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DoDEA School Health Services Guide

Promoting Health and Wellness

4040 North Fairfax Drive
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FOREWORD

The mission of the Department of Defense Education Activity (DoDEA) is to provide a quality education for eligible dependents of Department of Defense (DoD) military and civilian employees stationed on or near military bases/posts both overseas and in various states. The families and children served undergo frequent transitions that include reassignments, extended deployments, demanding work hours, prolonged periods in the field, and other unique demands that tax their cohesiveness and well-being. It is imperative that there be a comprehensive DoDEA health services program that promotes optimal physical, emotional, intellectual, and social health.

DoDEA encourages each administrator to coordinate with the school nurse to provide a school health services program that reflects the high standards of the National Association of School Nurses (NASN). NASN defines school nursing as "a specialized practice of professional nursing that advances the well being, academic success, and life-long achievement of students. To that end, school nurses facilitate positive student responses to normal development; promote health and safety; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self management, self advocacy, and learning."

This *School Health Services Guide* provides administrative guidance for the delivery of high-quality school nursing services for DoDEA students. This guide provides direction for a consistent program while allowing flexibility at the school level.

In concert with Goal 1 (Highest Student Achievement) and Goal 4 (Network of Partnerships Promoting Achievement) of the DoDEA Strategic Plan for 2001–2006, school nurses work in partnership with the military medical commands and parents to ensure that the health needs of students are met. This includes developing lifelong strategies for healthy living to ensure the highest student achievement attainable. The School Health Services Program described in this guide is designed to help all students succeed in school, work, and life. The School Health Services Program recognizes the importance of diversity as reflected in our schools and acknowledges that individual differences strengthen both school operations and society in general.

Joseph D. Tafoya
Director

TABLE OF CONTENTS

SECTION A

Overview of the School Health Services Program

A.1 Components of the School Health Services Program

A.2 Functions of the School Nurse

A.1 Components of the School Health Services Program

All schools in DoDEA shall have, as an integral part of the education program, a health services program managed by a school nurse. The School Health Services Program is not meant to take the place of health care provided by the family or other community agencies. Through school health programs, children and families can develop the knowledge, attitudes, beliefs, and behaviors necessary to remain healthy and to perform well in school. The DoDEA School Health Services Program includes the following elements:

- Specific written emergency procedures coordinated with available local medical resources.
- Illness and accident services with referral to appropriate community agencies.
- Health assessment including vision, hearing, scoliosis, and development screening.
- Safe administration, documentation, and monitoring of medications needed by students during the school day.
- Health assessment for placement and monitoring of students with disabilities.
- Early identification of health problems and intervention plans.
- Development of Individual Health Plans (IHPs) for students with identified health problems such as asthma, diabetes, allergy to insect stings, etc.
- Communicable disease control including an immunization program that ensures compliance with the DoDEA and local immunization requirements, including those of the states where Domestic Dependent Elementary and Secondary Schools (DDESS) are located.
- Health counseling and crisis intervention.
- Consultation, collaboration, and liaison services with local health care facilities.
- Health education including wellness promotion and disease prevention for groups and individuals.
- Documentation of health services provided and, where needed, individual Emergency Care Plans (ECPs).

A.2 Functions of the School Nurse

Provides health consultation and resource services.

1.1 Provides consultation to students.
- **1.1.1** Evaluates and interprets health information and developmental needs.
- **1.1.2** Provides guidance and information for health-related problem solving.
- **1.1.3** Makes referrals as indicated.
- **1.1.4** Follows up on consultations and referrals.

1.2 Provides consultation to teachers.
- **1.2.1** Identifies students with special health and developmental needs.
- **1.2.2** Interprets student health and developmental needs.

1.2.3 Collaborates with teacher on health education needs for program enrichment.

1.2.4 Assists teacher with health education resources to include an awareness of health careers.

1.3 Provides consultation to parents.

1.3.1 Interprets child's health and developmental needs to parents.

1.3.2 Refers parents to health resources available to meet the student's assessed needs.

1.3.3 Provides health information.

1.3.4 Coordinates with community services to meet the student's health and developmental needs.

1.4 Provides consultation to school administrators.

1.4.1 Identifies school health needs.

1.4.2 Consults on implementation of health screening and appraisal programs.

1.4.3 Reviews health policies and regulations with administration.

2.0 Coordinates health screening programs for vision, hearing, dental health, scoliosis, blood pressure, height and weight.

2.1 Schedules appropriate screening resources.

2.2 Implements screening procedures.

2.3 Identifies students with specific needs.

2.4 Refers students with identified problems.

2.5 Follows up on referrals as needed.

3.0 Participates in the identification of students with special needs.

3.1 Coordinates health care plans with appropriate resources.

3.2 Serves as a member of the Child Study Committee (CSC).

3.3 Provides or coordinates health-related services as needed as part of a student's IEP.

3.4 Provides assistance to students with chronic health problems such as diabetes, asthma, and epilepsy.

3.5 Communicates health-related findings and makes recommendations to faculty for modifications of the student's educational program as needed.

4.0 Maintains current individual health data.

4.1 Maintains a permanent school health record for each student.

4.2 Ensures that written reports of school-related student accidents/injuries are prepared and processed.

4.3 Maintains a nursing record of significant health room visits and medication administration.

4.4 Maintains a current health conditions list.

5.0 Provides illness and injury services.

5.1 Provides a written plan for dealing with medical emergencies and reviews the plan with staff.

5.2 Maintains medical supplies for emergency care.

5.3 Provides classroom teachers with first aid supplies and appropriate instructions for minor injuries.

5.4 Demonstrates skill in caring for the ill and injured, including assessment and referral as needed.

6.0 Promotes a healthy environment.

6.1 Identifies and reports undesirable health conditions throughout school campus to school administration.

6.2 Recommends alterations to environment to improve the quality of health in the school setting.

6.3 Develops and implements a plan for safe administration of medications.

6.4 Coordinates communicable disease screening and referrals as needed.

6.5 Coordinates the screening of student immunization records for compliance with DoD immunization policy (DoD Instruction 6205.1 or the state immunization policy in DDESS) with the military medical treatment facility.

7.0 Provides liaison services between the school, the home, community agencies, and health personnel.

7.1 Supports school partnerships with community organizations, advisory boards, and health care providers as needed.

7.2 Receives, makes, and coordinates referrals to and from appropriate health care providers in the community.

7.3 Promotes awareness of school health needs to ensure that the needs of the school population are considered in the community's overall health planning.

7.4 Facilitates communication of needs and coordinates services.

7.5 Participates on the Crisis Intervention Team (CIT).

8.0 Responds to professional responsibilities.

8.1 Maintains current state licensure.

8.2 Maintains certification requirements.

8.3 Participates in professional development activities and incorporates new learning into practice.

8.4 Reviews current professional literature.

9.0 Participates in evaluation and research activities to improve school nursing services.

SECTION B

DoDEA Policies, Regulations, and Instructions

B.1 Introduction

The following manuals, regulations, and memorandums provide guidelines within the framework of the School Health Services Program. They may be found in various locations. DoDEA regulations and manuals are available from the school administrator or by accessing the World Wide Web at the DoDEA home page, www.odedodea.edu. A search is made from the home page using a key word or document number. The "pdf" file number is included as a cross-reference when accessing the DoDEA home page.

Regulations for the Army and the Air Force are also available at the following Web sites: www.army.mil or www.af.mil.

This list represents the most current policies available at the time of printing. Abbreviations: M = Manual, I = Instruction, R = Regulation

B.2 Child Abuse

2050.3 (I) (00046.pdf)	Institutional Child Abuse
2050.9 (R) (00047.pdf)	Family Advocacy Program Process and Procedures for Reporting Incidents of Suspected Child Abuse and Neglect/Memorandum for DoDEA Managers and Supervisors on Child Abuse Reporting

B.3 Health Education

2700.1(R) (00101.pdf)	Comprehensive School Health, Physical Education, and Recreation Programs
2700.3 (M)	DoDEA Health Education Curriculum and Assessment Standards (1999)
2720.3 (M)	Drug Education Program
2720.4 (M)	Drug Education Guide, K–6
2720.5 (M)	Drug Education Guide, 7–12

B.4 Health and Safety

4800.1 (R) (00140.pdf)	DoDEA Safety Program
1015.5 (00004.pdf)	DoD Student Meal Program
4800.5 (R)	Blood-Borne Pathogen Exposure Control Program
1342.6 (M) (00022.pdf)	DoD Administrative and Logistic Responsibilities for DoD Schools
2720.1 (R)	First Aid and Emergency Care

B.5 Special Education

1342.12 (I)	Provision of Early Intervention and Special Education Services
2500.13 (M)	Special Education Procedural Guide
1010.13 (I)	Provision of Medically Related Services to Children
2500.1 (R)	DoDDS Home or Hospital Instructional Services
2500.14 (M)	Special Education Goals and Objectives
2500.8 (M)	Monitoring Procedures for Special Education Programs and Services for Handicapped Students

B.6 Immunizations

6205.1 (I)	Immunizations Requirements for DoD Dependent Schools or . . . State Immunization Certificate for DDESS

B.7 Support from Local Medical Treatment Facilities

Policy Manual 1342.6	Medical Support for the Department of Defense Education Activity (DoDEA) Interscholastic Athletic Program

SECTION C

Professional and Legal Issues

C.1 Introduction

School nursing is a specialty practice of professional nursing serving students, families, and staff within the educational setting. A DoDEA goal of school nursing, consistent with the goals of the National Association of School Nursing (NASN), is to advance "the well being, academic success, and life-long achievement of students." School nurses understand the professional and legal implications of providing health care within the educational arena. Each school health office has a set of school nurse reference books for guidance. See Section I of this guide for a list of these references.

C.2 Ethics

The American Nurses Association (ANA) Code of Ethics for Nurses outlines the ethical standards for professional nursing practice. This code provides guidelines for making ethical nursing decisions and outlines the nurse's responsibility to his or her clients and to the profession of nursing. It includes the obligation to protect clients and the public from incompetent, unethical, or illegal practice of nursing. The code is available in many nursing publications and on the ANA Web site at http://www.ana.org/ethics/code/ethicscode150.htm.

The Scope and Standards of Professional School Nursing Practice of the National Association of School Nurses provide direction for school nursing practice and a framework for evaluation. The purpose is to maintain and improve the quality of school nursing services. These standards of practice may be ordered from NASN through their Web site, http://www.nasn.org/. The Web site also contains NASN position statements and other publications that help clarify and define the role of nurses in the school setting. Many of the reference materials listed in Section I are NASN materials. School nurses may also find resource materials and professional development opportunities from their state school nurse affiliate of NASN. The Overseas School Health Nurses Association (OSHNA) is a state affiliate of NASN for school nurses working outside of the USA.

Nurses should be aware of and follow the nurse practice act of the state in which they are licensed.

Protection of Student Health Records

I. Purpose

DoDEA recognizes that student health records are distinct from other educational records. As with the issues surrounding educational records, DoDEA also recognizes its responsibility in regard to the collection, maintenance, and dissemination of student health records and the protection of the privacy rights of students as governed by the Privacy Act, the Freedom of Information Act, and the Records Act.

II. General Guidelines

The following guidelines regarding the protection and privacy of parents and students are consistent with the requirements of the Privacy Act. Under this provision, a student's health records are classified as private data and as such will be distributed only to parties with a need-to-know basis.

III. Definitions

A. Student Health Records

Student health records should include the following (if applicable):

1. Student health history completed by parents at time of initial registration (DD Form 120.1 Revised May 2002)
2. Mandated immunizations
3. Health and physical assessment data
4. Health screenings for vision, hearing, and scoliosis; injury reports
5. Health assessments and other evaluation reports related to eligibility for services under the Individuals with Disabilities Act (IDEA) and 504 of the Rehabilitation Act of 1973
6. Records for school medication, including original signed orders from a physician, written consent from the parent and/or guardian to administer medication, and medication logs for both routine and as-needed medications
7. Physicians' orders, correspondence, evaluation reports, copies of treatment records, institutional or agency records, and discharge summaries from outside health care providers or hospitals that have been released by parents and/or guardians to assist in planning individualized school health care or programs
8. Specialized assessments such as neurologic tests
9. Individualized emergency care plans for students with special health care needs, including routine and emergency interventions and methods for evaluating student outcomes
10. Health-related goals and objectives or an Individual Health Plan (IHP) contained within a student's Individualized Education Program (IEP) for students whose health care conditions affect their educational needs.

B. Private Data

For the purposes herein, student health records are records that are classified as private data on individuals by federal law and are generally accessible only to the student who is the subject of the data and the student's parent if the student has not

achieved the age of majority as determined by the local military regulations. Private records may not be released without the written consent of the parent or the eligible student except as authorized by published routine uses. This restriction applies to *any* type of release including written, spoken, or electronic transfer of student health information.

IV. Protecting Private Student Health Information

Students and their families have a right to expect that student health information will be kept private and only information necessary to provide appropriate health, safety, and educational interests will be shared. Ethical responsibilities that will govern this include the following:

A. The responsibility to respect privacy is an underlying fundamental right. This right includes the expectation that private data will not be disclosed without explicit permission unless disclosure serves a compelling purpose or is required by law.
B. The responsibility to do no harm often protects the rights of the student's individual freedom and autonomy when weighed against a parent's right to know. Can the disclosure be justified for the student's benefit? Will a decision to disclose do less harm to the individual than not disclosing?
C. Some instances in which nonconsensual disclosure is required occur when the cases include the following:
    1. Suspected child abuse
    2. Self-injury or suicide
    3. The duty to warn of possible harm to another person

V. Guidelines for Disclosure of Student Health Information

A. Principal or designee(s) will administer this program in each building.
B. The disclosure of a student's health records will be justified when it serves the best interests of the student's health and safety.
C. If written informed consent has not been secured, health information will be shared based on considering what is in the best interest of the student's health, safety, and education.
D. Not all health information needs to be shared with all personnel. A sense of ethical responsibility, professional judgment, and knowledge will be considered in sharing health information according to DoDEA policy to include confidential list of students' health problems should only be circulated to personnel who have a legitimate need to know.
E. The Individual Health Plan will be considered private information. Staff who receive the plan will be directed by the administration through the school nurse not to share it with others.

Legal References:

The Privacy Act (5 USC 552a)

Cross-References:

Guidelines for Protecting Confidential Student Health Information. The National Task Force on Confidential Student Health Information. The American School Health Association. Kent, Ohio. 2000.

C.3 Regulation of Nursing Practice

The school nurse in DoDEA is a licensed nurse whose ability to practice nursing and delegate care is governed by laws and regulations of the state where the nurse is licensed at the time of appointment. The school nurse must maintain an active license that meets licensure requirements of the state which may include continuing education units or DoDDS licensure, as appropriate. DDESS nurses must be aware of and follow the nursing practice act of the state in which they are licensed. DoDDS requires six undergraduate or graduate credits every six years to maintain a license.

C.4 Delegation of Nursing Care

Delegation of nursing care in the school setting is sometimes necessary, especially in schools without a full-time nurse. Care may be delegated to school secretaries, clerks, and paraprofessionals, or to teachers who give medications on a field trip. The school nurse must evaluate which nursing procedures can be safely delegated and assess the competence of the employee designated to provide the service. The school nurse must train and supervise the health aide, clerk, or other unlicensed employee carrying out the task. Supervision of the task is defined as the active process of directing, guiding, and influencing the outcome of the unlicensed person's performance of the health-related service. Supervision can be on-site with the nurse physically being present or off-site with the nurse providing direction through various means of written and verbal communication.

School nurses must provide clear written instructions for substitutes when no licensed nurse substitute is available. The principal will designate the person responsible for health services in the absence of the nurse. The principal will provide the opportunity for personnel to pursue first aid and CPR certification as outlined in the DoDEA First Aid and Emergency Care Regulation (2720.1). The school nurse shall prepare a folder of information and review procedures with any unlicensed personnel who will provide health-related services in the nurse's absence. The school nurse shall provide for the nurse substitute a place to document the medications, as well as training deemed appropriate for the unlicensed assistant.

C.5 Liability and Malpractice Protection

What to Do in the Event of a Lawsuit or the Receipt of a Subpoena or Summons, a Claim, Interrogatories, or Other Legal Papers

Lawsuits are initiated when the plaintiff serves a notice on the defendant that a legal action has been filed with a court. An employee of the DoDEA could be served with notice of such a lawsuit naming the employee as a defendant. As a general rule, the United States will be substituted for the DoDEA employee as the party defendant if the lawsuit alleges acts or omissions within the scope of the DoDEA employee's official duties and the United States is also named as a defendant in the lawsuit.

An employee could also be served with a subpoena or other summons to appear as a witness in a case in which the employee is not a named as the defendant. A subpoena could place the employee in a position of testifying in a case in a manner that violates DoD policy on the release of information in litigation.

It is imperative that DoDEA employees immediately contact the DoDEA Office of General Counsel upon receipt of a lawsuit, a summons or subpoena, a claim or interrogatories, or any legal process that relates to their official duties. The service of such legal documents starts the clock running on deadlines the employee must meet to ensure the protection of his or her legal rights, as well as those of the United States. Prompt legal guidance is critical to preparing an appropriate defense.

When a lawsuit is filed against a DoDEA employee in his or her personal capacity but the lawsuit alleges facts that are related to the employee's duties, the DoDEA Office of General Counsel will counsel the employee to ensure that he or she understands his or her rights and the procedures related to the lawsuit. The DoDEA General Counsel will help the employee prepare paperwork asking the U.S. Department of Justice (DoJ) to assist him or her in the litigation.

Every individual defendant who desires DoJ representation must request it in writing. DoJ representation is neither automatic nor compulsory; federal employees are free to retain counsel of their choice at their own expense. The DoDEA General Counsel will require an employee seeking DoJ assistance to produce a request for legal representation and a copy of the summons and complaint or other legal papers. The DoDEA General Counsel will forward the employee's request for assistance with all available factual information to the DoJ with a recommendation as to whether representation should be provided.

The DoDEA General Counsel, initially, and then the DoJ will determine whether DoJ representation is appropriate based upon a consideration as to whether the employee's actions giving rise to the suit reasonably appear to have been performed within the scope of his or her federal employment, and that it is in the interests of the United States to provide the requested representation. See 28 CFR § 50.15(a).

When the United States is also named as a party defendant, it may seek the dismissal of the lawsuit against the individual employee and seek to substitute the United States as the sole party defendant. Alternatively, if the DoJ determines that the employee's conduct is within the scope of official duties and that representation serves the interests of the United States, it may provide representation for the individual.

DoJ will not provide representation if the conduct is outside the scope of the employee's official duties and not in the interests of the United States. DoJ representation is generally not available in a federal criminal proceeding or investigation or in a civil case if the employee is the subject of a federal criminal investigation concerning the act or acts for which he or she seeks representation.

If the DoJ agrees to provide representation for an individual in a legal action, it will impose conditions on that representation. The DoJ provides a list of terms and conditions of representation. See 28 CFR § 50.15(a). Upon formal approval of representation, the DoJ litigating attorney will ask the DoDEA employee to execute a Form 399 that describes the limitations of DoJ representation so that the client may be fully informed before he or she enters into an attorney-client relationship with the litigating attorney.

The most significant condition of DoJ representation is that if the interests of the United States and those of the individual should become different during the course of the litigation, the Department of Justice may terminate its representation of the individual. This is a relatively rare event, because of the inquiries made before the decision is made to provide representation. However, it has been known to occur. It could arise in the event of an appeal should the Solicitor General determine that the assertion of a position on appeal conflicts with the interests of the United States. Should the interests of the United States diverge from those of the individual defendant, the DoJ will notify the DoDEA employee of that determination and that it intends to cease representation of that individual.

The Agency is not aware of any judgments rendered against individual DoDEA employees arising from work-related concerns. Nevertheless, an employee who remains a named party defendant in the lawsuit, regardless of whether he or she is represented by the DoJ, is personally responsible for the satisfaction of a judgment rendered solely against the employee. There is no right to compel indemnification from the United States or any agency thereof, such as the Department of Defense, in the event of an

adverse judgment. DoDEA employees concerned about their exposure to possible personal liability may wish to obtain professional liability insurance. When purchasing professional liability insurance, the nurse should ensure that the carrier will cover nursing practice in the employment locality.

Where multiple defendants make representation by a single attorney impossible, retention of private counsel at government expense may be authorized, provided the scope and interest criteria have been satisfied and funds are available. See 28 C.F.R. §§ 50.15(a)(10) and 50.16.

C.6 Consent for Health Services

When the sponsor enrolls the student in a DoDEA school, he or she gives consent for routine school health services by signing Registration Form 600 or the appropriate form used for DDESS. Although the parent has already consented to services at registration, it is recommended that the school nurse inform parents of schoolwide screening through parent newsletters or notes to the parent. The consent obtained at registration also covers care provided for medical emergencies. An emergency would include anything that requires prompt treatment and not just a condition that is life threatening. All reasonable efforts should be made to find and locate at least one parent when emergency treatment is necessary.

Special treatments and medications are not considered routine health services. These procedures require additional consent forms described in Section F of this guide. Sample consent forms are available in Section H. Additional consent forms such as a medical power of attorney are recommended for field trips and sports. See Section H for these forms.

The school nurse should follow local military regulations regarding the age of consent for adolescents. See additional information on adolescent health issues in Section F.11 of this guide.

C.7 Confidentiality

Nurses and educators are bound by both ethical and legal principles regarding the release of confidential health information. Student health information can be oral, written, or transmitted electronically. Students and their families have a right to expect that student health information will be kept confidential and be shared only with those who have a "need to know" in order to provide appropriate health services. School nurses should obtain permission from parents to share medical information prior to sharing the information with teachers. In the case of an adolescent, the nurse may need permission from the student for disclosure.

The Privacy Act allows parents access to their children's school records and prohibits schools from disclosing confidential student information. It limits disclosures to those that are consensual and authorized by published routine uses.

In certain circumstances the responsibility to disclose confidential information clearly outweighs the right to privacy. Suspected child abuse is one example in which disclosure is mandatory. The nurse must also disclose confidential information when a "duty to warn" exists. Such cases involve immediate and serious danger such as threats of homicide, suicide, or self-injury.

C.8 Documentation and Record Keeping

Maintaining accurate health records is not only a professional obligation but also a DoDEA requirement. School health records include the following: a student's health history, including mandated immunizations; health assessment data; health screening such as vision, hearing, scoliosis, and blood pressure; injury reports; incident reports; health assessments and other evaluation reports related to the CSC; referrals for suspected child abuse; consent forms for medication, and medication administration records.

According to DoDEA OSD 1303-02 Health Records Management, student health records, immunization records, parental permission forms, screening results, sports physicals, physician referrals, medication consent forms, and copies of accident reports are placed in the student record files (1903-01 and 1904-01) upon the transfer, withdrawal, or death of the student. Copies of health records may be hand-carried by a parent to a new school or mailed to the school with consent from the parent authorizing release of the records to the new school.

Other records used in the operation of the school health office, such as temporary health room passes and cards, may be shredded when they are no longer needed. The nurse should also shred any personal "memory jogger" notes as soon as pertinent information is entered into the school health record. The National Task Force on Confidential Student Health Information discourages the use of chronological logs with multiple student names for recording medications and health office visits. Under the Privacy Act parents have access to their children's records but not to those of other students. Best practice calls for the use of individual cards, paper files, or computer records.

DoDEA guidelines for storing, transferring, and deleting electronic health records will be released in a separate computer user's manual.

C.9 Child Abuse Reporting

All educators are under the obligation to report any suspected cases of child abuse and neglect, whether originating at school or in the home. This obligation is imposed by statute and by DoDEA. Failure to meet this duty may result in disciplinary or performance-related actions against the educator. Federal law attaches criminal penalties for refusing to report. The host nation may also impose criminal or civil penalties for failure to report a crime.

School nurses should help provide faculty and staff with an annual inservice session to help them recognize and report suspected child abuse and neglect. Educators and staff may come to the school nurse for help when they are not sure if they have sufficient information to reasonably suspect an incident of child abuse, but all suspected child abuse must be reported to the proper military representatives, using established reporting procedures. In talking to a student about possible abuse, the nurse should not continue questioning the student once there are sufficient facts to reasonably suspect child abuse. The nurse should immediately contact the appropriate family advocacy program official with the facts. Each military community will provide the name and phone number of this point of contact. The school nurse should also inform his or her supervisor that the report was made. Good nursing practice also dictates that the school nurses follow up on the suspected child abuse referrals. See Section F.7 of this guide for more information about the school nurse's role in child abuse. Child abuse must be reported according to established reporting procedures.

C.10 Laws Relating to Special Education

To meet the needs of special education students, it is important for the school nurse to understand relevant federal education laws. Most significant are the Individuals with Disabilities Education Act (IDEA), DODI 1342.12 (Department of Defense Dependents Schools [DoDDS]), and 32 CFR part 80 (Department of Defense Elementary and Secondary Schools [DDESS]). IDEA requires free, appropriate education in the least restrictive environment for students who qualify as disabled under the law. Students are evaluated for disabilities that significantly interfere with learning. Disabilities include mental retardation, hearing impairment, speech or language impairments, visual impairments, serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities. School nurses are part of the multidisciplinary evaluation team.

Each school must make an affirmative effort to identify children who need services. The school nurse helps with health assessment and coordinates with the medical facility for medical diagnostic evaluation and treatment.

Monitoring and compliance plans under IDEA and DoDEA are mandatory. Students must be evaluated for the need for related services such as counseling, speech therapy, physical therapy, and school health services. The related services are documented on the student's Individualized Education Program (IEP). Nursing services may be listed on

the IEP as a related service. Parents have the right to appeal their child's evaluation, placement, or provisions in the IEP.

Although school nurses may not be designated to provide direct services in every case, they are responsible for completing health assessments, participating in decisions about the student's health and safety needs in school, recommending appropriate accommodations to the school team, developing plans, providing consultation to other team members, and, when necessary, training an unlicensed employee and supervising health-related services done by that employee. Section F.8 of this guide contains more information about the nurse's role on the Case Study Committee (CSC).

C.11 References

National Association of School Nurses. (1997). *Overview of School Health Services,* Scarborough, ME: National Association of School Nurses, Inc.

National Association of School Nurses. (2001). *Scope and Standards of Professional School Nursing Practice.* Washington, DC: American Nurses Publishing.

National Task Force on Confidential Student Health Information. (2000). *Guidelines for Protecting Confidential Student Health Information*. Kent, OH: American School Health Association.

Schwab, Nadine C., & Gelfman, Mary H. B. (2001). *Legal Issues in School Health Services.* North Branch, MN: Sunrise River Press.

DODI 1342.12 (Department of Defense Dependents Schools [DoDDS])

CFR part 80 (Department of Defense Elementary and Secondary Schools [DDESS])

Privacy Act (5 USC 552a)
DOD Instruction 1342.12, 32CFR, part 80
Regulation 2050.9, Section I, Family Advocacy Program
This manual replaces Manual 2942.0
Child Abuse Regulation

SECTION D

Administration of the School Health Services Program

D.1 Health Office Equipment and Supplies

D.2 The School Year at a Glance

D.3 School Health Records

D.4 Accident/Injury Reports

D.5 Evaluation of the School Health Program

D.6 Coverage of Two or More Schools

D.7 Home Visits

D.8 Residence Halls

D.1 Health Office Equipment and Supplies

(Ref: DoD 1342.6-M-1, 1995 Administrative and Logistic Responsibilities for DoDDS)

The health office serves as a functional area to meet the health and first aid needs of students and staff. Procurement of supplies varies from school to school. The principal, school supply clerk, and supporting military treatment facility are the usual sources of health office equipment and supplies.

A school health office may include the following equipment:

- Locked storage cupboards for supplies, equipment, and medication
- File cabinets with locks
- Cot
- Refrigerator with freezer large enough for ice packs
- Vision screening equipment for appropriate grade level(s), such as Snellen symbol chart for elementary, Titmus for high school
- Audiometer
- Tympanometer
- Otoscope
- Electronic thermometer
- Consumable medical supplies (see list below)
- Stethoscope
- Sphygmomanometer (with adult and child cuff sizes)
- Weight scale with height bar
- Wheelchair
- Crutches
- Reflex hammer
- Room divider or screen

Suggested consumable supplies for the health office include but are not limited to the following:

- Adhesive tape
- Alcohol pads
- Antiseptic for wound care
- Applicators (sterile/nonsterile)
- Aromatic spirits of ammonia
- Band-Aids
- Disposable heating pads
- Flashlight
- Gauze pads (2x2, 4x4, sterile/nonsterile)
- Ice packs
- Safety pins in assorted sizes
- Saline, sterile

- Scissors
- Disinfectant solution for cleaning
- Splints: wooden, metal (finger)
- Kerlix or Ace wrap
- Tongue depressors
- Tweezers
- Cot paper
- Disposable gloves
- Sharps container
- Blood-borne pathogens clean-up kit
- Field trip first aid kits

D.2 The School Year at a Glance

Opening of School

At the beginning of the school year it is recommended the school nurse do the following:

- Participate in and present at faculty meetings. This is an excellent opportunity to disseminate information and explore faculty needs.
- Meet with administrators to discuss scheduling meetings and methods of communication.
- Obtain class lists from the school office.
- Create a confidential list of students' health problems. Information that could affect the student's health, academic progress, or behavior in the school setting is to be shared with staff members who have a need to know. Contact sponsors for additional information as needed.
- Review and update immunization records to meet current DoDEA and local requirements. (Reference DoDEA instruction 6205.1)
- Establish a working relationship with the military treatment facility in coordination with the principal.
- Request Standing Orders from the military treatment facility.
- Collaborate with district school nurses on district policies and procedures.
- Create or update a school nurse substitute folder.
- Check medical supplies and anticipate medical and first aid needs. Check pharmaceuticals and supplies for expiration dates.
- Create a plan for medication administration. Contact parents of students needing medications when necessary.
- Restock and redistribute first aid kits to classrooms, laboratories, shops, main office, etc.
- Inform new staff members about health service program and first aid procedures.
- Obtain a supply of forms to be used during the school year (see Section H: Sample Forms)

- Introduce parents to the School Health Services Program.

Suggested Health Services Monthly Schedule

Each school nurse will need to adjust his or her schedule to accommodate the individual needs of the school.

HEALTH SERVICES PROGRAM MONTHLY SCHEDULE *(Sample)*

August	Registration Opening of school activities (see previous list)
September	Review of records Kindergarten screening Vision screening Children's Eye Health and Safety Month National Pediculosis Prevention Month Bike/bus/walking-to-school safety
October	Hearing screening Safety programs Fire Prevention Week Child Health Month Healthy Lung Month
November	Great American Smoke-Out Red Ribbon Week Drug Education
December	Rescreenings World AIDS Day Safe Toys and Gifts Month
January	Screening referrals and follow-up Healthy Weight Week
February	Dental Health Month First Aid American Heart Month
March	National Nutrition Month National School Breakfast Week National Poison Prevention Week

American Red Cross Month

April	Scoliosis screening Counseling Awareness Month National Child Abuse Prevention Month Month of the Military Child National Youth Sports Safety Month
May	Better Hearing and Speech Month Asthma and Allergy Awareness Month National Mental Health Month Skin Cancer Awareness Month National Safe Kids Week National Teen Pregnancy Prevention Month Water safety National School Nurses Day
June	Closing of school activities (see the following list)

See http://www.health.gov/nhic/Pubs/nhoyear.htm for more ideas on monthly health observances.

Closing of School

At the end of the school year the school nurse should do the following:

- Determine medical supply orders for the next school year.
- Initiate referrals to the military treatment facility for children/families with ongoing health problems that need supervision over the summer.
- Compile a confidential list of students with health problems that need follow-up early in the fall.
- Attach individual medication records to current health records.
- Arrange the calibration of digital equipment during the summer (e.g., audiometer, electronic thermometer).
- Determine school supply needs for health office for next school year and submit request through school supply clerk according to requisition schedule.
- Notify parents about picking up student's medication on the last day of school; dispose of all unclaimed medications in accordance with medical treatment facility policy.
- Submit work orders when any equipment used in the health room needs repair.

- Leave an information file for the incoming nurse if not returning to the school site. This file should include a list of phone numbers of resource offices and people, information on special health problems of children returning to the school, and other information of value.
- Secure items that need protection over the summer months.

D. 3 School Health Records

The parent or guardian will complete the School Health History (DS Form 120.1 Revised May '02) upon initial registration of each child. Schools with computerized health records may use an alternate method or form to collect student health information from parents during registration.

The school nurse will use the information obtained from the DS Form 120.1 or the appropriate form used by DDESS and other available school health records to appraise the student's total health needs and to assist in program planning and health supervision. If the nurse determines that a student has special health care needs, an Individual Health Plan (IHP) should be written by the school nurse and filed in the student health record.

Student health records shall be handled in a confidential and professional manner according to the Privacy Act. School health records will be kept in a locked file in the nurse's office, and information will be shared only with school personnel on a need-to-know basis. References to special education programs are not a part of the student health record. Information of a sensitive and highly confidential nature, such as student pregnancy, suspected child abuse, HIV status, and referrals for drug/alcohol abuse, must be kept in a separate locked file and should not be released or transferred to a new school.

According to DoDEA OSD 1303-02 Health Records Management, student health records, immunization records, parental permission forms, screening results, sports physicals, physician referrals, medication consent forms, and copies of accident reports are placed in the student record files (1903-01 and 1904-01) upon the transfer, withdrawal, or death of the student. Copies of health records may be hand-carried by a parent to a new school or mailed to the school with consent from the parent authorizing release of the records to the new school.

D.4 Accident/Injury Reports

An **AIR** — **Accident/Injury Report** (DoDEA Form 4800.1) is completed for any student or employee when a Category 3 and above accident or injury occurs under any of the following circumstances:

- On school grounds
- At off-school locations as a result of school-sponsored activities

- On a school bus or van
- When a student is otherwise traveling to or from school to the extent that such information is obtainable from students, parents, police, medical or safety personnel

The staff member in charge at the time of the accident or injury should initiate the accident/injury report. This may or may not be the school nurse. The form is filed electronically. A copy of DoDEA Form 4800.1 will be retained at the school. One copy will be sent electronically to the safety POC at the district office and another copy to the regional safety officer (DoDEA Regulation 4800.1). See Section H for forms.

In the event of a fatal accident, immediately notify the school administrator, who will then assume responsibility for further action.

A **SIR — Serious Incident Report** (DS Form 4705) is the responsibility of the school principal. This report is not to be confused with the AIR — Accident/Injury Report. The school nurse may be asked to assist the principal in providing information regarding involvement with the incident.

D. 5 Evaluation of the School Health Program

Evaluation of the school health program is an ongoing process. A comprehensive evaluation of a School Health Services Program considers the following components:

- Written emergency procedures coordinated with local medical treatment facility (MTF)
- Illness and accident services
- Health assessment including school health screenings and identified health needs of students, school, and community
- Safe medication administration procedures
- Health assessment for placement and monitoring of students with disabilities
- Development of Individual Health Plans (IHPs) and Emergency Care Plans (ECPs) for students with identified health problems such as asthma, diabetes, allergy to insect stings, etc.
- Communicable disease control
- Immunization compliance
- Health counseling
- Crisis intervention
- Consultation, collaboration, and liaison services with local health care provider/ MTF
- Health education including wellness promotion and disease prevention
- Documentation of health services provided

Assessment tools may include analysis of data (i.e., student visits, health immunization records, follow-up on referrals); review of accident injury reports; review of local procedures and policies to determine effectiveness; and surveys of students, parents, staff, and community members.

D.6 Coverage of Two or More Schools

Some geographical areas may require that a school nurse be responsible for more than one school. In these instances both schools should have copies of *The School Health Services Guide* (DoDDS Manual 2942.0). Written plans for providing adequate medical coverage for both schools should be established by the principal and the school nurse in coordination with the local medical treatment facility. School personnel should be made aware of this arrangement and should be supplied with first aid kits for treatment of minor injuries. Faculty inservice prepares the staff for full utilization of the emergency plan.

Health office supplies will be maintained in both schools when the distance between schools warrants. The school administrator is responsible for maintaining the health office in the absence of a school nurse.

The school nurse confers with the respective principals to arrange for military transportation between schools or seeks approval of the regional director for travel expenses when a privately owned vehicle (POV) is used.

D.7 Home Visits

The community health nurse and the community social worker generally make all required home visits. At the discretion of the community health nurse or social worker and with notification of the school administrator, the school nurse may provide support through home visits during the school day, provided proper arrangements have been made for nurse coverage at the school. It is recommended that the administrator provide a second person to accompany the nurse on home visits. A home conference may be preferred over a conference at school because direct conversation with the parents may be easier to conduct in the home setting. Because the child is a product of the family and home environment, home visits also may help the school nurse gain added insight into the child's condition.

D.8 Residence Halls

The health of residence hall students is primarily the responsibility of parents and the residence hall supervisor. Each residence hall school will provide a handbook for parents

and students, which includes the requirements and regulations of the residence hall health program.

- The school nurse coordinates with the residence hall supervisor and local medical treatment facility to establish procedures for daily sick call, referral of students to the treatment facility during and after school hours, and emergency medical treatment of residence hall students. Written parent/sponsor authorization for emergency medical treatment, surgery, and/or anesthesia for each student must be on file in the residence hall office.

- When a student is unable to attend classes for an extended period because of accident or illness, parents may be required to take the student back to his or her home.

- Medications that can be self-administered, such as inhalers, insulin, and antibiotics, must be accompanied by the **Permission for Student to Retain Control of Prescribed Medication** form (see Section H, Sample Forms). This form must be filled out and signed by the physician, parents, and student. DEA-controlled substances such as Ritalin, Dexedrine, Adderall, etc., must be kept in a locked medication cabinet in the dorm nurse's office and be administered by the dorm nurse. School personnel will not administer over-the-counter (OTC) medications unless there is a doctor's prescription for the medication and the bottle is labeled by the pharmacist (as for non-OTC medications).

- The nurse is encouraged to coordinate with the residence hall advisory staff to provide an environment that is safe and that contributes to the emotional well-being of students. The school nurse and faculty will assist residence hall advisors in developing special programs for residence hall students.

SECTION E

The Health Education Program

E.1 Health Education

E.2 References

E.1 Health Education

Health education is an important part of a comprehensive school health program. The goal of the health education program is to help students learn how to make wise decisions that promote their health and well-being. The *DoDEA Health Education Curriculum and Assessment Standards* serves as the framework of the health education program. The standards align with the National Health Education Standards developed by the Joint Committee on National Health Education Standards. Copies of the *National Health Education Standards: Achieving Health Literacy* can be obtained from the American School Health Association, the Association for the Advancement of Health Education, or the American Cancer Society.

The role of the school nurse in the health education program is to supplement the health instruction given by the classroom teacher. The school nurse supports health promotion activities and assists teachers in obtaining appropriate materials and resource people. School nurses may coordinate inservice education on health-related topics. School nurses may sometimes assist the classroom teacher to enhance a specific health unit in the classroom.

E-2 References

Assessing Health Literacy: A Guide to Portfolios
CCSSO-SCASS Health Education Project (1997–1998)

DoDEA Health Education Curriculum and Assessment Standards
http://www.odedodea.edu/instruction/curriculum/health/index.htm

SECTION F

Health Services, Practices, and Procedures

F.1 Registration

F.2 Immunizations

F.3 Medication Policy

F.4 Office Visits and Emergencies

F.5 Universal Precautions

F.6 Health Screening Procedures

F.7 Child Abuse and Neglect

F.8 The Nurse's Role on the Case Study Committee

F.9 Substance Abuse

F.10 Crisis Intervention

F.11 Adolescent Health Issues

F.12 Ancillary Coverage in the Health Office

F.13 References

F.1 Registration

During registration the school nurse may do the following:

- Make personal contact with parent(s).
- Clarify health problems of students.*
- Gather health information to assist with the Individualized Education Programs (IEPs).
- Complete and file health records and medical forms as needed.
- Screen immunization records and refer as needed. (Registration is not complete until immunizations comply with appropriate regulations.)
- Prepare confidential list of students with health problems.

*Note: DoD Reg 1342.6 *(Administrative & Logistics Responsibilities)* requests sponsors to make an appointment for a complete health appraisal upon the first entry of a student into school for preschool, kindergarten, or 1st grade.

F.2 Immunizations

Immunization Screening

Students who enroll in Department of Defense Education Activity schools must meet specific immunization requirements prior to enrollment. The requirements displayed below represent the minimum requirements and do not necessarily reflect the optimal immunization status for a student. This certification of immunization, completed by the local medical authority, must be provided to school officials at the time of initial registration for placement in the student's health record file.

Students in DDESS may be required to obtain immunization certificates specific to the state where they attend school. Deadlines for these certificates are determined by the local school district.

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DEPARTMENT OF DEFENSE EDUCATION ACTIVITY

CERTIFICATE OF IMMUNIZATION

Students who enroll in Department of Defense Education Activity schools MUST meet specific immunization requirements. These requirements, displayed below, represent the minimum requirement and do not necessarily reflect the optimal immunization status for a student. This certificate of immunization, completed by the local medical authority, must be provided to school officials at the time of initial registration for placement in the official school records of the student.

STUDENT'S Name_____/_____

_ Last Name First Name MI Date of Birth (mo/day/yr)

Instructions for Local Medical Authority: In the shaded spaces provided, write the date **(mo/day/yr)** of each immunization and the total number of doses received. In the appropriate shaded space write the date of the last TB screening and the reaction/mm reading. Sign, stamp and date the bottom section.

IMMUNIZATION	DATE mo/day/yr	COMMENT Total # of doses	MINIMUM DoD REQUIREMENTS
HEP B Hepatitis B	Date of last dose	total # of doses:	All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is HBs/Ag-negative. Only monovalent HepB can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be given at least 4 weeks after the first dose, except for combination vaccines which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 6 months. (For information on Hepatitis B Vaccinations for infants born to HBsAG-positive mothers and infants born to mothers whose HBsAg status is unknown, it is recommended that the healthcare worker consult instruction on the National Immunization website at: **www.cdc.gov/nip**.)
DTaP/DPT/Td Diphtheria, Tetanus, Pertussis*	Date of last dose	total # of doses:	The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. Tetanus and diptheria toxoids (Td) is recommended at age 11-12 years if at least 5 years have elapsed since the last dose of tetanus and diptheria toxoids-containing vaccine. Subsequent routine Td boosters are recommended every 10 years. Pertussis vaccine is not required for children over the age of 6.
HIB Haemophilus influenza type b	Date of last dose	total # of doses:	Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax®[Merck] is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 and 6 months, but can be used as boosters following any Hib vaccine. **HIB immunization is not required for individuals five (5) years of age or older.**
IPV/OPV	Date of last	total # of	3 doses of Polio Vaccine (oral or injected), **last one**

Polio Vaccine	dose	doses:	**MUST be administered after the 4th birthday.**
MMR Measles, Mumps, Rubella	Date of last dose	total # of doses:	2 doses of live attenuated vaccine given singly or in combination, the first of which is to be administered after the 1st birthday (12 months). The second dose of MMR is recommended routinely at age 4-6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and that both doses are administered beginning after age 12 months. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.
VARICELLA Chicken Pox	Date of last dose	total # of doses:	1 dose of Varicella Vaccine through the age of 12 years, 2 doses for those 13 or older (at least one month apart), **or reliable history of the disease.** **DATE CHILD HAD DISEASE PER PARENT REPORT** _____/_____ mo yr
Pneumococcal Vaccine (PCV)	Date of last does	Total # of doses:	The heptavalent pneumoccal conjugate vaccine (PCV) is *recommended* for all children age 2-23 months. It is also *recommended* for certain children age 24-59 months. Pneumoccal polysaccharide vaccine (PPV) is *recommended* in addition to PCV for certain high-risk groups.
(circle one) **PPD** **TB tine/ monovac** **BCG**	Date of last test	Results: ☐Negative ☐Positive _____mm	TB testing recommended. Frequency determined by local medical command If **Positive**, date of chest X-ray ____/____/____ Result _____ Date of **INH** treatment. Started _____/_____/_____ Finished _____/____/_____

Immunization records for the student named above have been reviewed at

_____.

Location of Clinic

I certify that the minimum immunization requirements have been completed, and or initiated.

Immunizations are current until

_____ when _____ immunization(s) is/are due.

_____

Signature and Stamp of Medical Authority/Date

A request for an immunization waiver for **medical** reasons must be supported by official documents from a medical authority and provided to the school at the time of registration. I certify that the minimum immunization requirements have been waived.

Immunization(s): _____ Reason_____

_____

Signature of Medical Authority/Date

DEPARTMENT OF DEFENSE DEPENDENTS SCHOOLS

CERTIFICATE OF IMMUNIZATIONS

Students who enroll in DoD Dependent Schools (DoDDS) must meet specific immunization requirements. These requirements displayed below, represent the minimum requirement and do not necessarily reflect the optimal immunization status for a student. **This certification of immunization, completed by the LOCAL MEDICAL AUTHORITY, MUST be provided to school officials at time of initial registration for placement in the official school records of the student.**

_____ _____ _____

(Please Print) Name of Child Date of Birth Parent or Guardian

Instructions for Local Medical Authority: In the spaces provided, write the dates (Mo/day/yr) of each immunization received. In the appropriate space write the date of the last TB screening and the reaction/mm reading.

Hepatitis B Vaccine: All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is HBs/Ag-negative. Only monovalent HepB can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be given at least 4 weeks after the first dose, except for combination vaccines which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 6 months. (For information on Hepatitis B Vaccinations for infants born to HBsAG-positive mothers and infants born to mothers whose HBsAg status is unknown, it is recommended that the healthcare worker consult instruction on the National Immunization website at www.cdc.gov/nip.)

_____ _____ _____

Mo/Day/Year Mo/Day/Year Mo/Day/Year

Diphtheria, Tetanus, and Pertussis Vaccine: (Circle vaccine given.) The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. Tetanus and diptheria toxoids (Td) is recommended at age 11-12 years if at least 5 years have elapsed since the last dose of tetanus and diptheria toxoids-containing vaccine. Subsequent routine Td boosters are recommended every 10 years. ***Pertussis vaccine is not required for individuals older than six (6) years of age.**

DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td

_____ _____ _____ _____ _____ _____ _____

Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year

HIB (Haemophilus influenza type b): Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax®[Merck] is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 and 6 months, but can be used as boosters following any Hib vaccine. **HIB immunization is not required for individuals five (5) years of age or older.**

_____ _____ _____ _____ _____

Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year

Polio Vaccine (Circle vaccine given.) 3 doses of Polio Vaccine (oral or injected), **last one of which was administered after the 4th birthday.**

IPV OPV IPV OPV IPV OPV IPV OPV IPV OPV

_____ _____ _____ _____ _____

Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year

MMR (Measles, Mumps and Rubella): 2 doses of live attenuated vaccine given singly or in combination, the first of which is to be administered after the 1st birthday (12 months). The second dose of MMR is recommended routinely at age 4-6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and that both doses are administered beginning after age 12 months. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.

_____ _____ _____

Mo/Day/Year Mo/Day/Year Mo/Day/Year

Varicella Vaccine: 1 dose of Varicella Vaccine through the age of 12 years, 2 doses for those 13 or older (at least one month apart), (or reliable history of the disease) **DATE CHILD HAD DISEASE PER PARENT: REPORT:**

_____

Mo/Day/Year

Pneumoccal Vaccine: The heptavalent pneumoccal conjugate vaccine (PCV) is *recommended* for all children age 2-23 months. It is also *recommended* for certain children age 24-59 months. Pneumoccal polysaccharide vaccine (PPV) is *recommended* in addition to PCV for certain high-risk groups.

_____ _____

Mo/Day/Year Mo/Day/Year

PPD: Date: _____Results: Negative ☐ Positive ☐ ___mm. Preventive Medicine Referral Date: _____ INH Date: _____-_____

BCG: Date: _____

Other: Specify Vaccine (not to include TB Skin Test)

Vaccine _____ Date _____ Vaccine _____ Date _____

I certify that the minimum immunization requirements have been completed, and or initiated. Immunizations are current until _____ when _____ immunization(s) is/are due.

_____

_____

Signature and Stamp of Medical Authority/Date

A request for an immunization waiver for **religious ___ or medical** ___ reasons must be supported by official documents from church or medical authority and provided to the school at the time of registration. I certify that the minimum immunization requirements have been waived.
Immunization(s): _____,
Reason: _____
Waver duration: _____.

_____

Signature and Stamp of Medical Authority/Date

DEPARTMENT OF DEFENSE DEPENDENTS SCHOOLS
CERTIFICATE OF IMMUNIZATIONS

Students who enroll in DoD Dependent Schools (DoDDS) must meet specific immunization requirements. These requirements, displayed below, represent the minimum requirement and do not necessarily reflect the optimal immunization status for a student. **This certification of immunization, completed by the local medical authority, must be provided to school officials at time of initial registration for placement in the official school records of the student.**

_____ _____ _____
Name of Child Date of Birth Parent or Guardian

Instructions for Local Medical Authority: In the spaces provided, write the date (Mo/day/yr) of each immunization received. In the appropriate space write the date of the last TB screening and the reaction/mm reading.

Hepatitis B Vaccine: All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is HBs/Ag-negative. Only monovalent HepB can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be given at least 4 weeks after the first dose, except for combination vaccines which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 6 months. (For information on Hepatitis B Vaccinations for infants born to HBsAG-positive mothers and infants born to mothers whose HBsAg status is unknown, it is recommended that the healthcare worker consult instruction on the National Immunization website at www.cdc.gov/nip.)

_____ _____ _____ _____
Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year

Diphtheria, Tetanus, and Pertussis Vaccine **(Circle vaccine given.)** The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. Tetanus and diptheria toxoids (Td) is recommended at age 11-12 years if at least 5 years have elapsed since the last dose of tetanus and diptheria toxoids-containing vaccine. Subsequent routine Td boosters are recommended every 10 years. Pertussis vaccine is not required for children over the age of 6.

DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td

_____ _____ _____ _____ _____ _____ _____

Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year

HIB (Haemophilus influenza type b) Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax®[Merck] is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 and 6 months, but can be used as boosters following any Hib vaccine. **HIB immunization is not required for individuals five (5) years of age or older.**

_____ _____ _____ _____ _____
Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year

Polio Vaccine **(Circle vaccine given.)** 3 doses of Polio Vaccine (oral or injected), **last one of which was administered after the 4th birthday.**

IPV OPV IPV OPV IPV OPV IPV OPV IPV OPV

_____ _____ _____ _____

Mo/Day/Year Mo/Day/Year Mo/Day/Year Mo/Day/Year
Mo/Day/Year

MMR (Measles, Mumps and Rubella: 2 doses of live attenuated vaccine given singly or in combination, the first of which is to be administered after the 1st birthday (12 months). The second dose of MMR is recommended routinely at age 4-6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and that both doses are administered beginning after age 12 months. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.

_____ _____ _____

Mo/Day/Year Mo/Day/Year Mo/Day/Year

Varicella Vaccine: 1 dose of Varicella Vaccine through the age of 12 years, 2 doses for those 13 or older (at least one month apart), **or reliable history of the disease.** **DATE CHILD HAD DISEASE PER PARENT REPORT:**

_____ _____ _____

Mo/Day/Year Mo/Day/Year Mo/Day/Year

Pneumoccal Vaccine: The heptavalent pneumoccal conjugate vaccine (PCV) is recommended for all children age 2-23 months. It is also recommended for certain children age 24-59 months. Pneumoccal polysaccharide vaccine (PPV) is recommended in addition to PCV for certain high-risk groups.

_____ _____

Mo/Day/Year Mo/Day/Year

Other: Specify Vaccine(not to include TB Skin Test)

Vaccine _____ Date _____ Vaccine _____ Date _____

TB Skin Test: Date: _____ Results: _____

I certify that the minimum immunization requirements have been completed, and or initiated. Immunizations are current until _____ when _____ immunization(s) is/are due.

_____

_____

Signature and Stamp of Medical Authority/Date

A request for an immunization waiver for **religious ___ or medical** ___ reasons must be supported by official documents from church or medical authority and provided to the school at the time of registration. I certify that the minimum immunization requirements have been waived. Immunization(s): _____,

Reason: _____Waver duration: _____.

_____

_____

Signature and Stamp of Medical Authority/Date

"insert school letterhead"
Office of the School Nurse

DATE: _____

MEMORANDUM FOR Parents/Sponsor of

_____

SUBJECT: Incomplete Immunizations

1. DoDEA Instruction 6205.1 states that ***PRIOR*** to enrollment in DoDEA Schools, students shall meet specific immunization requirements.

2. The following required immunizations are missing from your child's immunization records:.

_____ Diphtheria/Tetanus/Pertussis: dose # ___ (after fourth birthday) or ____ ten year booster

_____ Hepatitis B: dose # 1 2 3 4
dose #1 due:_____ dose #2 due: _____ dose #3 due: _____ does #4 due:_____

_____ Haemophilus Influenza type B: dose # _____

_____ Measles/Mumps/Rubella: dose # _____

_____ Polio Vaccine after the fourth birthday or dose # _____

_____ Varicella (Chicken Pox): dose # 1 2 dose #2 due: _____

or provide reliable history (_____month _____year)

_____ No immunization records on file with the child's school records

3. Have your child's records reviewed as soon as possible by "*insert name and hours of local medical treatment facility"*.

4. DS Form 121.1 is attached and will need to be completed by the medical authority reviewing your child's immunization records.

5. Bring the completed DS Form 121.1 and your child's updated immunization record to school as soon as possible so that enrollment requirements for your child are complete.

Your child's registration for school year (insert year) will not be complete until we receive documentation of required immunizations.

If you have any questions, please call *"insert school nurse name and number"*.

_____

"insert name of Principal"

The minimum immunization requirements are listed on the Certification of Immunization (DoDEA Form 122) located in Section H. Students should meet immunization requirements prior to initial school enrollment.

Although the military services, and not the schools, are responsible for administration of immunizations, school nurses can assist in the following ways:

- Disseminate DoDEA Certification of Immunization form (DS 122) to parents and direct them to the local medical treatment facility. When the form is completed, the parent returns it to the school.
- Screen immunization records and complete the Certificate of Immunization form. The certificate is filed in the student's health record.
- Devise a system of notifying parents before the expiration date on the immunization form.
- Coordinate with the local medical facility to develop procedures that ensure that students receive required immunizations. Proper documentation is necessary, including the dates of the immunizations and a date showing how long the certification is current.

Medical and Religious Exemptions

An exception to the immunization requirement may be made for the following reasons:

- Medical — A child with a medical contraindication to one or more vaccines may be exempt from this requirement. The parent or guardian must present a statement from a licensed physician, nurse, nurse practitioner, or other health care professional that the physical condition of the child is such that the administration or one or more of the required immunizing agents is contraindicated, and whether the condition is permanent or temporary. If the condition is temporary, the vaccine must be received within 30 days of the exemption expiration date. For the protection of the medically exempt student and the safety of other students enrolled, the medically exempt student will be excluded from school during a documented outbreak of a contagious disease.
- Documented History — A student may be exempt from all or part of the MMR, varicella, and Hep B requirement through a blood titer test that shows that the student has had one or more of these diseases.
- Religious — A child's parent or guardian may claim exemption for religious reasons. If the parent maintains the need to continue the religious exemption during a documented outbreak of a contagious disease, the student will be excluded from school for his or her protection and the safety of the other students until the contagious period is over. Religious exemptions require a written statement from the parent stating that he or she objects to the vaccination based upon personal beliefs.

F. 3 Medication Policy

Administering Medication

The school nurse should encourage parents to administer necessary medications to their children at home if possible. When medications must be administered during the school day, the medication must be delivered to the school nurse in the original container, properly labeled by the pharmacy or physician, stating the name of the student, the medication, the dosage, and current date. Prior to administering the medication, the physician and parent must complete and sign a permission for medication form. (See Section H for the proper form.) This form, with signatures of both the physician and the parent, must also be on file before administering routine over-the-counter medications to students.

In DDESS, other medication/permission procedures may be substituted through agreements between the local military treatment facility and the school nurse.

The school nurse may train unlicensed personnel to give medications in his or her absence. Designated unlicensed personnel must demonstrate competency in administering prescriptive drugs before assisting students with medication. Inservice training shall include instruction in the safe administration of medication. (See Section I, Guidelines for Safe Administration of Daily Medications in the Absence of the School Nurse, and Section H for Medication Inservice.)

Medications given at school must be documented either on an individual log or in an adopted computerized student health management system. Written documentation must include time, dose, route, and signature of the nurse or person administering the medication. Best practice includes an individual log for each medication and each dosage time. (See Section H for Individual Medication Log.)

Standing Orders

Standing orders are written by a physician and apply only to students in which the order may be applicable. It is not necessary for the physician to have previously examined the student. Due to the complexity and joint service provision of health care services to the DoDEA organization, it is not feasible to provide universal standing orders for DoDEA school nurses worldwide. (A suggested form for the treatment of anaphylactic shock is included in Section H.) Individual specific standing orders should be obtained for children with long-term illnesses that require treatment at school. Standing orders must be renewed annually.

Storage of Medication

Medications must be kept in a locked cabinet at school, with the exception of asthma medication. Students diagnosed with asthma must have doctor and parental permission to carry their medication as well as a signed statement taking responsibility for the proper use of the medication. Written documentation of the administration of medication must include time, dose, route, and the signature of the person giving the medication. Best practice includes an individual log for each medication and each dosage time. (See Section H for Individual Medication Log.)

Administration of Medication on Field/Study Trips

The school nurse will establish a protocol for ensuring that medication is administered on field/study trips. A daily dosage of medication shall be prepared for students who receive prescribed medication at school. The labeled envelope will include the child's name, date, name of medication, dosage, and time of administration. (See Section H for Medication Log, Study Trip Administration.)

Medication Incidents

If a medication error occurs, the nurse should notify the child's parent, the child's physician, and the school principal. A Medication Incident Report should be completed. (See Section H for Medication Incident Report.)

F.4 Office Visits and Emergencies

Procedures for Illness and Minor Injury

The school nurse renders first aid and provides nursing care for the student who is injured or becomes ill at school. The school nurse determines the need for a student to be sent home or referred for medical evaluation.

If a student is ill and needs to be sent home because of illness or injury, one of the following actions should take place before releasing the student from school:

- A responsible parent or guardian is contacted to take responsibility for the student's transportation to the appropriate destination, whether home or the medical treatment facility. Under no circumstances should the student be released until the parent gives explicit instructions to release the child on his or her own recognizance.
- The designated emergency person is contacted if the parent or guardian is not available.
- The sponsor's supervisor is contacted if no one else is available.
- A Medical Referral Form is completed if deemed appropriate (see Section H).

Emergency Medical Care

In coordination with the local medical support facility, each school should have written procedures for first aid and emergency care that are clearly understood by all school staff: principals, teachers, volunteers, secretaries, student aides, etc.

If a student needs *emergency* medical care requiring an ambulance, the school nurse follows the emergency plan relevant to the community. In all cases, the following procedures are implemented:

- The ambulance is requested.*
- The parent is notified that the student is en route to the nearest medical facility.
- The school administrator is notified.

*A school official may accompany the student to the medical facility in an emergency.

Emergency Plans

Field/Study Trips — The nurse will develop an emergency care plan that is relevant to the respective community for health emergencies that may arise when students are away from the school area for an extended period of time. (See Section I for Study Trip First Aid.)
Other Unpredictable Emergency Events — There may be epidemics, bomb threats, and facility deficiencies that endanger the health and safety of students and school personnel. The installation commander may close the schools for such emergencies as he or she deems necessary. The administrator should develop emergency procedures in coordination with appropriate military officials. The nurse should work with the administrator and the faculty to ensure the safety of students.

Accident/Injury Report (AIR)

An Accident/Injury Report (AIR) DoDEA 4800.1 should be filed electronically and sent to the appropriate personnel if an injury occurs that causes a temporary disability, permanent disability, or death (see Section H for Accident/Injury Report).

F. 5 Universal Precautions

General Information

To control communicable disease transmission, school staff should use Universal Precautions and Body Substance Isolation as described in the Clinical Guidelines "Standard Precautions/Control of Communicable," p. 153. Any DoDEA regulations pertaining to blood-borne pathogens should be implemented.

School Nurse Role

The school nurse must ensure that all school employees understand the importance of universal precautions and proper hand washing to control the spread of contagious diseases. Information about universal precautions and procedures to follow should be distributed at the beginning of the school year when discussing first aid. Classroom and playground first aid kits are recommended for distribution. All staff should be provided with disposable gloves and instructed in proper use. Liquid soap dispensers are recommended for proper hand washing.

Universal Procedures

The following universal procedures should be followed by all school staff:

- Students should be encouraged to take care of their own minor injuries, cuts, scrapes, and bloody noses whenever possible. The student may need a reminder to thoroughly wash his or her hands afterward.
- Large blood spills — as from serious nosebleeds or wounds — may require assistance from school staff. The school employee must always wear gloves when making contact with the wounded person.
- Employees need to thoroughly wash their hands after contact with body fluids whether or not gloves were worn.
- Employees must wear disposable gloves for clean-up. They must use a disinfectant solution for cleaning (a bleach solution of 1.5 cups per gallon of water). It is recommended that the administrator responsible for any contracts inform the contractor of recommended OSHA standards.

F.6 Health Screening Procedures

Observation and Referral

Because teachers work closely with students each day, they play a key role in observing and detecting health problems. Observation, inspection, and attention to complaints of pupils are frequently much more important in finding clues to defects or abnormal conditions than many of the screening tests. These observations are not limited to any particular period of the day and should continue throughout the day as students engage in various school activities. Teacher-nurse conferences are helpful in understanding and sharing knowledge of students with health concerns.

Health Services Screening Program

In developing a health service screening program, the school nurse may want to consider the following:

- Age of the children to be examined. (E.g., it may be advisable to screen the kindergarten class in the classroom, where they will feel more secure. For older children, another location would be appropriate.)
- Classroom schedules.
- Time involved in the screening. (E.g., audiometric testing takes approximately two to five minutes per student with individual equipment.)
- Available equipment. Is the equipment available for multiple screening, or must screening be done individually? Must the equipment be shared with other schools, and if so, what is their schedule?
- Available locations for screening. Is the area used for other purposes? If so, will the screening have to be scheduled over a period of time? Will the times available allow for checking the students who need to be examined? Is a quiet area available for audiometric screening? Is a private area available for scoliosis screening?
- Available medical facility assistance. To what extent will the local medical treatment facility assist in the screening program? Cooperation and coordination with the local medical facility saves times on lengthy appointments and provides identification of students in need of service.
- Provisions for health instruction units. The appropriate materials that support the screening program should be distributed to the classroom teacher.
- Provisions for health office coverage during screening. Coverage should be arranged with the administrator.

Prior to Screening Students for Vision or Hearing

The schoolwide screening program should be coordinated with school administration, teaching staff, and medical and clinic support staff (e.g., physical therapy, occupational therapy, optometry, audiology, dental, etc.). Health screening forms are available with Health Master. The screening program involves the following:

- Obtaining a list of all students to be screened *prior* to actual screening.
- Contacting volunteer sources for assistance with the screening program.
- Informing the students and their families of the purpose of the screening, method of accomplishment, and that follow-up for further examination may be required. (Indicate that this is only a screening and not a substitute for a regular examination.)
- Preparing pertinent forms.

Vision Screening (Reference NASN *Vision Screening Guidelines for School Nurses)*

Adult observation, inspection, and student complaints are equally as important as an eye test in finding clues to defective vision or other abnormal eye conditions. The

teachers should note and refer to the school nurse for immediate care any students with the following symptoms:

- Red-rimmed, encrusted, or swollen eyelids
- Inflamed or watery eyes, recurring sties
- An eye that turns in or out
- Changes in vision, such as double or blurred vision
- Squinting, frowning, shutting, or covering one eye
- Difficulty with close work

Ideally, all students are screened upon entry into school and in kindergarten, 1st and 2nd grades, 4th or 5th grade, 7th or 8th grade, and 10th or 11th grade. High school students should be screened at least once during their high school years. The school nurse should consider any referral from a parent, instructional staff, physician, or student, as well as referrals for special education services from the Case Study Committee (CSC).

Referral criteria should be coordinated with the local medical facility. NASN guidelines indicate acuity in each eye should be at least 20/30. For younger children in preschool and kindergarten, vision must be at least 20/40. Students should be referred for more than one line of difference between the two eyes.

Notifying Parents of Screening Results

After the screening, the school nurse will forward a letter with the screening results to the parent, requesting that the parents make an appointment with an appropriate practitioner. The teacher should also be informed so that any necessary environmental adjustment can be made. (See Section H for Vision Screening Referral.)

Assessment Tools for Vision Screening

Most commonly used screening tools are the distance and near point vision tests. Examples for particular eye problems include the following:

- Distance vision: Snellen charts (symbol, letter, etc.), HOTV, Titmus, Keystone
- Near vision: Titmus, Continuous Text reading card, Snellen Near Point charts (letter or symbol, etc.)
- Color vision: Ishihara
- Hyperopia (determines greater than normal amount of farsightedness): Plus lens test
- Binocularity (amblyopia and poor ocular alignment): Stereo/depth perception test
- Tracking (determines if eyes work together)
- Eye alignment (determines potential misalignment, strabismus, or hyperphoria)

Hearing Screening (Reference NASN *The Ear and Hearing: A Guide for School Nurses)*

Any substantial reduction in the ability to hear may constitute a handicap. Anything that interferes with the child's hearing ability impairs early language growth and may have a strong influence upon the student's academic performance and the development of character and personality during childhood years. Symptoms reported by the classroom teacher that may need further evaluation are the following:

- Complaints of frequent earaches or pain in the area immediately adjacent to the ear
- Complaints of the ear being "stopped up"
- Complaints of noises such as ringing or buzzing
- Drainage from the ear, sometimes accompanied by an unpleasant odor
- Ears dirty with heavy encrustation of dried earwax
- Frequent colds or allergic symptoms
- Constant mouth breathing
- Poor balance in walking, running, leaping, and other similar activities
- Poor or defective articulation of speech sounds
- Misunderstanding or misinterpretation of oral communication
- Inattention, interrupting conversation of others, being unaware that others are talking, answering questions inappropriately, responding off topic, leaning forward to hear, or cocking the head in an effort to hear better

Students in kindergarten and in grades 1,2, 3, 7, and 11 should be screened annually. Students referred by a parent, instructional staff, physicians, or Case Study Committee should be considered, as should self-referrals.

Assessment Tools for Screening Hearing

- Audiometer
- Tympanometer
- Otoscope

Procedures for Screening Hearing

Three types of hearing tests are recommended for use in school hearing screening programs. The school nurse who has received training is qualified to do these hearing tests. Procedures for administering the tests are described below.

Pure Tone Screening (Sweep Test)

1. Select a room in the quietest part of a building. A soundproof room is not

necessary.
2. Give careful directions to the students before beginning. This may be done individually or to the entire class. Be sure they understand that they should raise their hand the moment they hear the sound.
3. Place earphones on each ear (red on right ear, blue on left ear). Be sure that earphones fit snugly and that nothing interferes in a way that would inhibit the passage of sound.
4. Set the frequency at 2000 Hz. Present a recognition tone of 40 dB.
5. Set the Hearing Threshold Level (HTL) at 20 dB (soundproof room) or 25 dB (non-soundproof room).
6. Present the tone (2000 Hz) for one to two seconds to the right ear. Tone may be presented twice to make sure the child hears the tone and understands what is supposed to be heard.
7. Proceed to 4000 Hz, 1000 Hz, and 500 Hz.
8. Repeat the procedure to the left ear.
9. Vary the length of the tone and the pauses to prevent establishing a rhythm.
10. Repeat if the student fails to hear any tone, but do not go above 25 dB.
11. Rescreen in two to three weeks any student failing to respond to two or more tones in one ear.

Pure Tone Threshold Test

1. Prepare the student for this test in the same manner as above.
2. Begin the test by setting the Hearing Threshold Level (HTL) at 50 dB.
3. Present the tone (2000 Hz).
4. Decrease the dB until the student no longer hears the sound.
5. Repeat Steps 3 and 4 for accuracy.
6. Record the last tone heard on the audiogram.
7. Test remaining frequencies (1000, 4000, and 500Hz) in the same manner.
8. Record the lowest dB heard for each tone on the audiogram. (It is unnecessary to establish a threshold above 60 dB.)
9. Record results on the student's school health record.
10. Request that the sponsor make an appointment with an appropriate practitioner if the student does not pass the threshold screening. A letter with the screening results should be sent home with the student or mailed to the sponsor. The teacher should also be informed so that classroom adjustments can be made.
11. Refer any child who repeatedly fails a screening to the teacher for the hearing impaired. (See Section H for Hearing Screening Referral.)

Impedance Testing

1. Examine the ear with an otoscope for any obstruction such as cerumen or a foreign body; examine *before* testing.

2. Explain the procedure to the student.
3. Insert the probe into the ear, making sure the tip is properly sized to prevent outside air from entering the canal.
4. If the instrument is computerized and records only a number, record numbers on the forms supplied with the machine.
5. If the instrument produces a graph, observe for proper results.
6. Record results on student school health record.
7. If the student does not pass the screening, a letter with screening results requesting the sponsor make an appointment with an appropriate practitioner should be sent home with the student or mailed to the sponsor. The teacher should also be informed.

Implications of Identifying a Hearing Loss

The following classifications are based on hearing levels through the frequency range most crucial for the understanding of speech and are a general guide to the degree of severity of hearing loss:

MILD HEARING LOSS (20–40 dB)
- Has difficulty hearing faint or distant speech.
- Needs favorable seating.
- May benefit from lip-reading instruction.
- May benefit from hearing aid.

MODERATE HEARING LOSS (41–59 dB)
- Can barely hear conversational speech at a distance of 3 to 5 feet.
- Needs hearing aid, auditory trainer, lip reading, favorable seating.
- Needs language therapy to aid with communication skills.
- Requires special education services.

SEVERE HEARING LOSS (60–85 dB)
- May hear a loud voice about 1 foot from the ear.
- Needs hearing aid, etc., in conjunction with language therapy to aid with communication skills.
- Requires special education services.

PROFOUND HEARING LOSS (85+ dB)
- May hear only very loud sounds (e.g., jet plane overheard and subway).
- Does not rely on hearing as the primary channel for communications.
- Needs amplification, plus all of the above mentioned services, but may be less successful in producing adequate speech and language.

Scoliosis Screening (Reference NASN *Postural Screening Guidelines for School Nurses)*

- **Students.** An early detection program requires some advance preparation to achieve maximum effectiveness and avoid confusion about scoliosis. Because the general public knows very little about scoliosis, it is essential to have some education before screening takes place. This education starts with the students in health classes and includes an explanation of the mechanics of the examination, emphasizing that personal privacy will berespected. The lesson includes general observations about the posture of students and adults and a discussion of kyphosis (hunchback), lordosis (sway back), and scoliosis (a lateral curvature of the spine).
- **Parents.** After educating the students, the parents should be informed of the planned screening. It is advantageous to have an information meeting for parents on the subject. Appropriate school health personnel can explain scoliosis and related concerns, and the planned screening program. A film and/or slide presentation for both the students and parents before screening may be appropriate.

Prescreening education is essential to the success of a screening program. Misinformation about scoliosis, such as the notion that scoliosis is contagious or results in loss of limbs, can result in misperceptions about the disease or condition. Parents can become upset when they receive positive findings without having prior knowledge of the condition and the screening program.

Notification from School to Parents

- **Notice of screening to take place.** Notification to the parents that the screening will take place should be sent home with those students to be screened (see Section H for Parent Notice of Scoliosis Screening).
- **Notification of results of screening.** The results of the screening are either given directly to the student or sent home BY MAIL to parents whose children have positive findings. Before notifying a parent of negative findings, it is recommended that a rescreening be completed by SOMEONE OTHER THAN THE ORIGINAL SCREENER. It is highly recommended that the second screener be another health professional who is familiar with spinal screening. (Note: The suggested notification form in Section H does not specifically state the presence of scoliosis or other specific findings, but merely suggests that a medical review is needed.)

Recommended Scoliosis Screening Ages

- Annual screenings are recommended for all children ages 10 through 14, in grades 5, 6, 7, 8, and 9. A student who is already being treated for scoliosis

should not be screened again. Statistical findings on screening programs indicate a likelihood of from 2 to 7 percent positive findings, depending upon the age group. After the initial screening, some students, especially girls, may ultimately need surgery to correct their scoliosis. In younger children, less traumatic methods of treatment, such as bracing, may be more appropriate.

Procedure for Scoliosis Screening

Preparation for Screening

1. Each student should be screened in private, in a separate room or behind a screen, in gym clothes when possible. Boys and girls must be screened separately and individually. The space must include a writing area where the screener can record information as the physical findings are observed. It is strongly recommended that females screen girls. If this is not possible, then a female chaperon MUST be present at all times when girls are being screened.

2. To help ensure accurate screening results, the students must wear proper attire.
    - Boys must remove their shirts and pants to the hips or wear gym shorts, so that the waistline and hips can be observed.
    - Girls must wear a bathing suit top, halter top, or bra and lower their pants to the hips or wear gym shorts, so that the waistline and hips can be observed.
    - All students must remove shoes or sneakers before screening.

Screening Procedures

1. The student is directed to stand erect with weight evenly distributed on both feet, facing the screener with feet together, knees straight, and arms relaxed at sides. Students should be encouraged to avoid slouching or standing "at attention." The screener should check the student from the front looking for the following:
    - Elevated shoulder
    - Unequal space between arm and side
    - Uneven waist creases

2. Next, the student is directed to bend forward at the waist (toward the screener) with hands together and head tucked in (as in a "diving" position). The screener should examine for the following:
    - Asymmetry (uneven contours) of the rib cage or upper back, i.e., one side higher than the other
    - Rib hump present in the upper or lower back
    - Curve in the spinous process alignment

3. The student is asked to turn so that his or her back is facing the screener. The screener should observe for the following:
    - Elevated shoulder
    - Hip prominence
    - Curve in spinous process alignment
    - Unequal space between arm and side
    - Unequal creases at waist

4. The student is asked to assume the diving position once more, bending forward at the waist with head tucked in. The screener should observe for the following:
    - Asymmetry (uneven contours) of the rib cage or upper back; i.e., one side higher than the other
    - Rib hump present in the upper or lower back
    - Curve in the spinous process alignment
    - Record findings on class roster

In the procedure outlined above, the screener remains primarily in one place, allowing the student to do the turning. This saves time and makes the screener's job easier. After the screening is completed, the school nurse, teacher, or other appropriate person notifies parents of children with positive findings.

Referral Criteria for Scoliosis Screening

- Any child with an obvious deformity
- Asymmetry of the back in the forward bends test
- Seven degrees or more on scoliometer; combined reading of 10 degrees or more between thoracic and lumbar readings on scoliometer
- Curve of the spine, lordosis, or kyphosis
- Two or more of these signs:
    - Shoulder or scapula asymmetry of 1 inch or more
    - Hip asymmetry of one-half inch or more space between arm and flank on one side
    - Uneven waist creases
    - Leg length difference of one-half inch

See Section H for Scoliosis Screening Referral form.

Follow-Up

- The school nurse or teacher should follow up by encouraging the parents to take the child for a professional observation. The results of the screening should be noted in the student's health record and shared with the classroom teacher to allow for environmental accommodations.

Dental Screening and Preventive Care

General health, well-being, and personal appearance are enhanced by good dental health. Dental disability may result from abnormal growth and development, traumatic injury, dental caries, or periodontal disease. The primary focus of dental screening and preventive care is to coordinate the activities of the classroom teacher to reduce the probability of the development of future dental disorders and to identify existing student dental health problems. The school dental program includes the following:

- **Screening and treatment referral.** Screening and treatment of student dental health disorders are the responsibility of the local dental clinic. The school nurse and clinic personnel coordinate screening procedures and practices. (See Section H for Dental Screening Report.)
- **Dental health education.** Learning activities directed by the classroom teacher, a dental hygienist, or the school nurse promote proper dental care. The benefits of daily mouth cleansing, tooth brushing, and proper dietary habits are valuable components of the health curriculum.
- **Dental emergencies.** Refer to *Clinical Guidelines for School Nurses,* p. 37.

F.7 Child Abuse and Neglect

Cases of child abuse and neglect will be reported in accordance with current DoDEA regulations and guidelines. Any employee who has reason to believe or suspect that a student has been abused or neglected shall report that information immediately according to established DoDEA procedures. Local policy and procedure shall be followed in accordance with DoDEA regulations and guidelines. (See Section I for DoDEA regulation 2050.9 "DoDEA Family Advocacy Program Process and Procedures for Reporting Incidents of Suspected Child Abuse and Neglect," 27 January 1998 and Memorandum of Understanding signed by FEA and DoDDS in November 1999.)

For other information on child abuse reporting, see Section C.9.

F.8 The Nurse's Role on the Case Study Committee (Special Education)

DoD Instruction 1342.12, and 32 CFR part 80 require that all handicapped children between the ages of 3 and 21, regardless of the severity and extent of their handicap, must be provided a "free and appropriate education." The school nurse's role may include the following:

- Home visits that identify children with exceptional needs who are not attending school
- Conferences with parents, community agencies, and instructional staff

- Observation of students at home and in school setting (classroom, cafeteria, playground, etc.)
- Screening, evaluation of assessment results, and medical history information

A major role of the school nurse in the early identification of a student with a suspected disability is to refer the student and family to the appropriate resources. Because of their professional background, school nurses are especially qualified to strengthen the link between educational and medical services. Health services for a child referred to the Case Study Committee (CSC) team may include the following:

- Vision and hearing screening, with follow-up as indicated
- Health and developmental history when appropriate
- Medical referrals/follow-up as indicated
- Written report of the above to the CSC

See Section H for Child Study Committee forms.

F.9 Substance Abuse

All schools should have a plan for implementing DS Regulation 2792.2 that establishes policies and procedures for helping students lead drug-free lives. The role of the school nurse in school substance abuse programs is threefold: drug abuse prevention and education, early identification of both users and potential users of mind-altering drugs or alcohol, and referral to local treatment programs. Drug abuse programs target a range of abused substances, including alcohol, tobacco, misused prescription and nonprescription drugs, inhalants, and other legal substances used for the purposes of altering the mind.

Drug Education

The school nurse may be asked to coordinate or participate in various educational programs, such as Drug Abuse Resistance Education (DARE), Choosing for Yourself, Students Against Driving Drunk (SADD), and Parents' Resource Institute for Drug Education (PRIDE). The nurse may also facilitate school participation in national and local campaigns such as the Great American Smoke-Out, the Red Ribbon Campaign, and Celebrate Sober. Students should be referred to substance abuse counseling resources as appropriate. Adolescent Substance Abuse Counseling Service (ASACS) is a contracted program that provides "in-house" counseling services and is available in some communities.

Identification

Medical Emergency

If a medical emergency at school exists because of suspected substance abuse, the school nurse should be summoned using the school's emergency procedures. An ambulance should be called while the nurse renders first aid. Information concerning the suspected substance abuse should be given to the local medical facility as quickly as possible. Parents should be notified of the incident and referred to the local medical facility. (See Section H for Behavioral Checklist for Suspected Chemical Abuse.)

Nonemergency

When no medical emergency exists but a teacher or other staff member suspects that a student is under the influence of alcohol or drugs at school, the student should be referred to the administration for disciplinary action. If the administrator determines that the nurse's input is needed even though no emergency exists, the administrator will ask for the nurse's assistance. To maintain his or her role as a health counselor, the nurse should try to remain separate from disciplinary decisions as much as possible. (See Section H for Behavioral Checklist for Suspected Chemical Abuse.)

Chronic Abusers

Upon reasonable suspicion that a student has a chronic problem with either drugs or alcohol or both, the student is often referred to the school nurse for further assessment. If information supports suspicion of a substance abuse problem, the student's sponsor should be contacted and the family referred to the Adolescent Substance Abuse Counseling Service (ASACS), if available.

Children of Alcoholics and Other At-Risk Students

The school nurse plays an important role in the identification of children at high risk for developing substance abuse problems. Identifying and referring these children to educational prevention programs and/or counseling maximizes the possibilities of academic success and self-esteem.

F.10 Crisis Intervention

Schools must establish a Crisis Management Plan and a Crisis Management Team. (See Reference Section re: DSM 2943.0.) The Crisis Management Team will respond to crises that affect the school population, for example, the death of a student or a teacher, a serious accident, self-destructive behaviors, or threats of potential or actual violence.

The school nurse should work with the school counselor and other members of the Crisis Management Team to formulate a crisis response plan for the school.

F.11 Adolescent Health Issues

Confidentiality

Minors may receive confidential medical care without their parent's knowledge or consent, in accordance with local military regulations. In communities where teen clinics are established, students who are dependents of civilian personnel may receive this care free of charge. Most often confidential care involves sexuality problems such as pregnancy testing, birth control information and examinations, and treatment for sexually transmitted diseases. In providing care, the individual health practitioner must determine if the teenager is mature enough to understand the medical treatment and to follow instructions. When students seek confidential medical care without parental permission, an accountability system is set up between the medical facility and the school nurse to verify that the student's absence is an "excused" absence with "make-up" privileges.

Contraception

Birth control information is a part of the health education curriculum in DoD secondary schools. Students requesting confidential medical appointments at local medical treatment facilities may receive assistance from the school nurse.

Pregnancy

Identification

The school nurse should assess the student who suspects pregnancy for related problems such as depression, denial, suicidal ideation and/or gestures, sexual assault or abuse, intentions to run away, family stress and/or violence. A student may have the pregnancy confirmed through a confidential pregnancy test at the local medical facility, depending on age and service. In other cases, a student may need parental permission and/or support to obtain a pregnancy test.

Pregnancy Test Results

Whether a student''s pregnancy test is negative or positive, the student may need follow-up counseling. For this reason, pregnancy test results should not be given to a teenager by phone, unless the student phones for the results from the school nurse's office. The school nurse is then available for guidance and support to the student.

Even if the pregnancy test is negative, the student still needs follow-up. The teenager needs to be counseled regarding issues such as sexual relationships, contraceptives, and sexually transmitted diseases. A sexually active teen who has never had a pelvic exam should be referred for a GYN exam and counseling at the teen clinic if such facility is available.

The student who is pregnant will need counseling regarding the choices available to her. The school nurse should refer the student to the local medical facility or other agencies for counseling support. Often the school nurse will facilitate discussion of the pregnancy between the girl and her parents. The school nurse should encourage prenatal care as well as infant care classes. The school nurse can initiate services in the school that help the pregnant student to stay physically and mentally healthy, that promote emotional support, and that provide appropriate educational strategies. The school nurse should collaborate with the family and the medical team to provide the pregnant student with medical, emotional, and social support to reduce stress.

Sexually Transmitted Disease

The school nurse should be a central figure in assessment, intervention, and prevention of sexually transmitted diseases (STDs). The incidence of STDs in teenagers has risen to epidemic proportions. Some STDs, such as chlamydia and gonorrhea are common causes of sterility in both men and women. Viral infections such as herpes and genital warts cannot be cured. AIDS is a viral infection that is fatal. Other serious STDs include hepatitis B and hepatitis C. For these reasons, prevention of STDs is part of the DoDEA secondary health curriculum, with education beginning in the primary grades. School nurses, especially at the secondary level, need to be familiar with the signs and symptoms of the various STDs and refer students for confidential care as needed.

Runaways

If a school nurse learns that a student has left home or a resident dorm without permission or knowledge, the school nurse must assess the situation and report essential information to the parents, the school administration, and if necessary, social work services and/or the military police. Through a cooperative effort with social work services, the school nurse can help identify reasons for the running away.

F. 12 Ancillary Coverage in the Health Office

Guidelines for Personnel Working in the School Health Office Who Are *Not* Registered Nurses

Observe the following general guidelines:

- Be honest with the students, parents, and teachers with whom you have contact. Tell them that you are NOT a registered nurse, but that you will try to help them to the best of your ability.
- Keep a record of all students who come into the health room, including the date, time, reason for the student's visit, and what you did for the student.
- Attempt to obtain a history of events leading up to the injury or illness that the student reports to you. Complete DoDEA forms when appropriate, such as accident reports.
- Do first aid in accordance with the DoDEA *School Health Services Guide* and skills learned in Red Cross first aid and CPR courses. Be sure to keep Red Cross certifications current.

Call the parent for any of the following reasons:

- Any illness or injury that causes you concern
- Eye, ear, or teeth injuries
- Head injury
- Second- or third-degree burns
- Severe pain
- Sprains or possible fractures
- Temperature higher than 100˚
- Vomiting
- Wounds that may require stitches

When dispensing medication, observe the following guidelines:

- Check all medications to make sure you have written parent permission, a container properly labeled by the pharmacy, and written instructions signed by the doctor. The pharmacy label and the doctor's instructions MUST MATCH IN ALL OF THE FOLLOWING AREAS:

    - Student's name
    - Doctor's name
    - Medication's name
    - Amount of medication to give
    - Time to give the medication

- If any one of the above doesn't match, return the medication to the parent to take back to the clinic for corrections.

When dealing with an illness or injury, observe the following guidelines:

- Notify the principal of any major health care concerns.
- Contact the parent/guardian. If you are unable to reach the parent, try the emergency contact number or notify the sponsor's commander.
- Send the student back to class if his or her temperature is below 100° and no other serious symptoms are evident. Instruct the student to come back to the health room if he or she continues to feel bad.
- Send a note home with the student if you have been unable to contact the parent regarding an illness or injury. Keep a copy of the note.
- Respect confidentiality of information obtained from students and families regarding an illness, injury, diagnosis, or medical treatment.
- Share information with the principal and/or the counselor whenever there is a risk to the student or a specific law or policy requires such reporting. Such situations include child abuse or neglect, suicidal thoughts or actions, possession of controlled substances, assault to others, theft, runaway, etc.
- Refer chronic health problems to the school nurse or to the military community health nurse when a school nurse is not available.

DO NOT do any of the following:

- Make a diagnosis or prescribe treatment or medication.
- Give medical advice.
- Take on the role of a counselor. (Refer student to the appropriate school personnel: counselor, school psychologist, and school nurse.)
- Give or apply any medication unless it comes in a pharmacy-labeled container with written instructions from the doctor and written permission from the parent.
- Accept medications in containers with alterations made by the parent on the pharmacy label or on the doctor's instructions.
- Give care beyond basic first aid for which you have current certification from the Red Cross.
- Perform any health procedures for which you would need a RN license to perform in the state or anything that requires more than a clean procedure.
- Perform tasks or take responsibilities that will jeopardize the health of others or your own liability.
- Transport sick or injured students in your POV.

For other information on delegation of nursing care see Section C.4.

F.13 References

The Ear and Hearing—A Guide for School Nurses (NASN, 1998).

Occupational Exposure to Blood-borne Pathogens—Implementing OSHA Standards in School Settings (NASN, 1994).

Postural Screening Guidelines for School Nurses (NASN, 1995).

Vision Screening Guidelines for School Nurses (NASN, 1995).

School Health Alert Clinical Guidelines for School Nurses.

1997 Red Book—Report of the Committee on Infectious Diseases, 24th Edition (ACA, 1997).

"Immunization Requirements for DoDEA…." DOD Instruction 6205.1.

Air Force Joint Instruction 48-110 "Immunizations and Chemoprophylaxis," November 1, 1995.

DSM 2943.0 (February 1990) *DoDDS School Action Plan for Crisis Intervention and Response to Death.*

SECTION G

Specific Illnesses and Injuries

G.1 School Clinical Guidelines

G.2 Resources

G.1 School Clinical Guidelines

The document *Clinical Guidelines for School Nurses from School Health Alert* will be used as the standard of care for specific illnesses and injuries in DoDEA. It was purchased by DoDEA and will be updated with new editions as they are made available. *Clinical Guidelines for School Nurses from School Health Alert* was chosen because it focuses primarily on health services. It was written specifically for school nurses who practice independently. It contains brief summaries of illnesses and injuries that school nurses deal with in their school nursing practice. This information is intended as a policy guide.

Please insert your school's copy of *Clinical Guidelines for School Nurses* in this Section of your *DoDEA School Health Services Guide*.

Supplemental DoDEA forms and specific guidance addressing issues such as asthma, ADHD, child abuse, etc., are available in Section H and Section I.

Communicable diseases are covered throughout the *Clinical Guidelines for School Nurses*. In addition, Section I of this DoDEA guide contains a quick reference chart. This chart was developed using facts from the Centers for Disease Control (2001) and *Clinical Guidelines for School Nurses from School Health Alert*.

General standing orders are specific orders written by a physician and apply to all students for whom the order may be applicable. See additional guidance, information, and sample forms in this guide under Sections F, H, and I.

G.2 Resources

Resources recommended and purchased by DoDEA for all school health offices are listed in Section I.

SECTION H
Sample Forms

Introduction

The forms contained in this section are examples of forms that may be used to record student health information and to document nursing activities, referrals to outside agencies, and health communication with parents and teachers. Use of these sample forms is optional. In some cases, such as the student health history form and the immunization certificate, more than one sample is provided. When more than one option is presented, the individual nurse or the district may decide which sample best meets the local needs.

If similar health information is collected through an adopted computerized student health management system, some of the forms in this section may not be necessary.

Working with the school administrator, each school nurse will determine the appropriate method of storing and producing reports of student health information based on the following factors: the needs of the individual school and the district; access to an adopted computerized student health management system; the availability of computer equipment in the individual school; and the completion of computer training on the computerized student health management software by the nurse.

Forms are available on DoDEA's Web site and on CD for personalization by a particular school or school nurse. DDESS should use appropriate state forms not available on DoDEA's Web site or CD.

H.1 Student Health History

H.2 Immunization Forms

H.2.1 Certificate of Immunization, Last Date Only
H.2.2 Certificate of Immunization, All Dates, Under 5 Years Version
H.2.3 [AU: There is no form H.2.3.]
H.2.4 Incomplete Immunizations, Registration
H.2.5 Delinquent Immunizations, Notice of
H.2.6 Disenrollment, Incomplete Immunizations

H.3 Medication Forms

H.3.1 Medication During School Day, Memorandum for Parents
H.3.2 Medication During School Hours, Physician/Parent Signatures
H.3.3 Medication "Hold Harmless" Permission Form
H.3.4 Medication Log, Study Trip Administration
H.3.5 Medication Incident Report

H.3.6 Student Allergic Reaction Information
H.3.7 Anaphylactic Emergency Information
H.3.8 Standing Order
H.3.9 Student Retention of Medications, Permission for
H.3.10 Medication Inservice

H.4 Medical Referral Forms
H.4.1 Vision Screening Referral
H.4.2 Hearing Screening Referral
H.4.3 Scoliosis Screening Referral *(page 2 not on disk)*
H.4.4 Dental Screening Report
H.4.5 Health Screening Record, Student
H.4.6 Student Health Referral
H.4.7 Medical Referral
H.4.8 Adaptive Physical Education Recommendations
H.4.9 Request for Specialized Health Care Procedures, Parents and Physician
H.4.10 Patient Assessment Checklist
H.4.11 Head Injury
H.4.12 Head Injury Flow Sheet
H.4.13 Eye Injury Flow Sheet
H.4.14 Shock Flow Sheet
H.4.15 Fractures, Dislocations, Sprains/Strains, Contusions

H.5 Memorandums for Teachers
H.5.1 Confidential Health Problems
H.5.2 Confidential Health Condition, Student
H.5.3 Behavioral Checklist for Suspected Chemical Abuse

H.6 Notices to Parents/Sponsors
H.6.1 Parent Notice of Scoliosis Screening
H.6.2 Parent Notice of Pediculosis
H.6.3 Additional Medical Information, Request for

H.7 Accident/Injury Reports *(copy of most current needs to be added)*

H.8 Asthma Documentation and Forms
H.8.1 Parent Letter, Peak Flow Monitoring
H.8.2 Referral to Physician
H.8.3 Asthma Management Plan
H.8.4 Asthma Information, Request for

H.9 ADHD Documentation and Forms

H.9.1 Referral, Teacher to Nurse
H.9.2 Health Assessment, Individualized, ADD/ADHD Referral
H.9.3 Physician Report to Nurse
H.9.4 ADD/ADHD Monitoring Scale, DoDEA
H.9.5 ADD/ADHD Monitoring Scale, Interpretation

H.10 History/Informational Forms

H.10.1 Health Assessment
H.10.2 Preschool Functional Screening
H.10.3 Social/Family/Medical History: Grades 6–12
H.10.4 Social/Family/Medical History: Middle School
H.10.5 Social/Family/Medical History: Preschool–Grade 5
H.10.6 Social/Family/Medical History: Three-Year Review

H.11 Health Services Information Sheets

H.11.1 Weekly Log of Nursing Activities
H.11.2 Conference Log
H.11.3 School Health Services Summary
H.11.4 End-of-Year Checkout, School Nurse

H.12 Miscellaneous Forms

H.12.1 Medical Power of Attorney
H.12.2 Authorization for Medical Care of Dependent
H.12.3 Sports Physical
H.12.4 Physical for Sports, Scouts, and Activities

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY
STUDENT HEALTH HISTORY

INSTRUCTIONS: SPONSOR/PARENT/GUARDIAN-READ CAREFULLY AND CHECK (✓) ALL CONDITIONS THAT APPLY TO YOUR CHILD.

Student #_____ Grade_____	**STUDENT'S NAME (Print) LAST FIRST M.I.**	CHECK ✓ Female ☐ Male ☐	Date of Birth: _____/_____/_____ mo. day yr.

HEALTH HISTORY

VISUAL DEFECT		**COMMENTS**	**CARDIOVASCULAR**		**COMMENTS**
WEARS GLASSES	☐	☐ For reading **ONLY** or ☐ Wears full-time	SICKLE CELL DISORDER	☐	
CONTACTS	☐		ANEMIA	☐	
COLOR DEFICIENCY	☐		CONGENITAL HEART	☐	
OTHER	☐		RHEUMATOID HEART		
HEARING DEFECT	✓		HEART MURMUR	☐	
EAR INFECTIONS Frequency:	☐	Last date:	RESTRICTIONS YES ☐ NO ☐	☐	Explain:
TUBE IN EAR(S) Left ☐ Right ☐	☐	Date of insertion:	OTHER	☐	
HEARING LOSS	✓		**RESPIRATORY**	✓	
MILD Left ☐ Right ☐	☐	Date of diagnosis:	ASTHMA Date of diagnosis:	☐	**Inhaler needed:** **@ school** YES ☐ NO ☐ **@ home** YES ☐ NO ☐
MODERATE Left ☐ Right ☐	☐	Date of diagnosis:	BRONCHITIS	☐	
SEVERE Left ☐ Right ☐	☐	Date of diagnosis:	CYSTIC FIBROSIS	☐	
HEARING AID(S) Left ☐ Right ☐	☐	Date:	TUBERCULOSIS Date of diagnosis:	☐	Type of treatment: Date of treatment:
CONGENITAL EAR DEFECT Left ☐ Right ☐	☐		NOSEBLEEDS	☐	Frequency:
ALLERGIES	✓	**ANA Kit Required**	SINUSITIS	☐	Frequency:
BEE STING	☐	YES ☐ NO ☐	**DERMATOLOGY**	✓	
FOOD Specify:	☐	YES ☐ NO ☐	PROBLEMS WITH BODY PIERCING/TATOOS	☐	
DRUG Specify:	☐	YES ☐ NO ☐	FEVER BLISTERS COLD SORES	☐	
ENVIRONMENTAL	☐		CONTACT DERMATITIS	☐	
SEASONAL	☐		ACNE	☐	
LACTOSE INTOLERANCE	☐		ECZEMA	☐	
ENDOCRINE	✓		DANDRUFF	☐	
DIABETES Date of diagnosis:	☐	**Insulin needed:** **@ school** YES ☐ NO ☐ **@ home** YES ☐ NO ☐	TINEA (RINGWORM) Body ☐ Head ☐ Feet ☐	☐	
HYPERGLYCEMIC	☐		**MUSCULOSKELETAL**	✓	
HYPOGLYCEMIC	☐		ARTHRITIS	☐	
THYROID DISORDER	☐		MUSCULAR DYSTROPHY	☐	
PARASITES (HISTORY OF)	✓		HISTORY OF FRACTURE Explain:	☐	Date:
MALARIA	☐		SCOLIOSIS	☐	Date of diagnosis:
PINWORMS	☐		DEFORMITY Explain:	☐	
SCABIES	☐		HERNIA	☐	
HEAD LICE	☐		OSGOOD-SCHLATTER	☐	

STUDENT HEALTH HISTORY – CONTINUED on the back.

NEUROLOGICAL		COMMENTS	GASTROINTESTINAL/ GENITOURINARY		COMMENTS
CEREBRAL PALSY	☐		BLADDER CONTROL PROBLEMS Explain:	☐	
SEIZURE DISORDER	☐	Date of last seizure: **Medication needed:** **@ school** YES ☐ NO ☐ **@ home** YES ☐ NO ☐	URINARY TRACT INFECTION Frequency:		Date of last infection:
MIGRAINE Frequency:	☐	Date of last migraine: **Medication needed:** **@ school** YES ☐ NO ☐ **@ home** YES ☐ NO ☐	BOWEL CONTROL PROBLEMS Explain:	☐	
SPINA BIFIDA	☐		**DENTAL**	✓	
SLEEP DISORDER	☐		BRACES	☐	
HEADACHES Frequency:	☐		CAVITIES Date of last dental exam:		
PSYCHIATRIC	✓		CANKER SORES		
ATTENTION DEFICT (HYPERACTIVITY) DISORDER ADD/ADHD	☐	**Date of diagnosis:** **Medication needed:** **@ school** YES ☐ NO ☐ **@ home** YES ☐ NO ☐	**NUTRITION METABOLIC**	✓	
DEPRESSION Date of diagnosis:	☐	**Medication needed:** **@ school** YES ☐ NO ☐ **@ home** YES ☐ NO ☐	NUTRITIONAL PROBLEMS Explain:	☐	
AUTISM	☐		OVERWEIGHT/OBESE	☐	
SUICIDAL, History of	☐	Date:	POOR APPETITE	☐	
SUBSTANCE ABUSE, History of	☐	Circle: Drugs, alcohol, tobacco, and/or inhalants Date:	**MISCELLANEOUS**	✓	
ANOREXIA	☐		THUMBSUCKING	☐	
BULIMIA	☐		MOTION SICKNESS	☐	

MEDICATION AND HOSPITALIZATION

DOES YOUR CHILD NEED TO TAKE DAILY MEDICATIONS AT SCHOOL? A Medication During School Hours form **MUST** be signed by a physician and a parent and **MUST** accompany prescribed medications. All medications taken at school **MUST** be maintained and administered from the health office under supervision of school personnel. SPECIFY ALL CURRENT MEDICATIONS *(including medications taken at home):*	YES ☐ NO ☐	Comments
HAS YOUR CHILD BEEN HOSPITALIZED? Specify the date and reason: Date: _____ Length of hospitalization**:** _____ Reason: mo./day/yr.	YES ☐ NO ☐	Comments

SPACE BELOW FOR PARENT TO PROVIDE ADDITIONAL INFORMATION CONCERNING OTHER MEDICAL CONDITIONS

(PLEASE PRINT)

PRIVACY ACT NOTICE

AUTHORITY: Title X, Section 133 7 1076, Title V, Section 301. PRINCIPAL PURPOSE: To record pertinent data concerning student's health. ROUTINE USES: Data is collected and entered into the automated Health Office Management System for use by professional health and education agencies. MANDATORY/VOLUNTARY DISCLOSURE/EFFECT OF NONDISCLOSURE: Voluntary. Without this information school personnel will not be able to provide appropriate education and health services.

Parent/Sponsor's Signature:	**Date:**

DSPA FORM 120.1 REVISED (May 2002). Previous Edition Obsolete

H.2 Immunization Forms

DEPARTMENT OF DEFENSE EDUCATION ACTIVITY

CERTIFICATE OF IMMUNIZATION

Students who enroll in Department of Defense Education Activity schools MUST meet specific immunization requirements. These requirements, displayed below, represent the minimum requirement and do not necessarily reflect the optimal immunization status for a student. This certificate of immunization, completed by the local medical authority, must be provided to school officials at the time of initial registration for placement in the official school records of the student.

STUDENT'S Name_____/_____

Last Name First Name M.I. Date of Birth (mo./day/yr.)

Instructions for local medical authority: In the shaded spaces provided, write the date **(mo./day/yr.)** of each immunization and the total number of doses received. In the appropriate shaded space write the date of the last TB screening and the reaction/mm reading. Sign, stamp, and date the bottom section.

IMMUNIZATION	DATE mo./day/yr.	COMMENT Total # of doses	MINIMUM DoD REQUIREMENTS
HEP B Hepatitis B	Date of last dose:	Total # of doses:	Three doses. The second dose should be given at least one month after the first dose. The third dose should be given at least two months after the second and at least four months after the first.
DTaP/DPT/Td Diphtheria, Tetanus, Pertussis*	Date of last dose:	Total # of doses:	Three doses given singly or in combination. **At least one MUST be administered after the 4th birthday.** Subsequent boosters are to be given every 10 years. ***Pertussis vaccine is not required for individuals older than 6.**
HIB Haemophilus Influenza Type B	Date of last dose:	Total # of doses:	Two to four doses in infancy. Three- and 4-year-olds with NO record of HIB in infancy require only ONE dose. **HIB immunization is not required for individuals 5 or older.**
IPV/OPV Polio Vaccine	Date of last dose:	Total # of doses:	Three doses (oral or injected). **Last one MUST be administered after the 4th birthday.**
MMR Measles, Mumps, Rubella	Date of last dose:	Total # of doses:	Two doses of live attenuated vaccine given singularly or in combination. **It is recommended, but not required, that one be administered *after the 4th birthday.***
VARICELLA Chicken Pox	Date of last dose:	Total # of doses:	One dose through the age of 12 years, Two doses for those 13 or older (at least one month apart), **or reliable history of the disease.** **DATE CHILD HAD DISEASE PER PARENT REPORT** _____/_____ mo. yr.
(Circle one) **PPD** **TB tine/monovac** **BCG**	Date of last test:	Results: ☐Negative ☐Positive _____mm	TB testing recommended. Frequency determined by local medical command. If **positive**, date of chest X-ray: ____/____/____ Result: _____ Date of **INH** treatment. Started: _____/_____/_____ Finished: _____/____/_____

Immunization records for the student named above have been reviewed at _____.

Location of Clinic

I certify that the minimum immunization requirements have been completed and/or initiated. Immunizations are current until _____**, when** _____ **immunization(s) is/are due.**

_____

Signature and Stamp of Medical Authority/Date

A request for an immunization waiver for **medical** reasons must be supported by official documents from a medical authority and provided to the school at the time of registration. I certify that the minimum immunization requirements have been waived.

Immunization(s): _____ Reason _____

Waiver Duration: _____.

_____

Signature of Medical Authority/Date

DEPARTMENT OF DEFENSE DEPENDENTS SCHOOLS

CERTIFICATE OF IMMUNIZATIONS

Students who enroll in DoD Dependents Schools (DoDDS) must meet specific immunization requirements. These requirements, displayed below, represent the minimum requirement and do not necessarily reflect the optimal immunization status for a student. **This certification of immunization, completed by the local medical authority, MUST be provided to school officials at time of initial registration for placement in the official school records of the student.**

_____ _____ _____

(Please Print) Name of Child Date of Birth Parent or Guardian

Instructions for local medical authority: In the spaces provided, write the dates (mo./day/yr.) of each immunization received. In the appropriate space, write the date of the last TB screening and the reaction/mm reading.

Hepatitis B Vaccine: Three doses: The second dose should be given at least one month after the first dose. The third dose should be given at least two months after the second and at least four months after the first.

_____ _____ _____

Mo./Day/Year Mo./Day/Year Mo./Day/Year

Diphtheria, Tetanus, and Pertussis Vaccine: **(Circle vaccine given.)** Three doses given singly or in combination, **at least one of which was administered after the 4th birthday and the last one within 10 years.** (Td recommended at age 11–12 if more than five years have elapsed since the last DTaP/DPT/Td. Subsequent routine Td boosters are required every 10 yrs) . ***Pertussis vaccine is not required for individuals older than 6.**

DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td

_____ _____ _____ _____ _____ _____ _____

Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year

HIB (Haemophilus Influenza type B): Two to four doses in infancy; 3- and 4-year-olds with NO record of HIB in infancy only require ONE dose.
***HIB immunization is not required for individuals 5 or older.**

_____ _____ _____ _____ _____

Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year

Polio Vaccine **(Circle vaccine given):** Three doses (oral or injected), **last of which was administered after the 4th birthday.**

IPV OPV IPV OPV IPV OPV IPV OPV IPV OPV

_____ _____ _____ _____ _____

Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year

MMR (Measles, Mumps, and Rubella): Two doses of live attenuated vaccine given singly or in combination, at least one of which was administered 28 days or more after the first dose, but **second dose recommended after the 4th birthday.**

_____ _____ _____

Mo./Day/Year Mo./Day/Year Mo./Day/Year

Varicella Vaccine: One dose through the age of 12, two doses for those 13 or older (at least one month apart),
or reliable history of the disease. **DATE CHILD HAD DISEASE PER PARENT REPORT:**

_____ _____ _____

Mo./Day/Year Mo./Day/Year Mo./Year

PPD: Date: _____Results: Negative ☐ Positive ☐ ___mm. Preventive Medicine Referral Date: _____ INH Date: _____-_____ **BCG:** Date: _____

Other: Specify vaccine (not to include TB Skin Test)
Vaccine: _____ Date: _____Vaccine: _____ Date: _____

I certify that the minimum immunization requirements have been completed and/or initiated. Immunizations are current until _____, when _____ immunization(s) is/are due.

_____
Signature and Stamp of Medical Authority/Date

A request for an immunization waiver for **religious ___ or medical** ___ reasons must be supported by official documents from a church or medical authority and provided to the school at the time of registration. I certify that the minimum immunization requirements have been waived. Immunization(s): _____
Reason: _____Waiver Duration: _____.

_____
Signature and Stamp of Medical Authority/Date

DEPARTMENT OF DEFENSE DEPENDENTS SCHOOLS
CERTIFICATE OF IMMUNIZATIONS

Students who enroll in DoD Dependents Schools (DoDDS) must meet specific immunization requirements. These requirements, displayed below, represent the minimum requirement and do not necessarily reflect the optimal immunization status for a student. **This certification of immunization, completed by the local medical authority, MUST be provided to school officials at time of initial registration for placement in the official school records of the student.**

_____ _____ _____

Name of Child Date of Birth Parent or Guardian

Instructions for local medical authority: In the spaces provided, write the date (mo./day/yr) of each immunization received. In the appropriate space, write the date of the last TB screening and the reaction/mm reading.

Hepatitis B Vaccine: Three doses: The second dose should be given at least one month after the first dose. The third dose should be given at least two months after the second and at least four months after the first.

_____ _____ _____

Mo./Day/Year Mo./Day/Year Mo./Day/Year

Diphtheria, Tetanus, and Pertussis Vaccine (Circle vaccine given): Three doses given singly or in combination, **at least one of which was administered after the 4th birthday and the last one within 10 years.** (Td recommended at age 11–12 if more than five years have elapsed since the last DTaP/DPT/Td. Subsequent routine Td boosters are required every 10 yrs). ***Pertussis vaccine is not required for individuals older than 6.**

DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td DTaP, DTP, Td

_____ _____ _____ _____ _____ _____ _____

Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year

HIB (Haemophilus Influenza type B**):** Two to four doses in infancy; 3- and 4-year-olds with NO record of HIB in infancy only require ONE dose. ***HIB immunization is not required for individuals 5 or older.**

_____ _____ _____ _____ _____

Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year

Polio Vaccine (Circle vaccine given): Three doses (oral or injected), **last of which was administered after the 4th birthday.**

IPV OPV IPV OPV IPV OPV IPV OPV IPV OPV

_____ _____ _____ _____ _____

Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year Mo./Day/Year

MMR (Measles, Mumps, and Rubella): Two doses of live attenuated vaccine given singly or in combination, at least one of which was administered 28 days or more after the first dose, but **second dose recommended after the 4th birthday.**

_____ _____ _____

Mo./Day/Year Mo./Day/Year Mo./Day/Year

Varicella Vaccine: One dose through the age of 12, two doses for those 13 or older (at least one month apart), **or reliable history of the disease.**

DATE CHILD HAD DISEASE PER PARENT REPORT:

_____ _____ _____

Mo./Day/Year Mo./Day/Year Mo./Year

Other: Specify vaccine (not to include TB Skin Test)

Vaccine: _____ Date: _____ Vaccine: _____ Date: _____

TB Skin Test: Date**:** _____ Results: _____

I certify that the minimum immunization requirements have been completed and or initiated. Immunizations are current until _____, when _____ immunization(s) is/are due.

_____

Signature and Stamp of Medical Authority/Date

A request for an immunization waiver for **religious ___ or medical** ___ reasons must be supported by official documents from a church or medical authority and provided to the school at the time of registration. I certify that the minimum immunization requirements have been waived. Immunization(s): _____,
Reason: _____Waiver duration: _____.

_____
Signature and Stamp of Medical Authority/Date

(Page Intentionally Left Blank)

[insert school letterhead]
Office of the School Nurse

DATE: _____

MEMORANDUM for: Parents/Sponsor of _____
SUBJECT: Incomplete Immunizations

6. DoDEA Instruction 6205.1 states that ***prior*** to enrollment in DoDEA schools, students shall meet specific immunization requirements.

7. The following required immunizations are missing from your child's immunization records:

_____ Diphtheria/Tetanus/Pertussis: dose # ___ (after 4th birthday) or
___ 10-year booster

_____ Hepatitis B: dose # 1 #2 #3
dose #2 due: _____ dose #3 due: _____

_____ Haemophilus Influenza type B: dose # _____

_____ Measles/Mumps/Rubella after 4th birthday or dose # _____

_____ Polio vaccine after the 4th birthday or dose # _____

_____ Varicella (Chicken Pox): dose # 1 #2 dose #2 due: _____

or provide reliable history (_____month _____year)

_____ No immunization records on file with the child's school records

8. Have your child's records reviewed as soon as possible by [*insert name and hours of local medical treatment facility*].

9. DS Form 121.1 is attached and will need to be completed by the medical authority reviewing your child's immunization records.

10. Bring the completed DS Form 121.1 and your child's updated immunization record to school as soon as possible so that enrollment requirements for your child are complete.

Your child's registration for school year [insert year] will not be complete until we receive documentation of required immunizations.

If you have any questions, please call *[insert school nurse name and number]*.

_____
[insert name of principal]

[insert school letterhead]
Office of the School Nurse

DATE: _____

MEMORANDUM for: Parents/Sponsor of _____

SUBJECT: Delinquent Immunizations

1. DoDEA Instruction 6205.1 states that ***prior*** to enrollment in DoDEA schools, students shall meet specific immunization requirements.

2. Our records indicate that your child needs additional immunizations to meet the minimum DoDEA requirements for continued enrollment.

3. The following immunizations are lacking:

   _____ Diphtheria/Tetanus/Pertussis: dose # ___ (after 4th birthday) or
   ____ 10-year booster

   _____ Hepatitis B: dose # 1 #2 #3
   dose #2 due: _____ dose #3 due: _____

   _____ Haemophilus Influenza type B: dose # _____

   _____ Measles/Mumps/Rubella after 4th birthday or dose # _____

   _____ Polio vaccine after the 4th birthday or dose # _____

   _____ Varicella (Chicken Pox): dose # 1 #2 dose #2 due: _____

   or provide reliable history (_____month _____year)

   ____ A copy of your child's immunization record.

4. DoDEA Instruction 6205.1 gives parents of currently enrolled students **10 DAYS** to provide the school with documentation satisfying the requirements, prior to disenrolling the student.

5. ***Bring your child's updated immunization record to school as soon as possible, but no later than***
   _____.

If you have any questions, please call *[insert school nurse name and school number]*.

_____
[insert name of principal]

[insert school letterhead]
Office of the School Principal

DATE: _____

MEMORANDUM for: Parents/Sponsor of _____

SUBJECT: Disenrollment

According to DoDEA instruction 6205.1, a student may be enrolled in a DoDEA school no longer than 10 days without a valid DoDEA Certificate of Immunization.

As indicated in the written notice sent to you, the 10-day grace period expired on _____. Today is the last day your family member may attend school until proof of the necessary immunizations is provided to the principal.

_____
[Insert name of principal]

MEDICATION DURING SCHOOL DAY, MEMORANDUM FOR PARENTS AUGUST 2000 H.3.1

[insert school letterhead]
Office of the School Nurse

DATE: _____

MEMORANDUM for: Parents/Sponsor of _____

SUBJECT: Student Use of Medication During the School Day

The school nurse accommodates parent requests for medication (including prescription, nonprescription, and over-the-counter) to be administered during the school day. According to *DoDEA Health Service Guide, DS Manual 2942.0,* school personnel may administer medications when certain criteria are met.

In order for school personnel to administer medications during school hours, the attached form ***MUST*** be provided to the school signed by the **parent** and a **physician**.

The medication will be in the original container, **properly labeled by the pharmacy or physician.** The label should indicate the name of the student and the physician, the medication, dosage, and frequency. The date of the prescription must be a current date.

All medications will remain at the school for the duration of the prescription. Any changes in the medication, dosage, or frequency will necessitate **a new form and a new, labeled container.**

Medications for acute illness (such as bacterial infections) are usually prescribed for administration three times a day and may be administered by the parent before school, after school, and before bedtime.

Please call *[insert school nurse name and phone]* if you have any further concerns.

_____
[Insert name and title]

Department of Defense Education Activity

[insert name of school]
Office of the School Nurse

To be completed by physician
Name of Student:_____

Diagnosis/Indication for Medication Administration: _____

Medication:_____ **Dosage:**_____

Time: _____ **Route:** _____

Duration:_____

Possible Side Effects:_____

Precautions/Restrictions:_____

Other Medications Taken:_____

_____ _____
Signature of Physician **Date**

Clinic: _____ **Phone:** _____

****

To be completed by parent:
I hereby give my permission for _____ to receive, from the school nurse and/or other trained school personnel, the above prescription at school as ordered. I understand that it is my responsibility to furnish the school with this medication. I give permission for the school nurse and health care providers at the medical treatment facility to exchange information about my child, the diagnosis for which this medication is prescribed, and my child's response to the medication.

_____ _____
Signature of Parent/Guardian **Date**

Parent daytime phone number #1_____, #2_____,

#3 _____

Parent e-mail address _____

NOTE: ***The prescription medication must be brought to school in the original container, properly labeled by the pharmacy or physician, stating the name of the student, the medication, the dosage, and current date. The medication will remain at school for the duration of the prescription.***

HOLD HARMLESS LETTER *(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)*	DATE 22-Dec-02

PRIVACY ACT STATEMENT

AUTHORITY: 44 USC 3101. PRINCIPAL PURPOSES: (1) To provide necessary information to authorized individuals to assist them in their administering of medications to your child in accordance with your instructions and the instructions of your child's physician; (2) To provide written assurance to said authorized individuals that they will not be held responsible for any harm or injury suffered as a result of the administering of medication in accordance with your instructions and the instructions of your child's physician. ROUTINE USES: This form will be included in your child's school health record and will not be released outside DOD channels. DISCLOSURE: Voluntary. The information requested on this form is needed to insure the safe administering of medication to your child. Failure to provide the information may constitute grounds for refusal to provide the service requested by you.

NAME OF CHILD	BIRTH DATE	NAME OF SCHOOL

We, the parents of _____, wish to advise you that he/she is under the care of Dr. _____ for _____ and that the physician has furnished medications together with written instructions for administering the medications to alleviate this condition. The medication(s), physician's instructions, and times for administering the medication(s) are as follows:

PHYSICIAN'S INSTRUCTIONS TO SCHOOL PERSONNEL

Due to the nature of the medications(s) and/or the child's condition(s), it is necessary that the medication(s) listed below be administered during school hours.

Medication(s)	Physician's Instructions	Hour(s) For Administering

Anticipated number of days the medication(s) must be given at school (_____)

PHYSICIAN'S SIGNATURE	PHONE	DATE

We are delivering to you the medication(s) and the physician's written instructions and request this medication be given to our child in accordance with the above instructions. We fully understand that you are under no obligation whatsoever to administer the medication but will only be doing so as our agent acting in our behalf specifically and solely for this purpose.

We agree to hold you, the school, its offices, agents, and employees harmless in administering the medication(s) pursuant to the physician's written instructions and our instructions as to the times for administering the medication(s). We further agree to notify you promptly when it is no longer necessary to administer this medication.

PARENT'S SIGNATURE	HOME PHONE	DUTY PHONE
	HOME ADDRESS	

[insert school letterhead]

Office of the School Nurse

STUDY TRIP MEDICATION ADMINISTRATION LOG

STUDENT'S NAME:_____

TEACHER/GRADE LEVEL: _____

DATE & TIME	MEDICATION/DOSE	SPECIAL INSTRUCTIONS	SIGNATURE	COMMENTS

This form is a part of the permanent record for students receiving medication during school hours. Fill in the above areas with the date and time the medication was given and the signature of the person administering the medication. ***Only DoDEA personnel or the parent of the student is allowed to administer medications.***

[Insert name of school nurse.]

[insert school letterhead]
Office of the School Nurse

Medication Incident Report

STUDENT'S NAME: _____

DATE OF INCIDENT: _____TIME: _____

Personnel Administering Medication:_____

Medication and Dosage Prescribed:_____

INCIDENT:

_____
_____
_____
_____
_____

ACTION TAKEN:

Parent Notified: Time _____ Person Contacted: _____
Physician Notified: Time _____ Person Contacted: _____
Administration Notified: Time _____ Person Contacted:_____

Describe circumstances leading to situation:

_____
_____
_____

Outcome/Follow-up:

_____
_____
_____
_____

_____ _____
Nurse's Signature Date Principal's Signature Date

[insert school letterhead]
Office of the School Nurse

Date_____

MEMORANDUM for: Parents/Sponsor of:_____

SUBJECT: Allergies

An indication was made on your child's Health Record that she/he has allergies. To better assist your child at school, please complete the questionnaire below and return it to the school health office. If you have any questions, call [insert name and school phone number].

1. What are your child's allergies?
___ Animals ___ Bees ___ Drugs ___ Environmental ___ Food ___ Insect bites ___ Wasps

Indicate specific allergens:_____

2. What kind of reaction does your child experience?

Localized swelling ___ Shortness of breath ___

Loss of consciousness ___ Hives (urticaria) ___

Other:_____

3. How has your child been treated after a reaction?

a. Received an injection: NO YES Specify: _____

b. Received oral medication: NO YES Specify: _____

c. Been hospitalized: NO YES Specify: _____

4. Does your child carry an Epi-Pen, ANA-Kit, or other medicine with her/him at all times? NO YES

5. Do you keep an Epi-Pen, ANA-Kit, or other medicine at home? NO YES

If you answered YES to either of the last two questions, the school should also have medication for your child. Bring the completed "Medication During School Hours" form (attached) and the labeled medication container to school. If your child must also carry the medication with him/her at school, please provide a completed "Permission for Student to Retain Control of Medication" form.

_____
Parent/Sponsor Signature Date

[insert school letterhead]
Office of the School Nurse

ANAPHYLACTIC EMERGENCY INFORMATION

Name of Student: _____Date: _____

Teacher(s):_____Grade:_____

Name of Parents:
Sponsor: _____ Duty #: _____
Spouse: _____ Duty #: _____
Home #: _____ Cell #: _____

E-mail Address: _____

Emergency Contact:
Name: _____Day Phone #:_____
Address: _____ Alt. Phone #:_____

Allergen:_____

Previous Response to Allergen: _____

EMERGENCY PLAN OF ACTION:
Monitor student for signs of anaphylaxis under direct observation for 30 minutes.

a. Sneezing, wheezing, or coughing	i. Dizziness and/or fainting
b. Shortness of breath or tightness of chest; difficulty in or absence of breathing	j. Involuntary bowel or bladder emptying
c. Itching, with or without hives, raised red rash in any area of body	k. Sense of impending disaster
d. Difficulty swallowing	l. Rapid or weak pulse
e. Swelling of eyes, lips, face, tongue, throat, or elsewhere	m. Skin flushing or extreme paleness
f. Hoarseness	n. Burning sensation, especially on face or chest
g. Sweating and anxiety	o. Blueness around lips, inside lips, eyelids
h. Nausea, abdominal pain, vomiting, and diarrhea	p. Loss of consciousness

FRONT

For anaphylactic reaction:

1. Administer epinephrine per medical orders. DOSAGE:_____
Type of kit: _____ Epi-Pen Jr. _____ Epi-Pen _____ Ana Kit
Expiration date: _____
Location of kit in school:_____

2. Delegate notification of
Principal by: _____
Parent by: _____
Medical Emergency Services by:_____

3. For absent breathing/pulse, initiate CPR.
Monitor pulse, respiration, blood pressure until arrival of EMS (every 5 minutes until stable, then every 15 minutes).

4. If anaphylaxis is result of insect sting and stinger is present, scrape or flick it off with fingernail, plastic card, etc.

Staff inservice on use of epinephrine

1. **Date of inservice: _____**
2. ***Signature/title of person providing inservice:***

_____

Signature of persons receiving inservice:

_____

_____

3. **Designated order of staff to administer epinephrine:**
#1_____
#2_____
#3_____
#4_____

Follow-up after use of epinephrine:
1. Sign and place all observations, notification, and documentation in student's record.
2. Properly dispose of needles in a sharps container.
3. Notify parents to replace medicines used.
4. Meet with all personnel involved. Plan update as necessary.

School nurse should review procedure on an annual basis. Physician orders must be renewed annually.
Time, date, and signature of the person administering the medication must be on file.
[Insert name of school nurse]

[insert school letterhead]
Office of the School Nurse
STANDING ORDER FOR USE OF EPI-PEN OR ANA-KIT

In the absence of a medical director of DoDEA schools, I _____
(print name of physician)

authorize the following nursing protocol to address anaphylaxis at *[insert school name]*.

Anaphylaxis is an allergic reaction that may be triggered by asthma, an insect bite, a drug allergy, or a food allergy. In the event of anaphylaxis, the Epi-Pen will be used for students enrolled in grades preschool through 12. The following procedure should be followed by a school nurse or designated nonprofessional first-aid provider trained by a licensed registered school nurse.

School nurses are authorized, when they encounter a student with a systemic reaction believed to be anaphylaxis, to administer subcutaneous epinephrine, even if this drug has not been previously prescribed for this student.

SYMPTOMS:	Mild	Rash, itching, hives
	Moderate	Breathing difficulty, wheezing
	Severe	**Severe breathing difficulty, vascular collapse**
	Anaphylaxis	**Laryngeal swelling, cardiac arrest**

DOSAGE MUST BE CHECKED before administration according to the schedule below.

When using the EPI-PEN JR./EPI–PEN:

0.15 Mg. for children 30 Kg. or less (Epi-Pen Jr.)

0.3 Mg. for children greater than 30 Kg. (Epi-Pen)

Immediately contact the emergency response system for your area. Notify the parent/guardian. If before reaching medical care facility, the child has not responded to the first dose of epinephrine or if respiratory/cardiovascular status seems to be deteriorating, a second dose of epinephrine may be given after 15–20 minutes.

IF IN DOUBT, TREAT FOR ANAPHYLACTIC REACTION.

_____ _____
Physician Date

This standing order is valid for one school year.

[insert school letterhead]

Office of the School Nurse

Permission for Student to Retain Control of Medication

(All three sections must be completed and signed.)

Section 1 (To be completed by physician)

Name of student: _____ Age: _____ Grade: _____

Diagnosis:_____ Duration of treatment: _____

Times of day/circumstances under which medication is to be given:
_____

Reason student must have possession of medication at all times:
_____

Expected results from using the medication:
_____

Expected time frame to achieve results following medication administration:
_____

What student should do if the expected results are not obtained in the specified time frame:
_____

I have instructed the student and the student's parent in the proper use and method of administering this medication and the legal consequences of using the medication inconsistently with the prescription or of sharing the medication with anyone else. I have provided the student and his/her parents with the following instructions regarding the symptoms of possible adverse reactions, contraindications, and what to do if student experiences difficulty with or while taking the medication:
_____
_____

The student's medical condition is such that the student must be in possession and control of the medication at all times and be free to administer the medication when needed. **In my opinion, the student possesses sufficient maturity and responsibility to follow my instructions.**

Physician's signature: _____ Phone: _____ Date: _____

FRONT

Section 2 (To be completed by parent)

Name of parent(s):_____ Home phone: _____ Work phone: _____

I have read the physician's statement and hereby consent to my child's retaining possession at all time of the above prescribed medication. I understand, and have informed my child, that any illegal use of the medication by the student (including the use of the medicine inconsistent with the prescription or sharing the medication with another) will result in disciplinary action. **During school hours my child has been instructed to take his/her medication in the nurse's office. I will provide extra medication to be kept in the school nurse's office as backup for the one carried by my child.**

Parent's signature: _____ Date: _____

***Section 3 (To be completed by student)**

I understand that I am required to retain possession and control of my prescribed medication in accordance with the terms set forth in Section 1 above. **I have been advised of my responsibility to use my medication only in strict accordance with the prescription.** I understand that any use of my medication inconsistent with the terms of my prescription is an illegal use, as is the sharing of my medication with another person. I agree to carry a pharmacy-labeled container of the medication, to keep a record of the times I use my medication, and to share the information with the nurse/instructor/coach who will help evaluate and monitor the effects of my medication. **During school hours I will take my medication under the supervision of the school nurse or the person designated by the school nurse and the school administrator.**

Student's signature: _____ Date: _____

***** *Guidance on the age of the student who signs this form needs to be obtained prior to its use.*

[insert school name]
Office of the School Nurse

MEDICATION INSERVICE

I have read the information on medication administration and I am aware of the uses, dosages, contraindications, and adverse reactions of the medications that I will give as outlined on the drug information sheet in the Sub File.

I have received training from the school nurse in the following areas:

1. Method of Administration
2. Proper Handling of Medications
3. Record Keeping
4. "Five Rights of Medication"

Date:_____Signature:_____
Trainee

Date:_____Signature:_____

[insert school nurse's name]

H.4 Medical Referral Forms

[insert school letterhead]
Office of the School Nurse

VISION SCREENING REFERRAL

Date: _____

SUBJECT: Vision Screening Referral

TO: Parents of _____

1. Your child's vision has been checked by school health officials and the findings indicate the following:
_____ Your child should be scheduled for a complete examination at the *eye clinic.*
_____ Children wearing glasses are recommended to have a yearly eye examination.
(*Please take this form with you to the appointment.)*

2. For an appointment, call *[insert local medical resource numbers].*
Return the form completed by the physician to the school nurse.

3. If you have any questions concerning the screening results or any problem getting an appointment, please contact *[insert name and school number].*

4. Screening results: with/without glasses:
Distance: Right 20/_____ Left 20/_____
Near: Right 20/_____ Left 20/_____
Comments:_____

****
INFORMATION TO SCHOOL NURSE FROM OPTOMETRY CLINIC

1. Vision without glasses: OD 20/_____ OS 20/_____
2. Vision corrected to: OD 20/_____ OS 20/_____
3. Ocular health: _____Normal _____ Abnormal
4. Extraocular muscle balance: _____Normal _____ Abnormal
5. Heterophoria/Heterotropia: _____ No Deviation _____ Deviation
Comments:_____
6. Are glasses to be worn at all times? Yes _____ No _____
7. Specific recommendations (reading glasses only, etc.) _____
8. Future clinic appointment date? _____

_____
Examiner/Date

1) Original to physician 2) Copy returned to school nurse 3) Copy for student file

[insert school letterhead]
Office of the School Nurse

HEARING SCREENING REFERRAL

Date: _____

To: Parents of _____

School health officials have checked your child's hearing. The findings indicate the following:
_____ Your child should be scheduled for a complete examination by your primary health care provider.
_____ Your child should be scheduled for an audiology exam.

1. Return the form completed by the physician/audiologist to the school nurse after your child has been evaluated.
2. If you have any questions concerning the screening results or any problem getting an appointment, please contact *[insert name and school number]*.

3. School Audiogram Results (*Record dB that each Hz was heard)*

RIGHT		LEFT	
500 @	2000 @	500 @	2000 @
1000 @	4000 @	1000 @	4000 @

History: OTM ____ Fluid ____ E.T. Dysf. ____ Tubes ____ Not Known ____
Tympanomatry: Type A _____ Type B _____ Type C _____ Not Done ____
OAE: Pass _____ Fail _____ Not Done _____
Visual Inspection: Canal _____ T.M. _____

Comments:_____

INFORMATION TO SCHOOL NURSE

1. Assessment: _____
2. Plan: _____
3. Recommendations: _____
4. Follow-up scheduled/due on: _____
5. Needs repeat audiogram __ or tympanogram __ on_____

_____
Physician's signature Date

1) Original to physician 2) Copy returned to school nurse 3) Copy for student file

[insert school letterhead]
Office of the School Nurse

SUBJECT: Scoliosis Screening Referral

TO: Parents of _____

1. Your child was screened at school for possible spinal problems. The findings indicate that further examination is recommended. See back of form for screening results.

2. Please make an appointment with your primary care physician. After the appointment, return the form completed by the physician to the school nurse.

3. If you have any questions concerning the screening results or any problem obtaining an appointment, please contact the school nurse at [insert local telephone number].

****

INFORMATION TO SCHOOL NURSE

1. Assessment:

_____

2. Plan:

_____

3. Recommendations:

_____

4. Follow-up scheduled/due on:

_____

_____
Physician's signature Date

1) Original to physician 2) Copy returned to school nurse 3) Copy for student file

Normal

- Head centered over mid-buttocks
- Shoulders level
- Shoulder blades level, with equal prominence
- Hips level and symmetrical
- Equal distance between arms and body

Possible Scoliosis

- Head alignment to one side of mid-buttocks
- One shoulder higher
- One shoulder blade higher with possible prominence
- One hip more prominent than the other
- Unequal distance between arms and body

Normal

- Both sides of upper and lower back symmetrical
- Hips level and symmetrical

Possible Scoliosis

- One side of rib cage and/or the lower back showing uneven symmetry

Normal

- No accentuation of normal back or hump
- No increased angle of lumbar spine
- Smooth arch of thoracic spine
- Lumbosacral angle flat

Possible Kyphosis/Lordosis

- Shoulders hunch forward excessively
- Excessive rounding of spine
- Increased angle between lumbar spine and sacrum
- Rounding remains prominent
- Difficulty touching toes
- Sway back remains

[insert school letterhead]
Office of the School Nurse

SUBJECT: Dental Screening Report

TO: Parents of

[place student label here]

As part of the *[insert name of school]*'s preventive dentistry program for children, your child has had his/her teeth visually inspected today. This exam is intended to identify dental problems that are visible to the eye and is not a substitute for a regular dental examination at the dental clinic. No x-rays were taken.

YOUR CHILD:

- has no visible dental problems; should still have regular check-ups to include dental x-rays.
- has some visible dental problems; should be seen at the dental clinic for a thorough examination.
- has been noted to have ***severe*** dental problems that require ***immediate*** attention.

Make an appointment for your child at the dental clinic listed below to which the sponsor is assigned. If your child has been noted to have severe dental problems and is currently not under treatment, please call or visit the clinic as soon as possible to begin treatment ***before*** your child has a dental emergency.

[Insert name and phone number of local dental clinic.]

KEEP YOUR SMILE HEALTHY!!!

1. Brush and floss your teeth every day. Children under 8 should get help from an adult at least once a day.
2. Reduce the frequency of sugary snacks and drinks.
3. Use fluoridated water and toothpaste to strengthen your teeth and prevent cavities.
4. Make a date and don't be late! See your dentist every year!

STUDENT HEALTH SCREENING RECORD

Student: _____ Birth Date: _____

Medical Concerns: _____

GRADE/ DATE	HT	WT	VISION R/L		HEARING R/L		SCOLIOSIS	DENTAL	SPORTS PHYSICAL	COMMENTS

Code:
P – Pass
F – Failed
R – Refer
U – Unable to Test
D – Deferred
N/A – Not Applicable

STUDENT HEALTH REFERRAL

Name: _____ Date:_____ Time Sent: _____

Referring Adult:_____

Complaint: (Specified by student, teacher, or parent)

____ Asthma ____ Headache ____ Sore throat ____ Burn
____ Head injury ____ Joint injury ____ Cut/laceration ____ Insect bite
____ Possible fracture ____ Earache ____ Stomach discomfort ____ Eye problem
____ Seizure ____ Cold symptoms ____ Possible fever ____ Skin problem
____ Vomiting/diarrhea ____ Personal ____ Other: _____

Comments: _____

Observations:

_____

Vital Signs: @ _____ Temp _____ BP _____ Pulse _____ Resp _____ LOC _____ PERRLAEOM _____
(as needed) @ _____ Temp _____ BP _____ Pulse _____ Resp _____ LOC _____ PERRLAEOM _____

Nursing Diagnosis (NANDA): _____

Plan: _____

Intervention (NIC):___ Rested ___ Elevation ___ Wound care ___ Injury immobilized ___ Cold application ___ Observed

Health Counseling: _____

Evaluation (NOC): _____

Resolution: _____ Return to class @ _____
_____ Return to class for belongings. Send back to nurse's office.
_____ Remain in nurse's office
_____ Referral to physician

Parents Notified: ___ No ___ Yes Telephone @ _____ Message left with_____
___Note sent home

Please:

[ ] Observe for_____.
[ ] Have your child evaluated by a licensed health care provider. (Form attached)
[ ] Read attached health information.

Readmittance criteria:

a. Fever free for 24 hours after school exclusion for temperature 100° F or higher
b. No significant nausea, vomiting, or diarrhea for 24 hours
c. Chicken pox (Varicella) lesions crusted and dry, at least 5–7 days from onset
d. Lice treatment initiated
e. Impetigo lesions covered and under care of medical provider
f. Conjunctivitis, signs of infection have cleared
g. Ringworm covered, under care of medical provider
h. Scabies, 8 hours after first prescribed treatment

[Insert name and title]

1) Retain original in nurse's office 2) Copy for parent/physician 3) Copy for teacher

[insert school letterhead]
Office of the School Nurse

DATE _____

Dear Health Care Provider,

_____ was seen in the school nurse's office. Please evaluate and ask parents to return this form to the school nurse. If you have any questions, please call me at *[insert school phone number].*

Thank you.
[insert school nurse name].

HEALTH CARE PROVIDER EVALUATION

S:_____
_____
_____

O:_____
_____
_____

A:_____
_____
_____

P:_____
_____
_____

When may the student return to school? _____

DoDEA criteria for readmittance to school:

a. Fever free for 24 hours after school exclusion for temperature 100° F or higher
b. No significant nausea, vomiting, or diarrhea for 24 hours
c. Chicken pox (Varicella) lesions crusted and dry, at least 5–7 days from onset
d. Lice treatment initiated
e. Impetigo lesions covered and under care of medical provider
f. Conjunctivitis, signs of infection have cleared
g. Ringworm covered, under care of medical provider
h. Scabies, 8 hours after first prescribed treatment

Any restrictions/limitations for physical education? NO YES (Please explain)
_____

Will medications be needed during the school day? NO YES
(If yes, please complete the attached form.)

Health Care Provider
Signature/Stamp_____Date_____

[insert school name]
Office of the School Nurse

ADAPTIVE PHYSICAL EDUCATION RECOMMENDATIONS

Name: _____ **Birth Date:** _____

Teacher: _____ **Grade:**_____

To Be Completed by Physician

Diagnosis or description of condition

_____

_____

Condition is: _____ Permanent _____ Temporary

If temporary, when may unrestricted activity resume?

_____

Functional restrictions
This condition is such that the intensity and type of activities should be restricted as follows:

_____ No competitive sports allowed.
_____ Activities should stop short of excessive fatigue or undue stress.
_____ No contact sports allowed; other activities allowed.
_____ Moderate exercise allowed, with all running, jumping, and gymnastics excluded.
_____ Minimal activity allowed; training in coordination only; simple nonstrenuous activity.
_____ Avoid activities involving the following areas or extremities:
_____ Recommended exercise:

_____

_____ _____
Signature/Stamp of Physician Date

Please call *[insert name and school phone number]* if you have any questions.

[insert school name]
Office of the School Nurse

PARENTS' REQUEST FOR SPECIALIZED HEALTH CARE PROCEDURE

We/I, the undersigned parent(s)/guardian(s) of _____,

request that the following specialized physical health care service be administered to our/my child.

_____

_____

(Name/type of service)

It is our/my understanding that the service will be administered using a standardized procedure.

We/I will notify the school immediately if the health status of our/my child changes, if we/I change physicians, or if the procedure is changed or canceled.

_____

Signature of Parent/Guardian Date

Parent daytime phone numbers:

Sponsor: _____

Spouse: _____

Home: _____

Cell: _____

Cell: _____

PHYSICIAN AUTHORIZATION FOR SPECIALIZED HEALTH CARE PROCEDURE

Student's Name: _____ Date of Birth:_____

1. Physical condition for which the standardized procedure is to be performed:

_____

2. Name of standardized procedure: _____

3. Individualized instructions:

_____

_____

_____

4. Precaution, possible untoward reactions, and interventions:

_____

5. Time schedule and/or indication for the procedure:

_____

6. The procedure is to continue until: _____

_____ _____

Signature/Stamp of Physician Date

PATIENT ASSESSMENT CHECKLIST

(To be completed by the attending school nurse or designee)

NAME OF VICTIM: _____

DATE: _____ TIME: _____

SIGNATURE & TITLE OF RESPONDER: _____

Primary Survey	Yes	No
Airway/Cervical Spine Stabilization		
Open airway (jaw thrust/chin lift)		
Remove debris		
Airway adjuncts		
Stabilize cervical spine (manual alignment)		
Breathing		
Look, listen, feel		
Rate, symmetry		
Auscultate breath sounds		
Circulation		
Palpate carotid		
Palpate radial (second responder)		
Jugular vein distention		
Skin temperature and color		
Disability/Limited Neuro Exam		
Level of consciousness		
AVPU		
Alert		
Verbal response		
Pain response		
Unresponsive		
Expose/Examine		
Expose/undress patient as needed		
Fahrenheit/Keep Patient Warm		
Vital Signs		

FRONT

Secondary Survey (Head to Toe) [AU: OK? First part says "Primary Survey."]	**YES**	**NO**
Head and Face		
Soft tissue injury		
Bone deformity/loose teeth		
Exposed bone or tissue		
Eye movement/pupillary response/PERRLAEOM		
Ear drainage/avulsion/bruise		
Nasal drainage		
Tenderness/pain		
Neck		
Soft tissue injury		
Impaled objects		
Tenderness/pain		
Tracheal deviation		
Jugular vein distention		
Chest/Thorax		
Soft tissue injury		
Rise and fall during respirations/symmetry		
Auscultate breath sounds		
Auscultate apical heart rate		
Tenderness/pain		
Impaled objects		
Abdomen/Flank		
Soft tissue injury		
Impaled objects		
Tenderness/pain		
Pelvis/Genitalia		
Soft tissue injury		
Impaled objects		
Bony deformities		
Urge to void		
Tenderness/pain		
Extremities		
Soft tissue injury		
Deformity		
Color		
Sensation		
Range of motion		
Tenderness/pain		
Pulse		
Posterior		
Log roll with manual cervical spine alignment		
Deformities		
Soft tissue injury		
Tenderness/pain		
Vital Signs		

VICTIM RELEASED TO: _____AT: _____BY:_____

[Insert School letterhead]
Office of the School Nurse

HEAD INJURY SHEET

Date:_____

Dear Parent,

_____was seen today for an injury to the head.

Time_____ Place_____

Part of the head receiving blow _____

Description of incident

_____

_____

Your child was observed at school for the following symptoms, and no problems were noted. Please continue to watch for any of the following symptoms:

1. Severe headache (Do NOT give aspirin, Tylenol, or other pain relievers to mask symptoms.)

2. Excessive drowsiness (Awaken the child at least twice during the night.)

3. Nausea and/or vomiting

4. Double vision, blurred vision, pupils of different sizes, or pupils that do not constrict when a light is shone in them

5. Loss of muscle coordination, such as falling down, walking strangely, or staggering

6. Any unusual behavior such as being confused, breathing irregularly, or feeling dizzy

7. Convulsion

8. Bleeding or discharge from the ear, nose, or throat

CONTACT YOUR LOCAL MEDICAL FACILITY IF YOU NOTICE ANY OF THE ABOVE SYMPTOMS.

[insert school nurse name and phone number]

HEAD INJURY

STUDENT NAME:

WHEN, WHERE, HOW INJURY OCCURRED, COMPLAINTS REGARDING PAIN AND FUNCTION

TIME OF INCIDENT: DATE:

ARRIVAL TIME IN HEALTH OFFICE: DEPARTURE TIME AND DISPOSITION:

SIGNATURE:

Record assessments & interventions by circling Yes, No, & intervention done, plus filling in blanks.

GLASGOW COMA SCALE			INITIAL	5 MIN	30 MIN	60 MIN
1. BEST EYE OPENING	Spontaneous	4				
	To voice	3				
	To pain	2				
	None	1				
	Swollen shut	S				
*2. BEST VERBAL RESPONSE	Oriented	5				
	Confused	4				
	Inappropriate words	3				
	Incomprehensible sounds	2				
	None	1				
3. BEST MOTOR RESPONSE	Obeys commands	6				
	Localizes pain	5				
	Withdraws to pain	4				
	Flexes to pain	3				
	Extends to pain	2				
	None	1				
GLASGOW COMA SCALE TOTAL						
PUPILS			INITIAL	5 MIN	30 MIN	60 MIN
RIGHT	SIZE					
	RESPONSE					
LEFT	SIZE					
	RESPONSE					

* PRE-VERBAL
5 Smiles, coos, cries appropriately
4 Cries
3 Inappropriate crying and/or screaming
2 Grunts
1 None

PUPIL SIZE MM: 1, 2, 3, 4, 5, 6, 7, 8, 9

PUPILARY RESPONSE
C Constricted
D Dilated
E Equal
F Fixed
N/R Nonreactive
R Reactive
S Sluggish
U Unequal

A person with significant head injury is always at high risk for a spinal injury. *Always take spinal precautions* if a person is *down* with a head injury.
Time: _____
Airway obstructed? YES NO
Abnormal breathing pattern/rate? YES NO R____
Abnormal pulse? YES NO P____
Abnormal Skull contour? YES NO
Describe:_____
Abnormal reflexes? YES NO
Describe:_____
Hand grips unequal in strength? YES NO
Describe:_____

NO TO ALL & GCS = 15
CONTINUE ASSESSMENT

YES TO ANY OR GCS BELOW 15
INTERVENE
Call Nurse-Time: _____
Nurse will decide whether to call 911 or wait for her assessment.
Call Parents-Time: _____
Refer to Dr. & send documentation.
Follow up for DX & RX info.

BLEEDING? YES | NO

SWELLING? YES | NO

IF YES
INTERVENE
Do NOT remove impaled object.
Apply pressure to bleeding unless depressed FX suspected, then just to edges.
Laceration may require sutures? YES NO
Call Nurse-Time: _____
Call Parents-Time: _____
Nurse will decide whether to ask parents to transport to Dr. or to call 911.
Send documentation with student for Dr., including date of last Td.
Follow up for DX & RX info.

WHETHER YES OR NO
INTERVENE
Apply ice
Observe 20-30 minutes

CONTINUE ASSESSMENT
Repeat initial assessment. Time: _____ BP: _____ P:_____
Abnormal behavior? YES NO
Distorted memory of incident? YES NO
Vision blurred? YES NO Sees double? YES NO
Eyes fail to move together? YES NO
Fluid leakage/bleeding from nose/ears? YES NO
Very severe headache? YES NO Dizziness? YES NO
Seizure? YES NO Neck Pains? YES NO
Mobility of arms/legs altered? YES NO
Vomited more than twice? YES NO

NO
INTERVENE
Inform Parents- Time: _____
Send head injury note home.
Send back to class.
Recheck later in day.

YES TO ANY
INTERVENE
Call Nurse-Time: _____
Call Parents-Time: _____
Nurse will decide whether to ask parents to transport to Dr. or to call 911.
Send documentation with student for Doctor.
Follow up for DX & RX info.

COMMENTS:
If shock assessment needed use reverse side of this sheet.
If assessment is done after a period of time elapses, be alert to the following signs of serious head injury:
CUSHING'S TRIAD - Increased systolic BP, decreased heart rate, widened pulse pressure. Is a sign of increased intracranial pressure.
RACCOON EYES - Discoloration & swelling around both eyes. Suggests basilar skull FX or facial FX.
BATTLE'S SIGN - Discoloration & swelling behind one or both ears. Suggestive of basilar skull FX.

(Page intentionally left blank)

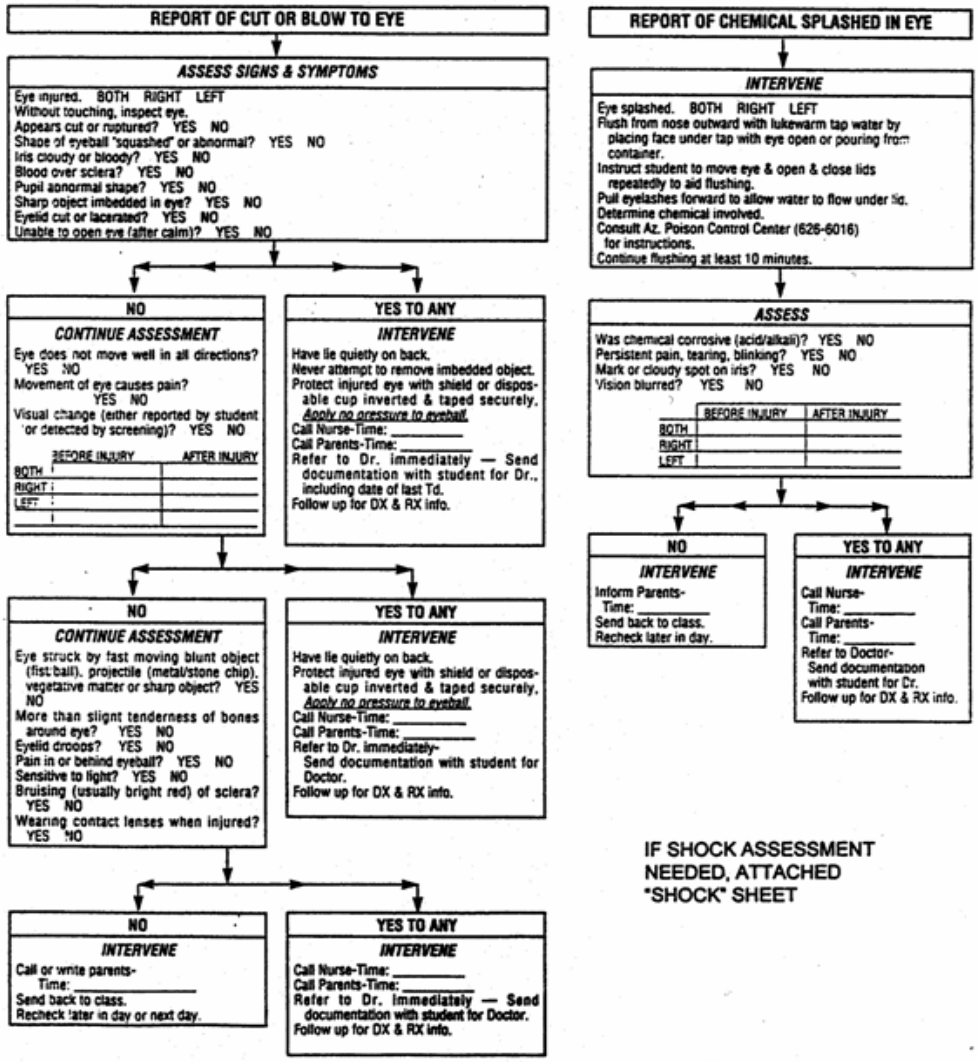
STUDENT NAME:

WHEN, WHERE, HOW INJURY OCCURRED, COMPLAINTS REGARDING PAIN AND FUNCTION

TIME OF INCIDENT: DATE:

ARRIVAL TIME IN HEALTH OFFICE: DEPARTURE TIME AND DISPOSITION:

SIGNATURE:



SHOCK

Record assessments & interventions by circling Yes, No, & intervention done, plus filling in blanks.

ASSESS SIGNS & SYMPTOMS

Rapid Breathing? YES NO
Rapid/weak pulse? YES NO
Decreased BP? YES NO
Restless or irritable? YES NO
Pale/bluish, cool, moist skin? YES NO
Slow capillary filling time? YES NO
Heavy sweating? YES NO
Dilated pupils? YES NO
Dull, sunken look to eyes? YES NO
Excessive thirst? YES NO
Nausea/vomiting? YES NO
Drowsiness/loss of consciousness? YES NO

Time							
R							
P							
BP							

NO, IS NOT SHOCK

INTERVENE TO PREVENT

Have lie down.
Preserve body heat.

YES, IS SHOCK

INTERVENE

Elevate legs 8-12" if no spinal injury.
Preserve body heat with blankets under & over.
Do NOT give anything to eat or drink.
Call 911-Time: _____
Call Nurse-Time: _____
Call Parents-Time: _____
Send documentation with student for Dr.
Follow up for DX & RX info.

NURSE: _____ SCHOOL: _____

ADDRESS: _____ PHONE: _____

PHYSICIAN'S REPORT:
Please write diagnosis and treatment and return to school nurse. Include any accomodations that will be required at school.

_____
Physician's Signature

FRACTURES, DISLOCATIONS, STRAINS, SPRAINS, CONTUSIONS

STUDENT NAME:

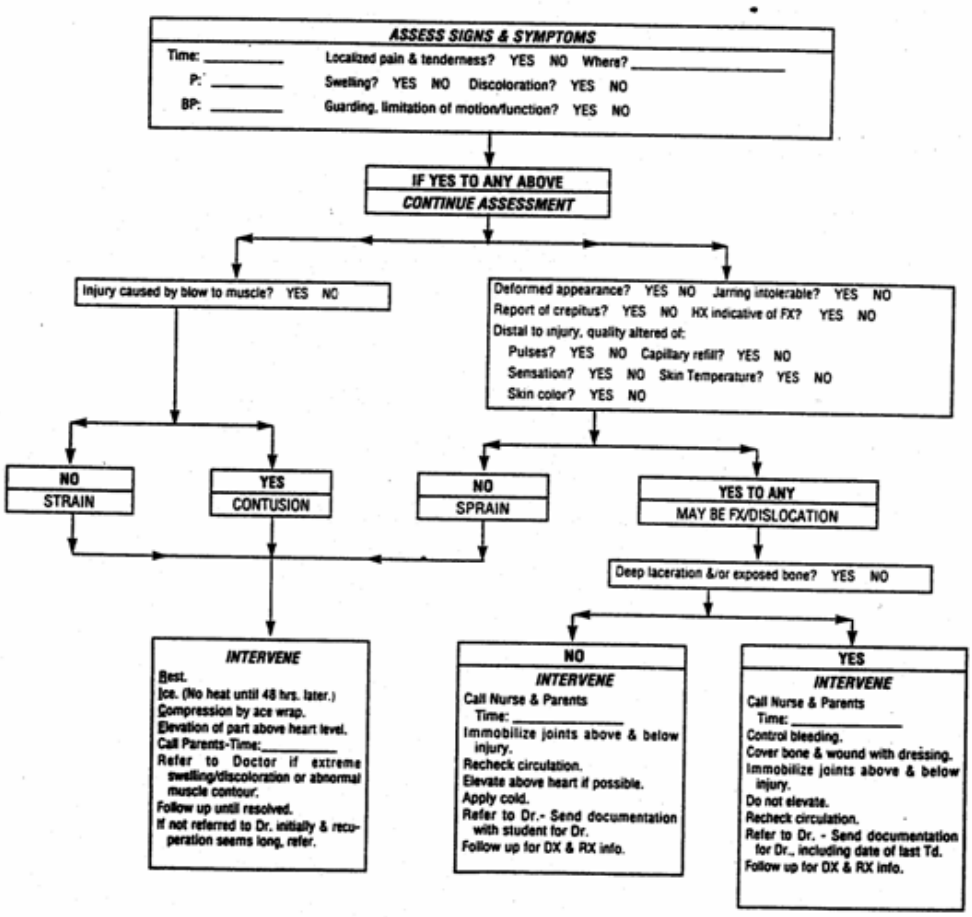
WHEN, WHERE, HOW INJURY OCCURRED, COMPLAINTS REGARDING PAIN AND FUNCTION

TIME OF INCIDENT: **DATE:**

ARRIVAL TIME IN HEALTH OFFICE: **DEPARTURE TIME AND DISPOSITION:**

SIGNATURE:

Record assessments & interventions by circling Yes, No, & intervention done, plus filling in blanks.



[insert school name]
Office of the School Nurse

TO: Department Head/Grade-Level Chairpersons

FROM: *[insert school nurse name"]*

SUBJECT: CONFIDENTIAL HEALTH PROBLEMS

The attached list is a **CONFIDENTIAL LIST** of students with chronic health problems. The purpose of preparing this list is **NOT** to make you worry excessively about a student, but to alert you to the fact that the student could have a potential problem in your class. In other words, if the student looks ill and/or requests a pass to see me, please allow him or her to go to the health office without undue delay.

Because students with problems are often very sensitive about being "different," it is usually better **NOT** to ask the student about his or her problem in the classroom setting. If you would like additional information about the student or what to do in case of emergency, **please see me before asking the student further questions.**

This list is not a complete list of students with health problems. Students with minor problems have been omitted. If there is anyone not on this list you would like to discuss with me, please contact me. Please circulate this list in your department/grade level. Each teacher may copy information about students that she or he has in a class or an activity. Teachers should then file the information. Remember that this is **CONFIDENTIAL INFORMATION.**

Each teacher in the department/grade level should sign below indicating that they have reviewed the list. After everyone has signed the list, the department head/grade-level chairperson should return the list to *[insert school nurse name]* in the health office.

Signature of department/grade-level members and date

Please note: This form is not recommended as a teacher notification method if a computer program is available to create confidential lists for teachers on an individual basis.

[insert school name]
Office of the School Nurse

TO: Classroom Teacher/Specialist

SUBJECT: Confidential Health Record

STUDENT'S NAME: _____

This student has the following medical problem(s):

___Activity restrictions: _____
___Allergic to: _____
___Asthma triggers: _____
___Attention Deficit/Hyperactivity Disorder
Medications @ _____
___Emotional problems: _____
___Frequent ear infections: _____
___Frequent nose bleeds: _____
___Visual impairment: _____
___Hearing loss: _____
___Heart condition: _____
___Medication daily for_____
___Medication PRN (as needed) for_____

Additional information:
_____
_____
_____

Please see me for further information.

_____
[insert name and title]

[insert name of school]
Office of the School Nurse

STUDENT: _____ **DATE:** _____

Teacher/Staff Member:_____
Check behaviors that you have witnessed and please document whenever possible. Use the back of this form if you prefer a narrative style of reporting what you know, or if you have other information that you feel may be important in our efforts to help this student.

_____ **Tardy** # _____ excused # _____ unexcused
_____ **Absent** # _____ excused # _____ unexcused

Smells of:
__ Ether/acetone, other "chemical" odor
__ Alcohol
__ Cigarettes
__ Mouthwash

Frequent requests to leave classroom:
__ Lavatory __ Phone __ Nurse __ Counselor __ Locker __ Office

Behaviors displayed in the school setting:
__ Falling asleep
__ Slurred speech
__ Incoherent
__ Stumbles
__ Unsteady gait
__ Sunglasses worn indoors
__ Bad hygiene
__ Eyes red or glassy
__ Sweaty
__ Nonresponsiveness
__ Lack of motivation
__ Negative change of dress
__ Defensiveness
__ Withdrawn; loner
__ Erratic behavior from day to day
__ Students "recognize" this student when drugs are mentioned or discussed
__ Unusual bruises, sores, or indications of self-inflicted injury
__ Class interruptions for this student
__ Frequent request for schedule change
__ Dramatic attention-getting behaviors
__ Negative change of friends
__ Talks frequently of drug/alcohol use
__ "Reacts" when drugs are mentioned
__ Name is often heard in connection with drug/alcohol use
__ Concern expressed by other students
__ Homework not completed/sporadic
__ Declining grades
From _____
To _____
__ Carelessness about appearance
__ Cheating
__ Fighting
__ Sudden outbursts; verbal abuse
__ Poor work performances
__ Nonproductive
__ Obscene language or gestures

Other behaviors of concern:_____

_____
Teacher/Staff Member Signature

H.6 Notices to Parents/Sponsors

[Insert school letterhead]
Office of the School Nurse

Date_____

Dear Parents:

This year, along with routine vision, hearing, and height and weight screening, there will be a posture screening of grade *[insert grade level to be screened]* for possible spinal problems, particularly scoliosis. Scoliosis is the medical term for sideward curve of the spine. It usually begins in the growing years of life, most commonly in adolescence, and affects at least 600,000 American children from the ages of 10 to 15. An estimated 10 out of every 100 children will develop scoliosis and 1 to 3 of these 10 will require active treatment. Girls are affected 8 to 10 times more often than boys. In 80 to 85 percent of the cases, the cause is unknown. A progressive disease, it can lead over the years to pain, crippling, heart and lung complications, and severe deformity.

When this condition is detected early, severe spinal deformities can be prevented. Interest in school screening is growing nationwide, and several state legislatures have passed laws requiring school screening.

The procedure is simple. I will look at the student's back as he or she stands and bends forward. Students are asked to wear pants and loose fitting T-shirts on screening day. Girls may wear bathing suit tops under a T-shirt if that would make them feel more comfortable.

If your child has a beginning or observable curvature, you will be notified and asked to have your child examined further by a physician.

Scoliosis is not rare, and early detection is possible though this program. If you have any questions, feel free to call me at school [insert school phone number].

[insert name and title]

[Insert school letterhead]
Office of the School Nurse

Date:_____

RE: Pediculosis/Head Lice

Dear Parent or Guardian,

Your child, _____, has symptoms of pediculosis—infestation with head lice. Even though lice do not jump or fly, they can be spread from one child to another when children share combs, brushes, clothing, and hats. An infestation of head lice can happen to anyone. It is not a sign of poor health habits or lack of cleanliness.

To control the spread of head lice, your child may return to school after he/she has been treated with a pediculocide shampoo. This is only the first step. The brushes and combs your child has used within the last week will need to be soaked in the pediculocide shampoo for one hour. Bedding, clothing, and hats must be laundered in very hot water (120°) on the same day or evening that your child is treated. As a precaution, stuffed animals, pillows, or other items that cannot be washed should be placed inside a plastic bag and sealed for one week. Ideally, nits should be removed. If not, reshampooing in 7 to 10 days is vital to kill newly hatched lice.

Working together, we can meet this challenge. I am available to discuss any questions you may have concerning this matter. Please call me at *[insert school number].*

[insert school nurse name]

Please complete the following and bring your child and this form to the school office when she/he returns to school.

_____ _____
Child's name Date of first shampooing

_____ _____
Parent's signature Name of treatment/shampoo

[insert school name]
Office of the School Nurse

TO: Parents/Sponsor of: _____

FROM: [insert your name & title]

SUBJECT: Additional Medical Information

On the *Student Health History* form, it was indicated that your child has _____.

In order to better understand your child's needs, more information is requested. I would appreciate any additional information you could give me concerning this condition.

Medical information, including medications, hospitalizations, surgeries, etc.:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Parent Signature **Date**

H.7 Accident/Injury Reports

Refer to *Users Guide for Accident/Injury Reports (A/IR),* August 2001, for information and current reporting forms. Available at www.odedodea.edu.

Consult with your district's safety and security officer for the most current DoDEA 4801 form.

H.8 Asthma Documentation and Forms

[insert school letterhead]
OFFICE OF THE SCHOOL NURSE

DATE: _____MEMORANDUM
TO: Parents/Sponsor of_____
SUBJECT: Asthma

An indication was made on your child's health record that he/she has asthma. In order to understand your child's needs, more information is requested. Please take a few moments to fill out the enclosed questionnaire. Take special care to include the names of medications your child takes, even if they will not be taken at school. If you are unsure as to whether or not information would be important, please list it anyway. The more information we gather, the more prepared we will be in case an emergency arises.

Our goal is to keep asthmatic children in school as much as possible. Prompt and appropriate treatment is only possible if the school is aware of the treatment regime your child is receiving and has the medication available for administration in the school setting.

Prompt treatment of asthmatic attacks shortens the duration and severity of the attack. The use of peak flow monitoring has been useful in the early treatment of asthma attacks, thus reducing the severity of the attack. A peak flow monitoring program will begin for your child. A baseline is established using your child's age and height. This baseline will be used to determine the extent of respiratory involvement and the need for PRN medication.

All medications administered at school require signed parent permission and signed doctor's instructions. **INHALERS ARE PRESCRIPTION MEDICATIONS.** Please bring to school your child's medication in a pharmacy-labeled container along with the required "Medication During School Hours" consent form (copy attached) signed by you and the child's primary physician.

If you would like more information regarding asthma care, please feel free to call me at school [insert school phone number]. The last page of this packet is a reference list for parents. Accurate, up-to-date information may be ordered using the attached form.

[insert name and title]

[insert school letterhead]

Office of the School Nurse

REFERRAL FOR RESPIRATORY EVALUATION

Name:_____Date:_____
History:
[ ] No known history of respiratory problems
[ ] History of asthma/respiratory problems (list when)_____
[ ] Has asthma
[ ] Currently having asthma exacerbation
[ ] Allergies (list)_____
Current Status:
S: _____
O:
Peak Flow Reading 100-80%_____ 80-65%_____ 65-50%_____ 50%_____
Respiratory Rate_____ Pulse Rate_____
[ ] Coughing [ ] Rhinitis
[ ] Wheezing [ ] Shiners
[ ] Retractions [ ] Other _____
A: _____
P: [ ] Start peak flow monitoring program at school & home
[ ] Asthma information to parent
[ ] Refer for asthma education
[ ] Refer to MTF for further evaluation
****

For the physician:

S:_____
O:_____
A:_____
P: [ ] No treatment at this time, but recommend _____
[ ] Prednisone burst (# days)_____ _____
[ ] Nebulizer treatment (how many) _____
[ ] New medications prescribed (attach permission & plan)
[ ] F/U on (date) _____
[ ] Refer to asthma education class
[ ] Asthma management plan (attach)
[ ] Referral to _____

_____ _____
Physician Signature/Stamp Date

[insert school name]
Office of the School Nurse

ASTHMA MANAGEMENT PLAN

INDIVIDUALIZED PEAK FLOW GUIDELINES
SCHOOL/HOME INSTRUCTIONS

_____ (child's name) is being treated by
_____ (physician's name & phone #).

Severity Level: mild intermittent / mild persistent / moderate persistent /severe persistent
Asthma Triggers: _____

Date: _____ Personal Best Peak Flow: _____
Peak Flow Readings: 100-80% _____ 80-65%_____ 65-50% _____ <50% _____

When using a peak flow meter to measure lung function, follow these instructions:

- ***If the meter reading is between 100-80%, the following actions are to be taken:***
  - ✓ **Daily long-acting medicine Dose Time**
    1. _____ _____ _____
    2. _____ _____ _____
  - ✓ **No restricted activities.**
  - ✓ **No short burst medicines administered @ school.**

- ***If the meter reading is between 80-65%, the following actions should be taken:***
  - ✓ **Continue daily medications listed above.**
  - ✓ **Add adrenaline-like/short burst medicine: _____ _____ puffs**
  - ✓ **Give three to six times in 24 hours.**
  - ✓ **Continue until peak flow is above 80% for two days.**
  - ✓ **Activities: restricted/not restricted. (Circle one.)**
  - ✓ **Additional medications to be given:**

    Medicine Dose Time
    1. _____ _____ _____
    2. _____ _____ _____

- ***If meter reading is between 65-50%, the following actions should be taken:***
  - ✓ **Continue adrenaline-like medication.**
  - ✓ **If meter reading continues in this zone, notify sponsor @ _____ or spouse @ _____, emergency contact @ _____**
  - ✓ **Activities restricted.**

- ***If the meter reading is in the 50% range or below and the child is experiencing respiratory distress, contact the parent or doctor immediately.***

_____ _____
Parent signature **Physician signature and date**

[insert school name]
Office of the School Nurse

REQUEST FOR ASTHMA INFORMATION

Student's Name _____ Date of Birth _____ Date _____
Sponsor _____Teacher/Grade _____

How long has your child had asthma? _____

Describe *last* asthma attack (what happened, how long it lasted, how it was treated).
_____
_____

How often does child have an attack requiring an emergency visit to the doctor or hospital? [ ] weekly [ ] monthly [ ] yearly [ ] never

What usually triggers your child's asthma? (Check all that apply.)
[ ] illness [ ] exercise [ ] emotions [ ] foods
[ ] smoke/odors [ ] weather [ ] medications [ ] allergens

Has your child ever had allergy testing?___ No___ Yes Allergies: (list)_____

Is your child exposed to second-hand smoke?___ No ___ Yes

Do you use a peak flow meter at home? ___ No___ Yes Best volume results _____

List all asthma medications taken. Include as needed inhalers & steroids:
_____
_____
Other medications taken:
_____

What is the severity of your child's asthma? [ ] mild intermittent [ ] mild persistent
[ ] moderate persistent [ ] severe persistent

Have you or your child ever attended an asthma class? _____ No _____ Yes

Do you have an asthma management plan? _____ No _____ Yes
If yes, please attach a copy.

If you would like to provide other information, or if you have questions, please write on the reverse side of this form. Thank you for this valuable information.

_____
Parent signature and date

ADD/ADHD REFERRAL
(To be completed by teacher and returned to nurse)

Date_____

TO: _____[Insert teacher's name]_____

FROM: ___[Insert school nurse's name]_____

_____ has been referred for an ADHD evaluation. Part of that evaluation will include a health assessment. To complete the assessment, I need to ask the following:

1) Length of time you have worked with student: _____.

2) This student is being referred for: *(Check all that apply.)*
   - ❑ Inattention
   - ❑ Hyperactivity
   - ❑ Impulsivity
   - ❑ Aggressive behaviors

3) The following indicators have been observed in the classroom: *(Check all that apply.)*

a. Impaired thought process related to:
   - inability to consistently process input
   - shortened attention span
   - decreased ability to exert mental effort
   - decreased ability to selectively focus, concentrate

b. Self-esteem alteration:
   - behaviors—impulsivity, aggression, and inability to self-control
   - inadequate peer relationships
   - internalization of negative feedback
   - self-perception that s/he is more tense, restless than peers
   - stigma of feeling "different" or singled out

c. Ineffective coping skills related to:
   - decreased ability to plan
   - decreased ability to self-limit behaviors
   - decreased ability to anticipate consequences of actions
   - decreased ability to generate several options of possible response to a stimulus
   - increased risk-taking behaviors

d. Sensory-perception alteration related to:
   - decreased ability to sort for relevant data
   - decreased ability to focus on the appropriate data
   - decreased ability to choose which sensory data to consider relevant
   - decreased rate of processing or incomplete processing of sensory inputs

Thank you for completing the form. Please return as soon as possible.

[insert school letterhead]

Office of the School Nurse

INDIVIDUALIZED HEALTH ASSESSMENT

NAME: DATE OF BIRTH:

PREPARED BY:

SUBJECTIVE:

's teacher has tried many classroom modifications for . H continues to experience difficulties in the classroom. There is a concern for h academic progress. The teacher is referring h for problems with inattention, hyperactivity, impulsivity, and aggressiveness.

OBSERVATIONS:

seems to be an active, alert year month old . H will make eye contact and is cooperative. H speech is clearly enunciated and in proper syntax. H appears to be well nourished. Clothing is clean, neat, and appropriate to place, age, and weather. Skin is warm and dry, hair clean, eyes clear. H moves about freely. Normal response for all soft neurological signs. Vision (near and distance acuity) is WLN, and PERRLAEOM. Hearing screening results are within normal limits (all frequencies @ 20dB), TM's clear, landmarks present.

Immunizations meet DoDDS minimum requirements. There were no medical concerns noted on the health history completed by the parents at registration. Receives medications at school for .

ASSESSMENT: Based on information received from the teacher, may be experiencing:

1) impaired thought process related to: inability to consistently process input, shortened attention span, decreased ability to exert mental effort, and/or decreased ability to selectively focus, concentrate;
2) self-esteem alteration due to: impulsivity, aggression, and inability to self-control; inadequate peer relationships; internalization of negative feedback; self-perception that s/he is more tense, restless than peers; stigma of feeling "different" or singled out;
3) ineffective coping skills related to: decreased ability to plan, decreased ability to self-limit behaviors, decreased ability to anticipate consequences of actions, decreased ability to generate several options of possible response to a stimulus, increased risk-taking behaviors;
4) sensory-perception alteration related to: decreased ability to sort for relevant data, decreased ability to focus on the appropriate data, decreased ability to choose which sensory data to consider relevant, decreased rate of processing or incomplete processing of sensory inputs.

PLAN:

1. Refer for a complete medical assessment by primary care physician.
2. Establish a school medication regime, if medication is prescribed.
3. Establish school monitoring program.

Submitted by: *[insert name and title]*

[insert school letterhead]

Office of the School Nurse

Dear Physician,

_____ was seen in your office. To ensure that all communication between the parents, the school, and you is accurate, please complete this form. I appreciate the time invested in this assessment. [insert name, title and phone number].

_____An initial diagnosis of Attention Deficit or Attention Deficit Hyperactivity Disorder was made.

The decision was made to place the child on a trial regime of:

- ❑ _____ to be given at home only.
- ❑ _____ to be given at home and at school.

_____A diagnosis was **not** made at this time. The child/family was referred for further assessment by: [Include name and title]

- ❑ Additional documentation is needed.
- ❑ Parents would like more time to consider the diagnosis.
- ❑ This is a follow-up visit and the established regime will continue.
- ❑ There will be a change in the medication regime:
  - o The at-home medication/dosage will be _____.
  - o The school medication/dosage will be _____.
  - o _____has been discontinued.

Additional comments:

_____

Physician's Signature & Date

***PARENTS, PLEASE RETURN THIS FORM TO THE SCHOOL NURSE*.**

DEPARTMENT OF DEFENSE
EDUCATION ACTIVITY

ADD/ADHD MONITORING SCALE

Name of Student: Grade:
Name of Rater:
Subject/Setting: Date:
Time(s) of contact: (When is the student with you?)

(Highlight or put an "X" by your response.)

1.	**Inattention**	**Almost Never**			**Almost Always**	**Not Observed**
a.	Fails to pay close attention to details, or makes careless mistakes in school work, chores, or other daily activities.	0	1	2	3	N/O
b.	Has trouble keeping attention on tasks or play activities.	0	1	2	3	N/O
c.	Has trouble listening when spoken to.	0	1	2	3	N/O
d.	Has difficulty following through on directions and fails to complete schoolwork, chores, or other responsibilities.	0	1	2	3	N/O
e.	Has difficulty organizing tasks or activities.	0	1	2	3	N/O
f.	Dislikes, avoids, or does not want to engage in activities that require sustained concentration.	0	1	2	3	N/O
g.	Loses things required for school work or other activities.	0	1	2	3	N/O
h.	Is easily distracted from tasks.	0	1	2	3	N/O
i.	Is typically forgetful in daily activities.	0	1	2	3	N/O

# of items with rating of 2 or 3:
Total Score:

2.	**Hyperactivity**					
a.	Often squirms in his/her seat or fidgets.	0	1	2	3	N/O
b.	Frequently is out of his/her seat at school or in other situations where students are expected to remain seated.	0	1	2	3	N/O
c.	Runs about or climbs excessively when he/she is not supposed to.	0	1	2	3	N/O
d.	Seems to have trouble playing quietly.	0	1	2	3	N/O
e.	Can be described as "always on the go" or as if "driven by a motor."	0	1	2	3	N/O
f.	Seems to talk excessively.	0	1	2	3	N/O

#of items with rating of 2 or 3:
Total Score:

		Almost Never			Almost Always	Not Observed
3.	**Impulsivity**					
a.	Frequently blurts out the answer to a question.	0	1	2	3	N/O
b.	Typically has difficulty waiting his/her turn.	0	1	2	3	N/O
c.	Frequently interrupts others or intrudes on others.	0	1	2	3	N/O

# of items with rating of 2 or 3:

Total Score:

4.	**Academic Performance**					
a.	Does not complete in-class projects.	0	1	2	3	N/O
b.	Does not return homework completed.	0	1	2	3	N/O
c.	Does not complete in-class written work.	0	1	2	3	N/O

# of items with rating of 2 or 3:

Total Score:

1. Have you noticed any of the following symptoms? ***(Highlight behaviors reported or noticed.)***

appetite loss insomnia headaches stomachaches staring often irritable

excessive crying motor/vocal tics nervousness sadness withdrawn moody

2. Have you noticed a change in behavior during the school day, as if effects of medication are wearing off? NO YES If yes, at what time?

Teacher comments (thoughts or observations you wish to share with the physician):

_____

Teacher Signature

Original to Physician

DEPARTMENT OF DEFENSE
EDUCATION ACTIVITY

ADD/ADHD MONITORING SCALE*
INTERPRETATION

The respondent indicates the degree to which the student in the school setting has exhibited each behavior. The rating number (0–3) is indicated in each category for each behavior.

SCORING

The total number of items for each rating of 2 or 3 only is indicated for each category. The total score for each category is the sum of all the rating numbers (0–3). The higher the total score, the greater the presence of ADHD-type symptoms.

INTERPERTATION

1. ADD-Predominantly Inattentive Type (ADHD-PI). At least six of the inattention symptoms endorsed and fewer than four of the hyperactive/impulsivity symptoms endorsed.

2. ADHD-Predominantly Hyperactive/Impulsive Type (ADHD-PH/I). At least six of the hyperactive/impulsivity symptoms endorsed and fewer than four of the inattention symptoms endorsed.

3. ADHD-Combined Type (ADHD-CT). At least six of the inattention and six of the hyperactive/impulsivity symptoms endorsed.

*The DoDEA ADD/ADHD Monitoring Scale (DEAMS) is based on the Georgia Diagnostic Interview Schedule for Children and Adolescents (G. W. Hynd and C. Riccio), using the DSM-IV symptoms and diagnostic criteria.

[Insert School Letterhead]
Office of the School Nurse

Health Assessment

STUDENT: _____ BIRTH DATE: _____
TEACHER/GRADE: _____

VISION: Date screened _____

	WITHOUT GLASSES	*WITH GLASSES*
Distance:	**R 20/_____ L 20/_____**	**R 20/_____ L 20/_____**
Near:	**R 20/_____ L 20/_____**	**R 20/_____ L 20/_____**

Instrument used: ☐ Titmus ☐ Random letter ☐ Tumbling E ☐ Preschool symbols
PERRLAEOM:_____
REMARKS:_____

HEARING: Date screened _____
Testing frequencies @ 20 or 25 dB. *Indicate dB at which student heard sound.*

	500	1000	2000	4000
Right				
Left				

Canals: _____ pink _____ erythema TM's: _____ clear _____ opaque _____ PE tubes
REMARKS:_____

MEDICAL HISTORY:
_____ Review of School Health Record
_____ Parent interview (Social/Family/Medical/History)
_____ Review of medical records

CURRENT INFORMATION:
Medications: _____
Minor neurological signs: ☐ achieved ☐ difficulty with _____
Height: _____ inches (%) Weight: _____ pounds (%)

RELATIONSHIP OF FINDINGS TO EDUCATIONAL FUNCTIONING:
_____ Vision is *WITHIN NORMAL LIMITS.*
_____ Hearing *is* *WITHIN NORMAL LIMITS.*
_____ Findings should *NOT* adversely affect classroom performance.
_____ Findings should *NOT* adversely affect one-to-one testing.
_____ Findings may adversely affect classroom performance.
_____ Findings may adversely affect one-to-one testing.
_____

RECOMMENDATION: ☐ Proceed with testing ☐ Hold testing until: _____
COMMENTS: _____

_____
[insert name and title] **Date**

Minor Neurological Signs

TASK	AGE NORMS	NORMAL RSPONSE	ACHIEVED/COMMENTS
FINGER OPPOSITION	5 years and older **Note:** Asymmetries Associated movements Tremors	6–8 years: easy transition; child may put same finger on thumb several times 8–10 years: smooth placing of fingers; barely discernable movement	
DIADICHOKINESIS (Alternating pronation/supination of forearm)	4 years and older **Note:** Asymmetries Directional confusion	4–7 years: awkward pronation & supination; associated movements noted on opposite extremity 8 years and older: smooth & correctly performed with no associated movement in opposite extremity	
FINGER TO NOSE (eyes open/eyes closed)	4 years and older: eyes open 5 years and older: eyes closed	7–8 years: finger may be missed once or twice; slight wavering of hand 8 years and older: finger placed correctly; smooth movement	
ONE-FOOT STANDING BALANCE (both right & left foot)	3 years and older **Note:** Asymmetries Muscle strength	3–5 years: able to stand 5–6 seconds with many extraneous balancing movements 5–6 years: able to stand for 10–12 seconds with many extraneous balancing movements 6–7 years: able to stand for 13–16 seconds with *minimal* balancing movements 7 years and older: able to stand for 20 seconds with no extraneous balancing movements	
ONE-FOOT HOP (both right and left foot)	3 years and older **Note:** Asymmetries Muscle strength **(One leg may often be better than the other.)*	3–4 years: few are able to hop—even a few times* 4–5 years: able to hop 5–8 times consecutively* 5–6 years: able to hop 9–12 times consecutively* 6–7 years: able to hop 13–16 times consecutively* 7 years and older: able to hop 20 times consecutively	
WALKING A STRAIGHT LINE	5 years and older **Note:** Associated movements	5–7 years: three deviations from the line are acceptable 8 and older: no deviations	
WALKING ON TIP-TOES	3 years and older **Note:** Associated movements Asymmetries Muscle tone Orthopedic problems Muscle strength	3–7 years: able to walk on tip-toes with decreasing associated movements (20 continuous paces) 7 years and older: able to walk on tip-toes with no associated movements	
WALKING ON HEELS	3 years and older	3–9 years; able to walk on heels with decreasing associated movements (20 continuous paces) 9 years and older: able to walk on heels for 20 continuous paces with no associated movements	
SKIPPING	3 years and older **Note:** Asymmetries in posture		

[Insert school letterhead]
Office of the School Nurse

Preschool Functional Vision and Hearing Screening
(for Children Ages 2 1/2 to 5 years)

NAME: _____ DATE: _____

This screening does not evaluate vision or hearing acuity. It does address whether functional vision and/or hearing seems adequate to continue with the assessment process.

VISION

Does the child . . .

___ a. have eyes that look forward, not inward or outward?
___ b. make eye contact with the objects?
___ c. follow moving objects with eyes?
___ d. look at objects without covering one eye or squinting?
___ e. hold objects at a normal distance from face?
___ f. move about without frequently bumping into objects?
___ g. move easily from one floor surface to another?

___ Functional vision seems normal.
___ A vision problem is suspected. Further evaluation is indicated.

HEARING

Does the child . . .

___ a. breathe through the nose with mouth closed?
___ b. speak in a normal tone of voice?
___ c. have a normal voice quality?
___ d. speak clearly without misarticulations?
___ e. look at the speaker's face rather than the speaker's lips?
___ f. look at the speaker straight on without turning an ear toward the speaker?
___ g. turn when name is spoken while child is not looking?

___ Functional hearing seems normal.
___ A hearing problem is suspected. Further evaluation is indicated.

Observer _____

Title _____

[insert school letterhead]
Office of the School Nurse

Social/Family/Medical History
Grades 6–12

Dear Parent, The information you provide will help the Medically Related Services Department and school's Case Study Committee identify your child's needs.

I. FAMILY INFORMATION

CHILD

Name _____ Grade _____ Date of Birth _____

[AU: The above CHILD info was embedded within a table. I removed the table so format would be the same as for SPONSOR and SPOUSE info below.]

SPONSOR

Name _____ Duty Phone _____ Home Phone _____

SPOUSE

Name _____ Duty Phone _____ Cell Phone _____

II. MEDICAL HISTORY

If your child has had any of the following serious medical illnesses or problems, please indicate below.

Condition	**Yes**	**No**		**Yes**	**No**
Frequent ear infections	☐	☐	Dizziness	☐	☐
Frequent ear fluid	☐	☐	Heart disease	☐	☐
Hearing problems	☐	☐	Loss of consciousness	☐	☐
Allergies	☐	☐	Frequent sore throats	☐	☐
Fainting	☐	☐	Prolonged fever	☐	☐
Severe reaction to injection	☐	☐	Encephalitis	☐	☐
Swallowing problems	☐	☐	Severe reaction to medication	☐	☐
Drooling	☐	☐	Seizures/convulsions	☐	☐
Dental problems	☐	☐	Meningitis	☐	☐
Eye problems	☐	☐	Head trauma	☐	☐
Asthma	☐	☐	Accidents	☐	☐
Headaches	☐	☐	Poisoning/ingestions	☐	☐
Breath-holding spells	☐	☐	Low blood count/anemia	☐	☐
Awkwardness	☐	☐	Excessive bleeding	☐	☐
Weakness	☐	☐	Paralysis	☐	☐
Muscle problems	☐	☐	Emotional problems	☐	☐
Chronic cough	☐	☐	Tremors	☐	☐
Bronchitis	☐	☐	Tingling in hands/feet	☐	☐
Chronic diarrhea	☐	☐	Unusual walk	☐	☐
Slow weight gain	☐	☐	Chicken pox	☐	☐
Kidney problems	☐	☐	Mumps	☐	☐
Genital problems	☐	☐	Measles	☐	☐
Joint problems	☐	☐	Scarlet fever	☐	☐
Arthritis	☐	☐	Whooping cough	☐	☐
Thyroid disease	☐	☐	Constipation	☐	☐
Chronic skin problems	☐	☐	Long-term separation from	☐	☐
Limp	☐	☐	mother/father		

III. PREGNANCY and BIRTH

A. List all pregnancies (including miscarriages, abortions, and live births)

Date	Length of Pregnancy	Birth Weight	Outcome	Complications (Prolonged Hospital Stay)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

B. Prenatal history *(Questions refer to the pregnancy with the child who is being evaluated.)*

1. Did you take any medication during the pregnancy? [ ] Yes [ ] No
   Explain _____
2. Did you smoke cigarettes during the pregnancy? ☐ Yes ☐ No
3. Did you drink alcohol during the pregnancy? ☐ Yes ☐ No
4. Did you use any illegal drugs during the pregnancy? ☐ Yes ☐ No
5. Was this a planned pregnancy? ☐ Yes ☐ No

6. Did any of the following occur during the pregnancy?

	Yes	No		Yes	No		Yes	No
Fever	☐	☐	Viral infection	☐	☐	German measles	☐	☐
Spotting	☐	☐	Kidney infection	☐	☐	Vaginal bleeding	☐	☐
Diabetes	☐	☐	Threatened miscarriage	☐	☐	Morning sickness	☐	☐
Toxemia	☐	☐	Sugar/protein in urine	☐	☐	Special diet	☐	☐
Surgery	☐	☐	RH factor problem	☐	☐	Accident/injury	☐	☐
Amniocentesis	☐	☐	Convulsions/seizures	☐	☐	Pre-term labor	☐	☐
Asthma	☐	☐	High blood pressure	☐	☐	X-rays	☐	☐

7. How long was labor? _____

8. How was the baby delivered? ☐ Vagina ☐ C-section ☐ Forceps/Vacuum assist

C. Infant's condition at birth

Birth weight _____ Length _____ Head circumference ____ APGAR scores _____

	Yes	No		Yes	No
Breathed immediately	☐	☐	Had seizures or convulsions	☐	☐
Cried immediately	☐	☐	Had infection	☐	☐
Resuscitation required	☐	☐	Had skin rash	☐	☐
Was jaundiced (yellow)	☐	☐	Had bleeding problem	☐	☐
Was blue	☐	☐	Had low blood sugar	☐	☐

D. Procedures or treatments used with infant:

	Yes	No		Yes	No
Fluids by needle (IV)	☐	☐	Feeding by tube	☐	☐
Transfusion	☐	☐	Incubator	☐	☐
Oxygen therapy	☐	☐	Breathing machine	☐	☐
Special lights for jaundice	☐	☐	Chest tubes	☐	☐
Medication	☐	☐	Antibiotics for infection	☐	☐

IV. DEVELOPMENTAL PROFILE

A. At what age did your child:

_____ Roll over	_____ Smile responsively	_____ Use fingers to eat
_____ Reach for objects	_____ Babble	_____ Use utensil to eat
_____ Sit alone	_____ Wave bye-bye	_____ Undress self
_____ Crawl	_____ Say first word	_____ Dress self
_____ Walk alone	_____ Put words together	_____ Toilet train
_____ Walk upstairs	_____ Say 3-word sentence	_____ Button clothes
_____ Pedal tricycle	_____ Say own name	_____ Tie shoes
_____ Skip	_____ Use pronouns	_____ Know some letters

B. Did your child exhibit any of the following during the first two years?

	Yes	No	Comment
1. Sleeping difficulties	☐	☐	_____
2. Rhythmic behaviors (rocking)	☐	☐	_____
3. Hard to comfort or console	☐	☐	_____
4. Floppiness (after 6 months)	☐	☐	_____
5. Stiffness	☐	☐	_____
6. Cried often and easily	☐	☐	_____
7. Not affectionate	☐	☐	_____
8. Poor eye contact	☐	☐	_____
9. Head banging	☐	☐	_____
10. Did not like being held	☐	☐	_____

V. FAMILY HISTORY

Please indicate ☑ on the chart below for anyone in the family who has had any of the problems listed.

	Other Children	Child's Father	Child's Mother	Father's Family	Mother's Family
1. Depression/psychiatric	☐	☐	☐	☐	☐
2. Alcohol problems	☐	☐	☐	☐	☐
3. Drug problem	☐	☐	☐	☐	☐
4. In trouble with the law	☐	☐	☐	☐	☐
5. Seizures/convulsions	☐	☐	☐	☐	☐
6. Neurological disease	☐	☐	☐	☐	☐
7. Cerebral palsy	☐	☐	☐	☐	☐
8. Muscle tics/twitches	☐	☐	☐	☐	☐
9. Thyroid disorders	☐	☐	☐	☐	☐
10. Genetic diseases	☐	☐	☐	☐	☐
11. Difficulty with right & left	☐	☐	☐	☐	☐

VI. PRESENT CHILD BEHAVIORS

Do you have concerns about your child's behaviors in any of the following areas?

	Yes	No		Yes	No
Lacks motivation	☐	☐	Nervous habits	☐	☐
Seems confused	☐	☐	Frustrated easily	☐	☐
Mean or nasty	☐	☐	Cruel to animals	☐	☐
Is a "loner"	☐	☐	Problems sleeping	☐	☐
Lacks self-confidence	☐	☐	Usually tired	☐	☐
Unusual interest in fires	☐	☐	Trouble with the police	☐	☐
Not liked by others	☐	☐	Uses foul language	☐	☐
Intentionally injures self	☐	☐	Frequent physical complaints	☐	☐
Sucks thumb or objects	☐	☐	Is overactive/"hyper"	☐	☐
Substance usage	☐	☐	Acts like child of opposite sex	☐	☐
Lies	☐	☐	Eats things that aren't	☐	☐
Fearless	☐	☐	food (dirt, paper, etc.)		

Do you have any concerns and/or information not listed above that would help us better assist your child?

_____

_____

_____

_____

_____

Signature of Parent/Guardian Date

_____

Signature of Evaluator Date

[insert school letterhead]

Office of the School Nurse

Social/Family/Medical History
Middle School

Dear Parent, The information you provide will help the Medically Related Services Department and school's Case Study Committee identify your child's needs.

I. FAMILY INFORMATION

CHILD'S

_____ _____ _____
Name Grade Birth date

First language: _____ Number of years in English-speaking schools: _____

Language(s) currently used at home: _____

FATHER'S

_____ _____ _____
Name (last, first) Age Occupation

Living in home ? Yes ❒ No ❒ Father's native language: _____

Relationship: Biological father ❒ Step-father ❒ Other ❒

MOTHER'S

_____ _____ _____
Name (last, first) Age Occupation

Living in home? Yes ❒ No ❒ Mother's native language: _____

Relationship: Biological mother ❒ Step-mother ❒ Other ❒

OTHER CHILDREN IN THE HOME

Name (last, first)	Age	Name of School

OTHER PERSONS LIVING IN THE HOME

Name	Age	Relationship

_____ _____ _____
_____ _____ _____

II. IDENTIFICATION OF CONCERNS

A. How do you think the school can best help your child? _____
_____

B. What are your child's strengths? _____
_____

C. Please list concerns you have about your child (be specific): _____
_____

D. Has your child had any serious medical illnesses or problems? ❒ NO ❒ YES

Please explain: _____
_____

E. Is your child on medication? ❒NO ❒ YES Name of medication: _____
Please explain purpose: _____

F. Please list your child's past evaluations and/or treatments provided by schools, physicians, clinics, counselors, or psychologists:

Date	**Where**	**What were the results?**
___/___/___	_____	_____
___/___/___	_____	_____

G. Has your child participated in any school programs? Yes ❒ No ❒
Special programs? Yes ❒ No ❒

Please explain: _____
_____

III. FAMILY HISTORY

Please indicate ☑ on the chart below for anyone in the family who has had any of the problems listed.

	Other Children	Child's Father	Child's Mother	Father's Family	Mother's Family
1. Hyperactive as a child	❒	❒	❒	❒	❒
2. Trouble learning to read	❒	❒	❒	❒	❒
3. Trouble with arithmetic	❒	❒	❒	❒	❒
4. Difficulty with coordination	❒	❒	❒	❒	❒
5. Difficulty with penmanship	❒	❒	❒	❒	❒
6. Left-hand dominance	❒	❒	❒	❒	❒
7. Speech/language problems	❒	❒	❒	❒	❒
8. Kept back in school	❒	❒	❒	❒	❒
9. Mental retardation	❒	❒	❒	❒	❒
10.Behavior problems as child	❒	❒	❒	❒	❒
11.Vision problems	❒	❒	❒	❒	❒
12. Hearing problems	❒	❒	❒	❒	❒

13. Birth defects	❒	❒	❒	❒	❒
None of the above apply	❒	❒	❒	❒	❒

IV. PREGNANCY AND BIRTH

Please recall the following as best you can:

	Yes	No	Comment
1. Was mother ill during pregnancy?	❒	❒	_____
2. Did mother take medication?	❒	❒	_____
3. Was the baby premature?	❒	❒	_____
4. Did the baby have trouble breathing?	❒	❒	_____
5. Was an extended hospital stay required?	❒	❒	_____
6. Was the baby's birth weight low/high?	❒	❒	Birth weight:_____
7. Were any birth injuries noted?	❒	❒	_____
8. Was the baby blue or jaundiced?	❒	❒	_____

V. MEDICAL HISTORY

If your child has had any of the following serious medical illnesses or problems, please indicate below.

Condition	Yes	No		Yes	No
Frequent ear infections	❒	❒	Dizziness	❒	❒
Frequent ear fluid	❒	❒	Heart disease	❒	❒
Hearing problems	❒	❒	Loss of consciousness	❒	❒
Allergies	❒	❒	Frequent sore throats	❒	❒
Fainting	❒	❒	Prolonged fever	❒	❒
Severe reaction to injection	❒	❒	Encephalitis	❒	❒
Swallowing problems	❒	❒	Severe reaction to medication	❒	❒
Drooling	❒	❒	Seizures/convulsions	❒	❒
Dental problems	❒	❒	Meningitis	❒	❒
Eye problems	❒	❒	Head trauma	❒	❒
Asthma	❒	❒	Accidents	❒	❒
Headaches	❒	❒	Poisoning/ingestions	❒	❒
Breath-holding spells	❒	❒	Low blood count/anemia	❒	❒
Awkwardness	❒	❒	Excessive bleeding	❒	❒
Weakness	❒	❒	Paralysis	❒	❒
Muscle problems	❒	❒	Emotional problems	❒	❒
Chronic cough	❒	❒	Tremors	❒	❒
Bronchitis	❒	❒	Tingling in hands/feet	❒	❒
Chronic diarrhea	❒	❒	Unusual walk, limp	❒	❒
Slow weight gain	❒	❒	Chicken pox	❒	❒
Kidney problems	❒	❒	Mumps	❒	❒
Genital problems	❒	❒	Measles	❒	❒
Joint problems	❒	❒	Scarlet fever	❒	❒
Arthritis	❒	❒	Whooping cough	❒	❒
Thyroid disease	❒	❒	Constipation	❒	❒
Chronic skin problems	❒	❒	Long-term separation	❒	❒

VI. DEVELOPMENTAL PROFILE

A. At what age did your child do the following:

_____ Roll over	_____ Smile responsively	_____ Use fingers to eat
_____ Reach for objects	_____ Babble	_____ Use utensil to eat
_____ Sit alone	_____ Wave bye-bye	_____ Undress self
_____ Crawl	_____ Say first word	_____ Dress self
_____ Walk alone	_____ Put words together	_____ Toilet train
_____ Walk upstairs	_____ Say 3-word sentences	_____ Button clothes

_____ Pedal a tricycle	_____ Say own name	_____ Tie shoes
_____ Skip	_____ Use pronouns	_____ Know some letters

B. Did your child exhibit any of the following during the first two years?

	Yes	No	Comment
1. Sleeping difficulties	❒	❒	_____
2. Rhythmic behaviors (rocking)	❒	❒	_____
3. Hard to comfort or console	❒	❒	_____
4. Floppiness (after 6 months)	❒	❒	_____
5. Stiffness	❒	❒	_____
6. Cried often and easily	❒	❒	_____
7. Not affectionate	❒	❒	_____
8. Poor eye contact	❒	❒	_____
9. Head banging	❒	❒	_____
10. Did not like being held	❒	❒	_____

VII. PRESENT CHILD BEHAVIORS

Do you have concerns about your child's behaviors in any of the following areas?

	Yes	No		Yes	No
Lacks motivation	❒	❒	Nervous habits	❒	❒
Seems confused	❒	❒	Frustrated easily	❒	❒
Mean or nasty	❒	❒	Cruel to animals	❒	❒
Is a "loner"	❒	❒	Problems sleeping	❒	❒
Lacks self-confidence	❒	❒	Usually tired	❒	❒
Unusual interest in fires	❒	❒	Trouble with the police	❒	❒
Not liked by others	❒	❒	Uses foul language	❒	❒
Intentionally injures self	❒	❒	Frequent physical complaints	❒	❒
Sucks thumb or objects	❒	❒	Is overactive/"hyper"	❒	❒
Substance usage	❒	❒	Acts like child of opposite sex	❒	❒
Lies	❒	❒	Stubborn	❒	❒
Fearless	❒	❒	Detention/suspension	❒	❒
Eats things that aren't food (dirt, paper, etc.)				❒	❒

Do you have any concerns and/or information not listed above that would help us better assist your child?

_____

_____

VIII. PARENTAL CONCERNS

Do you have current concerns about your child in any of the following areas?

	Yes	No		Yes	No
Has tantrums	❒	❒	Has trouble hearing	❒	❒
Is unable to accept limits	❒	❒	Favors one ear over other	❒	❒
Is aggressive	❒	❒	Has earaches	❒	❒
Clings to an adult	❒	❒	Speaks loudly or softly	❒	❒
Rarely smiles, giggles, laughs	❒	❒	Watches speaker's face	❒	❒
Doesn't play with other children	❒	❒	Rubs ears frequently	❒	❒
Doesn't separate from me easily	❒	❒	Has eyes that turn in/out	❒	❒
Will not work in a group	❒	❒	Squints	❒	❒
Is left out of group activities	❒	❒	Favors one eye over other	❒	❒
Has toileting difficulties	❒	❒	Holds things close to see	❒	❒
Difficulty following routine	❒	❒	Rubs his/her eyes	❒	❒
Feeding and dressing difficulties	❒	❒	Blinks a lot	❒	❒
Is easily distracted	❒	❒	Has visual problems	❒	❒
Darts from one activity to another	❒	❒	Has unclear speech	❒	❒
Persists when asked to stop	❒	❒	Difficulty expressing wants	❒	❒
Is clumsy	❒	❒	Uses incomplete sentences	❒	❒
Difficulty buttoning/zipping	❒	❒	Needs instructions repeated	❒	❒
Eye/hand coordination problems	❒	❒	Gives inappropriate answers	❒	❒
Poor control of body movement	❒	❒	Repeats what he/she says	❒	❒
Difficulty using crayons/scissors	❒	❒	Has very limited vocabulary	❒	❒
Difficulty writing letters	❒	❒	Is easily frustrated	❒	❒
Difficulty sitting through meal	❒	❒	Is extremely shy	❒	❒
Has unusual fears/nightmares	❒	❒	Demands attention	❒	❒
Can't tolerate change in routine	❒	❒	Frequently seems confused	❒	❒
Is very sensitive	❒	❒	Difficulty understanding		
Is stubborn	❒	❒	what is said to him/her	❒	❒

Other concerns: _____

_____

IX. ADDITIONAL INFORMATION

A. What types of group experiences has your child had? (e.g. daycare, preschool)
_____

B. Who cares for your child when he/she is not with you? _____

C. What type of play activities does your child enjoy? _____

D. What is your child's favorite toy? _____

E. What is your child's favorite food? _____
Does your child have a regular mealtime routine? Yes ❒ No ❒

F. How does your child get along with other children his/her age? _____

G. How does your child get along with brother(s) and sister(s)? _____

H. How does your child get along with parent(s)? _____

I. How does your child get along with other adults?_____

J. Is your child able to follow simple directions? (e.g., "Get your book.") Yes ❒ No ❒

K. Does your child have a regular bedtime routine? Yes ❒ No ❒
What time does your child go to bed? _____
Does your child sleep through the night? Yes ❒ No ❒

L. With whom does your child spend most of his/her time? _____
Primary language spoken by this individual? _____

M. What kind of activities does your child attend to the longest? (e.g., TV, story, blocks)_____

N. What after-school activities does your child participate in? _____

O. What household responsibilities does your child have? _____

RELEASE OF INFORMATION PERMISSION

I hereby authorize the release of the information on this form to school, medical personnel, or other agencies with a need to know.

_____
SIGNATURE OF PARENT OR GUARDIAN DATE

_____
SIGNATURE AND TITLE OF EVALUATOR DATE

[insert school letterhead]

Office of the School Nurse

Social/Family/Medical History
Preschool–Grade 5

Dear Parent, The information you provide will help the Medically Related Services Department and the school's Case Study Committee identify your child's needs.

I. FAMILY INFORMATION

CHILD'S

_____ _____ _____
Name Grade Birth Date

First language: _____ Number of years in English-speaking schools:_____

Language(s) currently used at home: _____

FATHER'S

_____ _____ _____
Name (last, first) Age Occupation

Living in home? Yes ☐ No ☐ Father's native language: _____

Relationship: Biological father ☐ Step-father ☐ Other ☐

MOTHER'S

_____ _____ _____
Name (last, first) Age Occupation

Living in home? Yes ☐ No ☐ Mother's native language: _____

Relationship: Biological mother ☐ Step-mother ☐ Other ☐

OTHER CHILDREN IN THE HOME

Name (last, first)	Age	Name of School
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER PERSONS LIVING IN THE HOME

Name	Age	Relationship
_____	_____	_____
_____	_____	_____

II. IDENTIFICATION OF CONCERNS

A. How do you think the school can best help your child?_____
_____

B. What are your child's strengths?_____
_____

C. Please list concerns you have about your child (be specific):_____
_____.

D. Has your child had any serious medical illnesses or problems? Yes ❒ No ❒
Please explain: _____
_____

E. Is your child on medication? Yes❒ No❒ Name of medication:_____
Please explain purpose:_____

F. Please list your child's past evaluations and/or treatments provided by schools, physicians, clinics, counselors, or psychologists:

Date	**Where**	**What were the results?**
____/____/____	_____	_____
____/____/____	_____	_____
Mo./ Day / Yr.		

G. Has your child participated in any school programs? Yes ❒ No ❒ Special programs? Yes ❒ No ❒
Please explain: _____
_____

III. FAMILY HISTORY

Please indicate ☑ on the chart below for anyone in the family who has had any of the problems listed.

	Other Children	Child's Father	Child's Mother	Father's Family	Mother's Family
1. Hyperactive as a child	❒	❒	❒	❒	❒
2. Trouble learning to read	❒	❒	❒	❒	❒
3. Trouble with arithmetic	❒	❒	❒	❒	❒
4. Difficulty with coordination	❒	❒	❒	❒	❒
5. Difficulty with penmanship	❒	❒	❒	❒	❒
6. Left-hand dominance	❒	❒	❒	❒	❒
7. Speech/language problems	❒	❒	❒	❒	❒
8. Kept back in school	❒	❒	❒	❒	❒
9. Mental retardation	❒	❒	❒	❒	❒
10.Behavior problems as child	❒	❒	❒	❒	❒
11.Vision problems	❒	❒	❒	❒	❒
12. Hearing problems	❒	❒	❒	❒	❒
13. Birth defects	❒	❒	❒	❒	❒
None of the above apply	❒	❒	❒	❒	❒

IV. PREGNANCY AND BIRTH

Please recall the following as best you can:

	Yes	No	Comment
1. Was mother ill during pregnancy?	❒	❒	_____
2. Did mother take medication?	❒	❒	_____
3. Was the baby premature?	❒	❒	_____
4. Did the baby have trouble breathing?	❒	❒	_____
5. Was an extended hospital stay required?	❒	❒	_____
6. Was the baby's birth weight low/high?	❒	❒	Birth weight:_____
7. Were any birth injuries noted?	❒	❒	_____
8. Was the baby blue or jaundiced?	❒	❒	_____

V. DEVELOPMENTAL PROFILE

A. At what age did your child:

_____ Roll over	_____ Smile responsively	_____ Use fingers to eat
_____ Reach for objects	_____ Babble	_____ Use utensil to eat
_____ Sit alone	_____ Wave bye-bye	_____ Undress self
_____ Crawl	_____ Say first word	_____ Dress self
_____ Walk alone	_____ Put words together	_____ Toilet train
_____ Walk upstairs	_____ Say 3-word sentences	_____ Button clothes
_____ Pedal tricycle	_____ Say own name	_____ Tie shoes
_____ Skip	_____ Use pronouns	_____ Know some letters

B. Did your child exhibit any of the following during the first two years?

	Yes	**No**	**Comment**
1. Sleeping difficulties	❒	❒	_____
2. Rhythmic behaviors (rocking)	❒	❒	_____
3. Hard to comfort or console	❒	❒	_____
4. Floppiness (after 6 months)	❒	❒	_____
5. Stiffness	❒	❒	_____
6. Cried often and easily	❒	❒	_____
7. Not affectionate	❒	❒	_____
8. Poor eye contact	❒	❒	_____
9. Head banging	❒	❒	_____
10. Did not like being held	❒	❒	_____

VI. PARENTAL CONCERNS

Do you have current concerns about your child in any of the following areas?

	Yes	**No**		**Yes**	**No**
Has tantrums	❒	❒	Has trouble hearing	❒	❒
Is unable to accept limits	❒	❒	Favors one ear over other	❒	❒

Is aggressive	❒	❒	Has earaches	❒	❒
Clings to an adult	❒	❒	Speaks loudly or softly	❒	❒
Rarely smiles, giggles, laughs	❒	❒	Watches speaker's face	❒	❒
Doesn't play with other children	❒	❒	Rubs ears frequently	❒	❒
Doesn't separate from me easily	❒	❒	Has eyes that turn in/out	❒	❒
Will not work in a group	❒	❒	Squints	❒	❒
Is left out of group activities	❒	❒	Favors one eye over other	❒	❒
Has toileting difficulties	❒	❒	Holds things close to see	❒	❒
Difficulty following routine	❒	❒	Rubs his/her eyes	❒	❒
Feeding and dressing difficulties	❒	❒	Blinks a lot	❒	❒
Is easily distracted	❒	❒	Has visual problems	❒	❒
Darts from one activity to another	❒	❒	Has unclear speech	❒	❒
Persists when asked to stop	❒	❒	Difficulty expressing wants	❒	❒
Is clumsy	❒	❒	Uses incomplete sentences	❒	❒
Difficulty buttoning/zipping	❒	❒	Needs instructions repeated	❒	❒
Eye-hand coordination problems	❒	❒	Gives inappropriate answers	❒	❒
Poor control of body movement	❒	❒	Repeats what he/she says	❒	❒
Difficulty using crayons/scissors	❒	❒	Has very limited vocabulary	❒	❒
Difficulty writing letters	❒	❒	Is easily frustrated	❒	❒
Difficulty sitting through meal	❒	❒	Is extremely shy	❒	❒
Has unusual fears/nightmares	❒	❒	Demands attention	❒	❒
Can't tolerate change in routine	❒	❒	Frequently seems confused	❒	❒
Is very sensitive	❒	❒	Difficulty understanding		
Is stubborn	❒	❒	what is said to him/her	❒	❒

Other concerns: _____

_____

IX. ADDITIONAL INFORMATION [AU: Correct numbering would make this section VII, not IX. Are there sections missing? If not, please correct number.]

A. What types of group experiences has your child had? (e.g., daycare, preschool)

_____

B. Who cares for your child when he/she is not with you? _____

C. What type of play activities does your child enjoy? _____

D. What is your child's favorite toy? _____

E. What is your child's favorite food? _____
Does your child have a regular mealtime routine? Yes ❒ No ❒

F. How does your child get along with other children his/her age? _____

G. How does your child get along with brother(s) and sister(s)? _____

H. How does your child get along with parent(s)? _____

I. How does your child get along with other adults?_____

J. Is your child able to follow simple directions? (e.g., "Get your book.") Yes ❒ No ❒

K. Does your child have a regular bedtime routine? Yes ❒ No ❒
What time does your child go to bed? _____
Does your child sleep through the night? Yes ❒ No ❒

L. With whom does your child spend most of his/her time? _____
Primary language spoken by this individual? _____

M. What kind of activities does your child attend to the longest? (e.g., TV, story, blocks)_____

N. What after-school activities does your child participate in? _____

O. What household responsibilities does your child have? _____

RELEASE OF INFORMATION PERMISSION

I hereby authorize the release of the information on this form to school, medical personnel, or other agencies with a need to know.

_____
SIGNATURE OF PARENT OR GUARDIAN DATE

_____
SIGNATURE AND TITLE OF EVALUATOR DATE

[insert school letterhead]

Office of the School Nurse

Social/Family/Medical History
Three-Year Review

Dear Parent, The information you provide will help the Medically Related Services Department and the school's Case Study Committee identify your child's needs.

I. FAMILY INFORMATION

CHILD'S

_____ _____ _____
Name Grade Date

_____ _____ _____
Birth Date Place of Birth Sex

First language: _____ Number of years in English-speaking schools: _____

Language(s) currently used at home: _____

FATHER'S

_____ _____ _____
Name (last, first) Age Occupation

Living in home? Yes ☐ No ☐ Father's native language: _____

Relationship: Biological father ☐ Step-father ☐ Other ☐

MOTHER'S

_____ _____ _____
Name (last, first) Age Occupation

Living in home? Yes ☐ No ☐ Mother's native language: _____

Relationship: Biological mother ☐ Step-mother ☐ Other ☐

OTHER CHILDREN IN HOME

Name (last, first)	Age	Name of School

OTHER PERSONS LIVING IN THE HOME

Name	Age	Relationship

II. UPDATE INFORMATION

A. Have there been any changes in the people who live in your home in the last three years? Explain. (e.g., new baby, marriage, illness, death)

_____

_____

B. How many moves has your child made in last three years? Explain.

_____

_____

C. Have there been periods of extended separation of family members in the last three years? Please explain.

_____

_____

D. Has your child or any family member had any significant illness or medical problem over the last three years?

_____

_____

E. Has your child received any additional services from other agencies other than the ones on his/her current IEP in the last three years?

_____

_____

F. Have you seen any major changes in your child's attitude, mood, general appearance, and/or social adjustment over the last three years?

_____

_____

G. Please list any other significant event(s) in your child's life over the past three years (e.g., death of family member or traumatic experience).

_____

_____

H. Other information or concerns that you would like to share?

_____

_____

_____ _____

Parent/Guardian **Date**

The above information was reviewed by _____ on _____.

WEEKLY LOG OF NURSING ACTIVITIES AUGUST 2001 H.11.1

Date: _____

Priorities: **1.** **2.** **3.** **4.** **5.**	**Wednesday: _____**
Monday: _____	**Thursday: _____**
Tuesday: _____	**Friday: _____**

Conference Log

Date	Time	Name	Problem	Action

[Insert School Letterhead]
Office of the School Nurse

SCHOOL HEALTH SERVICES SUMMARY

DATE: _____

Time Covered: Day ___ Week ___ Month ___ Quarter ___ Year ____

I. Health Supervision	**Number**	**Time Spent (minutes)**
A. Injured:	_____	_____
Ill:	_____	_____
B. Health consulting:	_____	_____
C. Special procedures:	_____	_____
D. Child abuse:	_____	_____
E. Medications:		
Initial instruction	_____	_____
Administration	_____	_____
Monitoring	_____	_____
F. Medical referrals:		
1. ADHD		
Initial referral	_____	_____
Follow-up	_____	_____
2. Asthma		
Initial referral	_____	_____
Follow-up	_____	_____
3. Medical		
Initial referral	_____	_____
Follow-up	_____	_____

G. Records:	**#Reviewed**	**#Recorded Time (minutes)**
Incoming	_____	_____
Outgoing	_____	_____
CSC	_____	_____
Medical	_____	_____
H. Health Conditions:		
Update	_____	_____
Notes	_____	_____
Calls	_____	_____

II. Screenings	#Referred	#Recorded	#Returned	Time (minutes)
Vision	_____	_____	_____	_____
Hearing	_____	_____	_____	_____
Ht. & Wt.	_____	_____	_____	_____
Blood pressure	_____	_____	_____	_____
Dental	_____	_____	_____	_____
Immunizations	_____	_____	_____	_____
Scalp/skin	_____	_____	_____	_____
Spinal	_____	_____	_____	_____
Communicable disease	_____	_____	_____	_____
Other	_____	_____	_____	_____

III. Health Education Activities	#Student	#Class	#Parent	#Staff	#Community
A. Planning	_____	_____	_____	_____	_____
B. Presenting	_____	_____	_____	_____	_____

IV. Meetings Attended	Number	Time Spent (minutes)
A. School		
Student Support Team	_____	_____
Child Study Committee	_____	_____
Crisis Intervention Team	_____	_____
Faculty	_____	_____
Wellness	_____	_____
Other	_____	_____
B. Community		
Community Red Cross	_____	_____
Health & Wellness	_____	_____
C. District		
Pupil Personnel Services	_____	_____
Nursing	_____	_____

V. Other Activities	Total	Time Spent (minutes)

School Nurse
End-of-Year Check-Out

1. Keys to medication cabinet are located in/at _____.
2. *School Health Services Guide,* DS Manual 2942.0, May 15, 1995, is located _____.
3. Health Master Main Program Manual is located _____.
4. School nurse file is located _____ and includes the following:
   - ✓ Student Health Conditions list, HO report #089 or Win School printout
   - ✓ Substitute folder
   - ✓ Community resources and phone numbers
   - ✓ Immunizations due next school year, HO report #157
   - ✓ Student Medication Prescription Summary, HO Report #061. Highlight names of students who will be returning and for whom new forms were sent home for anticipated medication administration next school year.
   - ✓ Vision, hearing, scoliosis, and dental referrals, list of
   - ✓ School Emergency Medical Response Procedure and phone numbers
5. Faculty first aid kits ready for 1st day of school are located _____.
6. Updated student health files are located _____. (List missing files.)
7. Confidential student folders returned from teachers and contents shredded.
8. Student health files for students transferring to the feeder school with copy of forwarded health concerns or immunizations needed are located _____. (Files should be purged for the receiving school of duplicate and/or no longer pertinent information.)
9. Health office supplies are in a safe place for use next year and are located _____.
   - ✓ Copy of supplies ordered during past school year from (a) local medical treatment facility and (b) catalogue venders.
   - ✓ List any new supplies needed/requested for next year use.
   - ✓ List any equipment turned in for repair over the summer. POC is _____.
   - ✓ List digital equipment being calibrated over the summer (scales, audiometer, other). POC is _____.
   - ✓ Provide wish list of equipment/supplies/materials needed for health service office.
   - ✓ Return any sharps containers for clinic disposal.
   - ✓ Return medication not picked up before nurse leaves for summer break to local medical treatment facility for disposal.
10. District school nurse liaison and phone number _____.
11. School nurse contacts/school nurse mentors are (name and phone #'s)
    - ✓ _____.
12. Perform normal school checkout duties.

Leave completed checkout list and written information on the nurse's office desk and give copy to principal.

H.12 Miscellaneous Forms

[insert school year]

MEDICAL POWER OF ATTORNEY

In the event that my dependent (NAME) _____, is injured or becomes ill, necessitating immediate medical examination or care, while under the supervision of or while participating in any activities sponsored by [*insert school name*], I authorize and release to any agent or employee of [*insert school name*] to take my dependent to any U.S. military facility or any civilian hospital if deemed necessary by the above referenced individual.

I understand that the above named personnel of [*insert school name*] will use all diligent and reasonable efforts to contact my spouse or me. If personnel of [*insert school name*] or the U.S. treatment facility can contact neither my spouse nor me after reasonable attempts, I authorize and release any physician or other qualified medical personnel to examine my child. I authorize any and all emergency care necessary for treating injuries or illness involving immediate danger to life or limb of my dependent. I further authorize non-emergency care and necessary treatment such as suturing superficial lacerations; treating colds, minor allergies, and minor gastro-intestinal upsets; splinting sprains; casting uncomplicated fractures; or other similar treatments.

MEDICAL INFORMATION ABOUT THE ABOVE NAMED DEPENDENT (to be completed by parent/guardian) for the purpose of sharing information with teachers and health care personnel on a need- to-know basis.
My dependent has the following medical problems (such as diabetes, seizures, asthma, heart and kidney disease):
_____

My dependent is allergic to the following: _____

My dependent takes the following medications on a regular and/or "as needed" basis (list name, amount, and

purpose of each medication): _____

Date of last tetanus booster: _____

EMERGENCY CONTACT INFORMATION (to be completed by parent)

Sponsor's home address: _____ Home phone #: _____

Sponsor's name: _____ Rank: _____

Sponsor's unit: _____ Work phone #: _____

Spouse's name: _____ Work phone #: _____

Cell phone #1: _____ Cell phone #2: _____
Other names and phone numbers to use in case of emergency if parents/guardians are unavailable:
_____
_____

Additional comments: _____

I AGREE TO NOTIFY THE SCHOOL IMMEDIATELY OF ANY CHANGES IN THE ABOVE INFORMATION.

Signature of Parent/Guardian_____ Date _____
Sponsor's Social Security Number _____-_____-_____
Are you a civilian "Pay Patient"? _____ Yes _____ No

PRIVACY ACT NOTICE: AUTHORITY: Title V, Sec. 301. PRINCIPAL PURPOSE: To refer to emergency medical facilities in parents'/guardians' absence. ROUTINE USES: (a) To obtain emergency medical care when parents cannot be reached; (b) To provide emergency contact names; (c) To supply health and medical information about student. This form is used by DoDEA employees and trained medical personnel in emergency. Social Security number of sponsor is required by military medical facilities in case of emergency referral. MANDATORY/VOLUNTARY DISCLOSURE/EFFECT OF NONDISCLOSURE: Mandatory. School personnel will not be able to provide emergency care and health services in parents' absence.

AUTHORIZATION FOR MEDICAL CARE OF DEPENDENT

In the event that my dependent _____ (full legal name) is injured or becomes ill and needs medical examination or care while under the supervision of a Department of Defense Dependents Schools (DoDDS) employee or while participating in any activity sponsored by a DoDDS Japan District high school (see above), I authorize and release my dependent to care by any U.S. military medical treatment facility, or if none are available, by the closest civilian hospital that can provide the required medical care.

DoDDS representatives will use all diligent and reasonable efforts to contact the dependent's legal guardians prior to emergency treatment. If the DoDDS representative and or the military medical treatment facility cannot contact the sponsor or sponsor's spouse after reasonable efforts, I hereby authorize and release the attending physician and/or any other qualified medical personnel to examine my dependent and initiate care for my dependent if necessary. I authorize any emergency care deemed necessary by the attending physician and/or qualified medical personnel for treatment of injuries or illness involving immediate danger to life or limb or possible permanent injury to my dependent. I also authorize non-emergency care as necessary (e.g., suturing lacerations, splinting sprains, casting uncomplicated fractures, treating colds, allergies, and minor gastro-intestinal illnesses).

Dependent's Medical Information (completed by sponsor and reviewed by school nurse). My dependent has the following medical problems:

_____

My dependent is allergic to the following:

_____

My dependent is currently taking the following medications:_____

Date of last tetanus booster: _____ Date/location of sports physical: _____

Sponsor Emergency Contact Information (completed by sponsor).
Full legal name: _____ SSN: _____
Home telephone_____ Duty telephone:_____
Cell phone: _____Spouse duty telephone:_____

Emergency contact (if sponsor is unavailable) Name: _____
Telephone: _____ Cell phone: _____

DoDDS Information. The following personnel are authorized to make medical care decisions regarding emergency and non-emergency medical care of my dependent. They are responsible for the physical health of my dependent and are authorized to represent me and approve medical treatment.

_____ _____ _____
Activity Sponsor Chaperon Chaperon/Activity Sponsor

_____ _____
School Nurse School Principal

It is my understanding that the DoDDS representative will carry a copy of this authorization letter at practices, rehearsals, when traveling, and at games and other competitions (original kept on file with school nurse).

_____ _____ _____
Sponsor Signature Date Spouse Signature (optional) Date

SPORTS PHYSICAL AUGUST 2001 H.12.3

APPLICATION TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS
MEDICAL CERTIFICATE TO BE COMPLETED BY EXAMINING PHYSICIAN

STUDENT'S NAME (LAST, FIRST, M.I.)	SCHOOL	GRADE

DATE OF BIRTH	HOME PHONE	SPONSOR'S DUTY PHONE

STUDENT'S APPLICATION

I AGREE TO NOTIFY MY SPORTS COACH OF ANY CHANGES IN MY HEALTH STATUS, TO INCLUDE ANY MEDICATIONS I MAY TAKE OR STOP TAKING. THIS APPLICATION TO PARTICIPATE IN ATHLETICS AT THE ABOVE SCHOOL IS MADE WITH THE UNDERSTANDING THAT I HAVE NEVER RECEIVED ANY MONEY FOR PARTICIPATION IN ATHLETIC EVENTS AND THAT I HAVE NEVER COMPETED UNDER AN ASSUMED NAME. AFTER I HAVE REPRESENTED MY SCHOOL IN ANY SPORT, I PROMISE NOT TO COMPETE IN ANY OUTSIDE ATHLETIC CONTEST IN THIS SPORT UNTIL AFTER THE SCHOOL SEASON HAS BEEN COMPLETED.

KEEP IN SCHOOL FILE

DATE	SIGNATURE OF STUDENT

PARENT OR GUARDIAN PERMISSION

I HEREBY GIVE MY CONSENT FOR THE ABOVE STUDENT TO HAVE A MEDICAL EXAMINATION (SPORTS PHYSICAL) PERFORMED BY LOCAL U. S. MILITARY HOSPITAL/CLINIC PERSONNEL, TO ENGAGE IN INTERSCHOLASTIC ATHLETICS AT THE ABOVE SCHOOL IN THE APPROVED SPORT(S) CHECKED BELOW, AND TO ACCOMPANY THE TEAM AS A MEMBER ON ITS SCHEDULED TRIPS.

DATE	PRINTED NAME OF PARENT OR GUARDIAN	SIGNATURE OF PARENT OR GUARDIAN

MEDICAL CERTIFICATE TO BE COMPLETED BY EXAMINING PHYSICIAN

	YES	NO
General health is satisfactory?		
Is visual correction required for competition? Glasses/Contacts Visual acuity: right /left Tested with/without correction		
Is there a bridge or false teeth?		
Are immunizations current? If no, list immunizations received.		
Are there health problems that should be evaluated or treated before participating in competitive sports? Explain:		
Is applicant's blood pressure normal? BP / Pulse		
Are there medical conditions that may affect participation? (e.g., asthma, diabetes) Please advise:		
Are there medications that may be required for participation? If so, please complete medication form.		

	Basketball		Golf		Wrestling
	Baseball		Gymnastics		Volleyball
	Cross Country		Soccer		
	Cheerleading		Swimming		Other:
	Field Hockey		Tennis		
	Football		Track and Field		

I have examined _____ and find him/her to be physically able to compete in the supervised athletic activities checked above. This certificate is valid for one year from date indicated below.

DATE	PRINTED NAME OF EXAMINING PHYSICIAN	SIGNATURE OF EXAMINING PHYSICIAN

INFANT, CHILD AND ADOLESCENT HEALTH ASSESSMENT

DATA REQUIRED BY THE PRIVACY ACT OF 1994

PRINCIPAL PURPOSE: Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedures for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program. **ROUTINE USES:** No information is disclosed outside DOD. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.

NAME OF SPONSOR	DEROS	TELEPHONE (HOME)	TELEPHONE (DUTY)

SPONSOR UNIT ADDRESS	SPONSOR SSN	SPOUSE'S WORK PHONE

CHILD HEALTH INFORMATION (SPONSOR)

NAME OF CHILD	BIRTH DATE	SEX

HAS YOUR CHILD BEEN UNDER THE SUPERVISION OF A PHYSICIAN? (IF YES EXPLAIN CIRCUMSTANCES AND CURRENT STATUS)

IS CHILD ENROLLED IN EXCEPTIONAL FAMILY MEMBER PROGRAM NO / YES LAST UPDATE:

IMMUNIZATIONS

	DATE	DATE	DATE	DATE	DATE	DATE
DTP/DTaP						TD
HIB						PPD
POLIO						
HEP B				INFLUENZA		
MMR			HEP A			
VARICELLA			OTHER			

MEDICAL HISTORY

	YES	NO		YES	NO
1. ANY HOSPITALIZATION OR OPERATIONS			14. HEAT STROKE OR EXHAUSTION		
2. ALLERGIES TO MEDICINE OR INSECT BITES			15. BROKEN BONES OR SPRAINS		
3. SPEECH OR DEVELOPMENTAL DELAYS			16. JOINT INJURIES (ANKLE / KNEE / WRIST)		
4. VISION PROBLEMS (GLASSES / CONTACTS?)			17. REQUIRED RESTRICTED PHYSICAL ACTIVITY		
5. EAR OR HEARING PROBLEMS			18. FAMILY HISTORY OF DEATH LESS THAN AGE 40		
6. SEIZURES OR CONVULSIONS			19. FAMILY HX OF HEART DISEASE/STROKE < AGE 55		
7. DIZZINESS OR FAINTING WITH EXERCISE			20. FAMILY HX OF HIGH CHOLESTEROL		
8. HEADACHES			21. FAMILY HX OF CANCER		
9. HEAD INJURY OR LOSS OF CONSCIOUSNESS			22. DENTAL OR ORTHODONTIC BRACES		
10. NECK OR BACK INJURY			23. CHICKEN POX (IF YES, DATE:)		
11. ASTHMA OR DIFFICULTY BREATHING			24. ROUTINE OR DAILY MEDICATIONS (LIST BELOW)		
12. HEART OR BLOOD PRESSURE PROBLEMS			25. FEMALES: AGE OF FIRST PERIOD:		
13. CHEST PAIN WITH EXERCISE			26. OTHER PROBLEMS (LIST BELOW):		

IF YOU ANSWER YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:

I GIVE PERMISSION FOR MY CHILD TO HAVE THE FOLLOWING DONE:	YES	NO
1. RECEIVE A PPD (SKIN TEST FOR TUBERCULOSIS)		
2. RECEIVE ANY IMMUNIZATION(S) NECESSARY		
3. RECEIVE A HEALTH SCREEN EXAMINATION FOR SPORTS/SCHOOL/SCOUTS/CDS/OTHER		
4. RECEIVE EMERGENCY MEDICAL CARE DURING SCHOOL OR ORGANIZATIONAL ACTIVITIES INCLUDING CDS		

TYPED OR PRINTED NAME OF PARENT OR GUARDIAN	SIGNATURE OF PARENT OR GUARDIAN

MEDICAL STAFF ASSESSMENT (FILLED OUT BY PHYSICIAN ONLY)

AGE: YRS MOS	HEIGHT: cm.(%ile)	WEIGHT: kgs.(%ile)	BP: / P
	HEIGHT: in.	WEIGHT: lbs.	

VISUAL ACUITY: RIGHT /LEFT /TESTED WITH / WITHOUT LENSES NORMAL ☐ ABNORMAL ☐

	NORMAL	ABNORMAL	N/A	COMMENTS
1. EYES				
2. EARS, NOSE & THROAT				
3. HEARING				
4. MOUTH AND TEETH				
5. NECK (SOFT TISSUES)				
6. CARDIOVASCULAR				
7. CHEST AND LUNGS				
8. ABDOMEN				
9. GENITALIA - HERNIA				
10. SKIN AND LYMPHATICS				
11. NECK				
12. SPINE - SCOLIOSIS				
13. EXTREMITES				
14. NEUROLOGICAL				

15. SEXUAL MATURITY RATING: BREASTS> PUBIC HAIR> MALE GENITAL> FEMALE GENITAL>

BASED ON THIS HX & PX EXAM, THE FOLLOWING ABORMALITIES WERE FOUND AND MAY NEED TREATMENT:

ANTICIPATORY GUIDANCE (CHECK ITEMS DISCUSSED)

☐	NUTRITION	☐	DENTAL CARE	☐	HEADSS	☐	
☐	AGE APPROPRIATE SAFETY	☐	BEHAVIOR	☐		☐	
☐	DEVELOPMENT	☐	RISK FACTORS	☐		☐	

PARTICIPATION RECOMMENDATIONS

☐ NORMAL SCHOOL ACTIVITIES INCLUDING PE

☐ CHILD DEVELOPMENT / YOUTH SERVICES

☐ COLLISION SPORTS

☐ CONTACT SPORTS

☐ NON-CONTACT SPORTS

☐ SCOUTS

THIS STUDENT HAS HEALTH PROBLEMS WHICH WOULD PROHIBIT HIM OR HER FROM PARTICIPATING IN COMPETITIVE ATHLETICS:

☐ NO

☐ YES

THE FOLLOWING HEALTH PROBLEMS SHOULD BE EVALUATED OR TREATED PRIOR TO PARTICIPATING IN COMPETITIVE SPORTS:

THIS DOCUMENT IS VALID FOR 1 YEAR FROM DATE INDICATED BELOW

DATE PHYSICIAN STAMP PHYSICIAN SIGNATURE

SECTION I
Information Sheets

Childhood Immunization Schedule, Recommended

For the most up-to-date schedule, see www.cdc.gov.nip

STUDY TRIP FIRST AID

SCHOOL PHONE:

AMBULANCE:

MILITARY POLICE PHONE:

BLEEDING:
1. PUT ON GLOVES and then clean the area with soap and water.
2. Apply a bandage.
3. For continued bleeding, apply direct pressure for 5–10 minutes.
4. For uncontrollable bleeding, summon help.

NOSEBLEEDS:
1. Apply direct pressure for 5 minutes using thumb and index finger against both sides of the nose.
2. Encourage the student to not swallow the blood.
3. Keep head upright.

SEIZURES:
1. Help the student to lie down on the floor.
2. Turn the head to one side.
3. DO NOT put anything in the student's mouth.
4. Note length of the seizure, nature of movement, level of consciousness.

FOREIGN OBJECTS IN EYE:
1. Have the student blink rapidly for a few seconds.
2. If discomfort persists, flush the eye with clean water.
3. Encourage the student NOT TO RUB THE EYE.

FAINTING/DIZZINESS:
1. Help the student put his/her head down below the heart.
2. Monitor breathing and level of consciousness.
3. If symptoms persist, summon help.

ASTHMA ATTACK:
1. Student may experience shortness of breath, wheezing, and coughing and may express the need to use an inhaler.
2. If needed, assist the student with use of inhaler.
3. Keep calm, reassure the student, and allow the student to rest.
4. If no relief, seek further medical assistance.

STRAIN/SPRAIN/CONTUSION:
If possible, elevate the area. Apply a cold pack—ALWAYS use several layers of clothing or padding between the cold pack and the student's skin.

Before administering medications . . .

STOP AND READ!

⇒ Is this the right ***student***? Ask the student his or her name.

⇒ Is this the right ***medicine***? Check the bottle for the student's name.

⇒ Is this the right ***dosage***? Check the pharmacy label with the information on the Medication Log. If there is a discrepancy, do not administer the medication. Contact the school nurse.

⇒ Is this the right ***time***? Most medications may be administered up to one hour before or after the time listed on the label. Contact the school nurse if there is a longer time discrepancy.

⇒ Is this the right ***route***? Pour oral medication in the cup and give to the student. Administer inhaled medication through a spacer.

After medication has been properly administered, the medication log ***MUST*** be initialed in the correct date block and signed in the signature block.

**** Students' daily Peak Expiatory Flow Rate should be noted on the flow sheet and medications administered accordingly. ****

[INSERT SCHOOL LETTERHEAD]
OFFICE OF THE SCHOOL NURSE

GUIDELINES FOR SAFE ADMINISTRATION OF DAILY MEDICATIONS IN THE ABSENCE OF THE SCHOOL NURSE

These policies/guidelines are to ensure the safe and consistent administration of medication to students.

1. The only medications given at school are those that follow the DoDEA guidelines, published in the DoDEA *School Health Services Guide.*

2. The Student/Parent Handbook explains the policy and requirement for parents.

3. Only medications properly prescribed by a physician with the proper permission forms that match the pharmacy labels on the medication will be administered.

4. Under no conditions will over-the-counter medications be given.

5. All medications are stored in the locked cabinet. *[insert local locations]*

6. Children are not allowed to carry their own medication and self-medicate, except for students who have a completed "Student Permission for Self-Medication" form on file.

7. Document all medication administered, using *[insert local procedure].*

MEDICATION ADMINISTRATION

1. When preparing and administering medications, devote your full attention to the job. DO NOT become distracted by answering the phone or talking to students, etc.
Medication errors are common when full attention is not given to preparing and administering the correct medication for the correct student.

2. Check the medication log for the names of students taking medication and the times the medication must be given at school. Read the information in the SUB FILE about the signs and symptoms of adverse reactions for the medications you will be giving.

3. Prepare the medications prior to the time the first medication is to be given.

4. The students should come automatically to get their medications at the appropriate times. If a student does not show up at the appropriate time, *[insert local procedure]*.
Document when students are absent by *[insert local procedure]*.

5. Procedure:

IT IS IMPORTANT TO REMEMBER ***"FIVE RIGHTS OF MEDICATION":***

RIGHT MEDICATION
RIGHT DOSE
RIGHT PERSON
RIGHT ROUTE OF ADMINISTRATION
RIGHT TIME

IT IS IMPORTANT TO READ THE LABEL ON THE CONTAINER *THREE TIMES:*

ONCE WHEN YOU TAKE THE CONTAINER FROM THE SHELF
ONCE WHEN YOU POUR THE MEDICATION (i.e., take it from the container)
ONCE WHEN YOU REPLACE THE CONTAINER ON THE SHELF

6. Secure the medicine cabinet after each medication is given.

7. NEVER ACCEPT AND/OR GIVE NEW MEDICATIONS UNLESS A REGISTERED NURSE IS AVAILABLE TO CHECK THE DOCTOR'S ORDERS AGAINST THE CONTAINER FOR ERRORS.

8. Handle "PRN" (as needed) medications with the same caution as daily medications. These medications are recorded *[insert local procedure].*

*******REFER TO FORM "MEDICATION INSERVICE," H.3.10*******

GUIDELINES FOR SUBSTITUTES AND OTHER PERSONNEL ASSIGNED TO WORK IN THE SCHOOL HEALTH OFFICE WHO ARE *NOT* NURSES

DO THE FOLLOWING:

- Notify the principal of any major health care concerns.
- Keep a record of all students who come into the health room, including the date, time, reason for the student's visit, and what you did for the student.
- Attempt to obtain a history of events leading up to the injury or illness that the student reports to you. Complete DoDEA forms when appropriate, such as accident reports.
- Provide first aid in accordance with the DoDEA *School Health Services Guide* and skills learned in Red Cross First Aid and CPR courses. Be sure to keep Red Cross certifications current.
- Call parent for any of the following:
    - Any illness or injury you believe is a cause for concern
    - Eye, ear, or teeth injuries
    - Head injury
    - Second- or third-degree burns
    - Severe pain
    - Sprains or possible fractures
    - Temperature higher than 100°
    - Vomiting
    - Wounds that may require stitches
- Give medications ONLY after the school nurse has trained you. Follow the **GUIDELINES FOR SAFE ADMINISTRATION OF MEDICATIONS** that you learned during your medication inservice. Refer to instructions as needed.
- Check all medications to make sure you have written parent permission, a container properly labeled by the pharmacy, and written instructions signed by the doctor. The pharmacy label and the doctor's instructions MUST MATCH IN ALL OF THE FOLLOWING AREAS:
    - Student's name
    - Doctor's name
    - Medication's name
    - Amount of medication to give
    - Time to give the medication

  If any of the above do not match, return the medication to the parent to take back to the clinic for corrections.
- Contact the parent/guardian first. If you are still unable to reach the parent, try the emergency contact number or go through the sponsor's commander.
- Send the student back to class if his/her temperature is below 100° and no other serious symptoms are evident. Instruct the student to come back to the health room if he/she continues to feel sick.
- Send a note home with the student if you have been unable to contact the parent regarding an illness or injury. Keep a copy of the note.

- Respect confidentiality of information obtained from students and families regarding an illness, injury, diagnosis, or medical treatment.

- Share information with the principal and/or the counselor whenever there is a risk to the student or a specific law or policy requires such reporting. Such situations include child abuse or neglect, suicidal thoughts or actions, possession of controlled substances, assault to others, theft, runaway, etc.

- Refer chronic health problems to the school nurse or the local military medical facility when the school nurse is not available.

- Be honest with the students, parents, and teachers with whom you have contact. Tell them that you are NOT a nurse, but that you will try to help them to the best of your ability.

FOR THE SAFETY OF STUDENTS AND TO PROTECT YOUR OWN LIABILITY:

- **DO *NOT*** make a diagnosis or prescribe treatment or medication.

- **DO *NOT*** give medical advice.

- **DO *NOT*** take on the role of a counselor. (Refer student to the appropriate school personnel: counselor, school psychologist, and school nurse.)

- **DO *NOT*** give or apply any medication unless it comes in a pharmacy-labeled container with written instructions from the doctor and written permission from the parent.

- **DO *NOT*** give or apply any new medications that have not first been checked by the school nurse.

- **DO *NOT*** accept new medications with alterations made by the parent on the pharmacy label or on the doctor's instructions.

- **DO *NOT*** give care beyond basic first aid for which you have current certification from the Red Cross.

- **DO *NOT*** perform any health procedures for which the state would require the performer to have an RN license, or anything that requires more than a clean procedure.

- **DO *NOT*** perform tasks or take responsibilities that will jeopardize the health of others or your own liability.

- **DO *NOT*** transport sick or injured students in your privately owned vehicle.

PLEASE POST

MEDICAL EMERGENCY PROCEDURES

All school staff have the responsibility to respond to medical emergencies as quickly and efficiently as possible. To provide prompt action during an emergency, the following people will assume the following responsibilities:

A. **Teacher** or Other **Adult** Observing an Incident

- Stay with the victim and remain calm.
- Immediately phone the nurse and the Main Office or send two responsible students (one to the Health Office and one to the Main Office). Ask the student messengers to request the help of the school nurse and the administrator.
- Continue to remain with the victim; give first aid as appropriate; direct students at the scene as needed.
- When the nurse and administrator arrive, escort the class away from the scene, if desirable.

B. **Nurse**

- Go directly to the scene of the accident or problem and assume leadership in administrating first aid and in directing people at the scene.
- After a quick initial assessment, determine if an ambulance is needed. If an ambulance is needed, send a student runner or adult to the Main Office to request an ambulance.
- Notify parents of the incident as soon as possible after giving emergency care.
- Complete the Accident Report. Follow up on cases, prevention, etc.

C. **Main Office Secretary**

- Notify the administration of the incident and location. Relay the message that a request for immediate help has been made.
- Send an administrator to the scene to help the nurse as needed.
- Send a student messenger back to the scene to relay that help is on the way.
- Stand by in the Main Office for messages from the nurse/administrator via runners.
- If the nurse requests an ambulance via messengers,

PHONE FOR AN AMBULANCE IMMEDIATELY BY DIALING _____.

- Be sure to instruct emergency personnel regarding the reason for the call, exact location of the incident, best means of reaching the scene, etc.
- Send a message to the accident scene that the ambulance call has been made.
- Send an administrator to meet the ambulance and to direct emergency personnel to the accident scene.
- Continue to communicate to the accident scene via runners as needed.

D. **Administrators**

- Go to the scene of the accident and assist as able with first aid and in controlling the crowd.
- Provide whatever support is needed to help the nurse with the emergency.
- If the nurse is not in the building, request help from the nurse at_____.
- Follow up on recommendations on the Accident Report for prevention of future occurrences.

[Insert school letterhead]
Office of the School Nurse

STATEMENT OF CONFIDENTIALITY AGREEMENT

As a volunteer assigned to work with the school nurse, I _____, understand that all health and medical information, whether verbal or written, is confidential. I agree to treat all health information with the highest respect and will not discuss or repeat any information that I learn about a child's health, medical, or psychosocial status except as directed by the school nurse.

Volunteer Assistant's Printed Name: _____

Volunteer Assistant's Signature: _____

Nurse's Signature: _____ Date: _____

Professional Library

The professional library of every DoDEA nurse should include the following references:

1. Vision Screening Guideline for School Nurses
   (National Association of School Nurses)

2. The Ear & Hearing: A Guideline for School Nurses
   (National Association of School Nurses)

3. Postural Screening Guidelines for School Nurses
   (National Association of School Nurses)

4. Overview of School Health Service (Third Edition)
   (National Association of School Nurses)

5. Quality Nursing Interventions in the School Setting: Procedures, Models, and Guidelines
   (National Association of School Nurses)

6. Clinical Guidelines for School Nurses/School Health Alert
   (School Health Alert) *This is in Section G in DoDEA Nurse's Manual.*

7. Clinical Guidelines in Child Health
   (Barmarrae Books)

8. The School Nurses Source Book of Individualized Healthcare Plans
   (Sunrise River Press)

I.9 Communicable Disease Chart

Communicable Disease Control

A communicable disease is any illness or disorder transmitted from a person or an animal to another person directly by contact with excreta or discharges from the body, or directly by substances or inanimate objects. Many communicable diseases are present at any given time whenever children are in close proximity of each other, as in schools. Students in close contact with each other should be observed routinely for signs and symptoms of communicable diseases. When a suspected communicable disease is observed, that student should be referred to the school nurse for assessment. After assessment, notification should be made to the student's primary provider, the teacher, and the principal if the illness is a suspected "reportable" communicable disease. As part of a preventative health program, the primary provider and the teacher should be given exclusion and readmittance parameters. Periodic information from the school to parents/community regarding the signs and symptoms, treatment, and exclusion and readmittance criteria for the more common "childhood" communicable diseases will help to foster the home-school partnership bond and alleviate fears and uncertainties within the community.

The school nurse should coordinate with the local medical treatment facility regarding communicable diseases, their signs and symptoms, treatment, and parameters for readmittance to school.

At all times the privacy of the student and his or her family should be of the utmost importance. Faculty and staff may need to be reminded that this information is confidential and is being shared with them on a need-to-know basis.

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Communicable Disease Control

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COMMUNICABLE DISEASE CHART

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
Fifth Disease (Erythema Infectiosum)	1–2 weeks.	Most contagious just before onset of fever, gradually declining during the following week, and low to absent by the time the rash appears. Disease often occurs in late winter and spring, so Dx may be suspected in pre-rash infective stage if it has occurred in other family members. These children should not be in school.	Fever, malaise, headache, "slapped-face" erythema of cheeks, lace-like rash on arms, trunk, chest, thighs, extremities. Rash may recur 1–3 weeks or longer if exposed to sunlight or heat; arthritis may be a complication. Fifth disease may be subclinical.	Watch those most likely to have complications. (Persons with anemia or immuno-deficiencies and non-immune pregnant women may choose to avoid exposure to contacts. They should be advised to consult with their physician.)	Droplets of respiratory secretions or secondarily by hands.	Exclude until fever free for 24 hours. Emphasize importance of hand washing. Concern for immuno-suppressed persons. Pregnant women who become infected in the first 4–5 months are at risk for spontaneous abortion. Advise pregnant staff to consult their doctor.	See pages 57 and 99 in CLINICAL GUIDELINES.
Chicken pox (Varicella zoster virus)	Average 14–16 days for new exposures.	day before to about 6 days after lesions appear. May be prolonged in altered immunity.	Slight fever and eruptions progress from red bumps to small blisters and pustules to crusts. All forms of rash may be seen at the same time.	Observe for eruptions during incubation period.	Airborne respiratory, i.e. directly from person to person through discharges of nose and throat.	Exclude at least 5 to 7 days or until all pustules are dry, longer for immuno-compromised persons. Exclude immuno-supressed children who are	See page 99 of CLINICAL GUIDELINES.

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
						non-vaccinated with negative hx. during outbreaks.	
Chlamydia (Chlamydia trachomatis)	If symptoms occur, they usually appear within 1–3 weeks of exposure.	Untreated sexual partner transmits the bacteria during vaginal, anal, or oral sex. Highly contagious, immediate infection.	"Silent disease"—75% of women and 50% of men have no symptoms. Most infected people are not aware of their infection. Untreated men may have urethral infection and swollen and tender testicles. Women may have vaginal discharge or burning sensation with urination. With infection spread there may be pain, nausea, and bleeding. Permanent and irreversible damage can occur. Screening yields definitive diagnosis.	Sexual contacts.	Sexually transmitted (acquired) bacterial infection.	Treat with antibiotics. If untreated, causes severe reproductive and other health problems including pelvic inflammatory disease (PID). Critical link to infertility and tubal pregnancy. May also cause adverse outcomes of pregnancy (neonatal conjunctivitis and pneumonia).	See CDC GUIDELINES 2001.
Conjunctivitis, bacterial (Pink or red eye)	24–72 hours.	Until discharges and symptoms have cleared.	Redness of sclera with tearing and irritation, swelling of lid, sensitivity to light, and thick purulent	Observe for symptoms.	Contact with eye discharges and articles soiled with discharge. Contagious, but transmitted less	Exclude until completion of 24-hr. effective treatment with ophthalmic solution, until	See page 95 of CLINICAL GUIDELINES.

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
			discharge with crusting during sleep. Itchiness may be present.		easily than viral form.	discharge and signs of infection have cleared. Hand washing.	
Head Lice (Pediculosis capitis)	The louse cycle: Eggs (nits) hatch in 7–10 days; the female is able to lay eggs 10 days later and has a life span of 30 days. Adults can survive 1–2 days off a human host.	Contagion remains possible as long as louse or nits are present on infected persons. Both the nymphs and adult lice feed on human blood.	Lice don't carry disease, but a sensitivity or allergic reaction to the saliva of the louse's biting the scalp causes itching. Scratching the scalp can result in secondary skin infection and enlarged lymph nodes. Newly laid nits are 3–4 mm from the scalp, and the egg casings may stay on the hair as it grows. Over an inch, it is likely a casing of an already hatched louse.	Observe for presence of nits or lice. Treat household and personal contacts if findings positive.	Direct contact with infested person, linens, brushes, hats, and scarves. Head-to-head contact; fabric items may be considered direct contact. Non-fabric items are low risk, such as headphones, solid helmets, and vinyl headrests. These should be cleaned for general hygiene.	Personal treatment: non-prescription lice shampoos (e.g., RID, Nix, A200. Pronto, R&C) and generic equivalents kill lice but not all nits. They must be used as directed on dry hair, not previously conditioned. Ideally all nits should be removed. If not, reshampooing in 7–10 days is necessary to kill newly hatched nymphs. Environmental treatment: Hot laundry (130° F for at least 5 minutes) and	See pages 83–86 of CLINICAL GUIDELINES.

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
						dryer for bed linen, night clothes, washable head wear, helmet liners, etc. Dry cleaning or storage in a bag for 2 weeks of unwashable items. Hot water (130˚ F) soaking of combs and brushes. Fumigation or insecticide sprays are not advised; vacuuming is sufficient. Educate families to treat promptly so the infected child can return to school the same day, no later than the next day.	

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
Hepatitis A, B, C	A=2–6 weeks. B=1–6 months. C=7–9 weeks.	A=may be short. B=may be long. C=unknown.	When any one of the Hepatitis viruses invades the body, it affects the liver and produces similar symptoms, which may include rash, achy joints, fever, malaise, jaundice, dark urine, light stools, headache.	A=IG for close contacts, household members. Exposure at school not considered close contact. *Vaccine preventable. B=sexually transmitted disease. Drug users are at higher risk. 10% of infected people develop chronic disease and become carriers. *Vaccine preventable. C=associated with blood transfusion. Contaminated needle piercing and tattooing implicated. No vaccine currently available.	A=Fecal-oral, transmitted by food and water. Virus is shed in stool of infected person; blood and secretions may be infectious. B, C=Contact with blood and other body fluids.	Universal precautions. Physician referral. A=Immune globulin is protective if given within 10–14 days of exposure. Return to school as soon as fever, jaundice are over and appetite has returned. B=post-exposure prophylaxis (HBIG) is effective because of long incubation period. C=Mild clinical course. Most infections are lifelong without significant damage. Chronic liver infection can result in cancer or liver failure.	See pages 74–76 of CLINICAL GUIDELINES.

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
Herpes simplex, Type 2, Genital	First episode usually occurs within 2 weeks after the virus is transmitted.	Throughout period of sexual contact with infected partner, from viral shedding and herpes sores.	Most have no or minimal symptoms. When symptoms occur, they are blisters on or around the genitals or rectum. Blisters break, leaving sores that may take 2–4 weeks to heal on first occurrence. Outbreaks may occur, usually less severe than the initial episode.	Sexually transmitted disease. No school exclusion.	Direct sexual contact. Newborn baby may acquire infection during vaginal delivery if mother has active lesions.	Oral acyclovir prescribed to suppress painful lesions. There is no cure.	See page 77 of CLINICAL GUIDELINES; CDC GUIDELINES 2001.
Herpes Simplex, Type 1, Oral	First episode usually occurs within 2 weeks after virus is transmitted.	While lesion is active with virus-containing fluid.	Blister usually on or around, throat, lips, and facial areas. Blisters break, leaving crusted sores.	Transmitted by contact with fluids in the blisters.	Direct contact with fluid-containing blister.	Oral-base topical pain reliever. Cold compresses to reduce swelling. Applying petroleum jelly to infected area to prevent cracking.	See CLINICAL GUIDELINES IN CHILD HEALTH, 1999, pages 225–227.

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
HIV Human Immunodeficiency Virus Due to the complexity and changing status of this infection, school nurses should consult other available resources.	Variable.	Infected persons are considered contagious with direct/indirect contact.	Minimal to no symptoms present at infection.	Sexually transmitted disease by contact with infected blood, semen, vaginal fluid, and breast milk. See route of infection. No school exclusion.	Direct sexual contact with infected persons; sharing needles or syringes with infected persons; transfusions of infected blood. Babies born to HIV-infected women may become infected before or during birth or through breast milk. Condoms (latex), properly used, provide a degree of protection against HIV infection.	Due to the current advances in medical treatment and the constantly changing regimen of care, treatment modalities are not listed in this document.	See CDC GUIDELINES 2001.
Impetigo, Streptococci or Staphlococcus	4–10 days.	Until lesions are clear; usually 1 –2 weeks.	Blister-like lesions, which develop into pustules, most commonly on hands and face. May occur anywhere on body.	Emphasize personal cleanliness. Stress hand washing and avoidance of common use items.	Contact with discharge from lesions or articles soiled by discharges or nasal carriers.	Exclude for 24 hrs. and prescribe ointment or oral antibiotic for moderate to severe cases. Cover dressing is required for school attendance.	See page 79 of CLINICAL GUIDELINES.

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
Measles Rubeola Virus	8–12 days from exposure to onset of symptoms; for fever, 14 days for rash. **[AU: Please clarify. It's not clear if "14 days" is referring to fever or rash.]**	1–4 days before onset of fever to 2–4 days after appearance of rash.	High fever*, severe cough, coryza and conjunctivitis, deep red maculopapular rash; becomes confluent. Rash at end of 2nd or 3rd day during height of fever. Leukopenia. Symptoms are usually severe.	Observe and exclude those with fever, rash.	Respiratory droplets and less common airborne droplets; direct contact with nasal or throat secretions. *Vaccine preventable.	Exclude at least 5 days after rash unless unvaccinated; then exclude for 14 days after onset of symptoms. No specific antiviral therapy. Exposure is not a contra-indication to vaccination; if vaccinated within 72 hours of exposure, may provide some protection.	See page 99 of CLINICAL GUIDELINES.
Meningitis (Viral or bacterial infection) Streptococ-cus pneumoniae & Neisseria meningititis	Dependent upon pathogen.	Dependent upon pathogen.	High fever*, headache, and stiff neck (in children over 2 years old). May develop over several hours or 2 days. Symptoms may include nausea, vomiting, photophobia, confusion, and sleepiness.	Direct contact.	Some forms are contagious through exchange of respiratory and throat secretions (e.g., coughing, kis-sing). Other forms (N. men-ingitiis, HIB) spread by close contact with infected persons.	Dependent upon pathogen.	See CDC GUIDELINES 2001.

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
			Infants may appear inactive, irritable, or exhibit vomiting or feeding problems. May progress to seizures.				
Mumps Parotitis Paramyxovirus	May occur 14–25 days after exposure.	Three days before to the 4th day of active disease. Virus has been isolated from saliva 7 days before to 9 days after parotid swelling.	Fever*; swelling and tenderness of parotid (30-40%) or salivary glands; orchitis (testicular inflammation) usually unilateral in post-pubertal males (20%-50%) or oophoritis (ovarian inflammation) in post-pubertal females (5%)	Observe for symptoms.	Spread through respiratory droplet or direct contact with saliva. *Vaccine preventable.	Exclude 9 days after onset of parotid gland swelling. For outbreak control, may consider excluding those not immunized until at least 26 days after the onset of parotitis in the last person with mumps in the affected school.	See CDC GUIDELINE 2001.
Pinworm Enterobius Vermicularis	2–8 wks. is estimate from acquisition of infection and deposit of eggs by female worm; eggs infective within a few hrs.	As long as females discharge eggs and eggs are viable.	Itching around the anus, disturbed sleeping, and irritability. Adult worms may be seem at night directly in	If pinworm infection occurs again, all family members. Playmates and schoolmates should be considered.	Pinworm eggs are infective within a few hours after being deposited on the skin. They can survive up to 2 weeks on clothing, bedding,	Children may return to school after the first treatment dose, bathing, and trimming and scrubbing nails. Treat with either	See CDC GUIDELINES 2001.

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
	after being deposited, usually in area of anus; eggs may remain infective in an indoor environment up to 2 to 3 weeks off host.		bedclothes or around the anal area. If pinworms are suspected, transparent adhesive tape (Scotch tape test) or a pinworm paddle are applied to the anal region. Test should be done as soon as waking in the morning, prior to bathing or bowel movement. Samples taken from under the fingernails may also contain eggs as a result of scratching.	Each infected person should receive the usual 2-dose treatment. In some cases it may be necessary to treat 4–6 times, with treatments spaced 2 weeks apart. Humans are only known hosts.	or other objects. Infection occurs after accidentally swallowing infective pinworm eggs from contaminated surfaces of fingers.	prescription or over-the-counter anti-enterobius drugs. Consult health care provider prior to initiating treatment. Treatment is a 2-dose course. The second dose should be given 2 weeks after the first. Bath upon awakening; change and wash underwear each day; change nightclothes frequently. Institute personal hygiene and hand washing. Trim fingernails short. Eggs are light sensitive, so open blinds/curtains in the daytime.	

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
Ringworm (Tinea Capitis) fungal infection	10–14 days. May persist 3 months to several years.	Viable fungus may persist on contaminated materials for long periods.	Asymptomatic in early stages, but scalp or back of neck may itch. Balding patches (round or oval) on scalp. Characteristic "black dots" where hairs break close to scalp within the patch. Patches may be small (1–2 cm), moderately large (up to 10 cm), or confluent so they appear irregularly shaped. Scalp may be smooth or scaly with pustules and crusting. Tender, boggy lesions (kerion), surrounded by pustules are due to hypersensitivity to fungus. Swollen posterior	Screen exposed children for signs of infection. Household contacts, especially cats, may be carriers.	Direct skin contact with lesions of infected persons or animals and fomite contaminated articles (combs, hats, backs of theater seats, barber clippers), bedding, and clothing	Exclude until under medical care. Require written medical statement of treatment and return. Treatment is a combination of oral (griseofulvin) and topical antifungal cream, lotion, or shampoo. Oral treatment is necessary because the fungus invades the hair shaft and goes beneath the skin. Griseofulvin is taken once or twice daily for 4–8 weeks and may be continued until cultures are negative. Additional topical treatment (selenium sulfide) reduces infectivity, so the student can	See page 100 of CLINICAL GUIDELINES.

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
			neck lymph nodes.			return to school as soon as treatment has begun.	
Ringworm Tinea (fungal infection of the skin) Classification 1. Pedis (athlete's foot) 2. Cruris (jock itch) 3. Corporis (body) 4. Onychomy-cosis (nails)	4–10 days.	As long as lesions are present and viable fungus persists on contaminated materials.	Flat, ring-like lesions on exposed skin areas. Edges are reddish brown with small blisters or pustules. Lesions may be dry and scaling or moist and crusted; scaly macules gradually expand outward, clearing in the middle. Itching is common.	Observe for symptoms. Inform Advise parents to check family members, pets.	Direct and indirect skin-to-skin contact with infected persons, animals, or soil. Monitor for secondary infection.	Corporis: May exclude to initiate treatment. Affected area should be covered with a topical fungicide and a loose dressing or clothing for school; institute cleaning at school.	See page 102 of CLINICAL GUIDELINES.
Scabies (Mites) Sarcoptes scabiei	Several days to 6 weeks. Itching may persist a month after treatment.	Until mites and eggs are destroyed by treatment, usually 1–2 courses of treatment a week apart.	Typical lesion is a "burrow" (tiny, pale, irregular line that marks the path of the mite). Rash: tiny (1–2 mm) erythematous papules, vesicles, pustules, and scabs. Intense	Frequently found in other family members.	Direct skin-to-skin contact; can be acquired during sexual contact; mites can burrow under skin in 2–5 minutes.	Exclude from school. May return 8 hours after first prescription treatment. Steroid ointments or lotions are contraindicated. Anti-scabetic lotions should not	See page 103 in CLINICAL GUIDELINES.

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
			itching, especially at night.			be used more than twice in a month. Watch for secondary infection.	
Scarlet fever (Scarlatina) Group A strep-tococcus	2–5 days.	From first day before fever to after 24 hours on antibiotics or 1 week after onset of rash.	Streptococcal: sore throat, sudden onset of fever. Rash is reddish-blue "goose flesh" and fades on pressure. Rash appears first on upper chest and face, then spreads to lower chest, abdomen, and arms. Rash and fever begin on 1st day; 5–7 days later, skin peels or flakes.	Observe for symptoms. Exclude those with fever and sore throat.	Person-to-person carriers: articles soiled by nose and throat secretion droplet; food may be contaminated.	Curable with penicillin/antibiotics. Complications (nephritis, carditis) are rare but severe. Return to school when fever-free and after 24 hours of antibiotics.	See page 99 in CLINICAL GUIDELINES.

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
Tuberculosis **myco-bacterium tuberculosis (childhood-primary)**	In a small number of children the germs set up a low-grade infection in the lymph nodes in the center of the chest. In 6–8 weeks the body defenses wall off the infection with scar tissue, and there are no further consequences other than a permanent positive tuberculin skin test. This person is a skin converter (SC) and has latent infection.	Active tuberculosis bacilli in the infected person. NOTE that in most children who inhale the disease, their body's defenses vanquish all the germs.	Positive tuberculosis skin test. Most cases develop no further symptom of TB in their lifetime. About 5% of skin converters develop more serious forms of TB in their lungs or other parts of the body, which, if untreated, can be serious.	Persons with whom the child has frequent contact should be skin tested.	Airborne, inhaled. In practically all cases, children who develop the disease catch it from prolonged household contact, not from casual or sporadic contact such as at school, on the bus, at parties, or at picnics. Risk of infection is related to exposure. The risk of developing disease is related to the health of the infected person and is greater for children under age 3, the elderly, those who are immuno suppressed or undernourished, diabetics, and substance abusers.	Children who convert are usually treated with isoniazid (INH), by mouth for 6–12 months. Sometimes Rifampin is given alone or with other medication preventively. Preventive therapy is designed to reduce the risk of more serious disease. For children with active disease, 3–4 medications may be given concurrently. Multidrug-resistant strains of TB bacteria have recently developed. BCG vaccine is used in many countries to prevent disseminated TB in infants. A history of BCG does not contraindicate PPD testing nor alter the interpretation.	See page 126 of CLINICAL GUIDELINES.

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
Venereal warts Human papillomavirus (HPV)	Warts may appear within several weeks after sexual contact with infected person or may take months to appear.	Infected partner can transmit at any contact. 30 strains of HPV are sexually transmitted. Diagnosis usually made on the basis of abnormal Pap smears.	Most HPV-infected persons have no symptoms but can transmit the virus to a sex partner. Warts appear as soft, moist, pink or red swellings; may be raised or flat, single or multiple, small or large. Some cluster together, forming a cauliflower-like shape. They may appear on the vulva, in or around the vagina, anus, cervix, penis, scrotum, groin or thigh. May lead to cervical cancer.	Sexual. No exclusion needed.	Sexually transmitted disease. Condoms may reduce, but do not eliminate, the risk of transmission to uninfected partners.	Visible warts may be removed, but no treatment is better than another, and no single treatment is ideal for all cases. No cure. Infection usually goes away on its own. Cancer-related types are more likely to persist.	See CDC GUIDELINES 2001.
Whooping Cough Pertussis	Usually 7–10 days, rarely more than21 days.	Three weeks from early cold-like symptoms or after onset of paroxysms (approximately 21 days).	Cold-like symptoms with irritating cough that becomes a paroxysmal series of coughs followed by high-pitched whoop or crowing, often followed by vomiting. Adolescents and	Exclude non-immune children for 14 days.	Droplet: person to person contact with nasal and pharyngeal discharge. *Vaccine preventable.	Exclude from school for (+) culture, then exclude for 5 days of a 14-day antibiotic treatment. All household contacts and other close contacts, such as those in child	See CDC GUIDELINES 2001.

DISEASE	INCUBATION PERIOD	CONTAGIOUS PERIOD	SYMPTOMS	CONTACTS	ROUTE OF INFECTION	TREATMENT	REFERENCE
			adults may not have "whoop." Classic pertussis is 6 to 10 weeks; many may be less than 6 weeks.			care, regardless of age and vaccination status, should also receive antibiotics treatment.	

*Elevated temperature of 100° F or greater demonstrates the need to exclude the student from the school setting. This student should be fever free (an oral temperature below 99° F) for 24 hours before returning to school. Fever is noted to be present at 100.4° F per CLINICAL GUIDELINES June 2001

The above is compiled from CLINICAL GUIDELINES for SCHOOL NURSES, SCHOOL HEALTH ALERT, MARCH 1999 and the CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) 2001.

This guidance was formulated by review of the material to be utilized as a ready reference for DoDEA school nurses.