HANDBOOK FOR SCHOOL HEALTH 2023-2024

PanCare of Florida, Inc. School Health Program
and
Bay District Schools, Student Services

HANDBOOK FOR SCHOOL HEALTH 2023-2024

This Handbook serves as a reference and guide for PanCare and school personnel. It is recommended that all individuals who have responsibility for school health-related services become familiar with the contents of the School Health Handbook.

HOW TO SEARCH THIS DOCUMENT:

Select Table of Content Title and click on Bookmark.

TABLE OF CONTENTS:

SCHOOL HEALTH NURSING and HEALTH TECHNICIAN SERVICES

School nurses are professionals whose primary actions are promoting activities for the prevention of health problems and assisting students with health problems which may interfere with learning.

The School Health Nurse responsibilities include:

1. Following and enforcing school policies and procedures affecting the health, safety and well-being of employees and students in the school health setting.
2. Conduct regularly scheduled visits to assigned schools and monitor PanCare Health Technicians' services, and to assess and evaluate performance standards, documentation and environment.
3. Train PanCare Health Technicians in the procedures and services provided in the school Health Room to include, but not limited to: minor First Aid, medication administration, and minor illnesses.
4. Assists with maintaining student health records.
5. Assists with sending School Health Screening referral letters and making contact with the parent/guardian.
6. Provides nursing assessments and consults with Health Care Providers, as needed, to identify existing or potential health problems.
7. Serves as a Liaison Consultant to school staff for student health issues and referrals.
8. Assesses students when health problems are suspected. The nurse will then refer and/or follow up as necessary.
9. Ensures school health documentation accuracy in accordance with state and district policy and procedures.
10. Alerts school administrators, the Director of Student Services and FLDOH-BC of suspected communicable diseases.
11. Performs CPR/AED, as needed.
12. Ensures compliance with FERPA/HIPAA confidentiality requirements.
13. Consults with school administrators, as needed, to ensure quality program implementation.

The PanCare Health Technician responsibilities include:

1. Following and enforcing school policies and procedures affecting the health, safety and well-being of employees and students in the school health setting.
2. Maintains health room facilities, equipment, supplies and medications according to BDS, PanCare and FLDOH policies and procedures.
3. Provides minor First Aid, medication administration, attending to minor illnesses and performing delegated services as prescribed by a Health Care Provider after receiving child specific training.
4. Provides services related to COVID-19 monitoring of symptoms and maintaining the isolation space.
5. Assists with organization and management of PanCare School Health Services Parental Consent forms. Consent forms are to be stored in the Health Room Consent Binders. At the beginning of the school year, Consent form information should be entered into Focus and Consent forms should be uploaded in Focus.
6. Documents health room visits in the BDS FOCUS system.
7. Maintains Health Room records and assists in Health Room services data collection for FLDOH and BDS reporting.
8. Maintains confidentiality of Health Room records according to FERPA/HIPAA requirements.
9. Assists with sending School Health Screening referral letters and making contact with the parent/guardian.
10. Ensures quality School Health program implementation.

SCHOOL RESPONSIBILITIES

A person will be designated at each school to serve as a contact person to the PanCare School Health Nurse and Health Technician.

1. Health records are to be maintained on each student and adequate filing space provided. Health records are to be completed upon registering at a new school.
2. An available meeting/ workspace outside of the Health Room will be provided, upon request, for the PanCare nurse to use during his/her visit.
3. Adequate physical facilities will be provided for the Health Room.
4. Medications requiring refrigeration are to be stored in a designated, locked refrigerator or in a locked container in a secure refrigerator, with a thermometer. No personal (staff) food is to be stored in the medication refrigerator.
5. The names, grades and teachers of new students will be provided to the PanCare Health Technician (HT).
6. Parental/Guardian consent for “PanCare School Health Services” form, informing parents of the grade specific health screenings to be implemented during the year, Health Technician services, Telehealth services, school physicals provided, vision services, and preventative dental services, will be completed at the beginning of each school year. The PanCare School Health Services parental consent form should be completed at the time of initial registration for all students.
7. In order to comply with FS 1006.062, and Bay District Schools’ policy 7.302, “Administration of Medication by School District Personnel”, the principal of each school will have designated school staff trained annually to administer prescription medications. New updated forms must be obtained from the parent/guardian at the beginning of each new school year and if the dosage is changed. All medications must be counted when received and are to be kept in their original containers in a locked cabinet. A log (Medication Administration Record- MAR) is to be kept by the person administering the medication. This form is to be filed in the student's health record at the completion of the course of treatment, or the last day of his/her attendance, whichever occurs first. New updated forms must be obtained from the parent/guardian if the dosage is changed and at the beginning of each new school year. *NOTE: All Over the Counter (OTC) medications require a completed “Permission to Administer Medication” form, signed by a Health Care Provider and parent/guardian.
8. Each school will have posted in strategic areas on the school campus a list of names of school personnel certified in CPR/AED and First Aid **A minimum of two school staff must be certified.**
9. Students with a chronic illness and physician statement/physician orders may need an Individualized Health Care Plan (IHCP). The school staff will notify the FDOHBC nurse, and the PanCare nurse/Health Tech of these students. FDOHBC is responsible for developing Individual Health Care Plans (IHCP) for all BDS students identified by BDS or PanCare as requiring a plan and to revise the plan upon notification by BDS or PanCare of a change in health condition or otherwise that may necessitate such a revision.
10. To comply with Florida statute and state rules and in accordance with DOE retention policy, all Health Rooms will have an activity log of students who seek health care services and the resolution of those visits. The activity log must be kept confidential.

PROCEDURE FOR BIOHAZARD WASTE MANAGEMENT

Purpose: The purpose of this procedure is to establish guidelines for the handling and disposal of biohazard waste in the School Health Room setting as it pertains to the school health environment.

Definitions:
Biohazard Waste - any solid or liquid waste which may present a threat of infection to humans. The term includes, but is not limited to: discarded sharps, human blood, and body fluids. Also included are used absorbent materials such as bandages, gauze or sponges which are visibly saturated with blood or body fluids.

Examples of items that can be considered Biohazardous Waste: Blood saturated gauze or cotton balls, tissue saturated with bloody nasal secretions, any porous material saturated with body fluids.

Examples of items not to be considered Biohazardous Waste: Band-Aids, cotton balls for fingersticks, blood glucose strips, gloves, catheters, any non-porous item that cannot be saturated with body fluids.

Biohazard Bags – red, impermeable bags visibly marked with the international biological hazard symbol and a phrase such as: BIOMEDICAL WASTE, BIOHAZARD, INFECTIOUS WASTE OR INFECTIOUS SUBSTANCE. The symbol will be orange or black.

Personal protective equipment (PPE) - devices used to protect the user from injury or contamination by shielding the eyes, face, and/or head, limbs, and/or torso. In the School Health Clinic setting these devices may include, but are not limited to: masks, face shields, non-sterile exam gloves, protective eyewear, and gowns.

Sharps- typically include, but may not be limited to: needles for delivering insulin or other medications and lancets used to obtain a blood specimen for testing.

Procedure:

I. All non-sharp biohazard waste will be disposed of directly into red biohazard bags or into a rigid waste container with a lid and a red biohazard bag. The rigid waste container is usually a red waste receptacle, identified with the biohazard symbol.

II. All used sharps will be placed immediately into a  puncture-resistant, leak-proof sharps container. Do not exceed the fill line as established by the manufacturer or other authority.

III. All employees who handle biohazardous waste must wear personal protective equipment (PPE) appropriate for conditions. Avoid aerosolizing contaminants in sharps or absorbent materials.

IV. Biohazard Waste Storage

A. Storage of biohazard waste shall not be for greater than 30 days. (64E-16.004 F.A.C.). The 30 day period begins when the first biohazard material is placed into the biohazard bag or when the Sharps Container is sealed. Indoor biohazard waste storage shall have restricted access from general traffic flow patterns and be accessible only to authorized staff.

1. The **Sharps Container** is considered full when the fill line is nearly reached or the container is nearly ¾ full if no line is present.
2. **Rx Destroyer Bottle -** when the bottle is full, tightly seal the cap. Bottle is full when contents are within 2 inches from the cap – DO NOT OVERFILL. Discard bottle and contents into Red Biohazard bag.

V. Biohazard Waste Disposal

A. **HEALTH TECH:** When a biohazard bag and/or Sharps Container is ready for disposal, the Health Tech will email the Confidential Secretary that the biohazard waste needs to be picked up/returned for disposal. Bay District Schools is responsible for the disposal of regulated medical waste generated within the Health Rooms.

B. **FOR BDS STAFF ONLY:** To place the pickup orders visit www.trilogymedwaste.com/product-store. Scroll to the bottom of the store (click load more a few times to get there). Select the Mail Back Sharps kit that best suits the needs of the location. Apply coupon code AC100 at checkout. On the order form in the "send us a note" field please enter the customer ID, then select "net 30" for payment method. The orders will be invoiced to the billing address on file but show which location each order was for. Contact BDS Student Services for additional information.

VI. Spill Cleanup – light biohazard spill, clean with Clorox wipe. Heavy biohazard spill, contact school maintenance for cleanup.

PROVISION OF HEALTH SERVICES – TASKS

Local Policy must be used in conjunction with the table below:

TASKS:

P = Provide these services

A = Assist *

N/A = Don't do at all

	School Health Nurse	Health Support Tech	UAPs & all Non-Medical School Staff
Case management	P	A	A
Child-specific training and delegation of tasks	P	A	N/A
Data collection (i.e. health problem list, surveys, monthly statistics)	P	P	P
Determine nursing diagnosis and develop health care plan	P	A	A
Develop a health education curriculum. Nurse with BDS approval.	A	N/A	N/A
Develop health policy and procedure	A	N/A	N/A
First Aid	P	P	P
IEP staffing / 504 Plan	A	N/A	N/A
Initial screenings (vision, hearing, BMI)	P	P	A
Managing communicable disease	P	A	A
Medication administration (Nurse as time allows/unusual circumstance)	P	P	P
Nursing assessment	P	A	A
Perform delegated treatments as prescribed	P	P	P
Provide health education	P	N/A	N/A
Record review (immunizations, physical exams, CUMs)	P	P	P
Scoliosis initial screening, recheck, and referral	P	A	N/A
Screening follow-up (vision, hearing, BMI, Scoliosis)	A	P	A

Screening recheck (vision, hearing, BMI)	P	P	N/A
Screening referral (vision, hearing, BMI)	P	A	N/A
Staff Wellness Programs	A	A	A
Taking verbal/phone order from medical provider	P	A	A

Note: A – "Assist" means assisting the School Health Nurse and/or UAP

UAP- Unlicensed Assistive Personnel

HEALTH ROOM MANAGEMENT

Emergency health needs arise from injury, sudden illness, or the progression of a minor discomfort. One of the roles of the UAP is the management of the school's health room if the Health Tech is not available. School personnel should respond quickly to provide first aid to minimize further injury to the student.

HEALTH ROOM RECORDS

1. **Enter the date, time and name of each student** who enters the health room on a daily health room activity log. This log should **include a brief description** of the reason for the student's visit, and the disposition of the student. **Record the time** the student **entered and left** the health room along with t**he initials of the individual responsible for the health room** at that time. This record must be maintained in a confidential manner.
2. Carefully document all accidents involving an injury on the Daily Health Room Log, in FOCUS (Nursing Notes) and on the BDS Accident Report Form. Accidents involving the need for first aid must include a phone call and/or written parental notification on the Report of Medical Symptoms Observed at School form. **NOTE: All head injuries must include a phone call to the parent.** Request the parent to pick the child up for observation and/or to take to the doctor. If a student is unconscious due to Head Injury- 911 must be called.
3. At the beginning of each school year, all parents should provide pertinent health-related information on the Parental Consent for School Health Services form, the Emergency Information Card and on the Parent Portal on the Medical Page. It is the responsibility of the enrolling parent to update this information annually. Confidential information should be maintained in a locked filing system or appropriate computerized records with security safeguards in the Health Room.
4. Students with special health needs should have emergency information in FOCUS and in their Health File, flagged for quick reference. School personnel should be knowledgeable of the medical needs of all students with special health needs.

GUIDELINES FOR ASSESSING INJURY

1. Maintain an area for the assessment and isolation of injured students. The area should be situated so that students may always be supervised and observed by adults while maintaining adequate privacy.
2. After treating any wounds, notify the parent/guardian of the injury and advise them to consult their family physician or local county health department to determine the need for tetanus toxoid administration.
3. Practice standard precautions always.
4. In some instances, an injured student should not be moved until emergency assistance arrives. Contact parents/ guardians immediately when a student is seriously ill or injured.

EMERGENCY FIRST AID

All school personnel should be trained in first aid and CPR. When an emergency situation arises, the closest person knowledgeable in first aid should administer first aid as promptly as possible. Keep first aid supplies in easily accessible locations that are known to all. **Refer to the School Safety Plan and BDS Safety & Security Web Page (Sgt. Doug Boortz, District Safety and Security Chief).**

Note: A student may disclose information of a private and personal nature during the course of care. This information must remain confidential unless maintaining confidentiality would cause harm to the student's health. If you feel the student's health may be in danger, advise the student you will share the information with other school or health staff.

CORONAVIRUS GUIDANCE FOR SCHOOLS

PanCare staff will follow current CDC, FDOH and Bay District Schools guidelines and protocols for COVID-19 symptomatic people in schools. For additional information contact:

Lyndsey Jackson
Bay District Schools
Supervisory School Nurse
(850)-767-4241
jacksle@bay.k12.fl.us

MEDICAL MARIJUANA USE BY QUALIFIED PATIENTS IN SCHOOLS

Bay District Schools Policy 7.305

Medical Marijuana use at school in accordance with § 1006.062, Fla Stat.

1. The Board strives to comply with state law to honor families' private medical decisions while ensuring a learning environment free of disruption. To that end, the School Board allows the administration of medications to students while at school when administration cannot reasonably be accomplished outside of school hours. Parents and Caregivers should administer students' medications, including Medical Marijuana, at home whenever possible. In those limited circumstances when it is medically necessary during the school day, the administration of Medical Marijuana products to qualified Bay District Schools students on School Board property shall be in accordance with this policy.

2. Medical Marijuana cannot be administered to a Qualified Patient while aboard a school bus or at a school-sponsored event.

3. This policy conveys no right to any student or to the student's parents, guardians or other Caregivers to demand access to any general or particular location on school or district property, a school bus, or at a school-sponsored event to administer Medical Marijuana.

Definitions: As used in BDS Policy 7.305 , the following definitions shall apply:

"**Qualified Patient**" means a student who is a resident of this state who has been added to the Medical Marijuana Use Registry by a qualified physician to receive marijuana or a marijuana delivery device for medical use and who has a valid qualified patient identification card in accordance with Florida law.

"**Designated Location**" means a location identified in writing by the school administration in its sole discretion as written in the student's Medical Marijuana Health Care Plan. The Designated Location shall be a location that minimizes the risk of disruption to the educational environment or exposure of other students to Marijuana.

NOTE:THE SCHOOL HEALTH ROOM CANNOT BE A DESIGNATED LOCATION FOR THE ADMINISTRATION OF MEDICAL MARIJUANA.

Administration of Medical Marijuana to Qualified Patients on school district property.

No school nurse, school health care personnel, school administrative staff, or school employee may administer, store, hold, or transport Medical Marijuana in any form. Medical Marijuana shall not be stored on School Board property.

PROCEDURE FOR OBSERVING STANDARD PRECAUTIONS

Purpose: The purpose of this procedure is to establish guidelines for observing universal precautions as it pertains to the School Health environment.

Definition: **Standard Precautions -** All students and all blood and body fluids will be treated as if known to be infectious with HIV, HBV, and other bloodborne pathogens. It is not possible to identify all students with infectious diseases by taking a medical history or conducting a physical assessment. Therefore blood or other body fluids or materials must be treated as potentially infectious.

Bloodborne Pathogens - Substances present in the blood that can cause infection or disease. For example, hepatitis B and hepatitis C viruses are bloodborne pathogens since they are spread through blood and can cause a liver infection.

Personal Protective Equipment (PPE) - Devices used to protect the user from injury or contamination by shielding the eyes, face, and/or head, limbs, and/or torso. In the health room setting these devices may include, but are not limited to, masks, face shields, non-sterile exam gloves, protective eyewear, and gowns.

Procedure I. In the presence of blood or body fluids, the provider must use appropriate PPE for the conditions.

PROCEDURE FOR HAND WASHING

Purpose: This procedure establishes guidelines for appropriate hand hygiene practices as a method of reducing infections.

Procedure: I. Indications for washing hands

A. Wash hands with soap and water when:
   1. Visibly dirty or contaminated
   2. Visibly soiled with blood or other body fluids
   3. Following use of the restroom

B. Perform hand hygiene with either soap/water or alcohol based hand rub:
   1. After contact with body fluids or secretions, mucous membranes, non-intact skin, or wound dressings
   2. Prior to handling medication or preparing food

******Although running water and soap are the preferred choice, alcohol-based antiseptic hand cleaning products or pre-moistened hand washing towelettes (antimicrobial-impregnated wipes) may be used for hand washing. If contact with blood or body secretions occurs, hand washing shall be done with soap and running water as soon as possible.***

II. Hand washing is one of the single most important procedures used to assist in the prevention of infections. The following procedure shall be utilized when washing hands:

A. Turn the faucet on.
B. Wet hands and wrists under warm, running water, holding fingertips down. (Avoid using hot water because repeated exposure to hot water may increase the risk of dermatitis).
C. Scrub hands, wrists, and fingers vigorously with soap for at least fifteen seconds, covering all surfaces of the hands and fingers.
D. Pay special attention to the fingernails and between the fingers.
E. Rinse hands and wrists thoroughly under running water holding the fingertips down. Leave the water running.
F. Dry hands with a clean towel or paper towel. Use the towel to turn the faucet off.

****When decontaminating hands with an alcohol based rub, apply product to the palm of one hand and rub hands together covering all surfaces of hands and fingers, until hands are dry. Follow manufacturer's recommendations regarding the volume of product to use.***

CONTROL OF COMMUNICABLE DISEASE

EARLY DETECTION

The school UAP has the unique opportunity for early detection of students suspected of having a communicable disease. Daily observations of the student by the school health aide/ Health Tech help detect deviations from normal health.

Any of the following signs and symptoms may indicate the beginning of a communicable disease:

SORE THROAT	NAUSEA	RASH	RED EYES (EYE DISCHARGE)
CHILLS	COUGH	FEVER 100.4 °F	
VOMITING	DIARRHEA	HEADACHE	

TRANSMISSION

Communicable diseases are transmitted primarily in face-to-face contact with the infected individual through coughing, sneezing, or direct contact with unsanitary conditions. Children should be encouraged to use tissues when coughing or sneezing.

Factors that contribute to the spread of disease include large numbers of students in any one room, limited bathroom facilities, and minimal hand washing by students, failure of staff to observe good hygiene, and failure to segregate a sick student or staff member.

Contrary to popular notion, the chance that disease can be spread via a toilet seat is extremely remote. HIV infection, AIDS, genital herpes, and other STDs have never been shown to spread from a toilet seat. Good hygiene and good sense dictates that one not sit on an obviously soiled toilet seat.

PREVENTION

There are few more important practices in prevention of disease than the simple washing of the hands. Hands constantly contact potentially contaminated surfaces and the face or mouth. Hand washing with soap and water before eating, after using the restroom, and after potential contamination (e.g., cleanup of blood) is strongly recommended.

REQUIRED NOTIFICATION

School officials are required to notify the PanCare school nurse and FDOHBC IMMEDIATELY of suspected cases of MEASLES, DIPHTHERIA, POLIOMYELITIS, CHICKEN POX, MENINGITIS or TUBERCULOSIS. School officials are also required to notify the county health department of any suspected disease conditions involving rubella, pertussis, or mumps.

RECOVERY

Most children recover uneventfully from communicable disease. However, there are some children who are at risk for serious complications. This includes children who are undergoing steroid therapy, children with sickle cell disease, those with generalized malignancy, or those who have an immunologic disorder.

PROCEDURE FOR HANDLING BODY FLUIDS

Contact with body fluids presents a risk of a variety of germs. No distinction is made between body fluids from individuals with a known disease from those individuals without symptoms or with an undiagnosed disease. The body fluids of all individuals should be considered to contain potentially infectious germs. The term “body fluids” includes semen, blood, vaginal secretions, drainage from scrapes and cuts, feces, urine, vomit, respiratory secretions and saliva. The following precautions have been established to prevent the transmission of disease for all persons potentially exposed to the blood or body fluids of any individual.

REMEMBER THERE IS NO SUBSTITUTE FOR GOOD HAND WASHING!

Disposable, non-sterile gloves should be used whenever cleaning up blood spills, vomit, urine, feces, etc. The wearing of gloves becomes even more important if the individual exposed to body fluids has cuts or abrasions on the hands.

DISPOSAL OF BODY FLUIDS AND CONTAMINATED MATERIALS

1. Assume the fluids come from an infected individual.
2. When a spill is discovered, block off the area, and notify housekeeping.
3. Wear disposable non-latex gloves.
4. Spray the area with a 10% bleach solution made daily unless the spill is on carpeting, then use alcohol.
5. Allow the spill to sit undisturbed for at least 10 minutes.
6. Cover a vomit spill with a sanitary absorbent agent (e.g., Fragra-sorb, SA-15, P129). Allow to dry, and then vacuum. If necessary, mechanically remove body fluid with a dustpan and broom, then apply rug shampoo (a germicidal detergent) with a brush and re-vacuum. Rinse the dustpan and broom in disinfectant.
7. Place all contaminated materials in a garbage bag. Double bag if the bag is contaminated with body fluids on the outside.
8. Dispose of your gloves and wash your hands thoroughly.

EMERGENCY FIRST AID FOR EXPOSURE TO BLOOD

An emergency situation may occur any time there is exposure to blood through injuries resulting in bleeding, or exposure to blood through needle sticks, instruments, or sharp objects. If blood exposure occurs, follow PanCare and BDS Incident Reporting Protocol. Significant, unprotected exposure to blood can cause bloodborne infections to spread. The occupational risk of acquiring bloodborne infections in a school setting is extremely low. Nevertheless, the following information is provided to school personnel for prevention of bloodborne infections.

Standard precautions apply to blood and other body fluids containing visible blood. Under standard precautions, blood and certain body fluids of all individuals should be considered potentially infectious for Hepatitis B Virus, and other bloodborne pathogens. Standard precautions also apply to semen and vaginal secretions.

Although transmission of HIV infection has not been documented during mouth-to-mouth resuscitation, the following precautions are recommended.

1. Use a barrier device.
2. Wear gloves when in contact with blood and other body fluids.
3. Equipment known or suspected to be contaminated should be disposed of or thoroughly cleaned and disinfected after each use.

COMMUNICABLE DISEASE PROCEDURES
FOR NOTIFYING PARENTS AND FOLLOWUP ACTIONS

Follow the procedures outlined below when a communicable disease is suspected or reported.

I. **When signs and symptoms of a communicable disease <u>are observed</u>**, as outlined in the Communicable/Non-Communicable Disease Chart, located in the Handbook for School Health (page 18), the HT should notify the PanCare School Health Nurse, the school administration, the parent and take the following actions:

<u>A. NO EXCLUSION From School</u>

If the symptoms indicate a <u>communicable</u> disease **which does not require exclusion,** in accordance with the Communicable/Non-Communicable Disease Chart, notify the PanCare School Health Nurse, the school administration, **<u>the parent/guardian and take the following actions</u>**:

1. <u>Send the student home with</u> **The Report of Medical Symptoms Observed at School**. This report informs parents of symptoms **<u>displayed by the student</u>** and provides a form (bottom half of Report of Medical Symptoms Observed at School) for the parent to provide a written statement notifying the school of the student's condition upon return to school.

B. **<u>EXCLUSION From School</u>**

If it appears that the student may have a communicable disease **which requires exclusion** in accordance with the Communicable/Non-Communicable Disease Chart, notify the PanCare School Health Nurse, the school administration, **<u>the parent/guardian and take the following actions</u>**:

1. **<u>Segregate the student from other students</u>** until the student can be removed from the school site by the parent/guardian.
2. Provide the parent with the Report of Medical Symptoms Observed at School.
3. **<u>Student re-entry:</u>** Require the parent to provide a note from a physician or nurse in accordance with the Communicable/Non-Communicable Disease Chart.

II. When one of the following communicable diseases listed is **<u>reported</u>** to the school:

<u>Notify the Director of Student Services, Andra Phillips, at 767-4310.</u> The Director of Student Services will notify the Florida Dept. of Health Bay Co. at 252-9604 extension 1197.

Diphtheria	**Measles-Rubella**	**Mumps (German Measles)**
Hepatitis	**Meningitis**	**Polio**
Measles-Rubeola (Regular)	**Meningococcal Disease**	**Whooping Cough (Pertussis)**

When one of the diseases listed above in Section II (diseases for which parents of exposed classmates are to be notified) <u>is confirmed</u> by the County Health Department, it shall be the responsibility of the Director of Student Services and/or the principal/ designee to take the following actions in addition to the actions outlined in Section IA and/or IB:

<u>A. Take further action as directed by the Administrator of the Florida Department of Health Bay County.</u>

B. **<u>Require that the parent/guardian of the identified student submit a written statement from the physician</u>** giving permission to return to school.

It is recommended that school personnel encourage parents to observe their child daily for signs and symptoms of communicable diseases and notify the school when the child has a communicable disease.

DISEASES THAT REQUIRE EXCLUSION FROM SCHOOL

Disease	Signs & Symptoms	Period Communicable	May Return to School
Chicken Pox	Small raised blisters, containing clear fluid.Eruption usually starts around the head and neck.	From 5 days before to 6 days after the first appearance of the skin blisters.	1 week after eruption first appears or when all the blisters have crusted.
Diarrhea	Clinical Syndrome with many different causes associated with loose, watery stools and often accompanied by vomiting and fever.	(Unknown) presumably for a duration of diarrhea and fecal excretion of microorganism.	Upon recommendation of physician or diarrhea no longer present.
Fever	Oral Temperature 100.4°F or greater. A lower temperature is not considered fever.	As long as elevated.	When fever is no longer present.
Head Lice	Scratching and itching of the scalp. Eggs may be attached to the base of the hair follicle.	As long as lice remain alive on the infested person or in the clothing.	After all nits and lice have been removed (refer to lice section for further information).
Influenza	Fever, Chills, headache, sore throat, cough, and aching muscles.	From the first to the fifth day of the disease.	On the 6th day after onset of symptoms or upon recommendation of a physician.
Measles-Rubella* (Regular Measles)	Fever, cold-like symptoms, eyes watery and sensitive to light, cough, red rash that begins on faces and behind the ears.	From one week before onset of rash to 4 days after onset of rash.	7 days after the appearance of rash.
Measles-Rubella* (German Measles)	Generalized red, blotchy rash with low grade fever or cold symptoms.	One week before and 4 days after the onset of the rash.	4 days after the onset of the rash.
Meningitis*	Infectious disease of the central nervous system. Disease is spread through direct contact with discharges from the nose and throat of infected persons.	Variable, depending on the causative organism.	With documentation of physician recommendation.
Meningitis, Meningococcal*	Severe type of bacterial meningitis. Fever, headache, vomiting, stiff neck and rash.	From onset of symptoms until 24 hours after antibiotic therapy.	With documentation of physician recommendation.
Mononucleosis	Fever, sore throat, swollen neck glands.	Prolonged: communicability may Persist for months up to a year after the infection.	Upon recommendation of the physician.
Mumps*	Fever, swelling of the salivary glands, usually the gland in front of the ear at the angle of the jaw: sucking on a lemon or a pickle causes pain.	From 6 days before to 9 days after the swelling begins.	9 days after onset of swelling or earlier if swelling has subsided.
Pink Eye (Acute bacterial or viral conjunctivitis)	Red, sore, watery eyes, swelling eyelids, thick yellow or white drainage from eyes.	3 to 14 days.	After eyes have cleared or when it is established that the child has been under treatment for 24 hours.

Disease	Signs & Symptoms	Period Communicable	May Return to School
Scabies	Tunnel-like lesions that itch intensely caused by a mite that burrows under the skin, eggs are deposited in the lesions.	Until mites and eggs are destroyed by treatment usually requiring two applications of medication.	After a note from the physician establishes that the patient is under treatment.
Scarlet Fever (Strep Throat with Rash)	Sore throat, headache, and fever. “Strawberry tongue”, generalized fine red rash with later peeling of the skin from the fingers and toes.	With adequate antibiotic therapy communicability is reduced within 12 to 24 hours after antibiotic therapy.	No longer have a fever AND Have taken antibiotics for at least 12 to 24 hours; ask the doctor how long you should stay home after starting antibiotics
Strep Throat	Sore throat, headache, and typically fever. Not usually, but sometimes accompanied by a rash (see above Scarlet Fever).	Same as above.	Same as above.
Tuberculosis*	Most children show no initial symptoms other than signs of chronic infection (fatigue, and irritability). In advanced disease, there is weakness, loss of appetite, weight loss, fever, night sweats, and cough.	Until Sputum is cleared of bacteria, usually 2-4 weeks.	With documentation of a physician or FDOH Bay County Epi Team.
Vomiting	Clinical Syndrome with many different causes associated with the voluntary or involuntary emptying of the stomach contents through the mouth.	(Unknown) presumably for the duration of vomiting.	When no longer vomiting.
Whooping Cough* (Pertussis)	Low grade fever, racking cough that progresses to severe cough and “Whoop”-like sound when the child takes a breath in.	From 7 days after exposure to 3 to 4 weeks after onset of the “whooping” stage.	7 days after appropriate antibiotic therapy has begun. Note from physician or FDOH Bay County Epi Team.

*When confirmed by the Florida Dept. of Health Bay Co. School Health parents of classroom contacts are to be notified.

Note: If a student is excluded from school with a confirmed diagnosis of a Communicable Disease, <u>DOCUMENTATION FROM A PHYSICIAN STATING DATE THEY CAN RETURN TO SCHOOL IS REQUIRED.</u>

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DISEASES THAT DO NOT REQUIRE EXCLUSION FROM SCHOOL

As long as Fever Oral Temperature 100.4°F or greater is present, they are EXCLUDED until fever is no longer present.

Disease	Signs & Symptoms	Period Communicable	Comments
Boil/Abscess	Infection of skin or underlying soft tissue. Area is red, swollen and tender. There may be drainage of thick, yellow pus.	While the lesion is draining.	Lesions must be covered with a clean dressing when draining.
Fifth Disease (Erythema)	Mild viral illness. Rash appears first. Usually afebrile. Characteristic “slapped-face” appearance, followed by rash to trunk & extremities which fades, but reoccurs on exposure to sunlight.	Before onset of rash or if temperature 100.4°F or greater is present. Probably not communicable after onset of rash.	Keep the student indoors. Limit physical activity. If there is a female teacher in the first trimester of pregnancy exposed to fifth disease in the classroom, she should contact her obstetrician.
Hand, Foot & Mouth	Sores in the mouth in the form of small red spots that can become blisters or ulcers. Skin rash on palms, hands, soles of feet. Genital area, knees, elbows, buttocks & elbows, may also develop a rash.	Most during the first week of illness, contagious for days or weeks. Adults can spread even if there are no symptoms of the virus.	Hand washing! Can return to school after symptoms go away.
Hepatitis A*	Gradual onset, fever, loss of appetite, nausea, abdominal pain, jaundice (whites of the eyes become yellow). Dark colored urine.	From approximately 14 days before onset of illness to a few days after onset. Most cases are not infectious 1 week after onset.	Good personal hygiene and hand washing after using the toilet and before eating.
Hepatitis B*	Same as Hepatitis A.	From several weeks before onset until recovery, a period of many weeks. Illness is only transmitted by contact with infected blood or body fluids.	Same as Hepatitis A.
Herpes Virus I (Cold Sores)	Fever blisters on face, mostly around the lips.	2 weeks but may be as long as 7 weeks.	Sores should be covered. Should not participate in contact sports; particularly wrestling.
Impetigo (FL Sand Sores) (Pus Pimples) *(Could turn into MRSA)*	Red, raised, sores on skin. May drain yellow fluid. Gradually form scabs.	As long as the sores are draining.	Sores must be covered. Should not participate in contact sports; particularly wrestling.
Molluscum Contagiosum	Small raised lesions, usually white, pink, or flesh-colored with a dimple or pit in the center.	As long as lesions are present. Only broken lesions spread disease.	Broken lesions should be covered while at school.
Pinworms	Itching during the night around the anal area.	Until pinworms are eradicated.	Treat by physician.
Ringworm (scalp, body, groin, nails, feet)	Round, scaly patches of temporary baldness, flat, round, spreading red, ring shaped lesions, redness and cracking of skin between toes.	As long as lesions are present.	May attend school as long as lesions are covered. NOTE: with lesions on neck and head, the child needs to be seen by a physician.

NONCOMMUNICABLE DISEASES

Animal Bites	**Call the Rabies Control Officer at 850-252-9542.**	Parents should be sure that the child is up to date on his/her tetanus immunization.
Creeping Eruption	Skin infection with characteristic corkscrew lesions, which causes a snake-like track with severe itching.	Treatment by a physician.

INDICATORS OF ABUSE AND/OR NEGLECT

Sometimes students who are abused or neglected are seen for the first time in the school health room. Everyone involved in delivering school health services should be sensitive to and familiar with signs and symptoms of abuse or neglect.

PHYSICAL ABUSE

Physical Indicators	Behavioral Indicators
Unexplained bruises	Apprehensive of adults
Hand marks	Behavioral extremes
Black eyes	Withdrawn
Patterned bruises	Aggressive
Unexplained cuts	Frightened of caregivers
Welts/human bites	Non-spontaneous
Burns – cigarette, immersion, and rope burns	Overeager to please
Unexplained fractures – skull, spiral, repeated fractures	Abdominal injuries – vomiting, distention, tenderness

SEXUAL ABUSE

Physical Indicators	Behavioral Indicators
Difficulty walking or sitting	Withdrawal
Bloody underclothes	Fantasy
Pain or itching in genital or anal area	Bizarre or unusual sexual behavior
Bruises in genital or anal area	Inappropriate sexual knowledge
Venereal disease	Poor peer relationships
Poor sphincter tone	Runaway
Pregnancy	Overprotective father

NEGLECT

Physical Indicators	Behavioral Indicators
Hunger	Signs of malnutrition Begging/stealing
Poor hygiene	Comes early/leaves late
Inappropriate dress	Constant fatigue
Lack of supervision	Poor attendance in school
Unattended medical needs	Delinquent
Overall poor care	Left unattended

GUIDELINES FOR REPORTING SUSPECTED CHILD ABUSE:

State statute 39.201 states 1) (a) Any person who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, as defined in this chapter, shall report such knowledge or suspicion to the department in the manner prescribed in subsection (2).

Oral reports to the Abuse Registry: 1-800-962-2873.

Report online to http://reportabuse.dcf.state.fl.us or FAX report to 1-800-914-0004

Reporters in the following occupation categories are required to provide their names to the hotline staff:

1. Physician, osteopathic physician, medical examiner, chiropractic physician, nurse, or hospital personnel engaged in the admission, examination, care, or treatment of persons;
2. Health or mental health professional other than one listed in subparagraph 1;
3. Practitioner who relies solely on spiritual means for healing;
4. School teacher or other school official or personnel;
5. Social worker, day care center worker, or other professional child care, foster care, residential, or institutional worker;
6. Law enforcement officer; or Judge.

The names of reporters shall be entered into the record of the report, but shall be held confidential and exempt as provided in s. 39.202.

All employees are required to report any suspicion of child abuse or neglect. The school administration should be notified as a courtesy. The person with the initial reasonable suspicion of child abuse has a legal responsibility to report to the Abuse Registry.

BDS/PanCare employees shall not contact the child's family or any other person to determine the cause of the suspected abuse or neglect. This is the responsibility of the abuse investigator and law enforcement officials.

A person requesting information regarding a case of child abuse or stating that he/she wants to take a student into custody, must present identification to show their authority to do so.

A law enforcement officer or representative from child protective services may take a student into custody if it is believed that a child is suffering from illness or is in immediate danger from his/her surroundings and that the student's removal is necessary. **IT IS THE RESPONSIBILITY OF THE AGENCY TAKING THE CHILD INTO CUSTODY TO NOTIFY THE PARENT.**

SCHOOL ENTRANCE REQUIREMENTS

The intent of the immunization and health exam requirements are to assure a healthy, protected school population and to identify and correct any health problems or potential health problems.

64F-6.002 School Health Services Plan:

(d) Communicable disease policies;
(e) Immunization policies that, at a minimum, include immunization requirements for schools as listed in Rule 64D-3.01 1, F.A.C., and s.232.032, F.S.;
(f) Initial school entry health examination policy;

64F-6 Maintenance of Records.

(1) Cumulative health records on each student shall be maintained in the school by personnel authorized by school board policy and governing authority of non-public schools. Such records shall include information regarding:
(a) Immunization status and certification;
(b) Health history, including any chronic conditions and treatment plan;
(c) Screening tests, results, follow-up and corrective action;
(d) Health examination report;

School Health Exam Requirements

INITIAL ENTRY INTO FLORIDA SCHOOLS

1. A school health exam (original or photocopy) signed or stamped by a licensed health practitioner and dated within **one year prior to registration** is required for each student initially entering a Florida school. *An appointment for a school health examination may be acceptable for registration purposes, but is at the discretion of the individual school district.*
2. School health exams may be documented on DOH-H form 3040, 6/02 Student Health Examinations or any other form that is inclusive of the same data.
3. **Students enrolling without the above information may be granted a 30-day exemption.** Parents or guardians should be referred to their private health care provider or the local county health department to meet this requirement. If these requirements have not been met within the allowed grace period (30 days), students should be excluded from school.
4. Any health professional, licensed in Florida or in the state where the student resided at the time of the health examination, who is authorized to perform a general health examination under licensure can certify that the health examination has been completed.
5. Any student may be exempt from the requirement of a health examination upon written request of the parent or guardian stating objections to the examination on religious grounds.

TRANSFER STUDENTS

A student transferring from another school must produce evidence of compliance with the Florida school entry health examination requirement. The former school should be contacted to verify that a valid health examination is on file or the information may be obtained via computer transfer.

FLORIDA SCHOOLS IMMUNIZATION REQUIREMENTS

Immunization Requirements for Entrance

Florida Certificate of Immunization (DH680) is required, documenting the following:

Public/Non-Public Schools K-12 (children entering, attending or transferring to Florida schools)

Diphtheria, Tetanus, and Pertussis (DTap)	5 doses or 4 if last dose given after age 4
Polio	3, 4, or 5 doses: If the 4th dose is administered prior to 4th birthday, a 5th dose is required for entry into Kindergarten
Measles, Mumps, Rubella	2 doses
Hepatitis B	2-3 doses depending on when the child started the vaccine series
Varicella	2 doses ALL Kindergarten-Gr. 9 children 1 dose Grades 11-12 OR documented history of varicella disease by a healthcare provider
Tetanus booster (Tdap)	Gr. 7-12 Tdap

Children entering, attending or transferring to Kindergarten through Grade 12 in Florida schools will be required to have documentation of a second dose of mumps and rubella in addition to the present requirement of 2 measles vaccines.

A second dose of varicella will be required for children entering, attending or transferring to Kindergarten. Students may not begin Kindergarten until **all** immunization requirements are met.

The 7th grade requirement has been modified to include only the Tdap vaccine.

Public/Non-Public Pre-K

Diphtheria, Tetanus, and Pertussis (DTap)	Age-appropriate doses as indicated
Polio	Age-appropriate doses as indicated
Measles, Mumps, and Rubella	1 dose
Hepatitis B	2-3 doses depending on when child started the vaccine series
Varicella	1 dose
Haemophilus influenzae type b (Hib)	Age-appropriate doses as indicated

Hepatitis B

1. All students entering or attending public or non-public school will be required to have the hepatitis B vaccine series.
2. Children who have no documentation of the hepatitis B vaccine series should be admitted after the first dose, issued a temporary medical exemption, and scheduled for the next appropriate dose.
3. An alternate two-dose hepatitis B vaccine series for adolescents 11 through 15 years of age has been approved. Children in this age group who receive the two-dose series should be considered in compliance with Florida's hepatitis B immunization requirements for school entry and attendance.

Varicella

1. Beginning with the 2008/2009 school year, children entering kindergarten will be required to receive two doses of varicella vaccine. The light gray highlighted area below indicates the year the two-dose requirement becomes effective. Each subsequent year thereafter, the next highest grade will be included in the requirement. The black highlighted area indicates grades that fall under the one-dose varicella requirement. The one-dose varicella requirement started in 2001/2002 school year.
2. Effective July 1, 2001 children entering or attending childcare facilities or family daycare homes are required to have varicella vaccine.
3. Varicella vaccine is NOT required if there is a history of varicella disease documented by the health care provider in the space provided on the DH 680.

These shots are available at the Florida Department of Health Bay County (Health Department) at no charge, or at a private physician's office. Florida Department of Health Bay County, 597 West 11th Street, (850) 872-4455, ask for Immunizations. Immunizations does not take appointments, walk-in only. 7:30 am - 4:30 pm Monday – Friday; Tuesday 8:00 am - 4:30 pm.

Make sure your child gets into school.

Age-appropriate doses of the following vaccines are required for:

Child Care and/or Family Day Care Entry

- — Diphtheria-Tetanus-Pertussis (DTaP)
- — *Haemophilus influenzae* type b (Hib)
- — Measles-Mumps-Rubella (MMR)
- — Pneumococcal Conjugate (PCV)
- — Polio (IPV)
- — Varicella (Chickenpox) — either vaccine or history of disease documented by healthcare provider

Preschool Entry

- — Diphtheria-Tetanus-Pertussis (DTaP)
- — Haemophilus influenzae type b
- — Hepatitis B (Hep B)
- — Measles-Mumps-Rubella
- — Polio
- — Varicella (Chickenpox) — either vaccine or history of disease documented by healthcare provider

Kindergarten Entry

- — Diphtheria-Tetanus-Pertussis
- — Hepatitis B
- — Measles-Mumps-Rubella
- — Polio
- — Varicella (Chickenpox) — either vaccine or history of disease documented by healthcare provider

7th Grade Entry

- — Tetanus-Diphtheria-Pertussis (Tdap)—In addition to all other immunization requirements

Forms Required for Immunization Documentation

The Form DH 680, *Florida Certification of Immunization*, must be used to document the immunizations required for entry and attendance in Florida schools. These forms must be completed by a Florida physician or a Florida county health department. If moving to Florida, get a copy of your child's complete immunization history before leaving the current state of residence. The local county health department or your private provider will need this information to complete the Form DH 680.

Don't forget to take your child's immunization record with you to every doctor's appointment. Keep your child's record in a safe place. Documentation of immunization is required for entry into most colleges, universities, and the military.

FREQUENTLY PRACTICED HEALTH ROOM PROCEDURES

A frequently practiced health room procedure is the measurement of a student's body temperature. Following is a description of measurement of body temperature and temperature protocol.

Measurement of Body Temperature
Elevation of body temperature is one of the first signs of an infectious disease. If a student complains of any of the symptoms listed below or displays any other signs of communicable disease, the temperature can be a valuable tool in assessing illness.

STUDENT COMPLAINT

HEADACHE	RUNNY NOSE
NAUSEA/STOMACH ACHE	SORE THROAT
VOMITING	RASH
CHILLS	COUGH
RUNNY EYES	EARACHE
JOINT OR NECK STIFFNESS	

A body temperature above normal (usually 98.6°F orally, 97.6°F axillary) may mean there is an infection in the body somewhere. Someone has a fever if their body temperature is 100.4°F or greater (non-contact or axillary). Remember that temperature rises as the day progresses. If the temperature is equal to or greater than 100.4°F the student must be sent home.

RECTAL TEMPERATURE SHOULD NEVER BE TAKEN. ALL GLASS MERCURY THERMOMETERS SHOULD BE REMOVED FROM THE SCHOOL.

TEMPERATURE PROTOCOL:

1. Use only a non-contact thermometer.
2. **Do not take temperatures orally.**
3. Follow proper protocol for disposing of PPE and performing hand hygiene.
4. **If a student's temperature is high, do not cover him/her with heavy blankets, even though there may be complaints of "feeling cold".**

EMERGENCY FIRST AID SITUATIONS

School Personnel should check with the school administrators and/or school health nurses for protocol for the management of emergency first aid situations. The following classifications and suggested management of emergency situations are adopted from the American Academy of Pediatrics, School Health: A Guide for Professionals. The PanCare School Health Nurse should be notified as soon as possible.

The following conditions require immediate *treatment* and EMS. Call 911 and assist the student.

1. Acute airway obstruction, choking
2. Cardiac and/or respiratory arrest
3. Drowning or near drowning
4. Massive hemorrhage, uncontrollable bleeding
5. Internal poisoning
6. Anaphylaxis (systemic allergic reaction)
7. Neck or back injury
8. Chemical burn of the eye
9. Heat stroke
10. Penetrating or crushing chest wound

The following conditions require immediate *evaluation*. Call 911 and assist the student.

1. Vomiting large quantities of blood
2. Crushing chest pain
3. Any period of unconsciousness
4. Drug overdose
5. Major burns
6. Head injury with loss of consciousness
7. Penetrating eye injuries
8. Seizure, cause unknown

The following conditions suggest medical *consultation* within one hour:

1. Laceration with controlled bleeding
2. Insect bites and stings without anaphylaxis
3. Burns with blisters
4. Loss of teeth due to injury
5. Acute emotional state
6. Possible reaction to drugs
7. High fever (over 103°F)
8. Asthma/wheezing
9. Non-penetrating eye injury
10. Insulin reaction in diabetic
11. Sprains and possible fractures

The following conditions require *attention* **by a trained staff person with school nurse/appropriate school personnel.**

1. Convulsion in a known epileptic
2. Abdominal pain
3. Fever (100.4°F-103°F)
4. Eating Disorders
5. Suicide Ideation
6. Pregnancy
7. STDs

HEALTH SCREENING

Health screenings allow one to identify suspected abnormalities early so that confirmation may be sought and parents be offered guidance in having remedial problems corrected or improved. The role of the health technician should be to assist with screenings under the direction and/or supervision of the school health nurse.

The health technician should also assist with verifying that permission to perform non-invasive health screenings has been obtained from the parent or legal guardian and that it is on file, in accordance with PanCare and the district's policy. The health technician should be aware that when performing invasive health screenings, such as Blood Glucose Monitoring, written parental consent is required.

All students who have failed a health screening and whose parents/caregivers have been notified of a need for further medical intervention should be followed up with to ensure the needed services were received.

Vision Screening

Purpose
The purpose of vision screening is to test certain visual skills of every student before entering school and to retest at various grade levels.

The standards, techniques, and criteria for conducting and administering vision screening are based upon the recommendations of the Florida Medical Association's School Health Advisory Committee.

Population
Vision screening is offered to all students in grades K, 1, 3, and 6, and all new enterers in grades K-5. Students in other grades may be screened when a problem is suspected and they are referred.

Process
Vision screening is performed by individuals trained in vision screening technique. The school health technician may assist in the screening process. Rescreening may be performed on students with suspected abnormal findings. Referral slips are sent to parents after rescreening, notifying them that a problem is suspected.

Hearing Screening

Purpose
The purpose of the hearing screening program is to administer a standardized test to every student before he/she enters school and at various grade levels to identify those students who may have hearing impairments and to refer students who fail hearing screening to appropriate resources for professional care.

Population
Hearing screening is offered to all students in grades K, 1, and 6, and all new enterers in grades K-5. Students enrolled in other grades may be screened when a problem is suspected.

Process
Hearing screening is performed by individuals trained in Vision-Auditory Screening technique. The health technician may assist in the screening process.

Following review of the screening results with the school health nurse, re-screenings may be performed on students with suspected abnormal findings. Referral slips are sent to parents of students with abnormal findings after rescreening, notifying them that a problem is suspected.

Scoliosis Screening

Purpose
The purpose of the scoliosis screening program is to identify scoliosis, which initially is a symptom-free lateral curvature of the spine.

Population
Scoliosis screening is offered to all students in grade 6. Students enrolled in other grades may be screened when a problem is suspected.

Process
Individuals performing scoliosis screening are trained in the procedure for screening for scoliosis. The health technician may assist with scoliosis screening. Rescreening may be performed on students with suspected abnormal findings. Referral slips are sent to parents after rescreening, notifying them that a problem is suspected.

Growth and Development Screening

Purpose
Growth and development screening is performed to obtain accurate height and weight measurements. These measurements provide insight into the student's growth and development if taken at regular intervals.

Population
Height and weight measurement is provided to all students in grades 1, 3 and 6. Students enrolled in other grades may be screened when a problem is suspected.

Process
Individuals performing height and weight screenings are supervised by the screening coordinator. The health technician may assist in height and weight screenings. Rescreening may be performed on students with suspected abnormal findings. Referral slips are sent to parents after rescreening, notifying them that a problem is suspected.

USING THE DAILY LOG:
A GUIDE FOR SCHOOL PERSONNEL

OFFICE VISIT/ILLNESS: Code each student that comes into the health room as an office visit/illness. Office visits/Illness should equal the total number of Outcomes, excluding parent contacts.

When a student is seen for more than 1 concern they MUST be coded more than 1 time. Add additional codes per service information provided below.

1. FIRST AID: code any student that needs first aid help in the Health Room or anywhere else on campus.

2. LICE/HEAD CHECKS/SCABIES:

- **FTTY:** means **F**irst **T**ime **T**his **Y**ear this student has been seen for head lice or scabies.
- **Recheck:** if the student continues to have lice/scabies with rechecks, only record this **one time** as a Recheck.
- For additional rechecks on the same student record as an **Office Visit.**

3. MEDS:

A. **DAILY MEDS:** code oral, nasal, inhalers, nebulizers, topical, eye drops/ointments, ear drops, etc. as
OFFICE VISIT + MEDS

B. **EMERGENCY MEDS:** code diastat, glucagon, Benadryl/epi-pen, nebulizer treatment as **OFFICE VISIT + COMPLEX PROCEDURE + MEDS**

4. COMPLEX MEDICAL PROCEDURES: record the number of complex medical procedures. Complex medical procedures include but are not limited to: Carb Counting, Glucose Monitoring, Insulin Administration, Cardiac Monitoring, Catheterization, Urine testing for ketones. **EX.** Code carb counting , glucose monitoring, and insulin injection as
OFFICE VISIT + 2 COMPLEX PROCEDURES + MEDS

5. OUTCOME:

- **PARENT CONTACT:** This category is labeled “PARENT” but refers to any contact with another adult regarding a student - a parent, school personnel, health care provider and/or nurse. Each contact is coded as PARENT CONTACT. The contact can be in person, by phone, by note, or by email. **EX.**There were 5 contacts regarding 1 student so 5 PARENT CONTACTS would be recorded.
- **SENT HOME:** code only the students that meet the criteria for exclusion. If a student is returned to class and the parent chooses to pick the student up, this is not coded as “SENT HOME”.
  SYMPTOMS REQUIRING EXCLUSION ARE: FEVER 100.4, VOMITING, DIARRHEA, HEAD LICE, BODY RASH
  (CHICKEN POX, MEASLES), EYE CONDITION (RED, ITCHY, DISCHARGE)
  See School Health Handbook-Diseases that Require Exclusion from School chart for additional information.
- **RETURNED TO CLASS:** code each student that returned to class. Students who do NOT meet the criteria for exclusion are “Returned to Class”.
- **911:** code each 911 call here. If the parent comes to the school, signs a waiver with EMS and then takes the student home or to a doctor, this is still a 911 call. Code this as **OFFICE VISIT + 911 + COMPLEX PROCEDURE (for monitoring the student).** This

may need an additional code for MEDS if a medication such as glucagon, epi-pen or diastat is administered.

6. <u>REFERRED TO:</u> if a referral is made, code the type of referral. A student may have more than one referral:

Abuse, Dental, Guidance Counselor, Healthy Start, Kid Care, Health Care Provider/PCP/Telehealth

Social Worker, Substance Abuse

7. <u>TIME OUT</u>: record the exact time that every student leaves the Health Room.

8. <u>PANCARE/BDS INITIALS</u>: the PanCare/BDS employee providing the medical service **MUST** initial AND sign at the bottom of the LOG.

9. <u>REASON FOR THE VISIT</u>: record short notes indicating what happened with the student (ex. skinned knee in PE, stomachache, headache, cold pack, daily meds, temperature 101.3).
NO ABBREVIATIONS

Daily Log coding is a BDS, PANCARE, and FDOH audit requirement.

DAILY LOG- sample

PANCARE OF FLORIDA, INC.

2023-2024 DAILY HEALTH ROOM LOG

***REQUIRED FIELDS MUST BE COMPLETED**

*SCHOOL:_____ *DAY/DATE:_____

			*Visit Reason						*Outcome				*Referred To:										
*TIME IN	*GRADE	*NAME	*OFFICE VISIT/ILLNESS	FIRST AID	FTTY LICE/SCABIES	Lice/Scabies # Rechecks	MEDS	COMPLEX PROCEDURE	PARENT CONTACT	SENT HOME	RETURNED TO CLASS	911	Abuse	Dental	Guidance Counselor	Healthy Start	Kid Care	Health Care Provider PCP & TeleHealth	Social Worker	Substance Abuse	*TIME OUT	*PanCare/BDS INITIALS	*REASON FOR HEALTH ROOM VISIT Symptoms : Headache, stomach ache, meds, etc. Hall Pass Information All Visits (except routine medications) MUST be documented in Focus under Nursing Notes DO NOT ABBREVIATE
		TOTALS																					

*PRINT NAME:_____ *SIGNATURE/TITLE:_____

*PRINT NAME:_____ *SIGNATURE/TITLE:_____

*PRINT NAME:_____ *SIGNATURE/TITLE:_____

PC 07/23

FROM THE HEALTH ROOM

School:_____ Date:_____

Dear Parent/Guardian:

We tried to reach you by phone today to let you know that your child,_____ was seen in the health room for an:
____ Illness:_____
____ Accident:_____
_____ Other:_____

While in the health room your child received the following treatment:
____Rest and returned to class
____ Ice for comfort
____Cleansed area and applied band aid
____Stayed in the health room

Communicating with you when your child has a health concern is important to us. Please update your phone information in the Parent Portal. If you have any questions, please contact the school at _____.

Thank you,
_____, School Health Technician

FROM THE HEALTH ROOM

School:_____ Date:_____

Dear Parent/Guardian:

We tried to reach you by phone today to let you know that your child,_____ was seen in the health room for an:
____ Illness:_____
____ Accident:_____
_____ Other:_____

While in the health room your child received the following treatment:
____Rest and returned to class
____ Ice for comfort
____Cleansed area and applied band aid
____Stayed in the health room

Communicating with you when your child has a health concern is important to us. Please update your phone information in the Parent Portal. If you have any questions, please contact the school at _____.

Thank you,
_____, School Health Technician

ALLERGIC REACTION – FOOD/INSECT BITES/STINGS

DESCRIPTION:

Reaction to stinging insects may vary from mild to extremely severe. Mild reactions will be manifested by redness, swelling, and itching at the sting site. More severe reactions usually occur very rapidly and are manifested by difficulty breathing, swelling of the face and lips, itching, cold and clammy skin, possible loss of consciousness, shock, and eventual death if untreated.

Intervention is necessary if the student develops any of the following symptoms:

1. Sudden onset. Symptoms beginning within 15 minutes after exposure to an inciting agent usually results in the more severe type of anaphylactic reaction.
2. Feeling of apprehension, weakness.
3. Feeling of fullness in throat.
4. Change in quality of voice.
5. Tingling sensation around the mouth or face, nasal congestion, itching, wheezing.
6. May be accompanied by hives.

TREATMENT:

For mild reactions apply cool compresses to the sting. If stung, remove the stinger by scraping; do not squeeze venom sack as this may cause additional venom to be injected. For more severe reactions, you may be required to use the child's medication and/or call 911 immediately. The school personnel trained in cardiopulmonary resuscitation and first aid should be called to aid the student prior to the arrival of the rescue squad.

1. If the student is still at school in 15-20 minutes, repeat a dose of adrenaline.
2. Cover with blankets if necessary to keep warm, but don't allow blankets to interfere with handling or observation.

LIMITS:

Children with known sensitivities to stinging insects should not be restricted from normal activities. However, they should be alerted to avoid areas that might attract stinging insects. Bright colored, dark, or rough clothing, scented hair sprays, perfumes, and other cosmetics seem to attract bees. Do not go barefoot outdoors.

MANAGEMENT:

1. Report acute reactions immediately to the principal or appropriate designee in order to initiate appropriate first aid treatment.
2. For students with known sensitivities to stinging insects, ask parents to describe past reactions so school personnel will know what kind of reaction to expect.
3. Some children who have had extremely severe reactions in the past may be required by their physicians to keep medications to treat insect stings readily available.
4. Know if your student is one of these children.
5. Encourage him/her to wear Medic-Alert identification.
6. Before any medications are administered, be certain you have on file the required parental permission form with parent and/or legal guardian signature and a statement written by a licensed physician stating the type of medication, dosage, and time it is to be administered.

Children with a History of Severe Food Allergies or Insect Sting Reaction

1. Update FOCUS on all students identified as having severe allergies.
2. If the condition requires medication(s), the parent/guardian and the physician will need to complete the "Permission for Administration of Medication" form.
3. Request student specific training.
4. Trained school personnel, the parent/guardian and/or the child must always take the epinephrine injection on field trips and other school sponsored activities away from the school campus.

In Case of Sting or Exposure to known Anaphylaxis Trigger

1. If the student is experiencing anaphylaxis symptoms and the epinephrine injection has been ordered by a physician and approved by the parent/guardian, use it as soon as possible.
2. Follow the guidelines for administration for the specific epinephrine injection that has been ordered by the physician.
3. The epinephrine injection should take place before any other action, but does not substitute for medical help. Call 911 immediately.
4. If the student is having an anaphylactic reaction to a food, insect or environmental allergen, do not send her/him to the health room. Call/contact the front office immediately for assistance. PanCare and/or school personnel will bring the emergency epinephrine injection to the student's location on campus.
5. After a sting or exposure to an anaphylactic trigger, it is very important to observe for symptoms. An adult is to remain with the student at all times, until EMS arrives.

ANEMIA

DESCRIPTION:

An inadequate supply of iron resulting in an inadequate number of red blood cells (oxygen-carrying cells) in the blood.

PHYSICAL FINDINGS:

1. Lack of energy
2. Fatigue
3. Pale skin, eyelids, gums
4. Fast pulse
5. Loss of concentration
6. Irritability
7. Headache
8. Dizziness
9. Numbness/tingling in extremities.

MANAGEMENT:

1. May experience low energy levels and an abnormal feeling of tiredness.
2. Limit sudden movements (may cause dizziness).
3. In case of dizziness, stop activity and assume head-between-knees position.
4. Due to anemia, the student may have fainting problems and may often fall asleep during classes.

FOLLOW UP:

Notify parent(s)/guardian(s) as necessary.

ANOREXIA NERVOSA

DESCRIPTION:

1. Preoccupation with weight, food, calories, fat grams, and dieting.
2. Ninety-five percent of cases are girls 12-18.
3. Excessive exercising.
4. Denial of any problems.
5. Usually high academic achievers.
6. Extreme thinness (loss of at least 25% of normal weight).
7. Anxiety about gaining weight or being “fat”.
8. Denial of hunger.
9. Refusal to eat.
10. Usually, cessation of menstruation.
11. Abnormally slow heart rate and low blood pressure, which mean that the heart muscle is changing.
12. Often associated with bulimia (binges of over-eating followed by vomiting).

MANAGEMENT:

1. Refer to the school nurse and follow the individual care plan.
2. Document action taken on student’s progress note.

FOLLOW UP:

Notify parent(s)/guardian(s) as necessary.

APPENDICITIS

DESCRIPTION:

1. Fever – usually low, between 99°F and 102°F orally.
2. Location of pain – begins in the pit of the stomach or navel and progresses to the right lower quadrant of the abdomen.
3. Severity of pain – mild at first but always increases in severity. Pain becomes worse when moving, taking deep breaths, coughing, and sneezing.
4. Student states abdominal tenderness.
5. Facial expression – child looks uncomfortable, worried and apprehensive.
6. Position of comfort – child prefers to lie down, usually on the left side with the right leg drawn up.
7. Age differences – all findings progress more rapidly in younger children.
8. Nausea, vomiting – usually present.
9. Diarrhea – almost never present.
10. Constipation – almost always present.
11. Inability to pass gas.
12. Abdominal swelling

MANAGEMENT:

1. If a child has symptoms 1-5 of above descriptions on first evaluation, notify parents immediately.
2. If the student has pain, low grade fever and continues to complain of abdominal tenderness, keep the child in the health room and observe for 15 to 30 minutes.
3. If symptoms persist, notify the parent again and suggest the parent take the child to the physician.
4. If a parent or relative is not available, and symptoms persist, call 911.
5. Document action taken on student's progress note.

ASTHMA

DESCRIPTION:

An allergic condition which causes constriction of the muscles in the lungs, inflammation of the inner lining of the lungs, and excess secretions of the small bronchial tubes. This reaction is caused by a response to a foreign substance (pollen, dust), virus or bacteria, physical factors (cold, sunlight), or other agents in which the patient is allergic.

PHYSICAL FINDINGS:

1. Rapid or sudden onset.
2. Respiratory difficulty, with cough and wheeze.
3. Prolonged expiration.
4. No fever in typical cases.
5. Student breathes easier sitting up.
6. Symptoms may be initiated or made worse by exercise.
7. Observe for nasal flaring and sternal retractions.
8. Choking sensation.
9. Red runny nose.
10. Pale skin.
11. Red watery eyes.
12. Nausea.
13. Perspiration.
14. Chest tightness.

MANAGEMENT:

1. Refer to the school nurse and follow the individual care plan.
2. During an acute asthmatic episode:
    a. Reassure the student, keep quiet and in a sitting position. For most students, this procedure will be all that is necessary for a student who has chronic asthma.
    b. If the student with asthma has medication at school, follow the instructions provided on the Medication Administration form.
    c. If the student has severe difficulty breathing, call 911. Notify the parent or guardian and principal.
3. Document action taken on student's progress note. Remember to record the name of the medication, dosage and time given.

National Asthma Education and Prevention Program

MANAGEMENT OF ASTHMA EXACERBATIONS: *School Treatment*

Suggested Emergency **Nursing Protocol** for Students with Asthma Symptoms Who Don't Have a Personal Asthma Action Plan

A student with asthma symptoms should be placed in an area where he/she can be closely observed. Never send a student to the health room alone or leave a student alone. Limit moving a student who is in severe distress. Go to the student instead.

See list of **Possible Observations/Symptoms** on back.

Immediate Assessment:

Is the exacerbation severe?

» Marked breathlessness, inability to speak more than short phrases, use of accessory muscles, or drowsiness OR

Is the student at High Risk of a fatal attack?

» Risk factors for a fatal attack (see back)*.

YES → **Take Immediate Actions**

» Treat with inhaled SABA.

» **Call 911** (student to ED).

» Contact parent/guardian.

NO ↓

If available, measure PEF: Is PEF < 50% of predicted or personal best?

YES → **Take Immediate Actions** (as above)

NO RESPONSE ↓

Consider epinephrine for life-threatening attack only** (see back).

NO ↓

Check and record respirations, pulse, and PEF rate.

Initial Treatment

» **Inhaled SABA:** Up to two treatments 20 minutes apart of 2–6 puffs by MDI or nebulizer treatments. (Note: medication must be authorized by a personal physician order or standing protocol signed by the school physician or public health physician).

» Restrict physical activity, allow student to rest.

» Administer oxygen (if appropriate and available).

» Contact parent/guardian.

» Assess response after ~ 10 minutes.

Good Response

(PEF ≥80% and no wheezing or dyspnea)

» Reassess after 3-4 hours.

» Follow school protocol for returning to class.

Incomplete Response

(PEF 50–79% or persistent wheezing or dyspnea)

» Repeat inhaled SABA.

» Reassess after ~ 10 minutes.

» Call parent immediately if response remains incomplete.

Poor Response

(PEF <50% or marked wheezing and dyspnea)

» Repeat inhaled SABA.

» **Call 911** (Student to ED).

» Contact parent/guardian.

» Consider epinephrine for life-threatening attack only** (see back).

With parental permission, send a copy of the health room encounter report to the student's physician. Obtain a personal asthma action plan.

ED: emergency department
PEF: peak expiratory flow
MDI: metered-dose inhaler
SABA: short-acting beta2-agonist (quick-relief inhaler)

AUGUST 2011

Possible Observations/Symptoms (May include one or more of the following):

- Coughing, wheezing, noisy breathing, whistling in the chest.
- Difficulty or discomfort when breathing, tightness in chest, shortness of breath, chest pain, breathing hard and/or fast.
- Nasal flaring (nostril opens wide to get in more air).
- Can only speak in short phrases or not able to speak.
- Blueness around the lips or fingernails.

*Risk Factors for Death from Asthma

Asthma history

- Previous severe exacerbation (e.g., intubation or ICU admission for asthma).
- Two or more hospitalizations for asthma in the past year.
- Three or more ED visits for asthma in the past year.
- Hospitalization or ED visit for asthma in the past month.
- Using >2 canisters of SABA per month.
- Difficulty perceiving asthma symptoms or severity of exacerbations.
- Other risk factors: lack of a written asthma action plan, sensitivity to Alternaria.

Social history

- Low socioeconomic status or inner-city residence.
- Illicit drug use.
- Major psychosocial problems.

Comorbidities

- Cardiovascular disease.
- Other chronic lung disease.
- Chronic psychiatric disease.

** **Consider administering epinephrine** if the student is unable to use SABA because respiratory distress or agitation prevents adequate inhalation from the SABA inhaler device and nebulized albuterol is not available and the exacerbation is **life-threatening**. Administer epinephrine auto-injector in lateral thigh as per local or state epinephrine protocol. Epinephrine is NOT first line treatment for asthma. Albuterol is the treatment of choice. Administration of epinephrine should be rare and is intended to prevent a death at school from a severe asthma attack. Most school nurses will never need to administer epinephrine.

ED: emergency department ICU: intensive care unit SABA: short-acting beta2-agonist AUGUST 2011

ATTENTION DEFICIT/HYPERACTIVITY DISORDER (ADHD, ADD)

DESCRIPTION:

Implicated in learning disorders and described as excessive physical activity, developmentally inappropriate inattention and impulsivity. The symptoms vary per age. Children aged five through nine always “have their motor running” as they are constantly climbing and running. Preadolescents are restless and fidgety. Adolescents tend toward impulsive social behavior such as going joy-riding instead of doing homework.

TREATMENT:

The usual medical approach is treatment with amphetamines, and the most often prescribed is Ritalin. This and all medication will require Permission to Administer Medication form signed and completed by a physician and parent or guardian.

MANAGEMENT:

1. Children with attention deficit/hyperactivity should not have any physical limits.
2. Do not require the student to sit still for long periods of time.
3. Do not try to suppress over activity by scolding and punishment.
4. Good communication with parents, teachers, and school staff is essential.
5. Some children are put on amphetamines, such as Ritalin.
6. It is important for the teacher to relay any information about the child’s behavior changes to the child’s parent and physician.
7. The child will also need to be monitored for any side effects from the medication.
8. Follow the individual care plan and refer to school nurse if needed.
9. Document action taken on student’s progress note.
10. Some of the most frequent side effects are:
    a. Loss of appetite and poor weight gain
    b. Nausea, stomachache, or headache
    c. Increased motor activity
    d. Frequent crying spells with little provocation
    e. Irritability
    f. Drowsiness
    g. Zombie-like state
    h. Tics
    i. Addiction

BACK/NECK INJURY

DESCRIPTION:

1. Pain, made worse by pressure or movement (do not move).
2. Pain may radiate into the arm or leg.
3. Nerve involvement: weakness, tingling, numbness, or inability to move an arm or leg.

MANAGEMENT:

1. DO NOT MOVE, bend, or rotate the neck of a student.
2. Assess a student's ability to move extremities slowly, and only a small amount. Test response to stimuli such as a finger touch or pin prick.
3. If sensation is intact, pain is minimal to absent, and student can move all extremities normally, allowing student to slowly sit up and then walk.
4. If all neurologic signs are normal and the patient can move all extremities freely, ice may be applied to relieve pain.
5. If pain, sensory impairment, or weakness persists, have the student remain lying down.
6. Keep student lying straight, with their head in line with the body, or in the position found after injury.
7. Keep as quiet as possible.
8. Notify parent or guardian to arrange for care and transportation to the hospital or physician’s office.
9. In the absence of the parent or guardian, the school principal or someone designated by the principal should accompany the student to the emergency room.
10. Record nature of injury and action taken on student's progress note.
11. Complete an accident report per school policy and procedure.

Students with minor injuries who remain at school should be observed several times during the school day.

BITES: ANIMAL AND HUMAN (Skin Broken)

DESCRIPTION:

1. Pain and bleeding.
2. Puncture wounds and/or lacerations, usually jagged.
3. Pieces of tissue may be torn away in severe bites.

RABIES PROPHYLAXIS:

While it is theoretically possible for any mammal to develop rabies, rodents have not been implicated in transmitting the disease. Therefore, a child bitten by a squirrel, rat, mouse, or rabbit is not considered to be in danger, but a physician should be consulted. Common carriers of rabies are dogs, cats, foxes, skunks, and raccoons. Bats carry rabies, but rarely bite (airborne infection from bat guano is only a theoretical possibility). Children who touch a dead or sick bat are at risk, a physician should be notified. Unprovoked bites (especially from a dog) raise greater suspicion than if an animal is provoked or teased. The biting animal must be confined and observed for 10 days. Notify the police and/or the Health Department 850-872-4455. A biting dog or cat which cannot be apprehended must be presumed to have rabies. The bitten child will require preventive rabies shots. Bites on fingers and face are more dangerous.

PREVENTION OF INFECTION:

Dog bites are likely to be open, jagged lacerations which can be thoroughly washed with soap and water. They have a low infection rate, and usually do not require prophylactic antibiotics.

Cat bites are usually deep puncture wounds and have a high infection rate. They often require prophylactic antibiotics.

Human bites have the greatest potential for infection. Also, consider transmission of Hepatitis B or HIV.

PREVENTION OF TETANUS:

1. No previous active immunization with tetanus toxoid: Tetanus immune globulin and begin series of tetanus toxoid.
2. Active immunization 5 years ago or longer: Booster of tetanus toxoid (adult Td).
3. Active immunization within the past five years:
   a. Mild bite: no booster.
   b. Severe bite: booster adult Td.
   c. Severe, neglected, old (over 24 DOH) or dirty bites-adult Td, unless patient has had one in the previous 12 months.

MANAGEMENT:

1. Put on gloves and control bleeding by using direct pressure on the area, if needed.
2. Wash with copious amounts of soap and water.
3. Apply loose dressing.
4. Topical antibiotics may be applied by parent or guardian.
5. Refer all except the most minor bites (skin not broken) to the physician.
6. Notify parent or guardian and principal.
7. Document action taken on student's progress note.

Many Vaccine Information Statements are available in Spanish and other languages.
See http://www.immunize.org/vis or http://www.immunize.org/vis/vis_spanish.asp

BLOODBORNE PATHOGENS

INTRODUCTION

The term “Bloodborne pathogens” refers to germs that can be spread through contact with blood or body secretions, or by touching mucous membranes (the inside of the mouth or nose, the lining of the eyelids, the lining of the genitals, and the area of the rectum and anus). All body secretions and excretions are considered potentially a source of disease transmission EXCEPT SWEAT. A variety of germs can be spread through contact with blood or body fluids. The germs most commonly described as “bloodborne pathogens” are HIV (Human Immunodeficiency Virus), HBV (Hepatitis B Virus), HCV (Hepatitis C Virus), and Syphilis. For persons providing care to others, the best means of preventing themselves from becoming infected with one of these bloodborne pathogens is to follow STANDARD PRECAUTIONS.

DISEASE INFORMATION: HIV

HIV was first identified in the early 1980s. The virus attacks the immune system, the body’s natural defense against infections. Damage to the immune system leaves the body vulnerable to infection and certain types of cancer, which can be fatal. When HIV has caused enough damage for the person to be at risk for these infections and cancers, the person is said to have AIDS (Acquired Immunodeficiency Syndrome).

How is HIV transmitted?

HIV is spread by sexual contact with an infected person, by sharing needles and/or syringes (primarily for drug injection) with someone who is infected, or, less commonly (and now very rarely in countries where blood is screened for HIV antibodies), through transfusions of infected blood or blood clotting factors. Babies born to HIV-infected women may become infected before or during birth or through breast-feeding after birth. In the health care setting, workers have been infected with HIV after being stuck with needles containing HIV-infected blood or, less frequently, after infected blood gets into a worker’s open cut or a mucous membrane (for example, the eyes or inside of the nose).

Although the HIV virus has been found in laboratory specimens in tears and saliva, no documented cases of transmission have occurred through tears or through saliva unless visible blood was present in the saliva. HIV is not spread through casual contact. The list below delineates low risk activities and encompasses “casual contact.”

THERE IS NO EVIDENCE THAT THE HIV VIRUS CAN HE SPREAD BY THE FOLLOWING:

1. Occupying the same room with an infected person.
2. Touching or hugging an infected person.
3. Non-sexual body contact, such as sports.
4. Coughing or sneezing by an infected person.
5. Shaking hands with an infected person.
6. Sharing bath and toilet facilities with an infected person.
7. Eating a meal at the same table with an infected person.
8. Traveling in the same vehicle with an infected person.
9. Sleeping in the same room (or bed) with an infected person.
10. Using the telephone touched by an infected person.
11. Eating food prepared by an infected person.
12. Wearing clothing used by an infected person.
13. Light kissing (mouth to cheek) with an infected person.
14. Swimming in a pool or other water with an infected person.
15. Working next to or with an infected person on a continuing basis.

If a caregiver has a significant exposure to blood or body fluids, and the source individual is determined to have HIV, the exposed caregiver should be evaluated for post-exposure treatment as soon as possible. Post-exposure treatment for HIV is most effective if begun within the first two hours after the exposure.

DISEASE INFORMATION: HBV

Hepatitis B Virus (HBV) is a bloodborne virus that attacks the liver. Most people who become infected with HBV will be sick for a short time and then recover. However, the virus can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death.

How is HBV transmitted?

Hepatitis B Virus is spread the same way that the HIV virus is transmitted – through contact with blood or body secretions of an infected person. Just as indicated above for HIV, the most common ways a person is infected with HBV is through sexual contact, through sharing needles with an infected person, or babies born to an infected mother. Although HIV and HBV are transmitted in similar ways, the Hepatitis B virus is a much stronger virus than the HIV virus. Unlike HIV, which dies quickly on environmental surfaces, Hepatitis B can live in dried blood for a week or more. Studies of healthcare workers receiving injuries involving blood exposure from infected patients indicate that the risk of developing Hepatitis B infection after an exposure is 30 times higher than the risk of developing HIV after an exposure.

Casual contact with infected persons does not result in becoming infected with HBV. Many children in the school system and most healthcare workers have now been vaccinated against Hepatitis B. If a caregiver who has not been vaccinated against the disease has an exposure to an infected person, the caregiver should receive post-exposure treatment as soon as possible and definitely within 7 days of the exposure.

DISEASE INFORMATION: HCV

Hepatitis C virus is found in the blood of persons who carry the germ. Over half of the people who carry HCV in their blood will not become ill from the virus. In others, the virus will damage the liver and cause cirrhosis (scarring) of the liver, liver cancer, liver failure, and death. Several different strains of Hepatitis C virus are present in the world. Persons with one particular strain of the virus are those most likely to develop severe liver disease. Other factors which contribute to the progression of the disease include alcohol consumption, exposure to chemicals toxic to the liver, taking street drugs, and sniffing paint thinner, glue, and/or other toxic chemicals. Persons infected with both HIV and HCV are more likely to rapidly develop severe liver disease than persons with HCV alone.

How is HCV transmitted?

HCV is spread by contact with the blood of an infected person. The most common means of exposure is through sharing needles. Transfusions prior to 1996 are another common means of infection. Sharing straws for snorting Cocaine has recently been recognized as a significant risk for exposure. Unlike HIV and HBV, acquiring HCV through sex with an infected person is possible but has a very low rate of occurrence.

As with HIV and HBV, transmission of HCV does not occur through casual contact.

Caregivers exposed to the blood of a person infected with HCV should be evaluated and the exposure reported and recorded. A medication for post-exposure prevention of HCV does not currently exist. However, if the exposed caregiver does develop infection, early treatment of the infection can be initiated.

DISEASE INFORMATION: SYPHILIS

Syphilis is a disease (STD) caused by the bacterium Treponema pallidum. It has often been called “the great imitator” because so many of the signs and symptoms are indistinguishable from those of other diseases.

How is Syphilis Transmitted? Syphilis is passed from person to person through contact with blood of an infected person or through direct contact with syphilis sore. Sores occur mainly on the external genitals, vagina, anus, or in the rectum. Sores also can occur on the lips and in the mouth. Transmission of the organism occurs during vaginal, anal, or oral sex. Pregnant women with the disease can pass it to the babies they are carrying. Syphilis cannot be spread by toilet seats, door knobs, swimming pools, hot tubs, bath tubs, shared clothing, or eating utensils.

Caregivers exposed to the blood of people infected with syphilis should report the exposure and begin therapy in a timely manner. The usual treatment for syphilis exposure is penicillin.

CEREBRAL PALSY (CP)

DESCRIPTION:

Cerebral palsy (CP) is a non-progressive disorder resulting from damage to a portion of the brain that causes muscular disability. In most cases, the brain is damaged by disease or injury during fetal life, during the birth process, or shortly after birth.

Many children with CP can attend regular classes. They will obviously need some help, both academically and physically. Cerebral palsy can be so severe as to preclude standing, walking, or learning any self-help skills such as feeding or using the toilet. On the other hand, the condition can be so mild that the child is just thought to be excessively clumsy.

PHYSICAL FINDINGS:

1. Involuntary movements that affect motor function
2. Paralysis
3. Weakness
4. Incoordination
5. Irregular muscle function
6. “Scissors” gait and toe walking are characteristic
7. Movements increase with emotional tension

TREATMENT:

A large portion of children with CP receive medication; many have difficulty swallowing. Medications are also used to control convulsions or spasms. This and all medication will require a medication permission form completed and signed by a physician and parent or guardian. (Coordination of physiotherapy and occupational therapy helps the child learn skills of daily living. Counseling is also helpful for the parents as well as the children).

MANAGEMENT:

1. Maintain good communication with parents, teachers, staff and physician. Any changes should be made known to all that are coordinating the child’s care.
2. Praise accomplishments and encourage independence.
3. Maintain a safe environment.
4. Avoid stress by allowing extra time for projects if needed.
5. Coordination of physiotherapy.
6. Counseling if needed.
7. Refer to the school nurse and follow the individual care plan.

CHEST INJURY

DESCRIPTION:

1. Student states they were hit in the chest by another person or object.
2. Has a recent history of accident, sports injury, or child abuse.
3. Types of injury:
    a. Rib fracture or contusion. Chest wall is thin and compliant in younger children, so the heart or lungs can be injured without rib fracture.
    b. Pneumothorax (air in the chest) or hemothorax (blood in the chest).
    c. Bruised or lacerated lung.
    d. Cardiac tamponade (blood in space around the heart causing compression of heart).

PHYSICAL FINDINGS:

1. Symptoms such as pneumothorax can develop slowly, even over 1 or 2 days
2. Rapid shallow respirations
3. Painful breathing
4. Distended neck veins
5. Cyanosis, paleness
6. Muffled heart sounds
7. Low blood pressure, alteration in pulse

MANAGEMENT:

1. Ask the following:
    a. How long has the child experienced pain?
    b. Does it hurt more on inspiration?
    c. Describe the pain.
2. If there is no pain or other symptoms, allow the student to return to class and observe 1 hour later.
3. If any symptoms persist, notify parent/guardian, refer to physician.
4. Refer baseball chest injury to physician even though asymptomatic at the time. **(There have been recent reports of sudden or delayed coma leading to death in children who have been struck in the chest by a baseball.)**
5. Document action taken on student's progress note.
6. Complete an accident report per school policy and procedure.

PARENT RECOMMENDATIONS:

1. Alert parents about the dangers of baseball chest injury and signs to look for.
2. Refer to physician for complications.

CHICKEN POX (Varicella)

DESCRIPTION:

Chicken pox is an acute disease with sudden onset of slight fever, mild constitutional symptoms, and skin eruptions which leave a granular scab. Lesions commonly occur in successive crops, with several stages of maturity present at the same time. The lesions tend to be more abundant on covered than on exposed parts of the body. Parents should be alert for symptoms of Reyes' Syndrome when a child is recovering from a viral infection especially the flu, chicken pox, or an upper respiratory infection. These symptoms include persistent or continuous vomiting, listlessness, disorientation, delirium and convulsions. It is very important to never give a child aspirin or aspirin-containing medication when they have a virus.

PHYSICAL FINDINGS:

1. Slight fever
2. Mild constitutional symptoms
3. Circular skin eruptions with granular scabs

INFECTIOUS AGENT:

1. Virus

MODE OF TRANSMISSION:

Spread from person to person by direct contact:

1. Droplet
2. Airborne spread
3. Secretions of the respiratory tract

PARENT RECOMMENDATIONS:

1. Isolate the child from other children.
2. Calamine Lotion or Lubriderm on dry lesions.
3. Topical 1% hydrocortisone cream.
4. Oral antihistamines are usually not helpful, but the sedative effect of Benadryl may be helpful.

SPECIAL INSTRUCTIONS:

DON'T USE ASPIRIN. SEE REYE'S SYNDROME INFORMATION, on p.94

MAY RETURN TO SCHOOL:

One (1) week after eruption first appears or when all the blisters have crusted.

COMMON COLD VERSUS ALLERGIC RHINITIS

DESCRIPTION of COMMON COLD:

Sneezing, sore throat, nasal congestion, headache, burning and/or watery eyes, fever, chills, aches, cough and malaise may occur. Most common infectious disease, which is an acute viral infection of the upper respiratory tract, and usually lasts 5 to 7 days.

COLD	**ALLERGY**
Nasal discharge gradually thickens and crusts	Nasal discharge remains watery
Less sneezing	More sneezing
Duration 1-3 weeks	Comes and goes during the entire season
Cough starts dry and becomes loose; worse with exertion	Little or no cough
Watering eyes; eyes usually not red	Eyes usually red
More palpable or swollen lymph nodes in neck	Fewer palpable or swollen lymph nodes in neck
Sore throat	
General, all-over achiness	

REMEMBER:

Children with allergic rhinitis may also “catch a cold.”

MANAGEMENT:

1. Limit exercise if coughing is troublesome. Coordinate with PE teacher or parent.
2. Exclude from school if the student has a fever (100.4°F or greater).
3. Cover mouth and nose while coughing/sneezing; frequent hand washing.
4. Encourage high oral fluid intake.
5. Diet as tolerated.
6. Document action taken on student’s progress note.
7. Refer to physician for complications: earache, fever, vomiting, headache, loss of appetite, sore throat, etc.

PARENT RECOMMENDATIONS:

1. Encourage high oral fluids intake.
2. No aspirin under age 18. Use pain relievers per package and physician directions.
3. Refer to physician for complications.

MAY RETURN TO SCHOOL:

1. When fever-free for 24 hours without fever-reducing medication. Do not send children to school with fever (100.4°F or greater)

CYSTIC FIBROSIS (CF)

DESCRIPTION:

An inherited rare disease of certain exocrine glands – those which produce sweat, saliva, pancreatic digestive juice, respiratory tract mucous, etc.

1. Mucous produced by the exocrine glands is excessively thick, causing obstruction of the gland's output.
2. This leads to infection, scarring, and eventual failure of the gland.
3. Though the disease affects all exocrine glands in the body, the thickened mucous secretions of the lungs cause the major pathology, which leads to pulmonary insufficiency, enlargement of the heart, and eventual death.
4. Other symptoms result from pancreatic insufficiency leading to poor absorption of food from the intestine.
5. Cough usually appears in the first year of life. It is a wet productive cough and gradually gets worse.
6. Repeated episodes of pneumonia occur. The bronchial tubes dilate, and the chest enlarges. Breathing is noisy and wheezing.
7. Stools are large and foul smelling from lack of pancreatic juice to digest proteins. This is more common in babies. By the time children start school, they are usually taking supplemental pancreatic enzymes which alleviates most of the intestinal symptoms.
8. Other problems that occur are cirrhosis of the liver, duodenal ulcer, diabetes, depressed growth rate, chronic sinusitis with polyps and decreased fertility.
9. Salt loss occurs because the abnormal sweat glands excrete too much salt. During hot weather, or if the patient has a fever, extra fluid intake is usually sufficient. In extreme cases, supplemental salt may be required. The "sweat test" is used to diagnose CF.

TREATMENT:

There is no cure for CF. All treatment is aimed at alleviating the symptoms, thus prolonging and improving the quality of life. Treatment must be comprehensive; all aspects are interdependent and important.

1. Lung involvement can be treated with antibiotics, chest therapy, and aerosol inhalation.
   a. Antibiotics are given orally and intravenously to combat the chest infections that lead to scarring and eventual pulmonary insufficiency.
   b. Chest therapy means percussion, vibration, and positioning while the child is coughing. This helps loosen the thick mucus so it can be coughed up and spat out or swallowed. It is important that CF patients cough; they should never be given cough suppressants. Coughing is the body's method of clearing the lungs and preventing pneumonia. Suppression of the cough is dangerous and could be fatal. For the CF patient coughing is as essential as breathing. Chest therapy is easily learned and can be given at home by the parent.
   c. Aerosol inhalation with medicines that help liquefy secretions and dilate the airway can be used prior to chest therapy to help clear the lungs.
2. Nutrition is especially important in the younger years, but school age children may also need pancreatic enzyme supplements plus other special food, vitamin and mineral supplements. Students requiring pancreatic enzymes may carry this medication on them.
3. Exercise is important, but must be limited due to the child's decreased lung function. Therefore, exercise that does not unduly increase breathing or heart rate such as moderate walking, archery, or golf would be appropriate.
4. Other treatments are: use of oxygen, psycho emotional support, and educational support, such as homebound services when necessary – (without a waiting period).

MANAGEMENT:

1. Encourage cough to remove mucus from the lungs. Most children swallow their coughed up mucus. This is harmless and is just as useful as spitting it out.
2. Reassure others that the cough is non-contagious, refer to parent.
3. Maintain good communication with parent/guardian, teacher, staff and physician. Any changes should be made known to all that are coordinating the child's care.
4. Counseling is helpful to the parents and the child.
5. A plan of action should be developed in case the child dies. This should be coordinated with the school nurse, counselor, and principal. Death of a school child is traumatic to the students and faculty. It is best to be prepared.
6. Refer to school nurse and follow Individual care plan.
7. Document any action taken on the student's progress note.

DENTAL EMERGENCIES - INJURIES TO MOUTH & TEETH

DESCRIPTION:

Injuries to mouth and teeth. Pain due to bleeding, swelling or toothache. Toothache is usually caused by dental caries or periodontal disease and this problem does not represent an emergency or life threatening situation. However, immediate care is indicated due to pain and general discomfort of the student.

TREATMENT:

TOOTHACHE, BLEEDING, SWELLING, PAIN

1. Notify parent/guardian.
2. Reassure the student and keep the student as quiet as possible.
3. Record action taken on student's progress note.

HARD BLOW ON THE MOUTH RESULTING IN A BROKEN TOOTH OR A TOOTH KNOCKED OUT

1. Notify parent/guardian immediately and request parents come for the student immediately. Inform parents that the student must see a dentist immediately.
2. Control bleeding by direct pressure.
3. Place the broken tooth or knocked out tooth in a glass of milk.
4. Rinse the damaged area of the mouth with warm water.
5. Record action taken on student's progress note.
6. Send the tooth to the dentist's office with the child.

BITTEN TONGUE OR LIP

1. Control bleeding by direct pressure.
2. If severe, notify parent or guardian.
3. Record action taken on student's progress note.

ULCERS IN MOUTH OR BLISTERED MOUTH

1. Remove the source of irritation.
2. Have the student rinse his/her mouth with tap water.
3. Notify parent/guardian.
4. Record action taken on student's progress note.

FOREIGN OBJECT WEDGED BETWEEN TEETH

1. Try to dislodge object with dental floss. Do not use a toothpick.
2. If unsuccessful, notify parent or guardian.
3. Record action taken on student's progress note.

RED, SWOLLEN, OR SORE GUMS

1. Have the student rinse their mouth thoroughly with a warm salt water solution (¼ tsp. table salt in a 4-oz. glass of water).
2. Instruct the student to repeat rinses every two hours, and after eating or tooth brushing, and before retiring.
3. If there is no improvement in 1-2 days, refer to a physician or dentist.

FRACTURED JAW

1. Immobilize jaw by placing a scarf, handkerchief, tie or towel under the chin, tying the ends on top of the child's head.
2. Obtain immediate dental care.
3. Record action taken on student's progress note.

ORTHODONTIC EMERGENCIES:

Protruding wire from a brace can be gently bent out of the way to relieve discomfort by using a tongue depressor or pencil eraser. If wire cannot be bent easily, cover the end with a piece of gauze, a small cotton ball or dental wax, to prevent irritation. Do not try to remove any wire embedded in the cheek, gum, or tongue. Obtain orthodontic care on the same day.

MANAGEMENT:

1. Follow treatment guidelines.
2. Refer all injuries of the face, mouth and teeth to parent or guardian.
3. Document action taken on student's progress note.

DENTAL CLINICS

PanCare Dental Clinic: 850-747-3350

Florida Department of Health Bay County Dental Clinic: 850-872-4455

DIABETES, TYPE I

All DIABETIC STUDENTS MUST HAVE AN INDIVIDUALIZED CARE PLAN DEVELOPED BY THE SCHOOL HEALTH NURSE. PLEASE CONTACT YOUR SCHOOL HEALTH NURSE.

DESCRIPTION:

Insulin Dependent Diabetes Mellitus (IDDM) is the inability to metabolize carbohydrates, due to insulin deficiency. IDDM occurs in children and adults and is characterized by:

1. Extreme thirst
2. Increased appetite
3. Frequent urination
4. Rapid weight loss
5. Nausea, vomiting and headache
6. Weakness and fatigue
7. Confusion and disorientation
8. Coma and death

HYPOGLYCEMIA (low blood sugar)

Hypoglycemia occurs due to too little food, too much insulin, or too much exercise. Symptoms develop suddenly and may progress to insulin shock.

Signs and symptoms:

1. Early: shaky, sweaty, pale, hungry, irritable, fast pulse, stomachache, nausea, and vomiting
2. Late: confusion, poor coordination, restlessness, mood changes (aggression, crying, bizarre behavior)
3. Advanced: convulsions and coma; permanent brain damage can result if reaction is untreated

TREATMENT:

Conscious and able to swallow.

1. Determine level of consciousness and check blood sugar level.
2. Give oral glucose: 4 oz. orange juice, soft drinks, candy bar, glucose tabs or gel. These items must be available at all times.
3. Wait 15 minutes and retest blood sugar level. If blood sugar level is above 70 and no signs or symptoms may return to class. If blood sugar level below 70 repeat oral glucose. If a student is not noticeably improved in 15 minutes notify the parent/guardian and refer to the student's individual diabetes medical management plan.
4. Follow with lunch or light snack, cheese crackers, ½ meat sandwich or peanut butter and 8 oz. milk.
5. Always notify parent/guardian of any event.
6. Record incident and action taken on student’s progress note.

Unconscious or unable to swallow (Do not leave alone)

1. Place in recovery position on their side.
2. Administer glucose gel and call 911 for assistance.
3. If available, give 0.5-1.0 mg glucagon IM (requires Permission to Administer Medication form and individualized training).
4. Notify Emergency Medical Service.
5. Notify parent/guardian and record incident and action taken on student’s progress note.

CHANGINGlife WITHDIABETES

Hypoglycemia (Low Blood Glucose)

Some Symptoms:

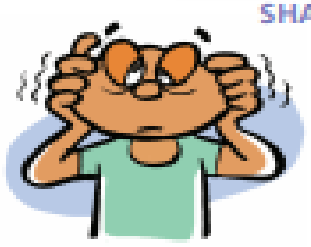
Causes: Too little food or skipping a meal; too much insulin or diabetes pills; more active than usual.

Onset: Often sudden.


SHAKY


FAST HEARTBEAT


SWEATING

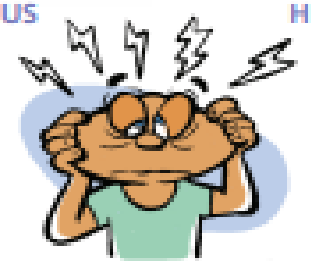

DIZZY


ANXIOUS


HUNGRY


BLURRY VISION


WEAKNESS OR FATIGUE


HEADACHE


IRRITABLE

IF LOW BLOOD GLUCOSE IS LEFT UNTREATED, YOU MAY PASS OUT AND NEED MEDICAL HELP.

What Can You


CHECK your blood glucose, right away. If you can't check, treat anyway.


TREAT by eating 3 to 4 glucose tablets or 3 to 5 hard candies you can chew quickly (such as peppermints), or by drinking 4-ounces of fruit juice, or 1/2 can of regular soda pop.


CHECK your blood glucose again after 15 minutes. If it is still low, treat again. If symptoms don't stop, call your healthcare provider.

For more information, call the Novo Nordisk Tip Line at 1-800-260-3730 or visit us online at ChangingDiabetes-us.com.

Concept developed by Rhonda Rogers, RN, BSN, CDE

novo nordisk®

HYPERGLYCEMIA (High blood sugar)

Hyperglycemia occurs due to too much food, too little insulin, illness or stress. Symptoms develop gradually and may progress to diabetic coma.

Signs and symptoms:

1. Early: extreme thirst and hunger, frequent urination, dry skin, blurred vision, drowsiness, nausea, headache
2. Late: confusion, drowsiness
3. Advanced: seizures, coma or death

TREATMENT:

Do not leave alone.

1. Check blood sugar level.
2. If blood sugar is less than 250, the student can eat a regular lunch; if sugar is greater than 250 refer to parents immediately. Notify the lunchroom to substitute high sugar foods with fruit. (Do not withhold lunch). If blood sugar is high and the child has signs and symptoms, request parent/guardian to pick up the child and notify physician.
3. Notify parent/guardian of increased blood sugar level.
4. Record actions taken on the student's progress note.

MANAGEMENT:

1. Establish liaison with parent, physician and school health personnel.
2. Inform principal, teachers (special areas and P.E.) and cafeteria manager of the student with diabetes.
3. Observe for signs and symptoms of high and low blood sugar.
4. Check blood sugar as ordered by physician.
5. Document any actions taken on the student's progress note.
6. Refer to school nurse and follow individual care plan.
7. Students with diabetes that have physical complaints or symptoms should be accompanied at all times.

Do not leave the student alone or send them to the bathroom or health room alone.

CHANGINGlife WITHDIABETES

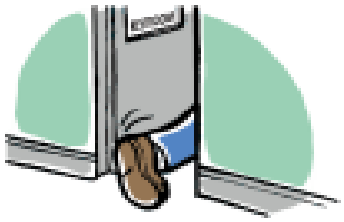
Hyperglycemia (High Blood Glucose)

Causes: Too much food, too little insulin or diabetes pills, illness, or stress.

Onset: Often starts slowly.

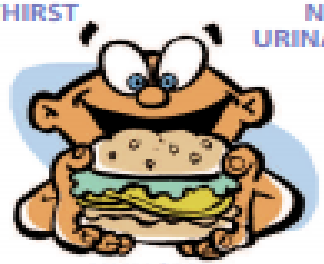
Some Symptoms:

EXTREME THIRST



NEED TO URINATE OFTEN

DRY SKIN



HUNGRY

BLURRY VISION

DROWSY

SLOW HEALING WOUNDS

HIGH BLOOD GLUCOSE MAY LEAD TO A MEDICAL EMERGENCY IF NOT TREATED.

What Can You Do?

CHECK BLOOD GLUCOSE

If your blood glucose levels are higher than your goal for three days and you don't know why,

CALL YOUR HEALTHCARE PROVIDER

For more information, call the Novo Nordisk Tip Line at 1-800-260-3730 or visit us online at ChangingDiabetes-us.com.

Concept developed by Rhonda Rogers, RN, BSN, CDE

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ENCOPRESIS

DESCRIPTION:

Fecal incontinence associated with fecal soiling of clothes and fecal odor. The student may be aggressive/disruptive or passive/withdrawn, depending on personality. Poor peer acceptance is common.

1. Fecal impaction with dribbles of liquefied stool around edges of impaction (most common).
2. Psychological – “withholding” stool (less common).
3. Congenital anal strictures or bands (rare).
4. Anal fissure causing painful bowel movement.
5. Child is too young to be toilet trained; children between 3 and 5 often are not yet fully trained. They need access to the toilet in or adjacent to the classroom.

TREATMENT:

1. Refer to parent/guardian for a change of clothes.
2. Refer to school nurse for evaluation, referral and follow-up.
3. Record action taken on student’s progress note.

MANAGEMENT:

1. Differentiate between staining of underpants with small amounts of stool and underpants that contain a full-size bowel movement. Children with impaction show lesser amounts of stool.
2. Make wash-up facilities plus change of clothing available. Protect the child's problem from other children as much as possible.

EYE TRAUMA

DESCRIPTION:

1. History of blow or another trauma to the eye.
2. Pain in the eye.
3. Redness of conjunctiva, tearing.
4. Eye held closed.
5. Alteration in vision.

TREATMENT:

1. If a student is unable to open their eye, do not force them. Apply cool cloth until the child can open his/her eye freely.
2. Check for visible lacerations on lids or eyeball. A small cut may be the only external evidence of a penetrating injury.
3. Check for foreign body.
4. Check for fluid or blood. May be accompanied by drowsiness.
5. Check for diplopia (double-vision).
6. Check extraocular movements.
7. Check for unequal or irregular pupils.
8. Check for vision one eye at a time, with a Vision Chart, if not available, have them look at something and try to read. Also, check for blurring and/or clarity.
9. Ice packs may be used if physician referral is not necessary.
10. Patch both eyes with 4X4 gauze pads prior to referral to physician (this minimizes eye movement).
11. Document any action taken on the student's progress note.
12. Refer to the school nurse for follow-up.

MANAGEMENT:

1. Refer to a physician if there is laceration on lid or other visible trauma to lid or eyeball, or if vision is impaired in any way.
2. Refer to parents for any eye injury.
3. CALL 911 FOR SEVERE EYE INJURY.

NOTE: Many school children are now wearing contact lenses which may lead to eye problems because the children often do not know how to exercise the proper care required to wear contacts.

FEVER

DESCRIPTION OF FEVER:

1. Temperature 100.4°F or greater. A lower temperature is not considered fever.
2. Students with fever (100.4°F or greater) MUST be sent home. They need to remain fever-free for 24 hours without fever-reducing medication before returning to school.
3. In most mild, 2-5-day childhood illnesses, fever is lowest in the morning, rises in afternoon, and is highest in the evening and at night. As the child begins to recover, the morning temperature will be normal with fever still present later in the day.

MANAGEMENT:

1. Isolate students who have a fever (100.4°F or greater) at school from others until they can go home.
2. Call the parent/guardian and notify them that the student has a fever and MUST go home.
3. Take the student's temperature every 30 minutes and chart the temperature on the Daily Log, in Focus and on the Parent Information Sheet for FEVER. Do this while waiting for the parent/guardian to pick the student up. Give the Parent Information Sheet for FEVER to the parent/guardian at pick up.
4. Immediately notify the school administrators and your Supervising nurse, if the parent/guardian says they are unable to pick the student up or if they refuse to pick the student up.
5. Offer plenty of water to avoid dehydration.
6. Call 911 if the fever is 104°F or above, regardless of the presence of other symptoms.

SUPERVISING NURSE

1. The Supervising Nurse will notify the District Nurse if the student has a fever and the parent/guardian is unable to pick the student up or refuses to pick the student up.

MAY RETURN TO SCHOOL:

1. When fever-free for 24 hours without fever-reducing medication.

ENVIRONMENTAL CLEANING

1. Schools should follow CDC and FDOH standard procedures for routine cleaning and disinfecting for COVID-19.

   https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html

PARENT INFORMATION SHEET

FEVER

Date: _____ School:_____

Dear Parent/Guardian:

One of the top priorities of Bay District Schools is the safety, health and well-being of our students and staff. We appreciate your efforts to work with us to provide a healthy environment for your student. A critical component of a healthy school environment is keeping children home from school if they are sick, especially when they have a fever.

Your child _____, was checked today for a fever.

FEVER: Temperature of 100.4°F or greater. A lower temperature is not considered fever.

EXCLUSION: Exclusion is mandatory with a temperature of 100.4°F or greater.

MAY RETURN TO SCHOOL: When fever-free for 24 hours without fever-reducing medication.

TEMPERATURE LOG

DATE	TIME	TEMPERATURE °F	HEALTH ROOM STAFF

FIFTH DISEASE (Erythema Infectiosum)

DESCRIPTION:

Called “Fifth Disease” because it was identified after red measles, German measles, scarlet fever and roseola.

MODE OF TRANSMISSION:

Droplets from respiratory secretions or secondarily by hands. About 50% of adults have had the disease as children and thus are immune.

INCUBATION PERIOD:

1-2 weeks. The most contagious period is just before the onset of fever, gradually declining during the following week and low to absent by the time the rash appears.

SYMPTOMS:

1. About a week after exposure, the patient develops a low-grade fever which lasts 5-7 days and then recovers with no other symptoms.
2. About a week after the fever goes away, a distinctive rash may appear. It resembles the appearance of a slapped cheek and there is a pink, lacy rash on the trunk, arms and legs. Adults, especially women, may have joint pain and swelling at this stage.
3. Often there is neither fever nor rash with this disease.

RECOMMENDATIONS AND SCHOOL RELEVANCE:

1. Children with the rash of Fifth Disease do not need to be isolated because they are no longer contagious by the time the rash is made.
2. Children with unusual long term blood diseases need special consideration.
3. Exposed pregnant women need advice from their physician or an infectious disease specialist.
4. Hand washing and proper tissue disposal should be scrupulously practiced.

FOREIGN BODIES: EYE, EAR (INCLUDING EARWAX), NOSE

FOREIGN BODY IN EYE:

1. Students should not rub their eyes.
2. Turn the eyelid up or down to look for foreign body. If seen, remove carefully with gauze pad. Notify parent/guardian and if pain is present after removal, advise parent/guardian to consult physician. Have the student close eyes until seen by a physician.
3. If the foreign body is not seen or is embedded in the eyeball, notify the parent/guardian to consult a physician. Have the student close eyes until seen by a physician.

FOREIGN BODY IN EAR:

1. Notify parent/guardian.
2. All objects should be removed by a physician; do not try to dislodge them.
3. Advise the parent/guardian to consult a physician.

FOREIGN BODY IN NOSE:

1. Students may attempt to blow objects out of their nose.
2. Do not attempt to remove foreign body with fingers or utensils.
3. Refer to parents and/or nurses.

FRACTURES, SPRAINS, AND DISLOCATIONS

SIGNS AND SYMPTOMS:

PAIN RAPID SWELLING DISLOCATIONS TENDERNESS

MANAGEMENT:

1. DO NOT MOVE the injured part and keep the student as comfortable as possible. Call 911 for all possible long bone injuries.
2. Notify parent/guardian.
3. In order to reduce pain and swelling, a cold pack may be used.
4. If unable to contact parent/guardian, call the emergency contacts. If you are unable to reach the emergency contacts this person, call 911. Have student's emergency contact information available for the emergency medical team.
5. Record incident on the daily health log and student's progress note. Follow BDS Incident Reporting Protocol (SAR) per school policy.

IF BONE IS PROTRUDING OR THE STUDENT SHOWS SIGNS OF SHOCK OR BLEEDING:

1. Call 911. Control bleeding with direct pressure elevation and/or use pressure points.
2. Raise feet.
3. Continue with the above procedure.

HAND, FOOT & MOUTH DISEASE (Coxsackievirus)

DESCRIPTION:

Name comes from the most common areas that rash appears.

MODE OF TRANSMISSION:

Droplets from respiratory secretions, airborne or secondarily by hands. About 50% of adults have had the disease as children and thus are immune.

An infected person may spread the viruses that cause hand, foot, and mouth disease to another person through: close personal contact, the air (through coughing or sneezing), contact with feces, contact with contaminated objects and surfaces.

INCUBATION PERIOD:

Most contagious during the first week of illness. People can sometimes be contagious for days or weeks after symptoms go away; people can continue to shed the virus for 1-3 weeks. The virus can survive for up to 4 days without a host. Some people, especially adults, may not develop any symptoms, but they can still spread the virus to others.

SYMPTOMS:

1. A skin rash with red spots, and sometimes with blisters, may also develop over one or two days on the palms of the hands and soles of the feet; it may also appear on the knees, elbows, buttocks or genital area. Children with the rash of Hand, Foot & Mouth Disease do not need to be isolated because they are no longer contagious by the time the diagnosis is made.
2. There is no specific treatment for H, F, M disease. OTC meds are sometimes needed to relieve pain and fever. If the oral temperature is 100.4°F or greater, then the child should be excluded from school until the fever is no longer present. The parent/guardian should talk with their healthcare provider to determine when it is appropriate for the child's return to school.

PARENT INFORMATION SHEET

HAND, FOOT & MOUTH DISEASE

Date: _____ School:_____

Dear Parent/Guardian:

Your child _____, was seen in the Health Room for what appears to be Hand, Foot, Mouth Disease.

DESCRIPTION:

Transmission: The viruses that cause H, F, and M disease (Coxsackievirus) can be found in an infected person's: nose and throat secretions (such as saliva, sputum, or nasal mucus), blister fluid, and feces (stool); it is a common viral illness that usually affects infants and children younger than 5 years old.

PARENT RECOMMENDATIONS:

Wash hands frequently.

Exclusion:
Exclusion is not mandatory with H, F, & M disease. There is no specific treatment for H, F, & M disease. OTC meds are sometimes needed to relieve pain and fever. If the oral temperature is 100.4°F or greater, then the child should be excluded from school until the fever is no longer present. The parent/guardian should talk with their healthcare provider to determine when it is appropriate for the child's return to school.

Evaluation:
Generally, a person with H, F, and M disease is most contagious during the first week of illness. People can sometimes be contagious for days or weeks after symptoms go away; people can continue to shed the virus for 1-3 weeks. The virus can survive for up to 4 days without a host. Some people, especially adults, may not develop any symptoms, but they can still spread the virus to others. Therefore, people should always try to maintain good hygiene (e.g. hand washing) so they can minimize their chance of spreading or getting infections.

Keep child's fingernails short and clean.

Stress the importance of good hand washing, and avoid contact with child's washcloth, towel or bed linen.

BDS PROTOCOL FOR CONTAGIOUS INFECTIONS
HAND, FOOT, AND MOUTH DISEASE

Following physician's diagnosis and parent notification to school:

School Administrator Procedures:

1. Notify – Student Services at 767-4311
2. Notify – Transportation at 767-4488 if the student is a bus rider; provide bus number(s)
3. **School Environmental Cleaning:** the diagnosed student(s) classroom(s) and designated common areas should be cleaned daily for 3 weeks (per the FDOH-BC) with a bleach water wipe down or disinfectant. Note: The Principal determines which areas on campus need to be cleaned.
4. Prevention actions: Wash hands often with soap and water; if water is not available use hand sanitizer with at least 70% alcohol; clean and disinfect frequently touched surfaces, avoid close contact; sneeze in arm
5. Alert school staff to watch for symptoms

Student Services Procedures:

1. Notify the Superintendent or his designee
2. Notify the Executive Director for Operations (Doug Lee)
3. Notify the Florida Department of Health Bay County at 252-9604 x1196

Transportation Office Procedures:

1. **Bus Environmental Cleaning:** If the student(s) is/are a bus rider, the diagnosed student(s) bus should be cleaned daily for 3 weeks (per the FLDOH-BC) with a bleach water wipe down or disinfectant.
2. Parent Notification for Multiple Classroom/School-Wide Outbreak:
   a. A school-wide outbreak is 2 or more confirmed or treated cases within a 4-week period. The FLDOH-BC determines if it is a school-wide outbreak.
   b. FLDOH-BC provides a parent letter to go home with students (for multiple classrooms or school-wide outbreak). The school administrator also posts the parent letter to the school website (school-wide outbreak only).
   c. School administrator sends a school-wide IRIS Alert notifying parents there are confirmed cases at the school (school-wide outbreak only).

HEAD INJURY

SIGNS OR SYMPTOMS:

HEADACHE	IMPAIRED CONSCIOUSNESS	DIZZINESS
NAUSEA	UNEQUAL PUPILS	VOMITING
AMNESIA	LOSS OF CONSCIOUSNESS	
BLEEDING FROM EARS, NOSE, AND MOUTH		

MANAGEMENT:

1. DO NOT MOVE STUDENT
2. Call 911 or delegate to staff
3. Immobilize head in position found, especially if neck injury is suspected.
4. Keep student quiet and lying down (without pillow) and maintain an open airway.
5. If vomiting, turn head and body to the side as a unit, keeping the neck and spine in line.
6. Do not give fluids.
7. In the absence of the parent or guardian, the school principal or someone designated by the principal should accompany the student to the emergency room.
8. Record nature of injury and action taken on the daily health log and student's progress note.
9. Complete an accident report per school policy and procedure.
10. For minor head injuries, contact parents by phone and notify the school administration.

HEAD INJURY
PARENT INFORMATION SHEET

School: _____ Date/Time of Injury:_____

Dear Parent/Guardian:

As we discussed on the phone today, your child, _____ received a minor injury to the head and was seen in the health room. No apparent problems were observed, but sometimes symptoms can occur several hours later. Therefore, you should watch for any of the following.

1. Severe headache
2. Nausea and/or vomiting
3. Double vision, blurred vision,or pupils of eyes appear to be different in size
4. Loss of muscle coordination, such as falling, walking strangely, or staggering
5. Any unusual behavior such as being confused, breathing irregularly, or dizziness
6. Convulsion
7. Bleeding or discharge from the ear
8. Your child should be checked carefully at bedtime and awakened at midnight (if bedtime is 8-9 p.m.) just enough to be sure he/she can be awakened and seems normal.
9. If your child shows any signs listed above, contact your doctor or hospital emergency room.

☐ We could not reach you by phone today. Communicating with you when your child has a health concern is important to us. Please update your phone information in the Parent Portal.

If you have any questions, please contact the school at _____.

Thank you,

_____, School Health Technician

HEADACHES, CHRONIC

DESCRIPTION:

A child experiencing chronic headaches may have a sudden or gradual onset of pain in the head. Headache is a common symptom of emotional anxiety as well as organic disease.

TREATMENT:

1. A short rest in the clinic is usually all that is necessary.
2. However, many children have headaches often, and parents will ask the school nurse or principal to give the child acetaminophen whenever he/she complains of a headache.
3. A permission form by a licensed physician is required to give the medication.

LIMITS:

A child with chronic headaches should not be restricted from normal activities.

MANAGEMENT:

It is important to maintain contact with the parent/guardian to inform them of headaches and medication given, and talking with the teachers/staff to let them know that the child does have chronic headaches, especially if they have medication ordered.

HEAT-RELATED ILLNESSES

	Physical Findings	Treatment
Sunburn	Redness and pain. In severe cases swelling of skin, blisters, fever, headaches.	Lotions and creams may be needed for mild cases with unbroken blisters. If breaking occurs, apply dry sterile dressing. Serious, extensive cases should be seen by a physician. Permission to Administer Medication form necessary for use of lotions and creams.
Heat Syncope (Fainting)	Same as simple fainting but is associated with heat and exercise.	If lying, elevate legs. If feeling faint, have student lie or sit with head between knees.
Heat Cramps	Painful spasms usually in muscles of legs and abdomen possible. Heavy sweating.	Firm pressure on cramping muscles, or gentle massage to relieve spasm. Give sips of water. If nausea occurs, discontinue water. Move to a cooler environment.
Heat Stroke (Sunstroke)	High body temperature (106oF or higher). Hot and dry skin. Rapid and strong pulse. Possible unconsciousness.	Move the victim to a cooler environment. Reduce body temperature with cold bath or sponging. Use extreme caution. Remove clothing, use fans and air conditioners. If temperature rises again, repeat. HEAT STROKE IS A SEVERE MEDICAL EMERGENCY. SUMMON EMERGENCY MEDICAL ASSISTANCE OR GET THE VICTIM TO A HOSPITAL IMMEDIATELY. DELAY CAN BE FATAL.
Heat Exhaustion	Heavy sweating, weakness, skin cold, pale, clammy. Pulse thread. Normal temperature possible. Fainting and vomiting.	Get victim out of sun. Lay victim down and loosen clothing. Apply cool, wet cloths. Fan or move victim to air conditioned room. Sips of water. If nausea occurs, discontinue water. If vomiting occurs, seek immediate medical attention.

MANAGEMENT:

Notify parents of all heat-related illnesses.

HEPATITIS A AND B

DESCRIPTION:

An inflammatory condition of the liver caused by a viral infection. Both viruses have different methods of transmission, hepatitis A (fecal, oral) vs. hepatitis B (blood and body fluids).

PHYSICAL FINDINGS ARE THE SAME FOR HEPATITIS A & B IN EARLY STAGES:

1. Fever, malaise, headache, fatigue.
2. Loss of appetite, nausea, stomachache, vomiting.
3. Jaundice.
4. Dark urine, light colored stools.
5. Mild in most cases; children are well in 7 days or less.
6. May have all symptoms except jaundice. Usually remain undiagnosed but are just as contagious.

MANAGEMENT:

1. Student may return to school as soon as afebrile, feels well, and has a good appetite.
2. Prolonged exclusion is rarely necessary.

MAY RETURN TO SCHOOL

When fever is no longer present.

HEPATITIS B – See also: Bloodborne Pathogens, p.46

HERPES SIMPLEX I (Cold Sores, Fever Blisters)

DESCRIPTION:

Infection caused by the Herpes Simplex I Virus, which has an affinity for the skin and nervous system.

PHYSICAL FINDINGS:

1. Small, dark to light, grayish-amber crusts around nose or lips.
2. “Canker-sores” inside cheeks or tongue may or may not be due to herpes simplex virus.
3. May come and go in susceptible children.
4. Usually comes and goes over a period of 1-3 weeks and then disappears.
5. May reappear with emotional or physical stress, (e.g., following pneumonia).

SPECIAL INFORMATION:

Herpes Simplex is contagious by contact but does not require exclusion from school.

MANAGEMENT:

1. Encourage frequent hand washing and discourage touching infected areas.
2. Refer parent to physician for topical medication to relieve discomfort and shorten the length of an outbreak.

HEMOPHILIA

DESCRIPTION:

Blood disorder is characterized by prolonged bleeding times due to lack of clotting factor.

PHYSICAL FINDINGS:

1. Mild cuts, bruises, and abrasions not a serious problem; they bleed longer, not faster.
2. Internal bleeding may occur anywhere in the body and is a serious problem.
3. Muscles and joints: tingling sensation, pain, warm and tender to touch, limitation of motion.
4. Abdominal: pain, tenderness, nausea.
5. Intracranial: headache, dizziness, visual disturbances, signs of a stroke.
6. Subcutaneous: large, purplish areas firmer than surrounding skin.
7. Prolonged bleeding likely to occur after dental extraction.
8. In severe cases frequent joint bleeding may lead to crippling.

MANAGEMENT:

1. Follow physician and parental recommendation.
2. Firm pressure for 10 minutes over skin lacerations or abrasions. Ice pack may help.
3. NO ASPIRIN (prolongs bleeding time).
4. Carefully observe student following minor trauma for possible internal bleeding.

FOLLOW-UP:

1. Refer to school health nurse for care plan.
2. Observe for early bleeding episodes. Many children do not report early bleeding even if they know it is beginning.
3. Notify parent/guardian of incident.

HIVES (Urticaria)

HISTORY:

A skin allergy which may be due to the following factors - in order of frequency:

1. Foods.
2. Medications.
3. Emotional factors.
4. Inhalants (e.g., pollens, dust).
5. Contact substances (e.g., dust, plants, cleaning products).
6. Physical factors (e.g., sun, cold).

PHYSICAL FINDINGS:

1. Round, reddish-pink wheals on the skin surface in size from ½ cm to 2-3 cm.
2. May become larger.
3. Tend to be clear in center with surrounding redness.
4. Not tender or painful, but itchy.
5. Characteristically short-lived but reappear, often in other parts of the body.
6. May be accompanied by swelling of lips, eyes, fingers, genitalia.
7. LARYNGEAL EDEMA IS THE MOST SERIOUS COMPLICATION: hoarseness and difficulty breathing.

MANAGEMENT:

1. Call parent/guardian.
2. Cold compresses for itching.
3. Give antihistamine or other medications prescribed by physician.
4. Keep in health room to make sure systemic symptoms not present.
5. If breathing difficulty present evacuate to medical facility immediately.

FOR KNOWN ALLERGIES FOLLOW INDIVIDUALIZED HEALTH CARE PLAN

IMPETIGO

DESCRIPTION:

Impetigo is a contagious skin infection which can spread to various parts of the body, and to other susceptible people. Impetigo is a sore with purulent drainage or honey-colored crusting, and may have localized redness.

TREATMENT:

If a student appears to have impetigo:

1. Wash area(s) with soap and water.
2. Cover with Band-Aid.
3. All impetigo sores must be covered during school attendance.

MANAGEMENT:

1. Give parents impetigo information sheet for treatment at home. (See next page).
2. Document action taken on student's progress note.

PARENTAL RECOMMENDATIONS:

1. Read impetigo information sheet carefully.
2. An oral antibiotic may be needed to treat the impetigo.
3. All impetigo sores must be covered during school hours.

IMPETIGO

PARENT INFORMATION SHEET

Date: _____ School:_____

Dear Parent/Guardian:

Your child _____, was seen in the Health Room for what appears to be Impetigo.

DESCRIPTION:

Impetigo is a contagious skin infection which can spread to various parts of the body, and to other susceptible people. Impetigo sores are honey-colored, crusting, may have localized redness and produce pus.

PARENT RECOMMENDATIONS:

To stop impetigo and prevent its spread, it is important to follow these instructions carefully:

1. Cleanse the sores with an antibacterial soap (like DIAL®) 3 times daily. It is essential to remove the crusts.
2. Follow each cleaning with an antibacterial ointment like or BACTROBAN® to the affected area. After sores are gone, continue the ointment for another 3 days.
3. Keep child's fingernails short and clean. Stress the importance of good hand washing, and avoid contact with child's washcloth, towel or bed linen.
4. Contact your child's physician if sores have not improved in 2 or 3 days, or if sores spread rapidly.

SPECIAL INSTRUCTIONS:

All impetigo sores must be covered during school hours. Otherwise, your child will be required to remain at home.

MAY RETURN TO SCHOOL

When covered or completely dry.

Influenza (Flu)

DESCRIPTION:

Influenza (Flu) is a contagious disease caused by influenza viruses.

MODE OF TRANSMISSION:

Spreads mainly from person to person through droplets made when people with flu cough, sneeze or talk. A person may also become infected by touching a surface or object with flu viruses on it, such as doorknobs, elevator buttons, desktops, and then touching his/her own mouth, nose or possibly eyes.

INCUBATION PERIOD:

People infected with the flu may be able to infect others beginning 1 day before symptoms develop and up to 5-7 days after becoming sick.

SYMPTOMS:

Flu signs and symptoms usually come on suddenly. People who are sick with flu often feel some or all of these symptoms:

1. Fever or feeling feverish /chills. Not everyone with the flu will have a fever.
2. Cough; sore throat
3. Runny or stuffy nose
4. Muscle or body aches
5. Headaches
6. Fatigue (tiredness)
7. Some people may have vomiting and diarrhea, though this is more common in children than adults.

RECOMMENDATIONS

1. Children sick with flu-like illness, should stay home for at least 24 hours after the fever is gone. A fever is defined as 100.4°F or greater.
2. Cover your mouth and nose with a tissue when you sneeze or cough. After using a tissue, throw it in the trash and wash your hands.
3. Frequent handwashing. Follow proper hand washing techniques and/or use an alcohol-based hand sanitizer.
4. Avoid touching your eyes, nose or mouth. Germs spread this way.
5. Routinely clean and disinfect surfaces and objects that may be contaminated with germs that can cause respiratory illnesses like flu.
6. If an outbreak of flu occurs, follow public health advice.

MAY RETURN TO SCHOOL:

Student may return to school when the fever is gone for 24 hours without the use of fever-reducing medicine and/or upon Doctor’s Recommendation.

HOW CAN YOU TELL THE DIFFERENCE BETWEEN A COLD AND THE FLU?

Because colds and flu share many symptoms, it can be difficult (or even impossible) to tell the difference between them based on symptoms alone. Special tests that usually must be done within the first few days of illness can tell if a person has the flu.

Signs & Symptoms	Flu	Cold
Symptom onset	Abrupt	Gradual
Fever	Usual	Rare
Aches	Usual	Slight
Chills	Fairly Common	Uncommon
Fatigue, weakness	Usual	Sometimes
Sneezing	Sometimes	Common
Chest discomfort, cough	Common	Mild to moderate
Stuffy nose	Sometimes	Common
Sore throat	Sometimes	Common
Headache	Common	Rare

RESOURCES:

https://www.cdc.gov/flu/resource-center/freeresources/print/print-schools-childcare.htm#Education

https://www.cdc.gov/flu/highrisk/children.htm

LACERATIONS (Cuts)

TREATMENT:

1. Put on non-latex gloves if needed. Clean with soap and water.
2. If laceration is minor apply a Band-Aid; if more extensive, apply gauze and secure with firm bandage or adhesive tape.
3. Notify parent or guardian. If severe, have a parent or guardian pick up the student.
4. Record the incident and action taken on the daily log. If follow-up activities are necessary, record on progress note for future reference.

BLEEDING:

1. Put on non-latex gloves.
2. Apply direct pressure on the cut for approximately 5 minutes with a sterile pad and elevate affected limb.
3. If unable to control bleeding, continue direct pressure and elevation.
4. Observe the student for shock and treat if necessary.
5. Notify parent or guardian.
6. Record the incident and action taken on the daily health log. If follow-up activities are necessary, record on progress note for future reference.
7. Complete an accident form, per school policy and procedure.

LEUKEMIA

DESCRIPTION:

A neoplastic disorder of the blood in which there is an overproduction of immature white blood cells. These white blood cells do not provide a defense against infection.

PHYSICAL FINDINGS:

1. Fatigue, pallor, difficulty in breathing, fever or infection.
2. Bruising.
3. Bleeding of mucous membranes.

MANAGEMENT:

1. Isolate from people with infectious diseases, especially chicken pox.
2. Wash hands especially before eating and after toileting.
3. Notify parents immediately of signs of infection or fever.
4. Be alert for cuts on body and notify parent.
5. Be alert for headache, blurring of vision and notify parent.
6. Document action taken on student's progress note.

HEAD LICE (Pediculosis Capitis)

DESCRIPTION

Diagnosis of head lice infestation is made by direct inspection of the hair and scalp for the presence of crawling forms and nits. Parasites and nits are most commonly found at the nape of the neck and behind the ears. The nits hatch in about ten days and reach maturity in about two weeks. They crawl from hair to hair and DO NOT jump, hop, or fly.

To examine a patient, part the hair with a wooden applicator stick. Usually nits and crawling forms can be seen with the naked eye, but a hand lens and flashlight may be useful. **Hand washing is essential after each exam.**

Often the crawling forms cannot be seen because there are so few. When they are not observed, diagnosis can be made by finding nits. The female louse cements nits on shafts of hair close to the scalp. Most recently laid nits will be attached at the base of the hair follicle.

PHYSICAL FINDINGS:

1. Presence of nits, small, round or oval, white specks that are glued to the hair shaft at the base of the hair follicle.
2. Presence of live lice on the scalp and hair.
3. Frequent head scratching.

TREATMENT: (see Head Lice Parent Information Sheet)

1. Only treat family members that are infested and their bedmates
2. Wash hair to remove all hair products.
3. Apply lice treatment per directions.
4. For the home:
    a. Wash and dry clothes, sheets, pillow cases and covers (or just 30 minutes in a heated dryer).
    b. Vacuum carpets, furniture, cars. DON'T USE LICE SPRAYS.
    c. Stuffed animals and other articles if unable to be washed should be vacuumed or bagged for two weeks.
    d. Soak combs, brushes and hair accessories in soapy hot water for at least 30 minutes.
    e. Remove clutter from home. Stray hairs can harbor nits which may be transferred to the head and re-infestation can occur.
5. Check scalp DAILY for nits for up to three weeks.

RECOMMENDATIONS FOR PREVENTING TRANSMISSION OF HEAD LICE IN SCHOOLS

1. Hats and coats should be stored separately. This may be accomplished in any of several ways:
    a. Assign individual lockers to students.
    b. Assign wall hooks 12 inches or more apart to each student.
    c. Let students hang their coats on the back of their seats or fold under desk.
    d. Let students hang their short coats on the back of their seats and long coats on the coat rack spaced so they do not touch.
    e. Store caps and scarves separately, or let each student keep them at his/her desk.
2. Items that come into contact with a student's head should be wiped with a dry cloth between students, i.e., helmets, headphones, etc.

3. In physical education classes, keep clothing separate.
    a. Number all clothes hooks, and assign a hook to one student for each period.
    b. Assign lockers to one student for each period.
4. Vacuum daily.
5. When an infestation is discovered the siblings of the infested child who attend that school should also be checked.
6. Infested students should be sent home with the Head Lice Parent Information sheet

STUDENT RE-ENTRY INSTRUCTIONS

1. To be readmitted to school the student must be free of head lice and nits at the base of the hair follicle.
2. When returning to school the student must be checked by the Health Tech/Designated School Staff.
3. The Parent must be present when the student is checked for re-entry.
4. The student may remain at school only if they are found to be free of head lice and nits at the base of the hair follicle.
5. If the student is found to still have head lice or nits at the base of the hair follicle, the Health Tech/Designated School Staff will discuss continued treatment with the parent.
6. Final re-entry decisions shall be made at the principal's discretion

PANCARE Procedure for HEAD LICE CHECKS & RE-ENTRY CHECKS

Purpose: The purpose of this procedure is to establish guidelines for PanCare Health Techs when responding to reports of a HEAD LICE infestation in school-age children in the school setting.

REMINDERS: Head Lice are the nuisances, not the students nor the family. Remember to keep the best interest of the child in mind by providing as much privacy and confidentiality as possible. Handle the situation kindly, gently, and with sensitivity. Strive to ensure that the child does not feel bad about himself/herself because of Head Lice. Keep in mind that anyone can get them.

Head lice: Reported Information

Question	Action
Name, grade, and classroom of the student? Is the student a BDS bus rider AM/PM?	Log in to FOCUS and obtain the health record and bus information.
Does the student complain of an itchy head? How long? Has the child's head been shampooed for head lice?	If preferred don gloves. **1. DISCREETLY** examine the head area around the back of the neck and behind the ears in small sections using the wooden end of a long cotton-tip applicator. 2. Check for live lice. 3. Check to see where the nits are located on the hair shaft. Are the nits at the base of the hair follicle? 4. Immediately following the examination, the applicator and gloves, if used, should be placed inside a plastic bag, sealed, and then disposed of in an outdoor dumpster after use. **Hand washing is essential after each exam.**

Head Lice: Following Physical Examination

Action	Plan
No nits or lice found	Student can return to class
Live lice or nits at the base of the hair follicle are found	1. If live lice or nits at the base of the hair follicle are found (confirmed), all siblings/children residing in the same household should also be screened. 2. Notify the school administrator/designee of all confirmed cases. BDS staff is responsible for notifying BDS Bus Transportation and scheduling cleanup. 3. Contact the parent/guardian to take the student home. 4. Give the Head Lice Parent Information Sheet and the GETTING RID OF HEAD LICE brochure to the parent, located in the PanCare HT training manual. Tell the parent the child will need treatment before returning to school. **BDS POLICY 7.302**: Any student with live head lice shall be **temporarily excluded** from attending school. Students with live head lice may not participate in school sponsored activities, or ride the school bus until the student has received treatment for head lice. Any student with nits at the base of the hair follicle will be **temporarily excluded** from school. Students with nits at the base of the hair follicle may not participate in school sponsored activities, or ride the school bus until the student has received treatment for head lice.
Confirmed live lice or nits at the base of the hair follicle	**NEVER** treat the student's hair with any lice treatment medications, including home remedies. **NEVER** cover the student's hair with any items (shower caps, plastic bags, ect).
Student re-entry to school	To be readmitted to school the student must be free of head lice and nits at the base of the hair follicle. **The Parent must be present when the student is checked for re-entry. (BDS 7.302).** 1. Following the instructions above, discreetly examine the head area for head lice and nits at the base of the hair follicle. 2. If the student is found to be free of head lice and free of nits at the base of the hair follicle, the student will be cleared to return to class and cleared to ride the bus.

	3. If head lice or nits at the base of the hair follicle are found, the student must return home with the parent. The student may return to school for a RE-ENTRY check when they are free of head lice and free of nits at the base of the hair follicle. 4. Notify school admin/designee that the student did not pass the re-entry check. **Final re-entry decisions shall be made at the principal's discretion.**

PARENT INFORMATION SHEET

HEAD LICE

Date: _____ School:_____

Dear Parent/Guardian:

Your child _____, was checked today for head lice.

HELPFUL INSTRUCTIONS:

1. **Only treat family members that are infested.**
2. Wash hair prior to treatment to remove all hair products so the treatment product will work.
3. Apply lice treatment per directions.
4. For your home:
    a. Wash and dry clothes, sheets, pillow cases and covers (or just 30 minutes in a hot dryer).
    b. Vacuum carpets, furniture, cars.
    c. Stuffed animals and other articles if unable to be washed should be vacuumed or bagged for two weeks.
    d. Soak combs, brushes and hair accessories in soapy hot water for at least 30 minutes.
    e. Remove clutter from home. Stray hairs can harbor nits which may be transferred to the head and reinfestation can occur.
5. Check scalp DAILY for nits for up to three weeks.

STUDENT RE-ENTRY INSTRUCTIONS

1. To be readmitted to school the student must be free of head lice and nits at the base of the hair follicle.
2. When returning to school the student must be checked by the Health Tech/Designated School Staff.
3. The Parent must be present when the student is checked for re-entry.
4. The student may remain at school only if they are found to be free of head lice and nits at the base of the hair follicle.
5. If the student is found to still have head lice or nits at the base of the hair follicle, the Health Tech/Designated School Staff will discuss continued treatment with the parent.
6. Final re-entry decisions shall be made at the principal's discretion

MENSTRUAL DISCOMFORT

MENARCHE – AGE OF ONSET OF MENSES:

1. Average 12-14, but may be 9-16
2. Often irregular periods during the first six months to two years
3. There can be intermenstrual pain and/or bleeding. Lasting few hours to 3 days. Usually associated with ovulation.

PMS (PREMENSTRUAL SYNDROME) SYMPTOMS:

1. Altered Emotional State:
    a. Tension, anxiety, depression, irritable, hostile, sad. Avoids social contact. Change in work habits, libido, efficiency. Fatigue, lethargy, agitation.
2. Physical symptoms:
    a. Backache, headache, swollen or tender breasts, joint and muscle pain, nausea, diarrhea, sweating & palpitations.
    b. Altered appetite.
    c. Fluid/electrolyte changes: abdominal bloating, weight gain, edema.

MANAGEMENT:

1. If only mild discomfort, student should be encouraged to continue normal activities.
2. If pain persists, have student lie down.
3. For chronic discomfort, notify parent or guardian and advise medical attention.
4. Document action taken on student's progress note.

TREATMENT: (Parental recommendations)

1. Provide a comfortable, quiet rest area.
2. Warm pack to abdomen.
3. Mild exercise and reassurance.
4. Keep supply of pads.
5. Refer severe menstrual disorders to parent.
6. Recommend to parents – Tylenol, Motrin, etc., rest in bed, follow-up with physician if no relief.

Methicillin-Resistant Staphylococcus Aureus (MRSA)

DESCRIPTION:

Staphylococcus aureus is a type of bacteria commonly found on the skin or in the nose of healthy individuals. Some Staphylococcus aureus is resistant to certain antibiotics, which makes it more difficult to treat than a normal staph infection. The name methicillin-resistant Staphylococcus, or MRSA, is used for the drug-resistant strain of the bacteria. Although antibiotics from the methicillin family are ineffective against the treatment of MRSA, many other sensitive antibiotics are prescribed for treatment.

MRSA appears as a bump or infected area on the skin that may be red, swollen, painful, and warm to touch, full of pus or other drainages, and/or accompanied by a fever. Also, complaints of a "spider bite" should raise suspicion of a possible MRSA infection.

DIAGNOSIS:

A laboratory test is necessary to determine if an individual is infected with MRSA. Typically, the infection is drained and a sample of the fluid/pus from the infection is tested by a laboratory.

TREATMENT:

If a student appears to have MRSA:

1. Do not touch lesions.
2. Cover lesions with a Band-Aid. Disposable gloves must be worn when changing bandages, Band-Aids or other wound dressings. Keep all lesions, especially those that are draining or are pus-filled, covered with clean, dry bandages.
3. Frequent hand washing with soap and water is imperative. Alcohol-based hand hygiene products may be used if hand washing is not immediately available.

MANAGEMENT:

1. Call parent/guardian and ask if they are aware of what appears to be a red, raised lesion on their child. If not aware, suggest they take their child to the physician. If they are aware, ask the parent/guardian, if the child has already been to the physician and has MRSA been confirmed?
2. Give the parent/guardian the CDC MRSA Fact Sheet for Parents. (See link below).
3. Document action that was taken on student's progress note.

PARENTAL RECOMMENDATIONS:

1. Read the MRSA information sheet carefully.
2. An oral antibiotic may be needed to treat the MRSA. If antibiotics are prescribed, be sure to take all of the doses (even if the infection is getting better), unless your healthcare professional tells you to stop taking it.
3. All MRSA sores must be covered during school hours.
4. **Instruct your child not to share anything, especially towels.**

MAY RETURN TO SCHOOL (Centers for Disease Control):

Generally speaking, unless directed by a physician or a public health official, a child with an MRSA skin infection should not be excluded from early childhood care and education settings if the infected skin can be kept covered with a clean, dry bandage, preventing the infected skin from coming in to contact with other children, the environment or the child's hands.

Exclusion from early childhood care and education settings should be reserved for those with wound drainage ("pus") that cannot be covered and contained by using the bandage technique mentioned above. (See CDC MRSA Factsheet for Early Childhood Care and Education Professionals.)

ENVIRONMENTAL CLEANING (Centers for Disease Control):

In general, it is not necessary to close early childhood care and education facilities to disinfect them when MRSA skin infections occur. When MRSA skin infections occur, more focused cleaning and disinfection efforts, in addition to normal cleaning routines, should be performed on surfaces that are likely to contact uncovered or poorly covered infections.

The decision to close an early childhood care and education facility for any communicable disease should be made by the facility's officials in consultation with local and/or state public health officials. However, in most cases, it is not necessary to close a facility because a student has an MRSA skin infection. (See MRSA Factsheet for Early Childhood Care and Education Professionals.)

RESOURCES:

Centers for Disease Control and Prevention
Methicillin-resistant *Staphylococcus aureus* (MRSA)
Factsheets &Posters

MRSA Factsheet for Early Childhood Care and Education Professionals
https://www.cdc.gov/mrsa/pdf/mrsa_earlyed_factsht.pdf

MRSA Fact Sheet for Parents
https://www.cdc.gov/mrsa/pdf/MRSA_ConsumerFactSheet_F.pdf

MRSA Fact Sheet for Parents (Spanish)
https://www.cdc.gov/mrsa/pdf/MRSA_CnsmrFactSht_SPAN.pdf

MOLLUSCUM CONTAGIOSUM

DESCRIPTION:

Small raised lesions, usually white, pink, or flesh-colored with a dimple or pit in the center. Contagious as long as lesions are present, can last years.

TREATMENT:

If a student appears to have Molluscum Contagiosum:

1. Do not touch lesions.
2. Only broken lesions are contagious, cover with Band-Aid.
3. All broken lesions must be covered during school attendance.

MANAGEMENT:

1. Call parents and ask if they are aware of what appears to be small raised lesions on their child. If not aware, suggest they take their child to the physician. If a child has already been to the physician has Molluscum Contagiosum been confirmed?
2. Document actions taken and information provided on FOCUS.

PARENTAL RECOMMENDATIONS:

1. All broken lesions must be covered during school hours.
2. **Confirmed Molluscum Contagiosum - instruct your child not to share anything, especially towels.**

MONONUCLEOSIS (Glandular Fever, Mono)

DESCRIPTION:

An acute viral syndrome characterized clinically by fever, sore throat, lymphadenopathy, splenomegaly; characterized hematologically by mononucleosis and lymphocytosis of >50%, including >10% atypical cells; and characterized serologically by the presence of heterophile and Epstein-Barr (EBV) antibodies.

PHYSICAL FINDINGS:

1. Milder in young children, more severe in high school and college age.
2. Fever, malaise, and fatigue.
3. Sore throat and enlarged, red tonsils and swollen lymph glands.
4. Fever may last 1-2 weeks; fatigue and malaise may last 4-6 weeks.

MANAGEMENT:

1. Refer to parents if a student has symptoms.
2. A child with a fever 100.4°F or greater must be excluded from school.
3. Document action taken on student's progress note.

MAY RETURN TO SCHOOL

Upon written recommendation of physician.

NOSEBLEED

DESCRIPTION:

1. Most nosebleeds are due to tiny ruptured blood vessels near the tip of the nose on the inner wall (the nasal septum). Nosebleeds are most common in children four to ten years.
2. Children with colds or nasal allergies have more nosebleeds, not only because the lining of the nose is more irritated, but because they pick more and blow harder.
3. Since more colds occur in winter, more nosebleeds occur then.
4. Vigorous exercise in hot weather can also bring on nosebleeds in children.
5. Repeated nosebleeds in the same child are common.

TREATMENT:

1. The child should be in a sitting position with the upper body tilted forward so the blood does not run back down the throat and be swallowed. For comfort, the student may rest his/her forehead against the wall. Excess blood irritates the stomach and causes vomiting.
2. The best treatment is firm pressure pinching the end of the nose shut.
3. After the bleeding stops, have the child rest in the school clinic for fifteen or twenty minutes before going back to class.

MANAGEMENT:

1. Always notify the parents. Very few children with nosebleeds need to be referred to the physician.
2. There are three main reasons for referral:
    a. There is bleeding from other parts of the body, blood spots under the skin, blood in the urine, etc.
    b. The bleeding occurs almost daily.
    c. The bleeding won't stop.
3. The child may need to be excused from recess or other outdoor physical activity for several hours after the nosebleed.
4. Document action taken on student's progress note.

PINK EYE (Conjunctivitis)

DESCRIPTION:

1. Redness of whites of eyes.
2. Purulent or watery discharge.
3. Redness and/or swelling of eye-lids.
4. Itching and rubbing of eyes.
5. Crusts in inner corners of eyes, especially on waking from sleep.

MANAGEMENT:

1. Allergic: Discharge remains watery without pus formation.
2. Infectious (bacterial): usually more severe with pus formation and more crusts. Requires treatment. Must be excluded from school/refer to physician.
3. Viral: usually less severe, often with no pus; runs a 3-5-day course and goes away.
4. Document action taken on student's progress note.

All three may or may not be associated with a common cold. (If uncertain, notify parent).

TREATMENT:

1. Wash eye gently with cool compresses for temporary relief of symptoms.
2. Encourage students not to touch their eyes and keep hands clean to prevent spreading.

PARENTAL RECOMMENDATIONS:

1. Wash eye gently with cool compresses for temporary relief of symptoms.
2. Over the counter drops may be given, such as Visine®.
3. Antibiotic drops or ointments may be prescribed by physicians for infections.

MAY RETURN TO SCHOOL

After eyes have cleared or when it is established that the child has been under treatment for 24 hours.

PINWORM

DESCRIPTION:

1. Common intestinal worm. Tiny white thread-like worms that live in the bowel.
2. Most commonly found in school-age children.
3. Eggs are too small to see, and contaminate whatever they come in contact with, i.e.: bedclothes, underwear, hands and food. (Even eggs floating in the air can be swallowed and cause infection).
4. Pinworms are highly contagious.

PHYSICAL FINDINGS:

1. Usually at night pinworms travel to the rectal opening and lay eggs on the outside skin.
2. Causes itching of rectum and may be very annoying.
3. Restless sleep is a frequent sign of pinworms.

MANAGEMENT:

1. Obtain prescription from a private physician.
2. Wash hands and fingernails with soap often during the day, especially before eating and after using the toilet.
3. Wear tight underpants day and night. Change them daily.
4. For several days after treatment, clean the bedroom floor by vacuuming or damp mopping
5. After treatment, wash bed linens and night clothes (do not shake them). Dry in the dryer.
6. Keep the toilet seats clean.
7. Keep fingernails cut short.

NOTE: Students cannot be excluded from school for pinworms.

POISON IVY/OAK (Contact Dermatitis)

DESCRIPTION:

1. Reaction begins 1-4 days after exposure.
2. Contents of blisters and weepy skin cannot cause rash in another individual or even in another location on the patient.
3. Early: itching, redness, small papules and vesicles.
4. Later: increase of all early signs plus larger blisters and generalized weeping of skin.
5. Healing: dryness, crusting and gradual shedding of crusts and scabs. May take 2-3 weeks.
6. Most common on hands, forearms, and face.
7. No fever.

TREATMENT:

1. Wash thoroughly after exposure (usually too late when discovered at school).
2. Try to prevent scratching. Loose dressings may help.

MANAGEMENT:

1. Notify parent of exposure or of break-out.
2. Document action taken on student's progress note.

PARENT RECOMMENDATIONS:

1. Calamine Lotion or Lubriderm® on dry lesions.
2. Topical 1% hydrocortisone cream.
3. Oral Antihistamines usually not helpful but sedative effect of Benadryl® may be helpful.
4. Refer to physician if severe or infected.
5. Warn against re-exposure, as the reaction may be worse next time.

REYE'S SYNDROME

Reye's Syndrome is a very serious disease that you should know about. Some people develop Reye's Syndrome as they are getting over a viral illness like the flu or chickenpox. Reye's Syndrome usually affects people from infancy through young adulthood; however, no age group is immune. It can develop 3 to 5 days after the onset of chickenpox, upper respiratory infection, or other fever-causing illnesses. It affects the liver and brain, is non-contagious, and is often misdiagnosed as encephalitis, meningitis, diabetes, poisoning, drug overdose or sudden infant death.

Typically, Reye's occurs when someone is recovering from a viral illness and begins to feel better. Watch for these symptoms, usually occurring in this order:

- Relentless or continuous vomiting
- Listlessness (loss of pep and energy with little interest in their environment)
- Drowsiness (excessive sleepiness)
- Personality changes (such as irritability, slurred speech, sensitivity to touch)
- Disorientation or confusion (unable to identify whereabouts, family members or answer questions)
- Combativeness (striking out at those trying to help)
- Delirium, convulsions or loss of consciousness

Reye's Syndrome should be suspected in anyone who vomits repeatedly. Phone your physician immediately if these symptoms develop. Voice your concern about possible Reye's Syndrome. If your physician is unavailable, take the person to an Emergency Room promptly. Two liver function tests (SGOT, SGPT) can be done to determine the possibility of Reye's Syndrome. There is a 90% chance of recovery when the syndrome is treated in its earliest stages by physicians and nurses experienced in the treatment of Reye's.

Studies have shown that using aspirin or aspirin-containing medications to treat the symptoms of viral illnesses increases the chance of developing Reye's Syndrome. If you or a member of your family has a flu-like illness, do not use aspirin or aspirin-containing medications. In fact, you should consult your physician before you take any drugs to treat the flu or chickenpox, particularly aspirin or anti-nausea medicines. Anti-nausea medicines may mask the symptoms of Reye's Syndrome.

The National Reye's Syndrome Foundation (NRSF), the U.S. Surgeon General, the Food and Drug Administration, and the Centers for Disease Control recommend that aspirin and combination products containing aspirin not be taken by anyone under 19 years of age during fever-causing illnesses.

Aspirin is a part of the salicylate family of medicines. Another name for aspirin is acetylsalicylic; some drug labels may use the words acetylsalicylate, acetylsalicylic acid, salicylic acid or salicylate instead of the word aspirin. Currently, there is no conclusive data as to whether other forms of salicylates are associated with the development of Reye's Syndrome. Until further research has answered this question, the NRSF recommends that products containing any of these substances should not be taken during episodes of viral infections.

The NRSF is a non-profit, tax-exempt organization with affiliates located in 50 states. The NRSF has pioneered the movement to disseminate knowledge about the disease in an effort to aid in early ~ and also provides funds for research into the causes, cure, care, treatment and prevention of Reye's Syndrome.For additional information, please contact: National Reye's Syndrome Foundation:
426 N. Lewis Street, P. 0. Box 829, Bryan, OH 43506-0829, Phone: 1- 800-233-7393
E-Mail: nrsf@reyessyndrome.org Web: www.reyessyndrome.org or reyessyndrome.wordpress.com

RHEUMATOID ARTHRITIS, JUVENILE

DESCRIPTION:

An inflammatory disorder of the connective tissue, characterized by joint swelling and pain or tenderness. It may also involve organs such as the skin, heart, lungs, liver, spleen, and eyes. Signs and symptoms may include: joint pain, swelling, stiffness, impaired motion, rash, temperature of 103°F or higher, tiredness, weight loss, eye problems (pain, red, blurred vision), growth disturbances.

TREATMENT:

Encourage movement and P.E. activities to maintain optimal mobility. However, limitations may be a consideration. Provide emotional support. Student may experience undue fatigue – allow rest time if needed. Notify parent/guardian as needed.

MANAGEMENT:

Affected bones may be longer or shorter than normal. Joints may be swollen and stiff in the mornings or after periods of inactivity, so movement should be encouraged. Student should be permitted to ambulate every hour or so to alleviate stiffness, adequate positioning of desk/chair should be considered (feet flat on floor).

Notify parents of student's condition when in the health room.

RINGWORM

DESCRIPTION:

1. Contagious disease which is caused by a fungus.
2. It appears as a flat, spreading ring-shaped sore.
3. Can be spread from contact with infected people, tubs and showers, contaminated floors and furniture.

TREATMENT:

1. If a student appears to have ringworm, wash area(s) with soap and water.
2. Cover with Band-Aid.
3. All ringworm must be covered during school hours.

MANAGEMENT:

1. Give parent ringworm information sheet for treatment at home (see next page).
2. Document action taken on student's progress note.

PARENT RECOMMENDATIONS:

1. Read ringworm information sheet carefully.
2. Sometimes an oral fungicide is needed to halt the spread of the fungus on the child or to treat ringworm.
3. If ringworm is on the child's head, neck or face must go to the physician for treatment. Must have a note from a physician confirming treatment to return to school.

MAY RETURN TO SCHOOL

If ringworm is on the child's head, neck or face must have a note from a physician confirming treatment to return to school.

PARENT INFORMATION SHEET

RINGWORM

Date: _____ School:_____

Dear Parent/Guardian:

Your child _____, was seen today for Ringworm.

Ringworm is a contagious disease which is caused by a fungus. It appears as a flat, spreading, ring-shaped sore. It can be spread from contact with infected people, animals, tubs and showers, contaminated floors and furniture.

To stop ringworm and prevent its spread, it is important to follow these instructions carefully:

PARENTAL RECOMMENDATIONS:

1. If the ringworm is not on the face, neck or head wash it thoroughly with soap and water to remove the crusts 4 times daily.
2. Apply a fungicidal medication to the affected area. This is any medicine that is used to treat athlete's foot, such as MICONAZOLE OR CLOTRIMAZOLE which is available without a prescription, or consult a pharmacist for professional recommendations. Ointment as instructed on the ointment tube.
3. Stress the importance of good hand washing and launder towels, linen and clothing with hot water and/or fungicidal agent.
4. If ringworm has not improved in 3 to 4 days, contact your child's physician.

SPECIAL INSTRUCTIONS:

All ringworms must be covered during school hours to prevent the spread of the fungus.

Otherwise, the child should remain at home.

If the ringworm is on the child's face, neck and head take the child to the physician. Your child may return to school when he/she brings a note from the physician stating he/she has been treated.

SCABIES

DESCRIPTION:

Scabies is a highly contagious skin disease caused by a mite too small to see with a naked eye. The most common symptom is a rash that itches intensely at night. Scabies is usually spread from person to person by close physical contact.

PHYSICAL FINDINGS:

1. Typical lesion is a pus-filled lesion or a tiny, pale, irregular line which marks the path of the scabies mite under the skin.
2. Rash: tiny papules, vesicles, pustules and scabs.
3. Location: back of hands, web of fingers, front of forearms, lower abdomen, chest, and axilla. Less common on lower legs. Rare on face, mid-back, palms and soles (a good diagnostic clue).
4. Itching is intense, especially at night.
5. Frequently found in other family members.
6. Impetigo is frequently the result of a secondary infection due to scratching.
7. Itching may persist for 2 weeks after treatment.
8. An outbreak is considered to be over when 2 incubation periods (12 weeks) have passed without a new case being identified.

MANAGEMENT:

1. Give parents scabies information sheet for instructions at home. (See next page).
2. Check siblings in school for scabies.
3. Watch for impetigo as a secondary infection due to scratching.
4. Document action taken on student’s progress note.

PARENT RECOMMENDATIONS:

1. Read scabies information sheet carefully.
2. All family members should be treated at the same time.
3. A second treatment may be necessary.
4. Medical attention is needed because a prescription is required.
5. The child will be excluded from school unless a note from a physician is written stating the child has been treated.

FOLLOW-UP:

1. Student should be cleared by a physician's note before returning to class.
2. Watch for new lesions. A second treatment may be necessary.
3. Watch for impetigo; refer to nurse, instruct parents accordingly.

MAY RETURN TO SCHOOL

After note from physician establishes that patient is under treatment.

PARENT INFORMATION SHEET

SCABIES

Date: _____ School:_____

Dear Parent/Guardian:

Your child _____, was seen in the health room today for what appears to be scabies on your child's _____.

Scabies is a highly contagious skin disease caused by a mite too small to see with a naked eye. The most common symptom is a rash that itches intensely at night. The rash can be anywhere on the body but is usually in the webs of the fingers and trunk of the body. Scabies is usually spread from person to person by close physical contact.

To stop scabies and prevent its spread, it is important to follow these instructions carefully:

1. Take your child to the physician to obtain the prescription needed.
2. Before going to bed at night have your child take a warm soapy bath, using a rough bath cloth cleaning the skin thoroughly. Be sure to clean the tub and launder the bath cloth and towel in hot water before using again.
3. Apply the prescribed lotion on the child from the neck to the feet, covering every inch. Do not wash this off. It is necessary for your child to sleep with this on. Itching, mild burning and/or stinging may occur after application of the lotion. You will not usually be contagious after one treatment if these instructions and your physician's directions have been followed carefully.
4. The next morning, wash all sleepwear and bedding in hot water. Have the child take a warm bath and put freshly laundered clothing on.
5. Treat all family members and contacts at the same time. Pregnant women and infants under 2 months of age should seek special treatment by a physician.

SPECIAL INSTRUCTIONS:

May return to school with a note from the physician that establishes the patient has been treated.

SCARLET FEVER (Strep Throat with Rash)

DESCRIPTION:

Scarlet fever, also called “scarlatina”, is one of the most common contagious childhood diseases. It usually occurs when a child is infected with the Group A Streptococcus. This infection can occur anywhere in the body, but the most common site is in the tonsils and/or pharynx, thus “strep throat”.

PHYSICAL FINDINGS:

This germ produces a toxin which causes the typical scarlatina rash: diffuse redness of cheeks and upper chest on a background that feels like goose flesh. Later the rash spreads to other parts of the body and, after 5-10 days peeling of the skin results. Large sheets of skin peel in severe cases. Most cases are mild and the child is only ill for a few days, but rarely, severe cases may occur. The disease itself is no cause for concern, but two major complications, acute rheumatic fever of the joints and heart, and acute glomerulonephritis (kidney disease) can be extremely serious.

MANAGEMENT:

1. Monitor student’s temperature.
2. Visualize throat for redness, swelling or thin pus exudate.
3. Notify parents if fever, exudate or rash is present.
4. Recommend medical evaluation as complications can occur if untreated.
5. Document action taken on student’s progress note.

INFECTIOUS PERIOD:

Children are most contagious a day or two before the rash breaks out and 4-5 days thereafter, roughly corresponding to the time fever is present. However, children with strep throat who do not develop a rash are every bit as contagious and are subject to the same complications.

RETURNING TO SCHOOL:

1. Children may be considered non-contagious after they have been fever free for 24 hours.
2. Proper antibiotic treatment shortens the illness markedly and hastens return to school.

FOLLOW-UP:

1. Encourage completion of the course of antibiotics.
2. Obtain medication administration permission form from physician and parents to ensure compliance.
3. Watch for complications: high fever, arthritis and blood in the urine are only some examples. The child must see a physician immediately.
4. Participation in PE: Uncomplicated cases may go back to full activity on return to school. If a parent or physician recommends no PE for a few days, their request should be granted.

MAY RETURN TO SCHOOL

48 hours after antibiotic therapy has been initiated. Must have a note from a physician confirming date of physician visit.

SEIZURES (Epilepsy, Convulsions, Fits)

DESCRIPTION:

Epilepsy is a condition where there is spontaneous discharging of the central nervous system causing the patient to exhibit activities or behaviors which are involuntary. These activities may vary from staring, to falling to the ground with stiffening and/or shaking. Usually, there is loss of consciousness with the episode and no memory for the event. After the seizure has occurred, the person is usually drowsy or falls asleep. It is appropriate to allow the person to sleep after his seizure.

TREATMENT:

Most individuals can have their epilepsy partially or completely controlled with the use of anticonvulsant medication (e.g. Phenobarbital, Dilantin, etc.). However, medications are only effective if they are taken on a routine basis each day. The most common cause of recurrence of seizures in treated patients is noncompliance with the prescribed medication administration.

LIMITS:

In general, the only limits for patients with seizures would be swimming alone, rope climbing or mountain climbing, taking baths alone. In some individuals, excessive heat or high pitches of emotion (good or bad) may trigger seizures.

MANAGEMENT:

If known, follow IHCP for Seizures. Almost all seizures are self-limited events and the abnormal activity will stop with time. In some instances, the administration of medication intravenously or intramuscularly is necessary to stop the seizure activity. Should a patient have a seizure, the responsibilities of those around him would include:

1. Keep calm. You cannot stop the seizure. Let it run its course and do not try to revive the child. Ease the child to the floor and loosen his clothing, but do not restrain his movements any more than is absolutely necessary to protect him from hurting himself.
2. Keep the child away from hard, sharp or hot objects which may cause injury.
3. Do not force his/her mouth open and do not force anything between his teeth. If the mouth is already open you might place a soft object (a folded handkerchief will do) between the side teeth.
4. Turn the head to one side so that the saliva can flow out of his mouth. Place something soft under his head.
5. After the seizure stops and the child appears to be relaxed, let him sleep or rest quietly in a place where he will not be disturbed.
6. If the seizures last more than five minutes, or the child seems to pass from one seizure to another without gaining consciousness, notify the rescue squad and then the parent.
7. If the student falls during a seizure and there is a possibility of injury because of the fall, an Accident Report must be completed.
8. Important data to note when a patient has a seizure would include:
    a. Precipitating events.
    b. Patient's behavior just prior to the seizure.
    c. The type of abnormal activity and its duration.
    d. The duration of the post-seizure sleep or drowsiness.
9. Refer to school nurse and follow individual care plan.

Before any medications are administered, be certain that you have on file the required parental permission form with parent and/or legal guardian signature and a statement written by a licensed physician stating the type of medication, dosage and time it is to be given.

SICKLE CELL ANEMIA

DESCRIPTION:

Sickle Cell Anemia is a severe chronic, inherited disorder of the red blood cells. It is marked by episodes of pain due to clogging of the small blood vessels by the abnormally shaped ("sickle-shaped") red blood cells. It is more prevalent in individuals of African or Mediterranean descent.

PHYSICAL FINDINGS:

1. Pain, abdominal and aching bones
2. Swelling of joints
3. Poor appetite
4. Generalized weakness
5. Paleness
6. Jaundice (yellowing of eyes)
7. Shortness of breath on exertion
8. Fever
9. Swelling of lymph glands

MANAGEMENT:

DO NOT APPLY ICE BAG FOR CARE OF JOINT PAIN OR INJURY

1. Swollen joints may cause difficulty in ambulation/writing.
2. Allow student to have unlimited access to water and restrooms.
3. Allow student to participate in physical activity with the provision that the student be permitted to stop when tired without embarrassment.
4. Give prompt attention to minor injury, a student with crisis will appear very ill and crisis period may last hours to a week.
5. Notify parent or guardian for body temperature 99.°F and above.
6. Notify parent of guardian as needed.
7. Pain attacks are the only complications of sickle cell anemia that is likely to occur in the classroom.
8. Keep change of clothes at school to avoid chilling.

CRISIS:

Period in which symptoms become severe; the student will be absent during these periods. BE ALERT FOR SIGNS AND SYMPTOMS OF CRISIS! Treat as normal child during non-crisis periods.

MEDICATIONS:

Analgesics such as aspirin for joint pain may be ordered.

STY

DESCRIPTION:

An infection of the sebaceous glands of the eyelid.

PHYSICAL CHARACTERISTICS:

1. Tiny abscess (0.5-1.0 mm) on the edge of the eyelid.
2. Slight redness and swelling around abscess.
3. Occasional redness and tearing of the eye.

TREATMENT:

1. Warm compresses.
2. Ophthalmic antibiotic drops or ointment usually necessary (must be prescribed by physician).
3. DO NOT use Bacitracin® or other topical ointment.
4. Refer to physician if no improvement in 2-3 days.
5. School exclusion is not necessary.

MANAGEMENT:

1. Watch for unusual spread; should heal in 3-5 days.
2. If infection continues or a cyst develops, refer to an ophthalmologist.

TICKS

Health Technicians do NOT remove ticks.

If a student has a tick NOTIFY the PARENT/GUARDIAN immediately.

When ticks bite, they inject some cement around their mouth parts which makes it hard to get them out whole. The separated mouth cannot be left in, since it will often cause an itchy nodule and become infected. Even the cement sometimes causes this reaction and needs to be excised with a needle.

TOURETTE'S SYNDROME

DESCRIPTION:

A neurological tic disorder characterized by:

1. Involuntary muscular movements
2. Uncontrollable vocal sounds
3. Tics
4. Hyperactivity.
5. Short attention span
6. Restlessness
7. Decreased concentration
8. Poor impulse control, actions such as: jumping, tapping, skipping or touching one's self

MANAGEMENT:

1. Watch for low self-esteem, self-demeaning behavior, misdirected anger, social isolation, depression, psychological distress.
2. Medication if symptoms are very severe; may help student cope, and decrease stress.
3. Group psychotherapy may be helpful.
4. Provide student with privacy area if student displays a compulsive need to touch one's genital area.
5. Do not react to obscenities.
6. Show the student acceptance and respect to foster feelings of self-worth and self-esteem.
7. Change in diet may help with actions.
8. Medications required at school must have Permission to Administer Medications form.

LEGISLATION – SCHOOL HEALTH SERVICES PROGRAM

Overview | Statutes & Rules | Information | School Entry | School Privacy | Child Obesity Links | School Nursing | Practitioner Volunteers | Wash Your Hands! | Questions

LEGISLATIVE AUTHORITY

Legislative authority for school health programs and services can be found in Florida Statutes (F.S.) administered by the Department of Health, and the Department of Education. Rules under the Florida Administrative Code (F.A.C.) provide the specific guidelines that implement the programs required by statute.

FLORIDA STATUTES (Laws of Florida Online – to search all Florida statutes)

39.201	Mandatory reports of child abuse, abandonment, or neglect; mandatory reports of death; central abuse hotline (amended 2006)
381.01	Legislative intent; public health system.
381.0022	Sharing confidential or exempt information. (amended 2006)
381.0031	Report of diseases of public health significance to department.
381.0054	Healthy lifestyles promotion. (amended 2006)
381.0056	School health services program. (amended 2006)
381.0057	Funding for school health services.
381.0059	Background screening requirements for school health services personnel.
381.00593	Public school volunteer health care practitioner program.
381.88	Insect sting emergency treatment.
401.2915	Automated external defibrillators. (amended 2006)
402.3025	Public and nonpublic schools
402.3026	Full-service schools.
464	Part I, Nurse Practice Act.
624.91	The Florida Healthy Kids Corporation Act.
743.01	Removal of disabilities of married minors.
743.064	Emergency medical care or treatment to minors without parental consent.
743.0645	Other persons who may consent to medical care or treatment of a minor.
1002.20	K-12 student and parent rights. (section (3) Health Issues) (amended 2007)
1002.22	Student records and reports; rights of parents and students; notification; penalty.
1002.23	Family and School Partnership for Student Achievement Act. (amended 2006)
1002.33	Charter Schools. (see sections: (9), and (17). (amended 2007)
1002.42	Private schools. (amended 2006)
1003.22	School-entry health examinations; immunizations against communicable diseases; exemptions.
1003.42	Required instruction. (amended 2006)
1003.453	School wellness and physical education policies; nutrition guidelines. (new 2006)
1003.455	Physical education; assessment. (amended 2007)
1003.46	Health education; instruction in acquired immune deficiency syndrome.
1003.54	Teenage parent programs. (amended 2004)
1003.57	Exceptional students' instruction. (amended 2006)
1006.061	Child abuse, abandonment, and neglect policy.
1006.062	Administration of medication and provision of medical services by district school board personnel.
1006.0625	Administration of psychotropic medication; prohibition; conditions.
1006.20	Athletics in public K-12 schools. (amended 2007)
1006.465	Background screening requirements for certain non-instructional school district employees and contractors.

FLORIDA ADMINISTRATIVE CODES (Florida Administrative Code Online – to search Florida's Administrative Code)

All the following documents are in pdf format & less than 100 KB unless indicated otherwise.

6A-1.0955	Education Records of Pupils and Adult Students.
6A-3.0121	Responsibility of School District and Parents for Students with Special Transportation Needs who are transported at Public Expense.
6A-6.024	School Entry Health Examinations.
6A-6.0251	Use of Epinephrine Auto-Injectors. (new 2008) (Word document)
6A-6.03028	Development of Individual Educational Plans for Students with Disabilities.
6A-6.0525	Rules Relating To Teenage Parent (TAP) Programs.
64B9-14	Delegation to Unlicensed Assistive Personnel (sections .001-.003).
64D-3.046	Immunization Requirements: Public and Nonpublic Schools, Grades Preschool, K-12 (new 2007 – formerly 64D-3.011).
64E-2.035	Emergency Treatment of Insect Stings.
64E-2.039	Guidelines for Automated External Defibrillators (AED) in State Owned or Leased Facilities.
64E-13	School Sanitation.
64F-6	School Health Services Program.
65C-22.006	Record Keeping (Health Records). See Chapter 65C-22, Child Care Standards, for full text. (amended 2007)

MISCELLANEOUS REQUIREMENTS

Clinic Requirements – State Requirements for Educational Facilities, December 2007; Chapter 5, Section 5(g) & (h).
Records – General Records Schedule GS7: Public Schools (excerpts relating to school health records only).