS. DYFS caseworkers may interview a child at school as long as they present proper identification, but only in the presence of the school principal or designee.

   The purpose of the school representative is to provide support and comfort to the child, not to participate in the investigation.

3. School Districts are mandated to provide annual delivery of information and in-service training to school personnel concerning:
   - child abuse or neglect
   - instructional methods and techniques relative to issues of child abuse or neglect in the local curriculum
   - personnel responsibilities pursuant to N.J.S.A. 9:6-8.10 et seq.

   All new school district employees, both paid and voluntary, must receive the required information and training as part of their orientation.

4. Consult the **Documentation of Services** table, below, to document the referral.
5. For more information on this topic, consult the **Resources** and **References** tables provided at the end of this section.

| **Accompanying Critical Issues** |
|---|
| **The Role of the School Nurse**<br>The school nurse is in a position that facilitates awareness of possible cases of abuse and or neglect. It is not the responsibility of the nurse, or of the person suspecting the abuse, to investigate the allegations. Indeed, the school nurse should not examine the child unless the student presents him/herself to the nurse with a specific complaint of injury, and the need for emergency care is possible. If abuse is suspected, DYFS will conduct any examination or investigation. |
| **Good Faith Report**<br>No school personnel can be discharged from employment or in any manner be discriminated against with respect to compensation, tenure or terms, conditions, or privileges of employment as a result of making in good faith a report or causing an allegation of child abuse to be reported. |

**Documentation of Services**

1. Document all referrals to DYFS on the individual student health record (form A-45), stating only:
   - the fact that the referral was made
   - the date and time
   - the name of the DYFS staff member to whom the report was made

**Resources**

**District Board of Education Policy and Regulations**

**County Prosecutor's Office**

**DYFS Protocols**

**References**

National Task Force on Confidential Student Health Information. (2000). *Guidelines for protecting confidential student health information*. Kent, OH: American School Health Association.

Schwab, N., & Gelfman, M. H. B. (Eds.). (2001). *Legal issues in school health services.* North Branch, MN: Sunrise River Press.

# 8. Managing Chronic Health Conditions

## OVERVIEW

The term "children with special healthcare needs" refers to children and adolescents who have a chronic illness or disability. In many educational settings, the term "medically fragile children" is used. In May 1997, the American Federation of Teachers published a manual entitled, *The Medically Fragile Child in the School Setting*. It defines medically fragile children as students with specialized healthcare needs that require specialized technological healthcare procedures for life or health support during the school day. Medically fragile children have also been described as persons with complex medical care needs who require technology, specific services, or some form of ongoing medical or nursing support.[7] These students may not require special education.

In the past, many children with special healthcare needs would have been institutionalized, hospitalized, sent to special schools, or kept at home and deemed unable to learn. Children with special healthcare needs – both the chronically ill and the medically fragile – are now being included in the regular educational setting. These children may need adaptations for daily functioning, prolonged or periodic hospitalizations, and/or special services in the educational setting. All need school health services – such as administration of medication, Individual Healthcare Plans, Individual Emergency Healthcare Plans, and coordination among educators and other care providers. The school nurse is in the ideal position to coordinate these efforts.

The passage of P.L. 94-142 and Section 504 of the Rehabilitation Act, and of P.L. 99-457, P.L.101-476, the Individuals with Disabilities Act (IDEA) 1990, as amended in 1997, with final revised IDEA regulations being published in 1999, have provided access to school for children with chronic and handicapping conditions. It has been shown that every child has the ability to learn and to benefit from school. The challenge for the school is to effectively include children with special healthcare needs in the regular school setting. This means that schools must adapt their environment and programs to safely and effectively accommodate these children.

Children with special healthcare needs represent about 10% to 15% of the population of children and youth from birth to age 20. A national survey found approximately 7% of the children under age 18 to be limited as a result of a health condition or fair or poor health. New medical techniques and technology have resulted in more children surviving illness, especially severe chronic illness, major trauma, and low birth weight. There has been a decline in mortality and morbidity from infectious diseases.

Over the past 20 years, the number of children and adolescents with special healthcare needs in schools has grown as a result of three factors: improved medical technology, enhanced social attitudes promoting inclusion, and legislation requiring education in the least restrictive environment. These three factors are strongly interrelated: The movement for social inclusion and autonomy for individuals with special healthcare needs is supported by medical practice and the existence of assistive technology; technology is influenced by changing social attitudes; and attitudes find their expression in advocacy and law, resulting in a greater presence of children with healthcare needs.

[7] American Federation of Teachers. (1997). *The medically fragile child in the school setting* (2nd ed.). Washington, DC: Author.

Pathophysiology or factors that create special healthcare needs include but are not limited to:

- congenital anomalies or birth defects (mental retardation or cleft palate)
- chronic illness (asthma, seizure disorder, diabetes)
- perinatal factors (prematurity)
- hereditary-genetic conditions (sickle cell anemia, cystic fibrous, Duchenne muscular dystrophy)
- injuries and infections (near-drowning, head trauma, meningitis, HIV/AIDS)

Children with special healthcare needs receive treatment intervention according to their particular condition. The assessment of need should include:

- history
- current status and management
- ability for self-care
- psychosocial issues
- academic issues
- nursing considerations, including staffing and training needs
- working with the child's healthcare provider(s)
- other related services (PT/OT, speech, etc.)
- payment of nursing or outside services
- preparing the school environment
- DNR/DNI orders

Children with special healthcare needs may need:

- Individualized Educational Plans
- 504 Plans

Children with special healthcare needs should have:

- Individualized Healthcare Plan (IHP)
- Individualized Emergency Healthcare Plan (IEHP)
- Individualized Emergency Evacuation Plan (IEEP)

The healthcare needs of school children have changed a great deal over the last few years. More and more children are coming to school with major medical issues – both acute and chronic. Many come to school with serious emotional and social issues that effect their ability to learn. As the healthcare professional in the school setting, the certified school nurse must assess the needs of the student and the available services, and formulate plans for care. As the nurse may be the only professional with daily and ongoing contact with the student, s/he may be the first to see changes in the student's condition that warrant a change in the treatments or services that benefit the student.

The chronic illnesses outlined in this chapter – diabetes, asthma, sickle cell anemia, Lyme disease, and HIV/AIDS – are those that have been addressed by the N.J. Department of Education with a guideline document or position paper. In addition other illnesses, social or emotional issues can be researched, and appropriate healthcare plans formulated. In June 1998, the National Association of School Nurses (NASN) published a position statement on IHPs, the conclusion of which states:

> *It is the position of the National Association of School Nurses that each student with a relatively complex health condition or the need for modification of the school environment due to a health condition should have an IHP. It is also the position of NASN that the professional school nurse should be responsible for the writing of the IHP in collaboration with the student, family, and healthcare providers.*[8]

When working on an IHP, IEHP, or IEEP, one must keep in mind the N.J. Nurse Practice Act, the nursing process (assessment, diagnosis, planning, implementation, and evaluation); and the tenets of Section 504 of the Rehabilitation Act, P.L.99-457, and P.L. 101-476 (IDEA). Guidance from *Standards of Professional School Nursing Practice* and *The School Nurse's Source Book of Individualized Healthcare Plans,* Volumes 1 and 2 (see References, below) can provide assistance in formulating plans. However, the professional school nurse, who is hired for her specialized assessment skills and knowledge of not only medical but also educational and psychosocial issues, is accountable to provide the best possible plan for the student with a unique set of healthcare needs.

### Resources

**National Association of School Nurses (NASN)**
http://www.nasn.org

### References

American Federation Teachers. (1997). *The medically fragile child in the school setting* (2nd ed.). Washington, DC: Author.

Arnold, M., & Silkworth, C. (Eds.). (1999). *The school nurse's source book of individualized healthcare plans* (Vol. 2). North Branch, MN: Sunrise River Press.

Haas, M.B. (Ed.). (1993). *The school nurse's source book of individualized healthcare plans* (Vol. 1). North Branch, MN: Sunrise River Press.

National Association of School Nurses. (1998). *Position statement: Individualized healthcare plans.* Scarborough, ME: Author.

National Association of School Nurses. (1997). *Nursing practices management: Compendium of individualized healthcare plans.* Scarborough, ME: Author.

National Association of School Nurses. (1997). *Standards of professional school nursing practice*. Scarbourgh, ME: Author.

[8] National Association of School Nurses. (1998). *Position statement: Individualized healthcare plans*. Scarborough, ME: Author.

# Topic 8A: Managing Students With Chronic Health Conditions

In managing students with chronic health conditions, the role of the certified school nurse is to assess the health needs of the child in the school setting and coordinate with school staff, the family, healthcare providers, and community agencies to provide a comprehensive health program that facilitates the maximum educational opportunity for the student. In order to do this, the school nurse incorporates the roles of case manager, healthcare provider, counselor, educator, and child advocate.

## PROTOCOL

**The role of the school nurse:**

The responsibilities of the certified school nurse include, but are not limited to, the following list.

1. Identify students with chronic health conditions or special healthcare needs at school enrollment, annually, or as necessary.
2. Conduct initial and annual parent/guardian conferences to obtain health histories, developmental histories, and family assessments, and to review students' current health status.
3. Determine students' present healthcare needs based on data obtained.
4. Obtain necessary orders and instructions from healthcare providers.
5. Develop individualized healthcare plans (IHPs) that focus on restoring health, promoting wellness, and minimizing or removing health barriers to learning.
6. Review IHPs annually and revise as necessary.
7. Educate appropriate school personnel to the nature and educational relevance of students' health conditions.
8. Provide and/or supervise direct nursing care to allow students to remain in the least restrictive educational environment.
9. Establish and maintain communication and coordination with parents/guardians, healthcare providers, school personnel, and community agencies.
10. For more information on this topic, consult the **Resources** table, below.

**Resources**

American Federation Teachers. (1997). *The medically fragile child in the school setting* (2nd ed.). Washington, DC: Author.

Haas, M.B. (Ed.). (1993). *The school nurse's source book of individualized healthcare plans* (Vol. 1). North Branch, MN: Sunrise River Press.

Hootman, J. (1996). *Quality nursing interventions in the school setting: Procedures, models, and guidelines.* Scarborough, ME: National Association of School Nurses.

**NASN**: http://www.nasn.org

**School Nurse Forum**: http://www.schoolnurse.com

**School Asthma & Allergy Knowledge Exchange**: http://www.schoolasthma.com

# Topic 8B: Asthma

Asthma is chronic lung disease characterized by acute episodes or attacks of breathing problems such as coughing, wheezing, chest tightness, and shortness of breath. These symptoms are caused by airway swelling, blocked airways, and increased responsiveness of the airways to a variety of stimuli or "triggers". The triggers that cause an asthma episode vary with individuals, but there are common triggers. The exact etiology of asthma remains equivocal. Although a familial tendency has long been recognized, environmental factors are now thought to contribute to the presence of clinically recognized asthma. There are no clear markers to predict the prognosis for an individual child. Factors associated with continuing asthma are allergy, a family history of asthma and/or allergy, perinatal exposure to passive smoke and aeroallergens.

**Authorization**

P.L. 1993, c. 308 supplementing N.J.S.A. 18A:40-12.3

**Accompanying Critical Issues**

**Clinical Diagnosis**

A clinical diagnosis is determined if:

- episodic symptoms of airflow obstruction (coughing, wheezing, shortness of breath or rapid breathing, chest tightness) are present
- airflow limitation is at least partially reversible
- alternative diagnoses are excluded

There are three steps for diagnosing asthma in children:

- medical history to include family history of allergy and asthma, symptoms and frequency of symptoms, and medication that the child is taking
- physical examination
- objective measurements

**Treatment**

In the treatment of the child with asthma, the primary goal is to allow the child to live as normal a life as possible. The child should be able to:

- participate in normal childhood activities
- experience exercise tolerance similar to peers
- attend school to grow intellectually and develop socially

Asthma can be controlled with proper diagnosis and management. It cannot be cured. New approaches emphasize preventing episodes by reducing the constant presence of inflammation in the lungs. With long-term therapy, children with asthma need not suffer from symptoms. Effective management of asthma will allow the student to maintain a normal activity level, prevent acute symptoms and episodes, and avoid side effects from medications.

Any school nurse authorized to administer medication under the provisions of N.J.S.A. 18A:40-12.3 must receive training in airway management and in the use of nebulizers and inhalers consistent with nationally recognized standards, such as: The American Academy of Allergy, Asthma and Immunology, and the National Heart, Lung, and Blood Institute Guidelines.

**Reporting Requirements**

Reporting is not required at the present time, but a mechanism for tracking is in the process of being set up by the Department of Health and Senior Services.

**Accompanying Critical Issues** table, continued

**Prevention Guidelines**

- Develop an asthma management program in your school.
- Develop school policies and procedures to meet the needs of students with asthma, referencing P.L. 1993, c. 308 supplementing N.J.S.A. 18A:40-12.3.
- Individualize an asthma action plan for students with asthma. An Individualized Healthcare Plan (IHP) and Individualized Emergency Healthcare Plan (IEHP) should be written by the school nurse in collaboration with the student (if appropriate), the parent/guardian, and the student's healthcare provider. The asthma action plan should be signed by a parent/guardian and healthcare provider. The IHP and IEP should be signed by the parents/guardians.
- Another consideration for the school setting is the removal of all pets, animals, insects, plants, and cut flowers from the classroom, as these are triggers for some students with asthma.

**Documentation of Services**

1. Document services on a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Health Record).
2. Document all referrals, follow-up, and parent/guardian conferences on the reverse side of form A-45.
3. File any healthcare provider documentation with the individual student health record.

**Resources**

**Allergy and Asthma Network/Mothers of Asthmatics**
2751 Prosperity Ave., Suite 150, Fairfax, VA 22031
Phone: 800-878-4403 or 703-641-9595
http://www.aanma.org

**American Academy of Allergy, Asthma and Immunology**
611 East Wells St., Milwaukee, WI 53202
Phone: 800-822-ASMA or 414-272-6071
http:www.aaaai.org

American Academy of Allergy, Asthma and Immunology. (Sept. 2000). *Topic of the Month: Does your child's school trigger allergies?* Available: http://www.aaaai.org/misc/topicofthemonth/0900/checklist

**American Academy of Pediatrics**
141 Northwest Point Blvd., Elk Grove Village, IL 60007-1098
Phone: 800-433-9016 or 847-228-5005
http://www.aap.org

**American Association for Respiratory Care**
11030 Ables Lane, Dallas, TX 75229
Phone: 972-243-2272
http://www.aarc.org

**American College of Allergy, Asthma, and Immunology**
85 W. Algonquin Rd., Suite 550, Arlington Heights, IL 60005
Phone: 800-842-7777 or 847-427-1200
http://acaai.org

**American Lung Association**
For the affiliate nearest you, call: 800-LUNG-USA
http://www/lungusa.org

**Americans with Disabilities Act, 28CFR Section 38.302**

**Asthma and Allergy Foundation of America**
1233 20th St., NW, Suite 402, Washington, DC 20036
Phone: 800-7-ASTHMA or 202-466-7643
http://www.aafa.org

**Asthma and Allergy Foundation of America/New England Chapter**
220 Boylston St., Chestnut Hill, MA 02467
Phone: 617-965-7771
Fax: 617-965-8886
E-Mail: aafane@aol.com
http://www.aaffa.org and http://www.asthmaandallergies.org

**Asthma and Schools Organization**
1201 16th St., NW, Suite 521, Washington, DC 20036
Phone: 202-822-7481
Fax: 202-822-7775
http://www.asthmaandschools.org

Centers for Disease Control. (2000). Salmonellosis associated with chicks and ducklings – Michigan and Missouri. *MMWR, 49*(14), 297-9.

Environmental Protection Agency. (1995). Indoor air quality: Tools for schools, 1995. Washington, DC: Environmental Protection Agency.

**Healthy Kids: The Key to Basics**
Educational Planning for Students with Chronic Health Conditions
79 Elmore St., Newton, MA 02459-1137
Phone: 617-965-9637
E-Mail: erg-hk@juno.com

Kansas Department of Health and Environment, Office of Epidemiological Services and Public Information. (1997). *Animals in Kansas schools: Guidelines for visiting and resident pets*. Topeka, KS: Author.

National Association of School Nurses (2000). *Position statement: Animals in the classroom*. Scarborough, ME: Author.

National Association of School Nurses (2000). *Position statement: Indoor air quality*. Scarborough, ME: Author.

**National Asthma Education and Prevention Program**
National Heart, Lung, and Blood Institute Information Center
P.O. Box 30105, Bethesda, MD 20824-0105
http://www.nhlbi.nih.gov

**National Asthma Education Program Information Center**
4733 Bethesda Ave., Suite 530, Bethesda, MD 20814-4820
Phone: 301-951-3260

**Pediatric Asthma Coalition of New Jersey**
1600 Route 22 East
Union, New Jersey 07083-3407
Fax: 908-851-2625
Phone: 908-687-9340
www.pacnj.org

**Rehabilitation Act of 1973, § 504 (IDEA)**

Adams, R. M., & Ozias, J. M. (Eds.). (January 1998). Animals in school: A zoonosis threat? [newsletter supplement]. *School Health Alert*.

**U.S. Department of Education**
Office for Civil Rights, Customer Service Team
Mary E. Switzer Building, 330 C St., SW, Washington, DC 20202-1328
Phone: 800-421-3481 or 202-205-5413
http://www.ed.gov/offices/OCR

U.S. Department of Health and Human Services. (February 2000). *Healthy people 2010*. Washington, DC: Author.

**U.S. Environmental Protection Agency**
Indoor Environments Division
401 M Street, SW (6604J), Washington, DC 20460
Phone: 202-233-9370
Indoor Air Quality Information Clearinghouse
Phone: 800-438-4318
http://www.epa.gov/iaq

**References**

**American Academy of Allergy, Asthma and Immunology** (see above)

**American Academy of Pediatrics** (see above)

# Topic 8C: Diabetes

Diabetes Mellitus is a chronic metabolic disorder characterized by abnormal carbohydrate, fat, and protein metabolism and caused by a decrease or absence of the secretion of insulin by pancreatic beta cells. Diabetes is one of the most common chronic diseases of childhood: Out of every 1000 young people under 18, 1 to 3.5 individuals are affected.

A current theory is that a viral or autoimmune disorder causes the beta cell abnormality, which in turn results in the absence of or deficient insulin production. It is felt that heredity and obesity play a role in this disorder. Since diabetes affects not only the carbohydrate but also fat and protein metabolism, it has far-reaching effects on many systems of the body. Over a long period of time, diabetes can produce complications of the vascular and neurological systems. With these systems compromised, neuropathies, ocular changes, circulatory difficulties, and renal complications occur.

Diabetes falls into two categories:

- Type 1. Most children and adolescents with diabetes suffer from Type 1, or "insulin dependent," diabetes.
- Type 2. In this form of diabetes, diet and/or oral medication may be sufficient enough to control the glucose imbalance. Many adults are classified as having Type 2 diabetes. However, with the rise in obesity and lack of exercise, Type 2 diabetes has been recognized and is on the rise in young adults and children under 10 years old.

Diabetes is diagnosed using a complete history and physical, accompanied by extensive blood work and urinalysis. Symptoms of diabetes include:

- frequent urination (polyuria)
- excessive thirst (polydipsia)
- increased food intake (polyphagia)
- weight loss
- changes in behavior
- bedwetting in children

**Accompanying Critical Issues**

- As is true for any child with a chronic illness in school, the school system has a responsibility to provide appropriate diabetic care necessary for the child's long-term well being and optimal academic performance. Consult the References at the end of this topic to review the recommendations of the Task Force on Diabetes in the Schools entitled, *Guidelines for the Care of Students with Diabetes in the School Setting*.
- Every diabetic child should have an Individual Healthcare Plan (IHP) and an Individual Emergency Healthcare Plan (IEHP), so that s/he may be medically cared for and have regular school attendance. The plans should include routine and emergency treatment agreed upon by the school nurse, parent/guardian, and the child's healthcare provider. Care plans, treatments, and orders of the family healthcare provider may be reviewed by the school physician. [See *Guidelines for the Care of Students with Diabetes in the School Setting* under **References**, below].
- A child with diabetes may be a candidate for a 504 Accommodations Plan.

| | |
|---|---|
|  | **Documentation of Services** |
| | 1. Document all services on a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Health Record). |
| | 2. An individualized healthcare plan, health provider instruction, orders for medication, and an emergency care plan should be in place and documented. |
| | 3. All of these documents should be placed with the student's individual health record. |

**Resources**

**American Diabetes Association**
http://www.diabetes.org

**American Diabetes Association of New Jersey**
19 School House Rd., Somerset, NJ 08873
Phone: 888-DIABETES (342-2383)
http://www.diabetes.org/adaNJ/info.asp

**Juvenile Diabetes Foundation International**
The Diabetic Research Foundation
120 Wall St., New York, NY 10005
Phone: 800-JDF-CURE or 212-785-9500
Fax: 212-785-9595
http://www.jdf.org

**Juvenile Diabetes Foundation, Central Jersey Chapter**
740 Broad St., Shrewsbury, NJ 07702
Phone: 732-219-6654
Fax: 732-219-8722
E-Mail: centraljersey@jdrf.org
http://www.jdf.org/chapers/NJ/Central-Jersey

**Juvenile Diabetes Foundation, Mid-Jersey Chapter**
28 Kennedy Blvd., Suite 180, East Brunswick, NJ 08816
Phone: 732-296-7171
Fax: 732-296-1433
E-Mail: midjersey@jdrf.org

**Juvenile Diabetes Foundation, Rockland/Bergen/Passaic Chapter**
560 Sylvan Ave., Englewood Cliffs, NJ 07632
Phone: 201-568-4838
Fax: 201-568-5360
E-Mail: rockland@jdrf.org
http://www.jdf.org/chapters/NJ/Rockland-Berg-Pass

**Resources**, continued

**Juvenile Diabetes Foundation, South Jersey Chapter**
295 Rt. 70 West, Suite #2, Cherry Hill, NJ 08002
Phone: 856-429-1101
Fax: 856-429-1105
E-Mail: southjersey@jdrf.org
http://www.jdf-sj.org

**The Diabetes Mall**
http://www.diabetesnet.com

**Camp Nejeda Foundation**
P.O. Box 156, Stillwater, NJ 07875-0156
Phone: 973-383-2611

**Pump Information**
http://www.minimed.com
http://www.animascorp.com
http://www.disetroniscusa.com

**References**

NJ Department of Education. (2000). *Guidelines for the care of students with diabetes in the school setting.* Available: http://www.state.nj.us/njded/edsupport/diabetes.

Hathaway, W., Groothuis, J., Hay, W., Paisley, J. (Eds.).(1991). *Pediatric diagnosis and treatment.* East Norwalk, CT: Appleton & Lange.

# Topic 8D: Do Not Resuscitate Orders

According to federal legislation (P.L. 101-746, Individuals with Disabilities Education Act), every student is entitled to a free, appropriate public education in the least restrictive environment. Due to the high risk of medically fragile students and those with chronic illnesses – who in the past would not have survived to be able to attend school – new problems challenge families, professionals, and school personnel in caring for these students in the school setting. It is possible that some children will be at risk of dying during the school day, and that some families may wish not to pursue lifesaving medical protocols, due to the lack of benefit to the student's condition or quality of life that is likely to result from following these protocols. Do Not Resuscitate, or DNR, orders would allow the student to die with dignity. The family may wish that certain medical protocols be rendered to the student, such as oxygen, suction, and pain medication.

**Authorization**

N.J.A.C. 6A:16-2.1(d)11

**Accompanying Critical Issues**

- Some parents/guardians of healthy students may be concerned about the effect of the death of a classmate in the school setting on their child. This is a legitimate concern.
- School administrators might fear the legalities of school personnel responding to a medical emergency in good faith.
- Staff may have differing opinions about the ethics of students dying in school.
- The American Academy of Pediatrics encourages pediatricians to become involved in developing DNR orders.
- Once the family has decided to pursue this type of protocol, the family, the student if appropriate, the school physician, the school nurse, the student's family healthcare provider, and the local emergency medical services provider should meet and design a plan that specifically meets the goals for this student.

**The Role the School Nurse**

The school nurse should take a leadership role in being proactive with DNR orders:

- The nurse should review all applicable state statutes and regulations.
- The plan needs to include specific written emergency orders from the family healthcare provider and parents/guardians.
- The plan must be reviewed by the school physician, the district board of education, and the district board of education's legal counsel.
- Community emergency medical services protocols must be clear.
- The plan should be reviewed whenever a change occurs in the student's condition and at least every six months.

The school nurse is responsible for providing appropriate response to DNR orders. The school physician is responsible for instructing the school staff in DNR orders.

| | Documentation of Services |
|---|---|
| | 1. The existence of the DNR orders must be referenced on a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Health Record). |
| | 2. A copy of the DNR orders should be placed with the student's individual health record. |
| | 3. A copy of the DNR orders should be kept with the local emergency medical services provider. |

## Resources

American Academy of Pediatrics Committee on Bioethics. (1993). Guidelines on forging life-sustaining medical treatment. *Pediatric Nursing, 20*(5), 517-521.

Baltimore County Public Schools. (1997). Management of do not resusciate orders. In *Manual of school health nursing practice* (Rev. ed., pp. 43-47). Towson, MD: Author.

Beckman, L. E. (1995, May). *DNR orders: What should a school district do?* Paper presented at the 16th National Institute on Legal Issues of Educating Individuals with Disabilities, Washington, DC.

National Association of School Nurses. (1995). Do not resuscitate position statement [updated version available: http://www.nasn.org]. Scarborough, ME: Author.

National Education Association. (1994). Policy on do not resuscitate orders. West Haven, CT: Author.

Schwab, N., & Gelfman, M. H. B. (Eds.). (2001). *Legal Issues in school health services.* North Branch, MN: Sunrise River Press.

## References

Americans with Disabilities Act of 1900, 42 U.S.C. 12101 et seq.

American Academy of Pediatrics Committee on Bioethics. (1994). Guidelines on foregoing life-sustaining medical treatment. *Pediatrics,* 93, 532-536.

American Academy of Pediatrics Committee on School Health & Committee on Bioethics. (2000). Do not resuscitate orders in schools [Policy Statement RE9842]. *Pediatrics*, *105*(4).

Costante, C. C. (1998). [Do not resusciate orders in schools: Survey]. Unpublished raw data.

Costante, C. C. (1998). Managing DNR requests in the school setting. *Journal of School Nursing, 14*(4), 49-55.

Meunch, G. C. (1998). NJ Department of Health and Senior Services Directive to All Basic and Advanced Life Support Provider Agencies.

**References**, continued

Rushton, C. H., & Murray, J. C. (1994). To honor and obey: DNR orders and the school. *Pediatric Nurse, 20,* 581-585.

Scofield, G. R. (1992). A lawyer responds: A student's right to forgo CPR. *Kennedy Institute of Ethics Journa*l, 2(1), 4-10.

Ramer-Chrastek, J. (2000). Hospice care for a terminally-ill child in the school setting. J*ournal of School Nursing, 16*(2), 52-56.

Younger, S. J. (1992). A physician/ethicist responds: A student's rights are not so simple. *Kennedy Institute of Ethics Journal, 2*(1), 13-18.

# Topic 8E: HIV and AIDS

The human immunodefiency virus (HIV) is a retrovirus with three modes of transmission: blood-borne, sexual, and vertical (mother to child). Vertical transmission can occur in utero, during delivery, or through breast feeding.

Until very recently, children in the school setting identified as having HIV disease were most likely to have acquired infection vertically. Infected infants and children typically had substantial and multiple health problems, many of which met the clinical definition of AIDS. These included moderate to severely impaired immune function, susceptibility to infections (common bacterial, as well as viral and opportunistic), delays in growth and development, cognitive and neurological problems, and chronic respiratory conditions. With improved treatments over time, many of these children have achieved puberty; some will enter the early adult years.

The course of HIV disease among children perinatally exposed is very different from that of infection acquired in adolescence or adulthood. In adolescents and adults, the initial infection sometimes manifests as mild cold or flu-like symptoms. While the virus replicates very rapidly during the earliest stage of infection, clinical symptoms of immune system dysfunction take years to appear. Left untreated, HIV will progress to Acquired Immune Deficiency Syndrome (AIDS) in an average of 10 years in adults. Adolescents with HIV disease, if otherwise healthy, will experience few, if any, symptoms of infection during this period of their lives.

Today, the course and manifestations of HIV disease in children are rapidly changing due to early identification and the use of new, more effective medications. As a result, the prognosis for HIV-infected children is significantly improved. The number of infected infants born annually in New Jersey has been reduced through widespread implementation of mandatory counseling, voluntary testing, and voluntary treatment of pregnant women found to have HIV infection. Nevertheless, many of the children born with HIV infection who are of school age today have chronic illness conditions that require supportive health and educational services. The kinds of supportive services needed by children with HIV may include:

- confidential administration of medication
- access to special fluids, supplements, or foods
- bathroom privileges
- early intervention and accommodations for learning, behavioral, or attention difficulties
- Child Study Team evaluation for special services related to learning, physical disability, or mental and emotional needs
- accommodations in getting from one class to another and managing heavy books

**Authorization**

N.J.S.A. 26:5C-5

N.J.A.C. 6A:16-1.5(c) establishes rules of confidentiality and rules of disclosure of records with HIV-identifying information.

N.J.A.C. 8:61-1.1 & N.J.A.C. 8:16-1.4 require public schools to assure that any student with HIV infection or AIDS or who lives with or is related to someone with HIV or AIDS is not excluded from general education, transportation services, extracurricular activities, or athletic activities, or assigned to home instruction or classified as eligible for special education for reason of HIV infection.

Since N.J. law does not address youth access to HIV counseling and testing, some providers may not provide HIV tests to youth under the age of 18 without parent/guardian consent. This legal situation differs from N.J. law on youth access to testing for sexually transmitted infections (N.J.S.A. 9:17A-4), which provides such access without parent/guardian consent based upon the youth's belief that they may be infected.

**Accompanying Critical Issues**

**Awareness of HIV Status**

Many children born with HIV are not aware of their infection, even if their caregivers are aware. School staff must be sensitive to the complex issues around disclosure faced by parents/guardians and other caregivers. Similarly, children with parents/guardians or other relatives suffering from HIV infection may not be fully aware of the reasons behind their parent/guardian's illness.

**Testing**

Testing for HIV infection can be done either through venous blood sample, urine sample, or sampling of oral mucosa transudate. The most sensitive antibody tests available (at time of printing) can detect antibody within one month of infection; standard tests for HIV Type 1 detect antibody at an average of three months after infection, but may detect antibody within six weeks after infection (see **Resources**, below, for a link to N.J. HIV counseling and testing sites).

**HIV Reporting**

The diagnosing physician or testing center is required to report a finding of HIV and/or AIDS with personal identifiers to the State Department of Health and Senior Services.

**Treatment**

Standards of best practice for treatment of HIV disease change rapidly as current research findings are tested clinically. For this reason, the N.J. Department of Health and Senior Services recommends that treatment be provided by a physician with specific experience and expertise treating HIV-infected children. Treatment regimens are often complex, requiring frequent dosing with multiple medications in coordination with meals. These medications have substantial side effects, which may require supportive care (see **Resources**, below, for information on providers in the N.J. Statewide Family Centered HIV Care Network who have expertise in counseling, testing, and treatment of children and youth with HIV infection). In some instances, the pediatric HIV specialist may not be authorized to also serve as the student's primary healthcare provider. The school health record should indicate the name and number of the physician who should be contacted in case of emergency.

**Accompanying Critical Issues** table, continued

| |
|---|
| **Disclosure of HIV Status**<br><br>Students, their parent/guardians, and employees are not obligated to inform school personnel regarding their HIV status and cannot be required to do so based upon state statute (N.J.S.A. 26:5C-5) and regulation (N.J.A.C. 6:16-1.5(c). These rules state that school staff with knowledge of or access to information that identifies a student as having HIV infection or AIDS must be shared only with prior written informed consent of the student age 12 or greater, or of the student's parent/guardian and only for the purpose of determining an appropriate educational program for the student.<br><br>The standards for maintaining confidentiality of records which identify the HIV status of an individual are established in N.J.S.A. 26:5C, and exceed those established for district educational records or general health records. Identifying records could include the written consent form, referral letters from healthcare providers, child study team evaluations, or medication records. Identifying information could be obtained either formally or informally. Any information that identifies an individual as HIV positive can be shared only with specific written consent from the parent/guardian or student age 12 or greater. The consent form should specify approved reasons for disclosure, the type of information to be disclosed, specific individuals to be informed by name and by title, and the date on which the consent expires. Generally, school health record disclosure consent forms should have an effective period no greater than one year. Even with such consent, information can be shared only for purposes of establishing an appropriate educational program for the student. See the section on "Access to and Disclosure of Student Health Records" for additional guidance on this topic. |
| **Required Immunizations**<br><br>Indication of those immunizations appropriate for a particular student with HIV disease should be provided by the student's physician. |
| **Staff Training**<br><br>Despite two decades of public education concerning the nature of HIV transmission, stigma and discrimination persists against those either infected or affected by HIV disease. While N.J. schools are no longer required to provide annual staff training in HIV disease, regular training of all staff is necessary in order to fulfill this mandate against discriminatory practices. |
| **Athletics/Sports**<br><br>Although HIV-infected children and adolescents should be allowed to participate in all sports activities, HIV-infected athletes considering participation in contact sports such as wrestling, boxing, or tackle football should be evaluated for bleeding tendency and the presence of exudative skin lesions that cannot be easily covered during sports. The American Academy of Pediatrics suggests that HIV-infected students be informed of the "theoretical risk of contagion to others and strongly encouraged to consider another sport." |

**Accompanying Critical Issues** table, continued

| **Prevention Guidelines** |
|---|
| • Maintain a system for alerting students and parents/guardians of the occurrence in the school of communicable diseases, so that students and parents/guardians can take action to protect their health regardless of whether they have disclosed their HIV status or other immune-compromising illness.<br>• Symptomatic or severely immune-compromised children who are exposed to certain communicable diseases should receive immune globulin prophylaxis, per physician's order.<br>• For a child with HIV infection, small health problems can quickly escalate. Attend promptly to fever, rash, diarrhea, changes in breathing, appetite, gait, motor skills, or behavior, and to unusual sleepiness.<br>• Practice Standard/Universal Precautions as appropriate to the school setting (see **Chapter 6** for more information). |

|  | **Documentation of Services** |
|---|---|
| | 1. School records that document delivery of services that are likely to identify a student as infected with HIV should be maintained in a locked cabinet separate from the general school health record and accessible only to school health staff with specific clearance for this access necessary to their duties. Such information should never be documented on form A-45. |
| | 2. The existence of special health records can be denoted in the individual student health record through a code such as SR for "special record." |
| | 3. For students with HIV, the student's medications and potential side effects should be noted. |
| | 4. The record must include written consent from the parent/guardian, or student if age 12 or greater, for any person with whom the student's HIV status may be discussed (such as the student's physician and the school physician). |

## Resources

Bradley, B. J. (1994). *HIV infection and the school setting: A guide for school nursing practice.* Kent, OH: American School Health Association.

National Association of State Boards of Education. (1996). *Someone at school has AIDS: A complete guide to education policies concerning HIV infection*. Alexandria, VA: Author. (Available: http://www.nasbe.org)

**National Pediatric and Family HIV Resource Center**
Phone: 800-362-0071
http://www.pedhivaids.org

**NJ HIV Counseling and Testing Sites**
http://www.state.nj.us/health/aids/ctsites.htm

**NJ Statewide Family Centered HIV Care Network**
NJ Department of Health and Senior Services
Special Child and Adult Early Intervention Services
Phone: 609-292-1078
http://www.njfamilyhivaids.org

**Adolescent Medicine Program: Project START**
University of Medicine and Dentistry of New Jersey – NJ Medical School
Phone: 973-972-0360

**HIV/AIDS Treatment Guidelines, Treatment Information Service**
http://hivatis.org

## References

National Pediatric and Family HIV Resource Center. (2000). *Making the invisible visible: Services for families living with HIV infection and affected children*. Newark, NJ: University of Medicine and Dentistry of New Jersey.

American Academy of Pediatrics, Committee on Pediatric AIDS. (2000). Education of children with human immunodeficiency virus infection. *Pediatrics*, 105, 1358-1360.

American Academy of Pediatrics, Committee on Pediatric AIDS & Committee on Infectious Disease. (1999). Issues related to human immunodefiency virus transmission in schools, child care medical settings, the home, and community. *Pediatrics*, 104, 318-324.

Dominguez, K. L. (2000). Management of HIV-infected children in the home and institutional settings: Care of children and infections control on schools, day care, hospital settings, home, foster care, and adoption. In M. Rogers (Ed.), "HIV/AIDS in infants, children, and adolescents," *The pediatric clinics of North America,* (Vol. 47, pp 203-239). Philadelphia: W.B. Saunders.

**References**, continued

Forsyth, B. W. C. (2000). HIV infection in children: A new hope. In J. A. Adnopoz & S. J. Berkowitz (Eds.), "Children affected by HIV/AIDS," *Child and adolescent psychiatric clinics of North America*, (Vol. 9, pp. 279-294). Philadelphia: W.B. Saunders.

Gross, E. J., & Hernandez Larkin, M. (1996). *The child with HIV in day care and school*. In C. Grady, C. Bechtel-Boenning, & M. Boland (Eds.), "HIV Infection/Perinatally Transmitted HIV Infection," *The nursing clinics of North America*, (Vol. 31, pp. 231-241). Philadelphia: W.B. Saunders.

# Topic 8F: Lyme Disease

Lyme disease is a bacterial illness that some people get after being bitten by ticks that are infected with the organism *Borrelia burgdorferi.* In some 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 the 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.

However, there are people who never manifest a rash. Multiple secondary circular lesions, red blotches and circles, and conjunctivitis and swelling around the eye can also 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, the first symptoms do not occur. If this happens, or if the early disease is untreated, other problems may develop involving joints, eyes, and the cardiac and nervous systems weeks to months after the tick bite.

**Authorization**

N.J.S.A. 18A:35-5.1 et seq.

| Accompanying Critical Issues |
|---|
| **Infection**<br>The bacteria that cause Lyme disease are spread by ticks. Transfer of 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 to 48 hours. A person cannot get Lyme disease from animals or other persons. |
| **Incubation**<br>The incubation period for EM is from 3 to 32 days after tick exposure; however, the early stages of the illness may be asymptomatic, and the person may present with later manifestations. |
| **Clinical Diagnosis**<br>Diagnosis is made clinically on the basis of history and physical examination findings. It is sometimes confirmed by laboratory tests. |
| **Treatment**<br>Treatment includes antibiotics and supportive measures.<br>• In-school antibiotic intravenous therapy should be coordinated with community health services.<br>• The IHP should be developed upon receipt of the healthcare provider's order. |
| **Reporting Requirements**<br>Lyme disease must be reported to the local health department within seven days of diagnosis by the diagnosing healthcare provider. |

**Accompanying Critical Issues** table, continued

**Prevention Guidelines**

- Develop a policy for environmental control on school grounds and school trips.
- The best way to prevent tick-borne diseases is to avoid tick-infested areas, including woodlands, wooded edges, and landscaped areas with dense ground cover, leaf litter, or shrubs. If this is not possible, take the following precautions when entering likely tick habitats:
  - Wear light-colored clothing. Ticks are dark in color and will be easier to see against a light background.
  - Tuck pant-legs into socks and shirts into pants. Ticks will be forced to crawl on the outside of clothing where they can be more easily seen and removed.
  - Conduct a daily tick check. Ticks removed within 24 to 48 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. They look like new "freckles."
- If a tick is found on a person, remove it immediately as per school physician's protocol. Notify the parent/guardian immediately and suggest that the parent/guardian contact the student's medical home for further treatment. To remove a tick, see appendix 8F.

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 on protected parts of the body.

**Documentation of Services**

1. Document services on a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Health Record).
2. Document all referrals, follow-up, and parent/guardian conferences on the reverse side of form A-45.
3. File any healthcare provider documentation with the individual student health record.

**Resources**

**NJ Governor's Lyme Disease Advisory Council**
http://www.state.nj.us/health/ed/gldac.htm.
A power-point presentation and talking points on Lyme disease is available at:

**Hunterdon County Lyme Disease Web Site**

http://www.co.hunterdon.nj.us

## References

NJ Department of Education. (1995). *Making a difference: Lyme disease prevention and education guide* [available from the NJ Department of Education Office of Publications].

NJ Department of Health and Senior Services. (1999). *Tick-borne diseases of New Jersey: A guide to understanding and preventing transmission*. Washington, DC: Author.

# Topic 8G: Sickle Cell Disease

Sickle cell disease is a common and often life-threatening disease. It is an inherited, noncontagious, hemolytic anemia (premature destruction of red blood cells with the release of hemoglobin) occurring in approximately 1 in every 400 African American infants born in the United States each year. Individuals of Mediterranean, Arabian, Caribbean, South American, Central American, and East Indian ancestry can also be affected.

| **Accompanying Critical Issues** |
|---|
| **Clinical Diagnosis**<br>Early identification can help prevent some of the serious medical problems associated with sickle cell disease. In New Jersey, universal newborn screening for the disease began in 1990. |
| **Chronic Disease**<br>As children with Sickle Cell disease grow, they are expected to develop along the same lines as children without the disease. However, some complications related to sickle cell disease influence their development. They:<br>• miss more school<br>• are not allowed to do things other children do because of physical limitations or overprotective parents/guardians and teachers<br>• need to go to the bathroom more frequently due to an inability to concentrate urine. They are required to drink more liquids – especially during periods of increased exercise and heat<br>• may be small for their age<br>• have delayed sexual maturation<br>• are often treated differently by parents/guardians, siblings, teachers, and others because "they are sick" |

|  | **Documentation of Services** |
|---|---|
| | 1. Document services on a form approved by the Commissioner of Education (form A-45, Health History and Appraisal Health Record). |
| | 2. An Individual Healthcare Plan, healthcare provider instruction, orders for medication, and specialized procedures, in addition to an Individual Emergency Healthcare Plan, should all be documented. |
| | 3. File all of these documents with the student's individual health record. |

## Resources

Pediatric Preventive Services, Health Promotion/Disease Prevention Services Unit, NJ Department of Health and Senior Services. (September 1999). *Sickle cell disease: Information for school personnel*. Trenton, NJ: Author.

For a directory of sickle cell/hemoglobinopathies treatment centers in New Jersey, refer to: *Sickle cell disease: Management for school nurses.* Available on the NJ Department of Health and Senior Services website: http://www.state.nj.us/health/fhs

For a directory for genetic centers for testing and family counseling in New Jersey, refer to: *Sickle cell disease: Management for school nurses.* Available on the NJ Department of Health and Senior Services website: http://www.state.nj.us/health/fhs

### Sickle Cell Information Center

Emory University School of Medicine, Atlanta, GA
http://www.emory.edu/PEDS/Sickle

## References

American Academy of Pediatrics. (1996). Health supervision for children with sickle cell diseases and their families. *Pediatrics, 98*, 467.

Bunn, H. F. (1997). Pathogenesis and treatment of sickle cell disease. *New England Journal of Medicine, 337*, 762-9.

Embury, S. H., Hebbel, R. P. , Mohandas, N., & Steinberg, M. H., (Eds.). (1994). *Sickle cell disease: Basic principals and clinical practice*. New York: Raven Press.

Platt, O. S., Branbila, D. J., Rosse, W. F., et al. (1994). Mortality in sickle cell disease: Life expectancy and risk factors for early death. *New England Journal of Medicine, 330*, 1,639-44.

Serjeant, G. R. (1997). Sickle cell disease. *Lancet, 350*, 725-30.

Wood, A. J. (1999). Management of sickle cell disease. *New England Journal of Medicine, 340,* 1,021-30.

Zimmerman, S., Ware, R. E., & Kinney, T. R. (1997). Gaining ground In the fight against sickle cell disease. *Contemporary Pediatrics, 14,* 154-177.

### Hydroxyurea reference:

Jayabose, S., Tugal, O., & Dandoval, C., et al. (1996). Clinical and hematological effects of hydroxyurea in children with sickle cell anemia. *Journal of Pediatrics, 129,* 559-65.

### Doppler reference:

Adams, R., & McKie, V., et al. (1992). The use of transcranial ultrasonography to predict stroke in sickle cell disease. *New England Journal of Medicine, 326,* 605-10.

# 9. Referrals for Assistance

## Overview

School nurses are frequently the first, and sometimes the only, school staff members with knowledge of families in need of assistance. In these instances, it is recommended that the school nurse collaborate with other school staff, to ensure that students receive the services they need, e.g. the health and social service coordinator in the Abbott districts. It is essential that nurses become familiar with the resources in their local communities and on the county and state level as well. The Internet provides access to a vast number of readily available resources and can be an expedient tool for locating service providers.

### MEDICAL CARE

The private medical provider in the student's medical home is the primary location for assessment and possible treatment of medical, surgical, psychiatric, or related problems. Additional referrals should originate from the student's medical home.

### EMERGENCY CARE

For emergency care, 9-1-1 emergency medical services should be used to take the patient to the nearest hospital emergency room.

### SOCIAL SERVICES

All N.J. counties have Welfare/Social Service Boards. It is advisable to become familiar with the services each county provides as well as the location and the telephone numbers of key personnel. Many municipalities also have these services available.

### NJ FAMILY CARE/NJ KID CARE

Free or low cost health insurance programs may be available to families without other health insurance coverage. (For one list of some special child health services, visit: http://www.state.nj.us/health/fhs/famhlth.htm)

### FREE AND REDUCED LUNCH

Customarily, families of school children are provided an opportunity for self-referral for the free and reduced lunch program at the beginning of each school year. However, family circumstances can change during the year and parents/guardians should be reminded that applications are available for this funded program throughout the school year.

### IMMUNIZATION PROGRAMS

Clinics offering free or low cost immunization are often conducted by local or county health departments. (See http://www.state.nj.us/health for a list of local health departments).

### DENTAL CLINICS

Some local hospitals have dental clinics for children who do not have a private provider. Low cost clinics are also available in dental schools such as UMDNJ – Newark.

## DYFS

In addition to providing investigative and protection services, the Division of Youth and Family Services (DYFS) offers assistance to families in need. They can help families locate a source of care, attempt to increase school attendance in cases of chronic absenteeism, and refer families to agencies dealing with psychological problems when those families are not able to secure these services on their own.

## EDUCATION AND SUPPORT GROUPS

A myriad of foundations, educational programs, and support groups are available to assist families with many medical, psychosocial, and crises situations. Attention deficit disorder, asthma, autism, bereavement, cancer, diabetes, Tourette's syndrome, and heart disease are but a few examples. Again, the Internet is an excellent starting place for locating these organizations.

## FOOD PANTRIES

Many food banks or pantries have been established to help provide essential nutrition for needy families.

## WIC

The Women, Infants, and Children (WIC) program is one of a few federally funded programs that provide nutrition for pregnant women, infants, and children.

# 10. Environmental Health and Safety

## Topic 10A: Environmental Health

Student health and well being are directly affected by the environment in which they learn. Cleanliness, absence of hazardous substances, availability of soap and water, containers for disposal of waste, accessible bathrooms in good working condition, adequate lighting, comfortable temperatures, and proper ventilation are essential elements in providing a healthful school environment.

**Authorization**

N.J.A.C. 6:22, "School Facility Planning Services"

**Accompanying Critical Issues**

- Although addressed in code under N.J.A.C. 6: 22, "School Facility Planning Services," the school nurse has a responsibility to ensure that the environment in which students learn is free of impediments to good health. By working collaboratively with school administration and those responsible for property services, the nurse plays a vital role in monitoring environmental conditions and identifying and remediating deficiencies.

**Documentation of Services**

1. Follow district policies regarding the reporting of areas of concern.
2. File copies of all reports and requests in the health office.
3. Follow-up to insure correction of deficiencies is essential.

**Resources**


Environmental and Occupational Health Sciences Institute. (1992). *Safe schools: A health and safety check: A manual of checklists covering environmental, health, and safety regulations for secondary occupational and career-orientation programs in N.J. public schools.* New Brunswick, NJ: Author.

Environmental and Occupational Health Sciences Institute. Safe schools newsletter [annual updates to the EOHSI manual listed above]. New Brunswick, NJ: Author.


**Environmental Protection Agency**

Available: http://www.epa.gov/iaq/schools/

**References**

Environmental and Occupational Health Sciences Institute. (1992). *Safe schools: A health and safety check: A manual of checklists covering environmental, health, and safety regulations for secondary occupational and career-orientation programs in N.J. public schools.* New Brunswick, NJ: Author.

Environmental and Occupational Health Sciences Institute. Safe schools newsletter [annual updates to the EOHSI manual listed above]. New Brunswick, NJ: Author.

# Topic 10B: Environmental Safety

The safety of the environment in which students learn and play is essential to their physical and emotional well being. Unrestricted access to exits in case of fire or emergency, a secure building with proper identification of visitors, corridors that are free of impediments, prompt clean-up of spills, prompt removal of snow and ice from walkways, and a playground which meets safety standards are all components of a safe school environment.

**Authorization**

N.J.A.C. 6:22, "School Facility Planning Services"

**Accompanying Critical Issues**

- The school nurse is responsible for monitoring the school environment for safety compliance, and for working with administrators and those responsible for property services to immediately ameliorate or remove any hazardous condition. It is recommended that the nurse conduct an assessment of environmental safety on at least an annual basis and promptly report any deviations following district policies.
- Earlier versions of N.J. Administrative Code stated requirements concerning safety and environmental health in the same chapter as requirements for school health services. New versions of the code, however, place these requirements in "School Operations and School Facilities." Appendix 10B presents a quick reference guide to N.J. regulatory requirements for school facilities with former and current citations.

**Documentation of Services**

1. Follow district policies regarding the reporting of safety hazards.
2. File copies of all reports and requests in the health office.
3. Note telephone calls to report safety hazards in a file designated for that purpose.
4. Follow-up to ensure correction of deficiencies is essential.

## Resources

Environmental and Occupational Health Sciences Institute. (1992). *Safe schools: A health and safety check: A manual of checklists covering environmental, health, and safety regulations for secondary occupational and career-orientation programs in NJ public schools.* New Brunswick, NJ: Author.

Environmental and Occupational Health Sciences Institute. Safe schools newsletter [annual updates to the EOHSI manual listed above]. New Brunswick, NJ: Author.

Education Development Center, Inc. (1997). *Injuries in the school environment: A resource guide* (2nd ed.). Newton, MA: Author.

## References

**Environment and Human Health, Inc.**
http://www.ehhi.org

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. School health programs: An investment in our nation's future. Available: http://www.cdc.gov