



Port Chester – Rye
Union Free School District



HEALTH SERVICES MANUAL

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Acknowledgement

This manual was compiled through the cooperative efforts of Lauren Montilli, R.N., Susan DePan, R.N., and Jeanette Spinelli, R.N. Many hours were invested compiling, writing, documenting, and editing the manual. The practice of school nursing has evolved significantly over the years and this new district Health Services Manual contains the latest guidelines and protocols for the practice of School Nursing in the state of New York, as well as the relevant policies of the PCRUFSD Board of Education.

We would like to thank Joe Durney for his guidance throughout this project as well as the use of his office while authoring the document. Also, we would like to thank Stacey Losito and Marcie DeCarlo who worked tirelessly to provide the necessary clerical support.

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Respectfully,

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Updated: 6/14 Jeanette Spinelli R.N.

Forward

School Health Services are a vital component to our School District's health program. Without the capable and ethical services of School Health Services Professionals, a considerable void would exist in the health services that are provided.

One of the major obstacles to successful educational achievement is poor health. Since all students in Port Chester must have the opportunity to develop their abilities, the health services program is an essential component of the total school program. The school population has changed dramatically over the years resulting in more complex medical and social problems. Professional school nurses must promote health on a daily basis by assessing and responding appropriately to emergency situations and assisting those students with medical conditions in order to achieve and maintain an optimal level of wellness. By promoting and maintaining an optimal level of wellness, students are more able to pursue excellence in their education.

This manual will serve as a guide to the many procedures necessary to effectively operate and manage the school health office. The information contained in this manual has been compiled in accordance with the program established by the New York State Education Department, the policies of the Port Chester Board of Education, and the guidelines of the New York State Nurse Practice Act.

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I. HISTORY OF SCHOOL HEALTH

A. Definition of School Nursing

School Nursing is a specialized practice of professional nursing that advances the well-being, academic success, and lifelong achievement of students. To that end, schools facilitate positive student responses to normal development; promote health and safety; intervene with actual and potential health problems; provide case management services and actively collaborate with others to build student and family capacity for adaptation, self-management, self-advocacy, and learning.

B. Functions of the School Nurse

The functions of the school nurse may include, but are not limited to, the following:

- Promoting and protecting the optimal health status of children.
- Screening, evaluation, and referring appropriately for findings of deficit in vision, hearing, scoliosis, growth, and other health-related areas.
- Identifying health conditions that may affect learning
- Interpreting the health conditions that may affect learning.
- Initiating referrals to parents, school personnel, physicians, and other community health resources for intervention and follow-through.
- Providing ongoing health counseling for students, parents, and school personnel.
- Recommending and helping to implement modifications of school programs to meet health needs of students.
- Collaborating with physicians and other community health resources to provide appropriate care of students.
- Maintaining, evaluating, and interpreting cumulative health data to accommodate individual needs of students.
- Participating as a health team specialist on the child education evaluation team to develop the Individualized Education Program, or 504 Plan.
- Planning and implementing school health management protocols for the child with special health needs, including the administration of medication and necessary treatments.

- Developing / following procedures and providing for crisis intervention for acute illness, injury, and emotional disturbances.
- Promoting and assisting in the control of communicable diseases through monitoring of immunization status, prevention, early detection, surveillance, reporting, and referral for care of contagious diseases.
- Recommending provisions for a healthy and safe school environment conducive to learning.
- Providing health counseling for staff and providing leadership support for staff wellness programs.

C. Professional Requirements of the School Nurse

Section 902 of Education Law allows Boards of Education to employ one or more school nurses, who must be Registered Professional Nurses (RNs) legally qualified to practice nursing in the state. A Licensed Practical Nurse (LPN) is a dependent practitioner who may be hired in a school setting to perform nursing tasks under the direction of a RN or School Physician but an LPN cannot assume the role of the school nurse.

All nurses employed by the School District:

- Must hold a valid NYS License to practice nursing.
- Must hold and maintain a current certification of CPR/First Aid/AED.
- Must familiarize themselves with and comply with Board of Education Policies related to Health Services (8121 & 8123).

II. HEALTH RECORDS, APPRAISALS, AND SPORTS PARTICIPATION

The purpose of keeping updated health records, appraising student's current health status, and determining fitness for program participation is to be able to indicate the need for any modifications, and discover any health problems, which may interfere with the learning process or require further assessment and/or treatment.

A. Initiating Health Records

A school health record must be prepared for each student. The health record should be established to provide procedures for collecting, organizing and maintaining information about students in an orderly, effective manner. All school health records should be considered as part of the district record system.

1. It must provide relevant information about the physical, intellectual, personal, social and environmental factors which can affect the student's health and education.
2. It is confidential and must be stored so that only duly authorized persons have access to it.

The school has an obligation to provide professional interpretation and advise whenever a pupil health record is made available to parents. It should be kept in mind that health record information might be shared with personnel of cooperating agencies only with the consent of the parent or guardian.

3. The United States Family Education Rights and Privacy Act of 1974 ensures the availability of student records to parents of students under 18 years of age, and to students and former students over 18 years of age and ensures confidentiality of such records with respect to third parties.
4. It must include all test, examinations and conferences.
5. It must record any diseases, serious illness, major injuries or operations which occur during each year.
6. It cannot be disposed of legally unless one has the consent of the Commissioner of Education. It is the responsibility of the school district clerk to request for the disposition of local district records.
7. It must be made available to the school physician when the child is examined.
8. Must be sent via inner office mail to another school in the district when the student is promoted from one school to another. The original pupil health records should be transferred from the jurisdiction of the school district where they are initiated. When the student transfers to another school district, a transcript or photocopy of the original, should be forwarded to the school district to which the pupil has transferred written request to the district.

RECORDING STANDARDS

Use only black ink

Correct error with one single line and initial it

No erasure or white out

Use standard medical abbreviation only

Records should never be transferred from the school district from which they originated. Copies forwarded to another school district should be marked **CONFIDENTIAL**.

B. Physical Exam Requirements for Students

NYS Education Law requires a physical examination for every student in grades K, 2, 4, 7, & 10 as well as new students to the district. It is recommended that a student's primary physician give this examination, as he/she is most familiar with an individual's health history. The physical examination form must be submitted to school within 30 days of entering.

While the law does not require that parents be notified of mandated health assessments, it is expected that district nurses will establish procedures to notify parents of all such

evaluations. It is not required that districts obtain signed parental permission forms for health assessments.

C. Immunization requirements for Students K-12

- Diphtheria Toxoid Containing Vaccine (DTP, DtaP): 3 Doses

Tetanus Booster is required 10 years after last vaccine administered

- Polio (IPV, OPV): 3 Doses
- Measles Mumps Rubella (MMR): 2 Doses of Measles Vaccine, 1 Dose Each of Mumps and Rubella (preferably as MMR)
- Hepatitis B: 3 Doses
- Varicella (Varivax): For students born after 1/1/98, 1 Dose is Required

Medical documentation by Physician of positive history of disease is also acceptable.

Each school in the district is required to complete a state mandated immunization survey to ensure all students are adequately immunized.

Students whose records indicate non-compliance with immunization requirements may be excluded from school at the discretion of the building principal.

D. PPD Test Requirements for Students

As of August 22, 2007, it is the policy of the PCRUFSD that the Mantoux (PPD) Tuberculin Test Policy be amended as follows:

All new entrants to the Port Chester Rye UFSD must have a tuberculosis (TB) Risk Factor Screening (see Board of Education Policy 5420-E documented by a licensed health care provider. This screening must be completed prior to the students first day of attendance. In the event the health care provider determines PPD testing is indicated, a Mantoux tuberculin screening test must be administered.

Any student visiting a country outside the United States for a period of one month or greater must, 90 days after his/her return, have a TB Risk Factor Screening documented by a licensed health care provider. In the event the health care provider determines PPD testing is indicated, a Mantoux (PPD) tuberculin screening test must be administered.

The only acceptable test is the Mantoux (PPD) tuberculin screening test. The Mantoux (PPD) tuberculin screening test must be administered, read, and reported by a trained health care professional and recorded in millimeters. Students with legitimate religious or health reasons must be excluded from these requirements with proper documentation from licensed health care provider.

INTERSCHOLASTIC SPORTS / ATHLETIC EQUIPMENT

E. Interscholastic Athletic Requirements

A. Criteria

1. Regulations of the Commissioner of Education requires Boards of Education to:
 - a. Provide adequate health examinations:
 - i. Before participation in strenuous activity, AND
 - ii. Periodically throughout the season as necessary.
 - b. Permit no pupil to participate in such activity without the approval of the school district medical officer (school physician).
2. Recommend the school physician or nurse practitioner perform that physical examination.
3. The school physician has final authority to determine the physical capacity of a student to participate in a sport.
 - a. Should consult with private health care provider(s).
 - b. Safeguard health of individual student.
4. The examination and approval should indicate the category of activities in which the student may participate.
5. Physical exams can be scheduled at any time.
6. Results valid for 12 months.
 - a. e.g. from June one year until end of June following year.
 - b. PROVIDED
 - i. Safe participation not in question because of illness or injury,
AND
 - ii. Prior to each sport's season, school nursing personnel interview student to update history, or have parent complete an interval health history
7. Unless full sports physical exam is within immediately preceding 30 calendar days, all students shall have a health history interview, or history:
 - a. Prior to start of tryout practice sessions.
 - b. Beginning of each season.
8. Prequalification
 - a. Any student whose safe participations is in question must be re-qualified.
 - b. By school physician or nurse practitioner.

- c. Determined by extent of injury or nature of illness
- d. Assessed on individual basis in conjunction with school personnel and private health care provider, if appropriate.
- e. Final decision made by school physician.

Any student deemed unable to participate in school's Physical Education classes will be considered ineligible to participate in school related athletic activities.

F. Work Permits

School districts in New York State are required by law to issue employment certificates to qualified applicants (11 to 18 years of age). A physical examination conducted within 1 year is required. Upon verification of the physical exam, the school nurse will complete the required Physical Fitness Certification Form. This form is necessary for work permit eligibility.

III. HEALTH SCREENINGS

A. Vision Screening

The purpose of a school vision-screening program is to identify students with visual impairments. Visual problems can and do affect the physical, intellectual social and emotional development of children. Early detection of vision problems will provide a child more opportunity for educational success. Because visual loss may impede normal development, the earlier visual impairments are diagnosed and treated, the more favorable the outlook for correction or improvement of the child's general well-being.

- Vision Screening (Distance Acuity) is conducted on all new entrants as well as students in grades K, 1, 2, 3, 5, 7, & 10.
 - In addition, all new entrants will be screened for color perception, near vision.
1. Screening procedures for near visual activity with reduced Snellen (13" or 14"):

Only once, within six months of school admission.

 - a. Have child sit at table or desk: Using Reduced Snellen Chart, follow manufacturer's directions for appropriate distances.
 - b. Have child cover left eye with occluder and read the letters on the card from the smallest line he/she was able to read on the distance acuity chart, moving across the line from left to right. Identify smallest line read correctly.
 - c. Record near visual acuity for right eye and note any facial or postural behavior exhibited.

- d. Repeat procedure (2) with right eye occluded and record the results for the left eye noting any facial or postural behavior exhibited.
 - e. Failure criteria:
 - Less than best acuity achieved on distance test.
 - More than a two-line difference between eyes.
If child fails first screening, a second screening using the same procedure should be performed unless a mechanical vision tester was used. In that case, a second screening should be completed using the Reduced Snellen Chart screening procedure. If child fails re-screening, notify parents and send a written referral for a professional eye examination.
 - f. If using mechanical vision tester, follow manufacturer's instructions using same referral criteria.
3. Color perception screenings:
Only once within six months of school admission.
- a. Follow manufacturer's directions for use of plates.
 - b. Acquaint the child with the screening materials and method of responding.
 - c. Have child keep both eyes open.
 - d. Show child how to use soft, dry paint brush or cotton-tipped swab to trace the symbols on the color plate if unable to verbalize symbols.
 - e. Failure criteria:

Follow manufacturer's instructions. Inform child, parents, and teachers about deficiency, including the implications and lack of correctability. Failure is not a cause for referral. Color deficiency cannot be corrected.

NOTE: Plates in mechanical vision testers are not acceptable for use.

B. Hearing Screening

The purpose of hearing screening is to identify students with possible hearing losses, which may affect their intellectual, emotional, social, speech, and/or language development. The key to successful remediation is early identification and intervention, which may prevent educational handicaps and permanent hearing losses.

- Hearing Screening is conducted on all new entrants as well as students in grades K, 1, 3, 5, 7, & 10.

C. Scoliosis Screening

Scoliosis is a spinal deformity, which can impair the body's range of motion, cause back pain and, in advanced stages, adversely affect other parts of the body. The purpose of scoliosis screening in schools is early identification of those students. With early identification and intervention, scoliosis may be prevented from progressing so that its interference with mobility, activity and comfort is minimized.

- Scoliosis screening is performed for all students in grades 5-9.
- Parents should be notified when scoliosis screening will occur for their child.

Parents or guardians are to be notified if their child has been identified as having a possible vision, hearing, or scoliosis problem so that they may seek out a further examination by a specialist/physician.

D. Height/Weight

In order to accurately follow each student's growth and development, it is recommended that height and weight measurements be recorded yearly.

IV. MEDICATION IN SCHOOL

A. Administration by Health Professional

The administration of prescribed medication to a student during the school hours is permitted only when the medication is necessary to allow the student to attend school or failure to administer the medication would seriously affect the student's health.

Parent(s) or guardian(s) must present the following information:

- A note from the family physician containing the following information: student's name, the date, and the name of the medicine, the purpose, dosage and time to be administered.
- A note from the parent(s) or guardian(s) giving the school nurse, teacher, Principal or other school staff permission to administer the medication.

B. Self-Administration

Self-Administration Education Law 16, Article 19, Section 916 allows students with asthma to carry and use a prescribed inhaler during the school day, with the written permission of a physician and a parent/guardian.

The self-administration of prescribed medication during the school hours is permitted only when the medication is necessary to allow the student to attend school or failure to administer the medication would seriously affect the student's health.

School nursing personnel may receive a request from a parent or physician to permit a student to carry and self-administer his/her own medication. Under certain conditions this may be allowed. Such decisions should be made on an individual basis.

Parent(s) or guardian(s) must present the following information:

- A note from the family physician containing the following information: student's name, the date, and the name of the medicine, the purpose, dosage and time to be administered. The physician must also document that he/she is granting that individual permission to self-medicate during school hours.
- A note from the parent(s) or guardian(s) giving the student permission to self-administer the medication.

C. Epi-pen

The prescriptive use of single dose epinephrine auto injector devices ("Epi-pens") has become an accepted and extremely beneficial practice in protecting individuals subject to serious allergic reactions. The use of Epi-pens in schools has also become a common method of protecting children against severe reactions that they may encounter during school hours.

The administration of epinephrine by Epi-pen, prescribed by a licensed prescriber, to a student with a known severe allergy needing an anaphylactic treatment agent may be performed by a school staff member responding to an emergency situation. Such a response is permitted under the Medical Practice Act (Education Law §6527[4][a]) and the Nurse Practice Act (Education Law §6908[1][a][iv]) and is covered by the "Good Samaritan Law" (Public Health Law §3000-a). Recently, questions have arisen regarding the authority of registered nurses, nurse-practitioners, physicians and physician's assistants, licensed by the State Education Department,

to provide training to unlicensed individuals in administering Epi-pens, prescribed by a licensed prescriber, to school children in the event of the onset of a serious allergic reaction when a nurse is not available. As this practice could be viewed as subjecting the licensee to potential professional misconduct charges, it is necessary to provide some clarity and guidance.

Subject to the conditions below, the New York State Education Department ("SED") shall not consider the mere action by a registered nurse, nurse practitioner, physician or physician's assistant of training an unlicensed person to administer an Epi-pen in an emergency to constitute an act of professional misconduct.

- The training provided must be premised upon the use of an Epi-pen only in an emergency situation where a nurse or other licensed individual is not available.
- The licensee providing the training must possess adequate knowledge, preparation and licensure to adequately provide the training.
- The licensee providing the training must not do so in a negligent or grossly negligent manner. Therefore, when a registered nurse, nurse-practitioner, physician or physician's assistant trains an unlicensed individual to administer an Epi-pen, prescribed by a licensed prescriber, in emergency situations where an appropriately licensed person is not available, the mere act of providing such training under the conditions noted above is not considered by SED to constitute professional misconduct on the part of the licensed

individual. SED will **not** view the provision of training per se to be grounds for charging the licensed individual with professional misconduct and does not anticipate initiating such charges solely on that basis.

V. EMERGENCY READINESS

Emergency readiness is a priority in developing a district wide program of emergency health services. Readiness includes all activities aimed at developing an increasing level of awareness about safety, increasing positive safety behavior, and improving the environment of the building (against hazards).

A. Emergency Information

Emergency information should be filled out for each student yearly. These instructions for emergencies, signed by the parent or person with parental authority, should include:

- Name, address, telephone numbers for parents/guardians during school hours.
- Name and telephone of person to contact in an emergency when parents cannot be reached.
- Name of family physician.
- Any special condition the child may have which would require special handling in an emergency. Students who have ongoing health problems may have special health needs, which will impact first aid care.
- The health information should be revised immediately when changes occur.
- It is advisable to have emergency information for all school personnel. Personal health emergencies involving school staff do occur.
- This emergency information is usually located in the health office of each school building.

B. Accidents Reports

According to Port Chester Board of Education Policy #8122, all accidents occurring in the classroom, on school property, or on buses, regardless of seriousness, must be reported to the school administration as promptly as possible. An Incident Report must be completed by the school nurse.

VI. STANDING PROTOCOLS: FIRST AID

A. Abdominal Pain

- Notify parent for immediate evaluation by own physician for extreme pain, walking bent over, blood in stool, suspected toxic ingestion, abdominal injury, lower quadrant groin tenderness, tense abdomen, intractable vomiting. If severe, consider transport to Hospital Emergency Department in consultation with private physician and parent.
- Advise parent to schedule physician evaluation for recurrent

- problem or acute problem with fever.
- For other problems not listed in #1, reassure patient, have patient lie down and rest, consider, if tolerated, giving hot water bottle or heating pad to protected skin, suggest clear liquids, or food, and/or encourage patient to use bathroom. If pain persists despite up to 45-60 minutes of rest, consider dismissal.

B. Abrasions, Lacerations, Puncture Wounds

Severe:

- Follow standard procedures from American Red Cross Manual, applying constant pressure with dry sterile dressing.
- Notify parent to have patient seen by own physician, or –
- Arrange for transportation to Hospital Emergency Department immediately via ambulance, for life-threatening bleeding.
- Check tetanus status to inform parent. See also Severed Limb for avulsions with salvageable tissue.

Minor:

- Clean with warm soapy water.
- Check for sensation, circulation, and function.
- Cover with dry sterile dressing.
- Notify parent as per general guidelines. Puncture wounds may require referral to own physician.
- Check tetanus status to inform parent.

Old Wound Infection

- If contact irritant present, remove and advise student and/or parent of possible casual relations (e.g. jewelry, make-up). Suggest to student to remove suspected offending agent.
- Clean with warm soapy water.
- If associated with significant redness, swelling heat, or ascending lymphangitis, and/or infection involving joint or cartilage, or is a puncture wound, refer to own doctor.
- If infection appears minor, suggest proper care to student and/or family, and follow-up in 24 hours to recheck. Nurse may re-clean wound at her discretion based on the condition of the wound and family situation and advise a referral as needed at that time.
- Check tetanus status to inform parent.

C. Allergic Reactions / Insect Stings

Mild (Localized Reaction, Redness, Swelling Around Bite)

- Administer epinephrine and/or Benadryl if available, per private physician orders.
- Wash area, apply ice or cold water to protected skin.

- Observe for progressive or delayed reaction. Alert teacher to do same when child returns to class. If epinephrine has been given,
- Child must be transported to hospital. If Benadryl has been given.
- Child should be managed per private physician order.
- Stock Benadryl may be given upon request of the parent and private physician and managed according to private physician's directions.

D. Alcohol Intoxification (See also Drug Overdose, Poisoning & Unconscious State)

With Loss of Consciousness:

- Evaluate airway, breathing, cardiac status.
- Institute cardiopulmonary resuscitations as appropriate; may administer oxygen via face mask at 2 liters per minute up to maximum of 4 liters per minute as needed.
- Attempt to keep head turned sideways or place patient on side; keep airway clear of vomitus. (Do not place own fingers in patient's mouth if patient is seizing.)
- Call ambulance and transport to Hospital Emergency Department.
- Notify parents to meet nurse or designee at Emergency Department.
- Follow protocol for notifying building administrator.

Without Loss of Consciousness:

- If combative, attempt to protect self and others.
- Encourage patient to lie down and rest.
- Conduct suspected substance use assessment.
- Contact parent to pick up student.
- Notify school administrator after incident.

E. Anaphylaxis (See Allergic Reactions, and Unconscious State; Life-Threatening Emergency)

Evaluate airway, breathing, cardiac status. Supportive First Aid for shock (keep warm, lying down, legs elevated).

- Administer Epi-kit or other medications prescribed by own doctor, if available or as listed under Allergic Reactions.

F. Bed Bugs:

If bed bugs are suspected in classroom, the rooms should be inspected. Insecticide treatments within schools should be avoided. School may contact a local pest specialist to verify bugs' identity. Many times what is presumed to be bed bugs are not. Anyone can bring bedbugs into the school environment. Children are not excluded if it is suspected they have bedbugs/bites

G. Bite

Human

- Clean with antibacterial cleaner or hand soap and warm water. If on face or hand, patient may need antibiotic. Notify parent to secure care with own physician same day.
- If skin is broken, notify parent of incident, advise to watch for signs of Infection. Treat for bruising with ice to protected skin.
- Complete exposure paperwork if skin integrity is compromised.
- Check tetanus status; notify parent.

H. Insect (See Also Allergies)

- If stinger visible, gently attempt removal by scraping or grasping stinger, not venom sac.
- If stinger embedded, do not attempt removal. Advise parent to see family physician on same day.
- Wash with antibacterial cleaner or soap and water.
- If know allergen and medication is available, administer medication per doctor's orders.
- If not, administer stock medication as needed per Allergic Reaction Standing Order.
- Provide ice pack to protected skin as tolerated.
- Monitor student for delayed reaction for up to 2-3 hours after the incident by alerting the parent or teacher to send the child back for re-check in 2 hours or sooner as needed.

I. Bleeding

Arterial

- Apply pressure, do not release.
- Call 911.
- Treat for shock, keeping patient calm, warm and reclined.

Nose

- Have patient firmly pinch both nostrils, hold for 5 minutes by the clock, while lying down on side or sitting with head bent forward if faint, or in position of comfort.
- Gently release. If bleeding persists, hold for 10 minutes more, apply ice to bridge of protected nose if desired.
- If bleeding persists after 20 minutes total, call parent to have patient evaluated by own physician. Continue to have patient pinch own nostrils until parent comes.
- If parent unavailable, and bleeding persists after 30 minutes, (total time), or if know bleeding disorder is present, transport patient to Hospital Emergency Department with nurse or designee via ambulance following standard procedures (See Accidents and Illnesses).
- Advise 10-15 minutes rest after bleeding stops before resuming activity.

J. Burns

Thermal

Second Degree (Redness and Blistering)

- Cover area with wet, clean dressing.
- Apply ice to protected area until pain stops but at least for 20 minutes.
- Advise patient not to break blister.
- Cover with dry sterile dressing.
- Notify parent to have burn evaluated by own physician.
- Be sure tetanus immunization is current within past 5 years; notify parent.
- Nurse may recheck at 24, 48, 72 hours for signs of infection at nurse discretion, unless dressed by own physician and bandage is not to be removed.

Third Degree (Redness and Blistering)

- Keep patient calm and lying down.
- Call ambulance as indicated. Nurse or designee meet parent at Emergency Department or Hospital of their choice.
- Cover with sterile burn sheet if available. Otherwise leave uncovered.

Chemical (See Also Eye)

- Remove contaminated clothing and have patient begin flushing area with running water for 20 minutes (protect your hands).
- Determine the causative agent from teacher. Call Life Line and proceed per advice.
- If extensive, cover with burn sheet if one available, otherwise leave uncovered.
- Notify parents to have patient seen by own physician. If extensive, may need transportation to Emergency Department.

K. Chest Pain

- Assess for localization, association with breathing, color of client's lips and mouth (pink vs. cyanotic), nature of onset, trauma, previous episodes, history of illness, or chronic medical condition.
- If pain is sudden onset, or if patient demonstrates air hunger, cyanosis, anxious look, or unstable vital signs (BP, respirations, pulse), or has an underlying medical condition, reassure, allow to rest and stay calm, call for ambulance transfer to Hospital Emergency Department and notify parents.
- If not immediate emergency, patient is pink and comfortable with stable vital signs, follow with frequent observation and vital signs every half hour until student is released to parent or improves and returns to class.
- Notify parents to pick up child if pain does not subside within one hour child worsens

L. Choking

- Follow directions for Abdominal Thrusts per American Red Cross.

M. Dental Problems

Broken Tooth

- Try to clean dirt and debris from area with tepid water. Take the individual to the dentist immediately.

Knocked Out Tooth

- DO NOT touch the root of the tooth. Plug the sink drain. Hold the tooth by the crown and rinse tooth off in running tepid water. Place in cow's milk or a tooth kit. If cow's milk is not available, place in moist, clean cloth. Recommend the individual and his / her tooth go to the dentist immediately.

Bitten Tongue or Lip

- Apply direct pressure to bleeding area with a sterile or clean cloth. If swelling is present, apply cold compresses. If bleeding doesn't stop readily, if known bleeding disorder, or if the laceration is severe, contact parent to arrange transportation to Hospital Emergency Department.

Object Wedged Between Teeth

- Allow the student to try to remove the object with dental floss. Advise the student to guide the floss in carefully so as not to cut the gums. If unsuccessful, call parent to arrange transportation to a dentist. DO NOT try to allow student to remove the object with a sharp or pointed utensil.

Orthodontic Problem

- If a wire is causing irritation, cover the end of the wire with a piece of gauze or dental wax and call the parent to take the individual to the orthodontist.
- If a wire is embedded in the cheek, tongue, or gum tissue, DO NOT attempt to remove it. Call parent to take the individual to the orthodontist immediately.
- If there is a loose or broken appliance, call parent to take the individual and the appliance to the orthodontist.

Toothache

- Rinse mouth with warm water. If swelling is present, place cold compresses on the outside of the cheek, DO NOT USE HEAT. Call parent to take the individual to the dentist.

N. Electrical Shock (See Also Asphyxiation)

Severe – Unconscious, not breathing and / or unstable vital signs.

- Remove patient from source using non-metal object and / or have

electrical source turned off; DO NOT ENDANGER YOURSELF.

- Immediately evaluate need for Cardiopulmonary Resuscitation / Automated External Defibrillator. (CPR / AED)
- Arrange for notification of parent and transport to Hospital Emergency Department.
- Check site for burn, treat accordingly.

Moderate – Description of jolt through the entire body, sensation of chest pain, palpitation, heaviness or residual tingling of extremities.

- Remove patient from source using non-metal object and / or have electrical source turned off; DO NOT ENDANGER YOURSELF.
- Monitor vital signs. Assess need for CPR / AED.
- Notify family the child needs to be seen for electrocardiogram.
- Check site for burns, treat accordingly.

Mild – Jolt through the entire body without any accompanying symptoms.

- Check site for burns, treat accordingly.
- Allow to rest and reassure.

O. Eyes

For eye examination check for lacerations, swelling, redness of lid or sclerae, double or blurred vision, extra-ocular movements, unequal or irregular pupils, pain.

Foreign Body

- Notify parent and arrange to have patient seen by own physician or at Hospital Emergency Department, if:
 - object is sharp
 - object is embedded
 - object became lodged at high speed
 - vision is blurred after 1 hour of rest
 - pain, photophobia, redness persists after one hour (eye is held closed)
 - pupils unequal in size or shape
- If none of the above, and object is easily seen, attempt removal once with moistened cotton ball.
- If object is not visible, or if multiple articles are seen, use eye cup (previously cleaned with solution of ½ water, ½ chlorine bleach) with warm water or saline or use irrigator until object is removed or for up to 15 minutes. DO NOT IRRIGATE IF SUSPICION OF PUNCTURE OF THE GLOBE EXISTS (e.g. what appears to be irregular pupil with or without apparent mucus strands). REFER IMMEDIATELY TO OPHTHALMOLOGIST
- Notify parent to arrange to send to own physician or Hospital Emergency Department if the sensation of grittiness persists, vision is abnormal after 1 hour of rest, or tearing, rubbing, or excessive blinking occur after 1 hour.

P. Fever

Send home any child with a temperature over 100.4 or 38⁰ C according to normal. Child may return to school when a febrile off anti-pyretic medication and well enough to learn. There is no minimal waiting period for return to school following fever.

Q. Fleas

Fleas, either cat or dog, need a host to survive. Either type may feed upon a person. Only adult fleas blood feed. Generally flea bites are noticed around ankles. Simply laundering or changing clothes will be sufficient to eliminate fleas from a person. Because a child is not likely to infest others or the classroom environment, exclusion is not typically required. Again, education is essential.

R. Fractures, Sprains, Strains

- Do not allow weight bearing until assessment is complete.
- Immobilize limb if obvious or suspected fracture. Use ace bandage if non-compound, non-complex fracture.
- First aid for shock (keep warm, lying down, legs elevated) as needed.
- Arrange with parent to transport to Hospital Emergency Department or own physician for severe injury, obvious, or suspected fracture.
- Give ice to protected skin and have patient elevate injured area. Advise continued rest, ice, compression, and elevation until pain and swelling subside or until evaluated by own medical provider. For mild sprains, patient may not need to be seen immediately by own physician, but parent should be notified to continue rest, ice, elevation, and, if possible, not weight bearing with follow up by their own physician as needed.

S. Frostbite

- Immediately notify parent and arrange transportation to Hospital Emergency Department for temperature less than 95⁰ F or if frostbite is extensive (anything more than an earlobe, toes, fingers, tip of nose, or spot on cheek).
- Re-warm area rapidly by placing the frostbitten part in very warm water (104⁰ – 108⁰ F) for 20-30 minutes or until a flush returns to skin. Keep rest of body warm.
- Do not rub or apply cold to frostbitten skin.
- If blister develops refer to own physician for same day referral.
- If no blister develops, notify parent regarding signs of infection and need for follow-up.

T. Headache

- Refer to own physician for fever with rash, extreme pain, any central nervous system (CNS) symptom, stiff neck, ill appearance, recurrence. Fever with petechial rash and headache requires immediate fluid precautions, isolation, and transport to the Hospital

Emergency Department.

- Otherwise, allow to rest in quiet dark area and give cold compress for forehead.

U. Head Lice (Pediculosis)New as of 2/2/10

Live Lice

- Diagnosis of head lice infestation (pediculosis) 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.
- Wearing gloves, inspect all areas of the scalp covered by hair using wood applicator sticks or forceps. Use a separate applicator for each student. Watch closely for movement on or near the scalp for nits on strands of hair.
- Document observation of lice or nits.
- Contact parent/guardian and explain the problem. Review carefully with parent or caregiver the “Parent Instruction Sheet for Head Lice”,
- Send any child home with live lice. Do not return the child to class.
- Attempt to preserve confidentiality and dignity of the student.
- Nits are encouraged to be removed before return to school.
- If an outbreak is established where notice is warranted administration may choose to send a letter, so consult your building principal and Director of Health.
- A child upon return to school must be checked by nurse.
- Instruct parents to remove nits with fine toothcomb after shampooing. Nits may also require manual removal with fingernails or tweezers.
- Contact schools where other household members attend; and screen other siblings that may be in the same school.
- If a student or family has a chronic problem with head lice (2 or more infestations in one month)refer family to Primary Care Provider.
- **Please check parent instruction sheet for head lice on district home page.**

Re-Admission to School

- The student will be admitted to school when after examination by the school nurse and no live lice found.

Classroom Outbreaks

- For classroom outbreaks and resistant or recurrent cases collaborate with the district physician.
In cases where treatment failure (live lice within ten days following adequate treatment) is suspected, particularly if the treatment was with an over-the-counter agent, the child must be seen by their own physician. In suspected treatment failure, do not allow the child back in school without a note from the physician that a different form of therapy has been prescribed and until the child is nit free ¼ inch from the scalp or upon consultation with the district physician. Notify the principal, since a nurse may not exclude a child
- In cases where re-infestation is suspected, advise the parents to do precautionary cleaning, as well as anywhere they regularly visit. Do not allow the child back in school after the second infestation (i.e. the third time) you find live lice, until they have a note from their physician of adequate treatment and until the child is nit free ¼ inch from the scalp. Notify

the principal, since a nurse may not exclude a child.

V. Seizures

Many seizure types-such as generalized absence [seizures](#) or complex partial seizures, which involve relatively brief episodes of unresponsiveness- don't require any specific first-aid measures.

- Stay calm
- Prevent injury.
- During the seizure, you can exercise your common sense by insuring there is nothing within reach that could harm the person.
- Pay attention to the length of the seizure.
- Make the person as comfortable as possible.
- Keep onlookers away.
- Do not hold the person down.

If the person having a seizure thrashes around there is no need for you to restrain them. Remember to consider your safety as well.

- Do not put anything in the person's mouth.
Contrary to popular belief, a person having a seizure is incapable of swallowing their tongue so you can breathe easy in the knowledge that you do not have to stick your fingers into the mouth of someone in this condition.
- Do not give the person water, pills, or food until fully alert.
- If the seizure continues for longer than five minutes, call 911.
- Be sensitive and supportive, and ask others to do the same.

After the seizure, the person should be placed on her left side. Keep in mind there is a small risk of post-seizure vomiting, before the person is fully alert. Therefore, the person's head should be turned so that any vomit will drain out of the mouth without being inhaled. Stay with the person until she recovers (5 to 20 minutes).

W. Sore Throat

- Severe sore throats, especially with difficulty swallowing saliva, need immediate referral to private physician or Hospital Emergency Room.
- Warm salt water (1/2 tsp. salt to 1 cup warm water) gargle may be offered.
- Over the counter cough drops may be allowed if available.
- If associated with fever, persists greater than 48 hours, or if pus on tonsils, refer to own physician.

VII. Standing Protocols: Communicable Diseases and Common Illnesses

DISEASE SPECIFIC INFORMATION

The following pages include information on infectious diseases that have specific implications for school health personnel working with school-age children. This list is by no means complete but includes diseases which are known to be transmitted, or have the potential of being transmitted, in a school setting. The information presented will enable

school health personnel to begin the process of assessing illness, referring for treatment, and providing follow up upon return to school. In-depth infectious / communicable disease information is available and should be included as part of the school health reference library.

A. Chicken Pox/Herpes Zoster (Shingles)

Definition: Acute viral disease characterized by fever and macular, papular and/or vesicular rash and crusting.

Etiology: Varicella – Zoster Virus (VZV).

Clinical Manifestations: Chicken Pox (Varicella): Generalized pruritic (itchy), papular, vesicular rash occurring in successive crops with a fever up to 102 degrees, and sometimes systemic complaints of malaise and respiratory symptoms. The rash may originate on the scalp, but usually originates on the trunk and spreads distally. Lesions exist in several stages of development, last several days, then dry and crust. Shingles (herpes zoster): VZV persists in a latent form after primary infection with chicken pox. Reactivation results in zoster or shingles. Lesions appear in the distribution of one to three sensory dermatomes (On one side of the body or the other). Often accompanied by mild to severe pain localized to the affected area.

Complications:

1. Superimposed bacterial infection, dehydration, pneumonia (rare in children), and central nervous system manifestations are the most common complications. Reye's Syndrome can follow some cases, especially when aspirin has been used for symptomatic treatment.
2. Immunocompromised individuals have more severe cases that may be prolonged with weeks to months of lesions and generalized symptoms.
3. Adults are at increased risk for complications.

Mode of Transmission: Direct contact with varicella or zoster lesions or by contaminated airborne droplets.

Incubation: Usually 14-16 days; may occur as early as 10 or as late as 21 days after exposure.

Period of Communicability: For most, one to two days **before** and 4- 5 days after the onset of the rash, or until all the rash lesions have formed crusts.

Reporting Requirements: Only for cluster or outbreak of cases.

Management:

1. Children with uncomplicated chicken pox may return to school on the sixth day after onset of the rash or after all lesions have dried

- and crusted. In cases of shingles, individuals with lesions, which cannot be covered, should be excluded until after lesions have crusted. Lesions that are covered appear to pose little risk. Hand washing is important if one has touched potentially infectious lesions.
2. Notify parents of students known to be at high risk. Susceptible immunocompromised individuals, including those who are receiving chemotherapy, should be referred to their physician if exposed. Within 96 hours of exposure, children at high risk can be given Varicella – Zoster Immune Globulin (VZIG).
 3. Vaccine: Live-Attenuated Varicella Vaccine. Trade Name: Varivax.
 - Children > 12 months and < 13 years of age require 1 dose of vaccine
 - > 13 years of age – 2 doses, 4-8 weeks apart.
 - Can prevent or modify the severity of illness if given within 3 days and possibly up to 5 days after exposure.
 - Vaccinated children can get Varicella Disease, though it is usually significantly milder.

➤ As of 2003, Varicella immunity is required for Kindergarten entry.

B. Conjunctivitis

Definition: Conjunctivitis is an inflammation of the mucous membrane that lines the eyelids and extends over the sclera, commonly called pink eye.

Etiology: Bacteria, virus, allergy, chemical or other irritants. Purulent conjunctivitis is defined as pink or red conjunctiva with white or yellow eye discharge, matted eyelids after sleep, and eye pain or redness of the eyelids or skin surrounding the eye.

Clinical Manifestations:

Bacterial: Sclera red or pink, lining of eyelid inflamed in one or both eyes, photophobia, tearing, minimal itching, blurred vision that clears with blinking, purulent discharge, dried discharge on awakening, and/or swollen eyelids.

Viral: Minimal itching, sudden onset, initially only one eye, photophobia, sclera red or pink, lining of eyelid inflamed in one or both eyes, profuse tearing, preauricular node enlargement.

Allergic: Red conjunctiva, swollen mucosa, profuse tearing which can become purulent, intense itching, burning, rubbing, nasal mucosa swollen or pale, usually both eyes involved.

Complications:

Mode of Transmission: Bacterial or viral conjunctivitis is transmitted by contact with discharge from conjunctiva or upper respiratory tract of infected persons or by contaminated fingers, clothing or other articles.

Incubation Period: Bacterial usually 24 – 72 hours; viral usually 5 – 12 days.

Period of Communicability: Bacterial or viral conjunctivitis is communicable any time during active infection.

Reporting Requirements: Not reportable unless an outbreak occurs.

Management:

Good hand washing techniques. Cool compresses for comfort. Follow treatment prescribed by appropriate health care provider.

School Consideration: With Symptoms of purulent conjunctivitis, exclude student until symptoms have resolved or written release to return to school is provided by student's health care provider. Refer to student for diagnosis and treatment. Maintain appropriate hygienic procedures. Observe for outbreaks. Notify parents by letter if ongoing transmission occurs.

Future Prevention / Educational Needs: Staff, parents and students require education about the various agents that cause conjunctivitis as well as the varying degrees of communicability. Parents should be instructed to thoroughly wash in hot water all clothes, towels and bed linens used by infected individuals.

C. Cytomegalovirus (CMV)

Definition: Viral infection which can occur congenitally, post-natally or at any age, and ranges in severity from asymptomatic to serious disease manifested by fever, hepatitis, pneumonitis and (in neonates) brain damage, stillbirth or prenatal death.

Etiology: Human CMV, a member of the herpes virus group.

Clinical Manifestations: The signs and symptoms will vary with age and immunocompetence of the individual. Asymptomatic infections are most common, especially in children.

1. Liver and spleen enlargement may occur when the disease is acquired in childhood.
2. An infectious mononucleosis-like syndrome may occur in adults.
3. Pneumonia and retinitis are common in immunocompromised individuals.

Congenital infections: Usually asymptomatic but some infants, asymptomatic at birth, later demonstrate a hearing loss, vision impairment, varying degrees of mental retardation, or coordination problems.

About 5% - 10% of those infants infected in-utero may develop severe disease including intrauterine growth retardation, neonatal jaundice, purpura, hepatosplenomegaly, microcephaly, brain damage, intracerebral calcification or chorioretinitis. Fetal risks are greatest in the first half of gestation.

Mode of Transmission: Direct person to person contact with secretions that contain the virus (primarily saliva, but also infected urine, semen, blood, tears, breast milk and vaginal secretions). The virus is not considered highly contagious but transmission in households and day care centers has been documented.

Virus is also found in white blood cells and has, therefore, been transmitted via blood transfusion. Transmission can occur from mother to child in utero, during delivery or post-natally through the ingestion of CMV positive human milk. Breast milk may not cause apparent illness since the milk contains maternal antibodies. The most severe form of disease occurs in the perinatal period. Fetal death may occur.

Incubation Period: Unknown in cases of household transmission; 3-8 weeks following blood transfusion.

Period of Communicability: Virus is secreted in urine and saliva for many months, and may persist for several years following primary infection.

Reporting Requirements: Not reportable.

Management: Exclusion of children with congenital infection from schools or institutions is not justified since asymptomatic infection is common in newborn infants and during infancy and early childhood.

The child with congenital CMV infections should not be singled out for exclusion or special handling. Hand washing, particularly after assisting with toileting or diapering or when exposed to saliva, is advised in caring for all children.

Pregnant or immunocompromised students and/or personnel who may be in contact with CMV infected individuals should be counseled about the potential risk. It should be remembered that many exposed adults and children are already immune but may not be aware of this since most infections are asymptomatic. Referral to primary health care provider is essential if the students/personnel have specific questions, concerns and/or issues.

D. Erythema Infectiosum (Fifth Disease)

Definition: Acute viral disease characterized by mild fever, lethargy and a blotchy maculopapular rash which begins on the cheeks and spreads to exposed areas of the extremities.

Etiology: Human Parvovirus B19.

Clinical Manifestations: Mild systemic symptoms, fever in 15 – 30% of individuals with a distinctive rash.

- Stage 1: On the face, this rash is intensely red with “slapped cheek” appearance and circumoral pallor.
- Stage 2: A symmetric maculopapular, lace-like rash on arms, trunk, buttocks and thighs.
- Stage 3: The rash can recur and fluctuate in intensity with environmental changes for weeks, sometimes months. Arthralgia and arthritis occur infrequently in children but commonly in women. Chronic anemia in persons with immunodeficiency. Aplastic crisis lasting 7 – 10 days in people with chronic hemolytic anemia (e.g. sickle cell disease).

Mode of Transmission: Primarily through contact with airborne droplets from nose and throat. Mother to fetus.

Incubation Period: 4 – 14 days, up to 20 days.

Period of Communicability: Most infectious before onset of rash and unlikely to be infectious after the rash appears.

Reporting Regulations: Check with local Department of Health for definition of outbreak. Report outbreaks to local Department of Health.

Management: Outbreaks frequently occur in spring months. In the absence of findings other than the characteristic rash, these children need not be excluded from school. There is a slight risk of fetal death during the first trimester of pregnancy if the disease is contracted during that time. Congenital abnormalities have not been reported. Pregnant school employees, students and individuals that are immunodeficient or have red blood cell disorders should consult their primary health care provider for advice if exposed. Notify parent/faculty by letter when an outbreak occurs.

E. Gastroenteritis

Definition: Bacterial or viral infections characterized by upper GI symptoms, diarrhea and abdominal discomfort.

Etiology: Can be caused by viral, bacterial or parasitic species. Usual species include campylobacter, salmonella, shigella and E.coli.

Clinical Manifestations: Gastrointestinal symptoms (nausea, vomiting, diarrhea, abdominal cramps). Traces of blood may occasionally be present in the stool. Some people may not show any symptoms.

Different organisms may cause other symptoms. Infectious disease references should be consulted for specific information.

Mode of Transmission: Fecal-oral; Enteropathogens are spread by

eating or drinking contaminated food or water or by contact with infected people or animals.

Incubation Period: Varies depending upon organism. Usually eight hours to several days. Infectious disease references should be consulted for specific information. Salmonellosis symptoms usually appear in less than 24 hours but may develop up to three days following exposure.

Period of Communicability: Consult infectious disease references. Most people pass shigellosis in their feces for 1-2 weeks. Generally limited to diarrhea phase. Shigellosis is highly communicable from person to person. *Campylobacter* is minimally communicable.

Reporting Requirements: Reportable if causative agent is salmonella, shigella, E.coli, or campylobacter.

Management: Children should be excluded during the diarrhea phase only. If a child has diarrhea or frequent stools combined with vomiting, fever, lethargy or other illness, they should be referred to their primary health care provider.

When there is an outbreak of gastroenteritis in schools, a food borne epidemic should be considered. The professional school health personnel should assess the possibility and plan accordingly. All personnel should be reminded of the importance of good hand washing, especially when assistance has been given for feeding and/or toileting.

When shigellosis is occurring in an elementary school setting, supervised hand washing upon arrival in the morning and after toileting are important parts of the control strategy.

Future Prevention/Educational Needs:

The following procedures may be considered to reduce the incidence of illness:

1. Staff should review and be aware of procedures on food handling, refrigeration and cooking.
2. When serving food, tongs or other appropriate utensils should be used whenever possible. When the use of utensils is not feasible, a barrier should be created through the use of deli paper, napkins or disposable gloves.
3. Food should be served in individual portions. Avoid the use of large shared bowls from which each child serves him/herself.
4. Consider bringing in only commercially prepared foods to school for shared consumption.
5. Food prepared in the classroom should be stored at a temperature adequate to prevent bacterial contamination. When heated, care should be taken to ensure that minimum temperatures are achieved and maintained.
6. All sports teams should be advised to supply adequate hydration during activity through means of other than shared drinking vessels.

7. Records should be maintained of educational programs for staff involved in food handling and use of infection control methods to prevent outbreaks.
8. Tables used for changing of diapers should be thoroughly washed before and following use and should be located separate from food preparation areas.
9. Hands should be washed prior to all food preparation and distribution. The importance of proper hand washing technique should be emphasized in health education at all levels.
10. Caution should be used when handling eggs for cooking or for chick incubation since there is evidence that salmonella may be transmitted through ingestion of uncooked or under-cooked eggs, even when the shells are intact. Emphasis should be placed on hand washing and gloves should be worn when handling incubating eggs.

F. Hand, Foot, and Mouth Disease (Coxsackie Virus)

Definition: A viral infection involving hands, feet and mouth. The illness is typically mild; complications are rare.

Etiology: Usually caused by the Coxsackie Virus A16, although other types of enterovirus can be involved.

Clinical Manifestations: Brief history of malaise, low-grade fever, sore mouth and loss of appetite. One to two days after this prodromal phase, vesicular oral lesions appear, followed by erythematous macules on hands, fingers, feet, toes and interdigital surfaces. Ninety percent have oral lesions; two thirds have the classic exanthem. Peak incidence is late summer and early fall.

Mode of Transmission: Spread by direct contact with nose and throat discharges and feces of infected people. Attack rates are highest in children under age 10.

Incubation Period: Usually 3 – 6 days.

Period of Communicability: During the acute stage of illness and perhaps longer, since these viruses persist in stool for several weeks after the acute infection.

Reporting Requirements: Report clusters.

Management:

1. Exclude only if student too ill to participate in school activities.
2. Treatment is symptomatic: acetaminophen, warm saline rinses, tepid baths, encourage fluids.
3. Emphasize proper hand washing after toilet use and need to avoid contact with nose throat discharge.
4. Notification of parents is not necessary, with the exception of those of any immune compromised students who are at risk of exposure.

5. There is a debate as to whether any congenital disorders are related to Coxsackie viral infections and pregnancy. Pregnant women should consult their health care provider for further information.

G. Hepatitis A (Infectious Hepatitis, HAV, HEPA)

Definition: Hepatitis A is more communicable and more common than other infectious diseases of the liver. It is often endemic in developing nations.

Etiology: Hepatitis A Virus (HAV).

Clinical Manifestations: Onset of clinical disease is usually abrupt with fever, malaise, anorexia, nausea and abdominal discomfort, followed with a few days by jaundice. It varies in clinical severity from mild illness lasting 1-2 weeks to severely disabling disease lasting several months (rare). In general, severity increases with age. Children may have mild symptoms or be asymptomatic. Complete recovery without sequelae is the rule. Diagnosis is by serology.

Mode of Transmission: HAV is shed in the feces of an infected person and is ingested by a susceptible person usually through food, water or feces-soiled hands.

Incubation Period: 15-50 days, averaging 25-30 days.

Period of Communicability: Maximum infectivity is during the latter half of the incubation period and continues for a few days after onset of jaundice. Most cases are probably not infectious after the first week of jaundice. No HAV carrier state exists. Infection causes life-long immunity.

Reporting Requirements: Reportable.

Management: If a case of hepatitis A is identified within the school, the local Department of Health plans and implements strategies to limit the spread of infection, working with professional school health personnel, administrators, parents, private health care providers and others as appropriate. Communication via letter to parents within the school and community is important to avoid irrational fears. Also, confidentiality should be maintained.

Vaccine: Hepatitis A vaccine is recommended for international travelers, persons in communities with high rates of the disease, in periodic outbreaks, for men who have sex with men, street drug users, recipients of certain blood products, and individuals with chronic liver disease.

After Exposure:

1. Immunoglobulin is recommended for all household and sexual contacts or other close personal contacts. Immunoglobulin (IG) given within 2 weeks of exposure is moderately protective against clinical illness. Its value is

- greatest when given early after exposure and declines thereafter. Giving IG more than 2 weeks after exposure is not indicated.
2. IG is recommended to all staff and students in school classes attended by diapered children and in some classes if the source case has not practiced careful hand washing or has shared food with others.
 3. Regular classrooms: Contact at elementary and secondary school is usually not an important means of transmitting Hepatitis A. Routine administration of IG is not indicated. However, when an epidemiological investigation shows the existence of a school or classroom centered outbreak, IG may be indicated for persons who have close contact with infected individuals. The local Department of Health should be consulted.
 4. If a food handler is diagnosed as having Hepatitis A, common-source transmission is possible but uncommon. IG administration may be considered if all the following conditions exist:
 - a. Infected person, without gloves, handles foods that will not be cooked before being eaten.
 - b. Contact can be identified and treated within 2 weeks of exposure.

Future Prevention/ Education Needs: Importance of good hand washing technique by all staff and students after toileting and before touching food. Avoid touching food to be eaten by others.

Other Actions:

- Hand washing after diaper changing.
- Cleaning diapering surface with approved cleanser.
- Proper disposal of diapers where they cannot be touched by others.
- Separation of diapering and food preparation areas.

H. Hepatitis B

Definition: Hepatitis B is a communicable disease that attacks the liver.

Etiology: Hepatitis B Virus (HBV). Important components surface antigen (HBsAg), Hepatitis B core antigen (HBcAG), and Hepatitis e antigen (HBeAG).

Clinical Manifestations:

Acute Hepatitis B: Flu-like symptoms with headache, fever, chills, nausea, vomiting, abdominal pain, jaundice (yellow eyes and skin), malaise, loss of appetite, joint / muscle pain and enlarged tender liver. Some individuals have no symptoms; some have a more severe clinical course requiring hospitalization with several weeks to months of work lost. Each year approximately 300,000 individuals, primarily young adults, are infected with HBV. Chronic HBV infection: Between 25-50% of children infected before 5-years of age become carriers whereas only 6-10% of acutely infected adults become carriers. They may develop persistent hepatitis, cirrhosis, or primary liver cancer. Carriers often have no

symptoms and have the highest concentrations of HBV in blood and serious fluids. A lower concentration is present in other body fluids such as saliva and semen.

Mode of Transmission: Hepatitis B Virus is found in all body fluids of infected people including blood, semen, saliva and urine, or any body fluid where there is visible blood. Blood and serious fluids have the highest concentrations of HBV. Needle stick exposures and exposure of blood and body fluids to the skin and mucous membranes can transmit HBV. The virus can enter the body through small cracks, cuts or abrasions in the skin or mucous membranes. The principal ways of transmitting Hepatitis virus is through sexual intercourse with an infected person, to infants born to women who are infected, when illicit drug users share contaminated equipment, piercing of the skin by contaminated instruments such as those used for tattooing, ear piercing, acupuncture, blood brothers, and dental or medical procedure.

Infection can also occur in settings of continuous close personal contact such as in households or among children in institutions for the developmentally disabled. Individuals should be aware that if a person bites another person and causes a break in the skin, then both the biter and person receiving the bite could potentially be at risk from exposure to blood. Any biting incident should be assessed by a health care professional for visible blood exposure to either person. When indicated, notify parent / guardian of the incident.

Incubation Period: Several weeks to six months after exposure (Average is 120 days)

Period of Communicability: An infected person can transmit the Hepatitis B virus as long as the virus remains in their blood and body fluids. Transmission can occur as early as four weeks before any signs or symptoms occur.

Management and Control: If a case of Hepatitis B is identified within the school, the local Department of Health plans and implements strategies to limit the spread of infection, working with professional school health personnel, administrators, parents, private health care providers and others as appropriate.

Vaccine: The American Academy of Pediatrics recommends vaccination of all infants, all adolescents, all children in populations of high HBV endemicity, and all children in other high risk groups. The series of three doses of Hepatitis B vaccine is required for school entry (K-12) for children born on or after 1-1-93.

1. Implement consistent and correct universal precautions at all times when anticipation of or contact with blood or any body fluid (BBF) visibly contaminated with blood and other potentially contaminated materials and environment.
2. Educate all students to avoid coming in contact with another person's blood/body fluids, and how to manage their own blood/body fluid incidents.
3. Use work practices and controls to reduce risk of exposure to blood and body fluids, i.e.,
 - a. Handling needles and other sharp instruments safely.

- * No recapping, bending or breaking needles.
 - * Disposing of sharp items in puncture resistant containers.
 - b. Prevent skin and mucous membrane exposure by use of gloves, masks, goggles or gowns when contact is anticipated.
 - c. Disposal of wastes contaminated with blood/body fluids in disposable plastic liners, which are sealed and disposed of daily.
4. Use consistent and correct clean-up procedures for the environment and contaminated materials; prompt removal of blood/body fluids. Clean contaminated surfaces with an EPA – approved tuberculocidal disinfectant.
 5. Prohibit sharing of personal items (i.e., toothbrushes).
 6. Clean and disinfect toys and objects after use and as needed.
 7. Wash hands immediately after removal of gloves following contact with blood/body fluids.
 8. Wash any skin or body part that comes in contact with blood and report the incident to a health care professional immediately.
 9. Cover all open lesions, sores, etc. with a bandage/Band-Aid.
 10. Pre-exposure prophylaxis: The U.S. Department of Health & Human Services and the Occupational Safety and Health Administration recommends that those identified to be at risk for occupational exposure of BBF's receive a series of three intramuscular injections of Hepatitis B over six months.
 11. Post-exposure prophylaxis: A single injection of Hepatitis B Immunoglobulin and Hepatitis B Vaccine series provide short and long term protection. The HBIG should be administered within 24 hours of exposure and not longer than 7 days following exposure.

Management: The risk of disease transmission in the school environment is theoretically small because blood or infected body fluid must get inside another person's body in order to transmit HBV infection. The child's health care provider should assess each HBV carrier on a case-by-case basis. Children who are chronic carriers of HBV and who have no behavioral or medical risk factors such as unusually aggressive behavior (i.e., biting, frequent scratching), generalized dermatitis or bleeding problems, need not be restricted in their learning or recreational activities. All facility staff should receive regular training about modes of transmission and infection control standards and universal precaution procedures. Incidents and injuries that lead to bleeding should be handled promptly according to standard operating procedures.

I. Herpes Simplex (Cold Sore)

Definition: Infections that primarily involve the skin and mucous membranes. While the virus can infect any area of skin, the lips and fingers (herpetic whitlow) are the most common sites of involvement.

Etiology: Herpes Simplex Viruses. Two types have major differences. Type I (HSV-1) usually involves the face and skin above the waist. Type II (HSV-2) usually involves the genitalia and skin below the waist in adults and is the most common cause of disease in the neonate. However, either type can be found in either site, depending on the source of infection.

Clinical Manifestations: (common in children)

Over 90% of primary infections due to HSV-1 are subclinical; but, because of the prevalence of the virus, symptomatic primary lesions are common. Gingivostomatitis is the most commonly recognized manifestation of primary HSV infection. Fever, irritability, and a painful ulcerative exanthem involving the gingiva and the mucous membranes of the mouth characterize it. In immunocompromised patients' severe local lesions and, less commonly, disseminated HSV infection with generalized vesicular lesions and visceral involvement can occur. People with atopic eczema and other forms of chronic dermatitis are at risk for a particularly severe form of primary HSV infection. Rarely, HSV has been known to cause conjunctivitis, encephalitis and meningitis.

After primary infection, HSV persists in a latent form within the ganglia that lie in the region of initial involvement. Therefore reactivation of the virus usually is manifested by "cold sores" (herpes labialis). These lesions appear as single or grouped vesicles in the perioral region, usually on the vermilion border of the lips. Fever, sunlight, local trauma, menses and emotional stress are recognized triggers.

Mode of Transmission: HSV infections are ubiquitous and are transmitted person to person throughout the year. Infections with HSV-1 result primarily from direct contact with infected oral secretions or lesions. Infections with HSV-2 usually are from direct contact with genital secretions and lesions.

Incubation Period: For gingivostomatitis, estimated 2 – 12 days. Not well defined for genital infection; estimated 2 – 14 days.

Period of Communicability: Difficult to define. HSV may be shed intermittently from the mouth or genital tract in the absence of clinical manifestations years after infection. In recurrent lesions, the virus is present in highest concentrations in the first 24 hours after the appearance of vesicles.

The amount of virus decreases rapidly and usually cannot be recovered after 5 days. HSV can be transmitted during primary infections or during recurrences, regardless of whether or not signs and symptoms are present.

Management:

1. Only those children with HSV gingivostomatitis (i.e. primary infection) who do not have control of oral secretions should be excluded from childcare or school. Exclusion of children with "cold sores" (i.e. recurrent infection) from school is NOT indicated.
2. Exclude student with vesicular or ulcerative skin lesions from participating in sports and games with close physical contact such as wrestling.
3. Skin lesions should be covered with a bandage or clothing when possible.

4. Wearing gloves, if direct contact with lesions is necessary.
5. No sharing of drinking vessels.
6. No mouthing articles.
7. No kissing.
8. Potential sexual abuse case reporting mandatory-for Type II

J. Human Immunodeficiency Virus (HIV), AIDS

Definition: HIV is a retrovirus found in the blood and body fluids of infected persons that creates a course of infection and subsequently the disease of AIDS. HIV infiltrates the white blood cells using them to replicate itself, destroying other white blood cells. Consequently over time, there are less and less white blood cells, which are essential to normal immune system function. Therefore, the infected individual becomes increasingly susceptible to opportunistic infections, cancers and diseases.

Etiology: Human Immunodeficiency Virus.

Clinical Manifestations: From the time of exposure to HIV, if one has been infected, an individual is capable of transmitting HIV to another person. Within approximately one month, the infected individual may have a fever, swollen lymph nodes, and diarrhea, skin rash and fatigue (flu-like symptoms). However, not everyone will notice these symptoms. Over time, usually 0-6 months, the individual develops antibodies to the HIV. The person may be asymptomatic, feel and look healthy, and not know he/she has HIV in their body.

This asymptomatic period may last upwards of 12-15 years. Eventually the individual will exhibit signs of immune deficiency-like symptoms, i.e., tuberculosis, pneumonia, dementia, Kaposi's sarcoma, etc. The course from being infected to the diagnosis of AIDS, as well as the length of living with AIDS, is variable. Early detection of the presence of the virus in an individual can lead to improved care and treatment, prevention of infection and disease and the transmission of the virus to others.

Mode of Transmission:

1. From a mother with HIV infection to her newborn during pregnancy, delivery or breast-feeding.
2. Between sex partners through contact of infected semen, vaginal or cervical secretions.
3. By direct inoculation of infected blood or blood-containing tissues through transfusion, transplantation of organs, reuse of contaminated needles or other injection equipment, or penetrating injuries with needles other sharp objects contaminated with blood (i.e. needle stick, tattooing, ear piercing, blood brother rituals, acupuncture, razors). The risk of infection after a needle stick exposure to HIV-infected blood is approximately 0.3%.
4. Contact of mucous membranes (eyes, nose, mouth) or non-intact skin to infected blood (i.e. cuts, scratches).

5. Individuals should be aware that if a person bites another person and causes a break in the skin, then both the biter and person receiving the bite could be at minimal risk from exposure to blood. Any biting incident should be assessed by a health care professional for visible blood exposure to either person. When indicated, notify parent / guardian of the incident.
6. No person has been shown to acquire HIV from exposure to teeth or saliva where there is no visible blood.

Incubation Periods: Generally, up to 0-6 months from time of exposure.

Period of Communicability: Once infected, an individual is considered always infectious to others.

Reporting Requirements: Unless school health personnel are conducting HIV testing, no reporting is required. Refer to the New York State Confidentiality Law and HIV Public Health Law, Article 27F (Appendix K). This law requires information about HIV and AIDS to be kept confidential. This law strictly limits disclosure to HIV-related information. This law applies to people and facilities providing health or social services. Within the school setting, HIV information can be shared only after parents have signed a disclosure form.

Management: The risk of HIV transmission in the school environment is theoretically small because blood or infected body fluid must get inside another person's body in order to transmit the HIV. Policies and procedures related to the HIV positive staff member or student should be written. Federal, state and public health laws relating to access to education or employment should be applied and each individual assessed on a case-by-case basis.

- Monitor for socialization, discrimination, and adjustment to program and early signs of new or recurring infection.
- Protect individual's right to privacy by planning confidentiality of health information and administration of medications.
- When known, the parent/guardian of an HIV infected child should be notified when there is an outbreak of an infectious disease, i.e., chicken pox, measles, cytomegalovirus, tuberculosis, herpes simplex virus.
- All facility staff should receive regular education/training about modes of transmission and infection control standards and universal precaution procedures.
- Incidents and injuries that lead to bleeding should be handled promptly according to established Exposure Control Plan procedures required by OSHA.
- Policy and procedures should be in place to manage a possible student exposure incident.

K. Impetigo Contagiosa

Definition: A superficial, contagious skin infection. It is one of the most common skin infections of children. Predisposing factors such as poor hygiene, anemia, malnutrition and warm climate favor outbreaks of the disease, most of which occur during the last summer and early fall.

Etiology: Two types of bacteria, either Group A Streptococci or Staphylococcus Aureus.

Clinical Manifestations: Streptococcal impetigo begins with a small red macule that turns into a vesicle and becomes pustular within hours. When the

vesicle breaks, a characteristic thick, honey golden colored crust forms from the exudate. Autoincubation may cause satellite lesions to appear. Other features include pruritis, burning, and regional lymphadenopathy.

Staphylococcal impetigo causes a thin walled vesicle to open, and a thin clear crust to form from the exudate. The lesion consists of a central clearing, circumscribed by an outer rim, much like a ringworm lesion and commonly appears on the face or exposed areas. Both forms usually produce painless itching, and may appear simultaneously and be clinically indistinguishable.

Mode of Transmission: Transmission is by direct contact. Lesions often are secondary infections of insect bites, or other breaks in skin integrity.

Incubation Period: One to ten days.

Period of Communicability: From onset of lesions and lasts until the lesions are dry or, up to 24 hours after antibiotic therapy is initiated.

Reporting Requirements: Reportable only if outbreak occurs.

Management:

1. Isolation of area, cover area with clean dressing. Establish good hand washing technique. Clean items and toys that child has been in close contact with and do not share items of clothing.
2. Exclusion from school: Student should not return until under treatment for 24 hours or until lesions are dry.
3. Assessment of the student should include a determination of their ability to participate in athletics without transmitting disease.

L. Lyme Disease

Definition: Bacteria transmitted by the deer tick cause Lyme Disease. Lyme Disease causes symptoms affecting the skin, nervous system, heart and/or joints of an individual. Over 50,000 cases [current] have been reported to the New York State Department of Health since Lyme Disease became reportable in 1986.

Lyme Disease can affect people of any age. People who spend time in grassy and wooded environments are at an increased risk of exposure. The chances of being bitten by a deer tick are greater during times of the year when ticks are most active. Young deer ticks, called nymphs, are active from mid-May to mid-August and are about the size of poppy seeds. Adult ticks, which are approximately the size of sesame seeds, are most active from March to mid-May and from mid-August to November. Both nymphs and adults can transmit Lyme Disease. Ticks can be active any time the temperature is above freezing. Infected deer ticks can be found throughout New York State.

Etiology: Infection is caused by the Spirochete *Borrelia Burgdorferi*

Clinical Manifestation: In 60% - 80% of cases, a rash resembling a bull's eye or solid patch, about two inches in diameter, appears and expands around or near the site of the bite. Sometimes multiple rash sites appear. The early stage of Lyme Disease is usually marked by one or more of the following symptoms: chills and fever, headache, fatigue, stiff neck, muscle and/or joint pain, and swollen glands. If Lyme Disease is unrecognized or untreated in the early stage, more severe symptoms may occur. As the disease progresses, severe fatigue, a stiff aching neck, and tingling or numbness in the arms and legs, or facial paralysis can occur. The most severe symptoms of Lyme Disease may not appear until weeks, months or years after the tick bite. These can include severe headaches, painful arthritis, swelling of the joints, and heart and central nervous system problems.

Mode of Transmission: Not all deer ticks are infected with the bacteria that cause Lyme Disease. Ticks can become infected if they feed on small animals that are infected. The disease can be spread when an infected tick bites a person and stays attached for a period of time. In most cases, the tick must be attached for 36 hours or more before the bacteria can be transmitted. Lyme Disease does not spread from one person to another. Transfer of the bacteria from infected pregnant women to the fetus is extremely rare.

Incubation Period: Early symptoms usually appear within 3 to 30 days after the bite of an infected tick and typically within 7 to 14 days. Late manifestations can occur months to years after initial infection. Lyme Disease is a bacterial infection. Even if successfully treated, a person may become re-infected if bitten later by another infected tick.

Reporting Requirements: Reportable

Management: Antibiotics have made it possible to treat Lyme Disease whether it has localized in the skin or spread systemically to other major organ systems. Early treatment is best to prevent complications. Refer persons with symptoms clinically compatible with Lyme Disease or history of exposure to their own health care provider.

Control Measures for Prevention:

1. Avoid tick-infested areas when possible.
2. If tick infested area (woods, bushy, un-mowed field) is entered, e.g., for field trips or science activities, protective clothing that covers arms, legs and exposed areas should be worn. Pants should be tucked into socks. Wearing light colored clothing helps to identify ticks.
3. Tick/insect repellents applied to the skin provide additional protection but should be applied and removed as directed in order to avoid toxic side effects (seizures in young children have been reported).
4. Teach persons to inspect themselves and pets after possible tick exposure.
5. If a tick is found, remove promptly by grasping with a fine tweezer close to the skin and gently pulling out. DO NOT SQUEEZE tick body. Cleanse the area thoroughly after removal. Refer to primary health care provider for follow-up. The tick should be saved and sent with student to health care provider.

6. Contact local Department of Health to see if it can be determined whether the tick is a deer tick.
7. Educate students and families about the disease, prevention, and treatment.

M. Measles (Rubeola)

Definition: Acute, highly communicable vaccine-preventable viral disease. Also called rubeola.

Etiology: Measles Virus is an RNA Virus.

Clinical Manifestations: Measles symptoms generally appear in two stages. In the first stage, the prodrome, the individual may have a runny nose, cough and a low-grade fever. The fever increases in a stepwise fashion and often peaks between 103 and 105 degrees Fahrenheit. The eyes may become reddened and sensitive to light, and Koplik's spots, little white dots on the mucous membranes, may appear. The second stage begins on the third to seventh day and consists of a temperature of 103-105 degrees F and a red blotchy rash lasting four to seven days. The rash usually begins on the face and head then spreads downward over the entire body. The rash usually lasts 5-6 days and disappears in the same order it appears.

Complications:

1. Diarrhea (most common).
2. Middle ear infection.
3. Bronchopneumonia.
4. Encephalitis – May cause permanent neurological damage (1 of every 1,000 cases).
5. Respiratory and neurological complications – May cause death (1-2 of every 1,000 cases).

The complications of measles are more common among infants and adults. Hospitalization occurs in 18% of cases.

Mode of Transmission: Transferred from person to susceptible person airborne by droplet spread. Those at risk are individuals with either inadequate or no immunization. Highly communicable in this group. After recovery from measles or after two doses of live virus vaccine, the individual is believed to have life-long immunity.

Incubation Period: Averages 10-12 days after exposure to onset of prodrome, range 7-18 days.

Incidence: Peak incidence during late winter and spring months.

Period of Communicability: One to two days before onset of symptoms (3-5 days before rash) to five days after appearance of rash.

Reporting Requirements: Reportable

Vaccination: Two doses of measles vaccine after the age of 12 months are required for new to school and daycare and for all students born on or after 1/1/85.

For those born before 1/1/85, one dose after the age of 12 months is required. A second dose is required for entrance to post-secondary education in NYS.

Management: A plan should be developed prior to a measles outbreak, which will enable the school to respond immediately. This plan should include but not be limited to:

1. Immediate contact with the local Department of Health.
2. Identification of un-immunized or inadequately immunized individuals. Such identification will be easier if a current list of individuals who have one or no measles vaccines has been continually maintained. This includes but is not limited to students who have not yet completed measles immunization requirements as well as those with medical and/or religious exemptions.
3. Identification of immunocompromised individuals.
4. Referrals of inadequately immunized and immunocompromised individuals to their own health care provider or the Department of Health.

To be effective post-exposure, the measles live virus vaccine must be given within 72 hours of exposure. Immunoglobulin may be given within six days of exposure to provide temporary immunity. A person with suspected measles should be excluded from school and immediately referred to their own health care provider for diagnosis and treatment. Individuals with confirmed cases may return to school upon approval from their primary physician.

Immunization requirements of school staff in the affected building:
Those born after January 1, 1985 should have a two measles – containing vaccines or titer showing immunity.

NOTE: If one physician-diagnosed case of measles occurs within the school, all students without record of two measles vaccines must have second doses of vaccine for continued school attendance.

N. Meningococcal Meningitis

Definition: Meningococcal disease is a severe bacterial infection of the bloodstream or meninges (a thin lining covering the brain and spinal cord). Meningococcal meningitis is a relatively rare, severe bacterial infection that usually occurs in a single isolated event.

Etiology: *Neisseria meningitidis* is a Gram-negative diplococcus with multiple serogroups known to cause invasive disease.

Clinical Manifestations: Sudden onset with rapidly progressive manifestations of shock, purpura, disseminated intravascular coagulation, and reduced levels of consciousness, is a

dramatic and often fatal presentation of meningococcal sepsis with meningitis. It may evolve to death within 24 hours.

Some cases of meningococcal meningitis are preceded by several days of upper respiratory tract or gastrointestinal symptoms. Fever is present in 90 – 95%, anorexia; myalgias, arthralgias, tachycardia; hypotension and various cutaneous signs such as petechiae can be present. Meningeal irritation symptoms are nuchal rigidity and back pain. Increased intracranial pressure is suggested by headache, emesis and occasionally seizures.

Mode of Transmission: Direct contact including respiratory droplets from nose or throat of an infected person. Many people carry this particular bacterium without any signs of illness, while others may develop serious symptoms.

Incubation Period: Two to ten days after exposure, usually within 5 days.

Period of Communicability: Until the bacteria is no longer present in discharges from the nose and mouth; susceptible organisms will disappear within 24 hours after appropriate treatment is started.

School Considerations:

1. Immediate referral for suspected cases.
2. Obtain accurate facts so information can be shared.
3. Classmates, teachers and other school staff usually do NOT require prophylaxis, (Usually rifampin) unless they have had prolonged, close exposure.
4. Exposed household, school or childcare contacts must be observed carefully. Exposed individuals who develop a febrile illness should prompt medical attention.
5. Because secondary cases can occur several weeks after onset of disease in the index case, meningococcal vaccine is a possible adjunct to when the outbreak is caused by a serogroup contained in the vaccine. Health department personnel will determine need.

O. Mononucleosis, Infectious

Definition: A viral infection characterized by high fever, sore throat and generalized lymphadenopathy.

Etiology: Epstein-Barr Virus (EBV), a member of the herpesvirus family.

Clinical Manifestations: Fever, exudative, pharyngitis, lymphadenopathy, hepatosplenomegaly, jaundice. A rash may occur, especially in patients treated with ampicillin. Central nervous system complications include aseptic meningitis, encephalitis and Guillain-Barre syndrome. The status of “chronic” infectious mononucleosis (Chronic

Fatigue Syndrome) is still controversial and in most, if not all, cases appear not be related to EBV infection

Mode of Transmission: Person to person spread via the oropharyngeal route via saliva; occasionally by blood transfusion.

Incubation Period: Estimated to be four to six weeks.

Period of Communicability: Prolonged, may persist for one year or more, 15-20% or more of EBV antibody positive healthy adults are long term oropharyngeal carriers.

Reporting Requirements: Not reportable.

Management: Treatment of symptoms.

In individuals who are immunocompromised, fatal disseminated infections or B-cell tumors can occur. Vulnerable students may need to be protected from infection. However, because of sub clinical infection and the carrier state, this disease may be endemic in the school.

Control: Use hygiene measures including hand washing to help prevent spread. Properly dispose of articles soiled with nose and throat discharge.

Infected students may require home tutoring if the course of disease is prolonged. Return to school is determined on an individual basis as symptoms subside. Physical education and/or athletics for recovering students may need adjustment. Due to hepatosplenic enlargement, in some cases students should have a written release from their health care provider prior to return to contact sports in physical education and interscholastic athletic participation.

Definition: Mumps is an acute viral infection characterized by fever, swelling and tenderness of one or more of the salivary glands.

Etiology: Caused by an RNA virus classified as a Rubulavirus.

Reporting Requirements: Reportable to local Health Department.

Clinical Manifestations: Symptoms include fever, swelling and tenderness of one or more of the salivary glands, usually the parotid gland (located just below the front of the ear). Approximately one-third of infected people do not exhibit symptoms.

P. Pertussis (Whooping Cough)

Definition: A highly contagious, vaccine preventable bacterial infection of the respiratory tract. In the U.S., adolescents and adults are recognized as major sources of the disease. Occurs endemically with periodic outbreaks.

Clinical Manifestations:

Catarrhal stage – mild upper respiratory symptoms, consisting of cough, runny nose, sneezing, and a low grade fever. The cough gradually becomes more severe. This stage lasts 1-2 weeks.

Paroxysmal stage – persistent cough, can progress to severe paroxysms of cough; children often have characteristic inspiratory whoop followed by vomiting. Disease in infants younger than 6 months of age may be atypical; apnea is a common manifestation and whoop often is absent. Adolescents and adults can have atypical course with persistent cough and no whoop. This stage lasts 1-6 weeks, but may last as long as 10 weeks.

Convalescent stage – symptoms wane gradually over weeks to months.

The duration of classic pertussis is 6-10 weeks. Complications include seizures, pneumonia, encephalopathy and death. Pertussis is most severe when it occurs during the first 6 months of life. In previously vaccinated persons, infection is often mild.

Hospitalization occurs in 20% of all cases and in 63% of all cases in infants less than 6 months of age.

Etiology: *Bordetella pertussis*, a Gram-negative bacillus.

Mode of Transmission: Close contact via respiratory secretions. Humans are the only host. Infants and young children are frequently infected by older siblings or adults who have mild or atypical illness that goes unrecognized and untreated.

Period of Communicability: Most contagious during catarrhal stage and the first 2 weeks after cough onset. Erythromycin therapy decreases infectivity and may limit spread.

Reporting Requirements: Reportable

Management: If a case of pertussis is suspected, report to local Health Department. Students and staff with suspected or confirmed pertussis should be excluded. May return to school after a 5-day completion of a 14-day total course of antibiotic therapy erythromycin or 5-day course of azithromycin or 7-day course of clarithromycin for those who cannot tolerate erythromycin or health care provider's choice of treatment.

Vaccine: Universal immunization with pertussis vaccine for children younger than 7 is recommended. The pertussis vaccine used in the United States are acellular vaccines in combination with diphtheria and tetanus toxoids.

Q. Pinworm Infection

Definition: A common infestation by intestinal parasite; generally benign. All ages are susceptible, autoinfection is common; and humans are the only host. While the infected person sleeps, female pinworms leave the intestinal tract and lay their eggs on the skin around the anus. Cases of pinworm infection are seen most often at schools, day care centers and other institutional settings.

Etiology: *Enterobius vermicularis*, a 4-mm worm, inhabits rectum or colon and emerges to lay eggs in the skin folds of the anus. Eggs remain viable for several days.

Clinical Manifestations: Perianal pruritus, especially at night. Restlessness during sleep. Females may complain of pain or itching of genitals. Vaginitis, salpingitis and pelvic peritonitis can occur because of aberrant migration of adult worm from perineum. Diarrhea may occur. If anus is inspected during the night, ova or white threadlike worms may be seen.

Mode of Transmission: Adult gravid female nematodes usually die after depositing eggs on the perianal skin. Thus, re-infection by autoinfection (child scratches their anus, gets

eggs under fingernails and then puts fingers in mouth) or infection acquired from others is necessary to maintain infestation. Egg contamination occurs by the fecal-oral route directly, indirectly, or inadvertently by contaminated hands or fomites, such as shared toys, bedding, clothing, toilet seats, and baths.

Incubation Period: From ingestion of an egg until an adult gravid female migrates to the perianal region is 1 to 2 months or longer.

Period of Communicability: As long as gravid female nematodes are discharging eggs on perianal skin and eggs remain infectious in an indoor environment; this period is usually 2-3 weeks.

Management:

1. Control is difficult in schools because rate of re-infection is high.
2. Refer student with symptoms.
3. Stress good personal hygiene to avoid autoinfection
4. Supervise hand washing in school setting.

R. Rabies

Definition: Usually transmitted by an animal bite resulting in an acute central nervous system infection.

Etiology: Rabies virus, a rhabdovirus of the genus Lyssa.

Clinical Manifestations: After a period of one to three months, rabies produces local or radiating pain or burning, a sensation of cold, pruritus, and tingling at the bite site. Early symptoms include irritability, headache, fever, and symptoms of itching or pain at the site of exposure. The disease eventually progresses to paralysis, spasms of the throat muscles, convulsions, delirium, and death.

Mode of Transmission: Animals introduce virus through the skin or mucous membrane; the virus then spreads to the central nervous system and replicates in the brain.

Incubation Period: Variable, but is normally two to eight weeks. Incubation periods over one year have been reported.

Period of Communicability: Person to person transmission is extremely rare. However, precautions should be taken to prevent exposure to the saliva of the diseased person.

Reporting Requirements: Animal bites should be reported to the local Health Department.

Management: When an animal bite occurs at or in route to school:

1. Clean and wash the wound immediately with soap and water.
2. Notify parent/guardian about incident and document notification.
3. Contact local Health Department or local Police as required by local Law and document notification.
4. Referral for rabies immune globulin and/or vaccine as indicated.
5. Tetanus prophylaxis and anti-bacterial treatment as required.

Future Prevention / Educational Needs: Educate students: Exposure of student or staff to a rabid animal does not always result in rabies. If preventive treatment is obtained promptly following a rabies exposure, most cases of rabies will be prevented. Untreated cases will invariably result in death. No sutures or wound closure advised unless unavoidable.

Removing all stray animals, having all pets vaccinated and staying away from all live or dead wild animals may minimize exposure to rabies.

S. Respiratory Infections

Definition: Includes common colds, influenza and acute respiratory disease. Infections of the upper respiratory tract affect the nose, pharynx and/or larynx. Infections of the lower respiratory tract affect the trachea, bronchi, bronchioles and/or lung alveoli.

Etiology: A large number of different agents (mostly viruses), each of which is capable of producing a wide spectrum of respiratory disease. These include respiratory syncytial virus, adenoviruses, rhinoviruses, coronaviruses, Coxsackie viruses, echoviruses, parainfluenza and influenza viruses and mycoplasma organisms.

Clinical Manifestations: Infectious disease references should be consulted for specific information:

1. Dependent on agent and severity of illness.
2. Constitutional reactions: chills, fever, headache, malaise, anorexia.
3. Localizing signs: coryza, conjunctivitis, lacrimitis, sneezing, coughing, rhinitis, pharyngitis, tonsillitis, bronchitis, pneumonia, and croup.
4. Gastrointestinal manifestations may occur with influenza, especially in children.
5. Individuals with compromised cardiac, pulmonary or immune systems are at increased risks of severe illness. Secondary bacterial infections may occur.

NOTE: Pertusis (Whooping Cough), a vaccine preventable bacterial infection with paroxysmal coughing episodes associated with inspiratory whoop, still occurs. All cases must be immediately reported to the local Health Department.

Mode of Transmission: Directly by oral contact or by droplet spread; indirectly by hands, tissues, eating utensils or other articles freshly soiled by respiratory discharge of an infected person. The hands carry viruses to the mouth, nose or eyes of the susceptible individual.

Incubation Period: 12 hours to 10 days, depending on agent, for influenza it is usually 1-3 days. Consult references for specific information.

Incidence: Seasonal in temperate zones with greatest incidence during fall and winter and occasionally spring. During an outbreak of influenza, the highest attack rates occur in school-aged children, with spread to families.

Period of Communicability: Shortly prior to and for the duration of active disease.

Reporting Requirements: None unless an outbreak occurs.

Management: Because of the association with Reye's syndrome, salicylates, i.e. aspirin, should be avoided when a viral illness is suspected. Yearly influenza vaccine is indicated for persons at greatest risk of serious complication from the disease, e.g. children with chronic diseases. In children, being vaccinated for the first time, two doses administered at least 1 month apart are necessary; thereafter, one dose/year.

To prevent spread of viruses, infection control procedures should include frequent hand washing, covering the mouth with tissues when coughing and sneezing, and sanitary disposal of tissues. Staff and students need frequent reeducation in these matters.

Proper disinfection/sanitization by custodial staff of all bathrooms, drinking fountains and hand washing areas should be performed routinely. Hand washing supplies in restrooms should be restocked frequently to ensure availability.

School attendance is permissible unless the individual has more severe infection with constitutional symptoms and discomfort. Suspected secondary infections should be referred to the private health care provider.

Closing of schools during influenza outbreaks has not been shown to be an effective control measure.

Any employee, student, or teacher suspected of having the FLU should not attend school.

Future Prevention/Educational Needs: Staff, parents and students require education about the causes of respiratory diseases and the measures that must be taken to contain the spread.

T. SARS (Severe Acute Respiratory Syndrome)

Definition: Severe acute respiratory syndrome (SARS) is a viral respiratory illness that was first reported in Asia in February 2003. Over the next few months the illness spread to more than two dozen countries in North America, South America, Europe, and Asia. By late July 2003, no new cases were being reported and the outbreak was considered contained.

Etiology: Coronavirus called SARS-associated coronavirus

Clinical Manifestations: Illness begins with a fever (temperature greater than 100.4 degrees F), possibly associated with chills or other symptoms, including headache, general feeling of discomfort, and body aches. Some people also experience mild respiratory symptoms at the outset. Approximately 10-20 percent of patients have diarrhea. After two to seven days, SARS patients may develop a dry cough with most developing pneumonia.

Mode of Transmission: Close person-to-person contact. Direct contact with respiratory droplets or with body secretions of an infected person. The virus can be spread when person touches a surface or object contaminated with infected droplets, then touches his/her mouth, nose or eye(s).

Incubation Period: 2-7 days up to 10 days.

Period of Communicability: Only when exhibiting symptoms such as fever and cough.

Reporting Regulations: Reportable to local Health Department

Management: As the SARS situation evolves worldwide and at the state and local levels, guidance will be developed. Schools should consult with their local and state Health Departments for the most up-to-date guidelines.

U. Scabies

Definition: A transmissible parasitic skin infection characterized by superficial burrows, intense itching and secondary infection. Infestations are usually not severe, with 3-50 mites found on an affected person. Immunocompromised persons may develop a more severe rash, referred to as crusted or Norwegian scabies.

NOTE: Much of the discussion on pediculosis applies equally well to scabies. However, there are some epidemiological differences of medical and public health importance.

Etiology: The mite, *sarcoptes scabiei* (ssp.) *hominis*, is not an insect; it is more closely related to ticks and spiders. Mites measure 0.3 to 4 mm. in diameter (about 1/5 the size of lice). To infect humans, the female mite burrows beneath the stratum corneum of the skin and lays her eggs in tortuous tunnels. In most of the cases, burrows occur somewhere on the hands and arms; can also occur in the axillary folds, waistline, thighs, navel, genitalia and buttocks. The classic site is the web between the fingers. In children younger than 2 years of age, burrows may occur on any part of the body, including head, neck, palms and soles.

Clinical Manifestations:

1. Intense pruritus is the earliest and most common symptom. Itching is usually worse at night.
2. Primary lesions are:
 - a. Burrows-gray or skin colored ridges up to a few centimeters long; scratching destroys burrows, so they are usually not found.
 - b. Vesicles – isolated, pinpoint and filled with serous fluid; may contain mites.
 - c. Papules – small, isolated; represent a hypersensitivity reaction and rarely contain mites.
3. Secondary lesions with erythema and scaling caused by scratching are present in more chronic cases.
4. A generalized urticarial rash may occur.

Mode of Transmission: Scabies is transmitted by person-to-person contact; most authorities feel that this contact must be fairly prolonged and intimate (i.e. sharing a bed, sponge-bathing an individual, or applying body lotions). Mites can be transmitted

via infested bedding, clothing or other fomites but this mode of spread occurs relatively infrequently.

Incubation Period: In a previously unexposed individual, 2-6 weeks may elapse between infection and onset of symptoms. In reinfected persons, rash and itching develop within 1- 4 days. The infected individual is capable of transmitting the mite during the entire incubation period.

Management: Because the incubation period for scabies can be several months, it is usually recommended that the infected individual and all of his or her family members and close contacts be treated simultaneously. The treatment of choice is 5% permethrin cream (Elmite) because of its efficacy and safety in use in infants and children. This treatment requires one application. The infested person should be thoroughly cleansed by means of a shower or bath and dried. The lotion or cream should be applied to the entire skin surface of the body below the neck. Special attention should be given to skinfold areas such as between digits, elbows, axillae, groin, and external genitalia, between the buttocks, below the breasts and in the bends of the knees. The lotion should be left undisturbed for the recommended time period and followed by a bath or shower. Itching often persists for more than one week after treatment, should not be interpreted as a sign of renewed activity by the mite. Secondary bacterial infection may require antibiotic treatment.

Other Consideration:

1. Suspect scabies in a rash that causes intense itching, especially at night. Inquire about any rashes/itching by other family members. If other siblings are in school, they should be checked for the presence of a rash.
2. Notify parents recommending referral to an appropriate health care provider for diagnosis and treatment of suspected cases. Students can be readmitted for 24 hours after treatment begins.
3. Individuals who have been adequately treated can be considered as non-communicable cases and readmitted to school even if a second treatment has been prescribed.
4. Monitor re-infestation to ensure that treatment was effective. Maintain close communication with family.

V. Streptococcal Disease (Strep Throat & Scarlet Fever)

Definition: Bacterial illnesses, the vast majority relatively mild. Occasionally these bacteria can cause severe disease such as necrotizing fasciitis or streptococcal toxic shock syndrome.

Etiology: Streptococcus pyogenes: Group A Beta Hemolytic Streptococci (GAS). There are certain strains that are more likely to cause severe disease than others.

Clinical Manifestations: In its typical form, the infection is manifested by sore throat, fever, a beefy red pharynx and tonsillar exudate. Other cases may present with fever or mild sore throat alone or have nonspecific symptoms such as headache, malaise, nausea,

vomiting, and tachycardia or be asymptomatic. None of these signs and symptoms is specific for streptococcal infections and may also present in viral infections.

The only sign and symptom statistically associated with serologically confirmed cases is cervical adenitis. For this reason, throat culture is the recommended way to determine Strep infection. Scarlet fever is associated with group A streptococcal (GAS), and produces an erythrogenic toxin leading to a diffuse pink-red cutaneous flush that blanches on pressure. It is seen best on the abdomen, lateral chest and cutaneous folds. Additional characteristic manifestations of scarlet fever are circumoral pallor surrounded by a flush face and the “strawberry tongue” and Pastia’s lines (dark red lines in the creases of the skin folds).

Rarely, invasive disease (bacteremia) has been reported with group A streptococcal (GAS).

Complications:

Local: Peritonsillar abscess, otitis media, sinusitis and mastoiditis.

General: Rheumatic fever, acute glomerulonephritis.

Mode of Transmission: Contact with respiratory secretions from clinically infected persons or with an infected wound lesion. People may carry group A streptococcal (GAS) in the throat or on the skin and have no symptoms of disease.

Incubation Period: 2-5 days.

Period of Communicability: Communicability is maximum during acute infection and gradually diminishes during a period of weeks. When treated, until 24 hours after initiation of antibiotic therapy.

Management:

1. All contacts with sore throats should be referred for medical evaluation.
2. Reinforce importance of following antimicrobial regimen as prescribed.
3. Children may return to school 24 hours after beginning antimicrobial therapy if they are afebrile.
4. Reinforce the importance of good infection control practices such as covering mouth when coughing or sneezing and proper hand washing and disinfecting of surfaces.

W.Tinea (Ringworm) - General

Definition: A skin infection caused by a fungus that can affect the scalp, skin, fingers, toenails or foot.

Etiology: Fungi of several types.

Clinical Manifestations: Refer to body area affected (see below).

Mode of Transmission: Direct or indirect contact with infected humans, animals and/or fomites.

Incubation Period: Unknown but usually symptoms occur 10-14 days after contact.

Period of Communicability: As long as fungi can be cultured from or demonstrated in the infected area.

Management:

Although there is probably no way to prevent the occurrence of tinea infections, the following strategies may help to reduce the incidence and confine the infection.

1. Develop educational programs for students, staff and parents, which include:
 - a. Emphasis on the nature of the infection, contributing factors, signs and symptoms, and mode of transmission.
 - b. Instruction and/or counseling related to personal hygiene measures including but not limited to:
 - Proper laundering of towels and clothing.
 - Special care of feet and skin between toes, especially after bathing.
 - Airing shoes and sneakers between wearing.
 - Using alternate pairs of footwear.
 - Avoiding the sharing of combs, brushes, clothing and towels with other persons.
 - For persons who have had fungal infections of the feet, regular use of fungicidal dusting powder on the feet and between the toes also may be a preventative measure.
 - Observation of pets for signs and symptoms of infection.
2. Maintain general cleanliness of showers, locker and dressing rooms in pools and gymnasiums, especially repeated washing of benches and floors with a fungicidal agent such as creosol. Shower rooms should be frequently hosed down and rapidly drained. Mats should be cleaned with an appropriate fungicidal solution to decrease the transmission of the fungus.
3. If student participates on interscholastic wrestling team, contact district Athletic Director for current requirements for students with skin lesions.

A. Tinea Capitis (Ringword of the Scalp)

Definition: Fungal infection of the scalp.

Clinical Manifestations: Occurs primarily in children between the ages of 3 and 9. Erythema and scaling of scalp with short, broken hairs and alopecia in area of infection; enlarges in size over time if untreated. Kerion, a boggy inflammatory mass surrounded by follicular pustules, is a hypersensitivity reaction to the fungal infection.

Management: All suspected cases require medical evaluation. Must be treated systemically with oral prescription medication, usually for 4-8 weeks.

It is not necessary to cut hair, shave the head or wear a head covering. Exclusion is generally not necessary; each case should be considered individually.

Personal hygiene instruction related to avoiding shared use of combs, brushes, towels and clothing.

B. Tinea Corporis (Ringworm of the Body)

Definition: Superficial tinea infections of the non-hairy skin may involve the face, trunk, or limbs but **not** the scalp, beard, groin, hands or feet.

Clinical Manifestations: Complaints may include mild pruritus, pain, scaling. History may reveal close contact with infected animal(s) or person(s). The lesion starts as a small, red colorless or depigmented circle that progressively enlarges. The circular border is elevated and sometimes scaly; it is dry or moist and crusted. The center starts to heal, as the area becomes larger. Usually seen on arms, face and neck but may occur elsewhere on the body.

Management: Topical applications of recommended medication as directed. Improvement of lesion(s) may be obvious within 2 weeks, a minimum of 4 weeks of treatment is recommended.

Management: Need to evaluate the individual students' activities (i.e. wrestling), to minimize skin to skin contact until medical treatment has been initiated.

Exclusion from school is generally not necessary. Each case should be considered independently.

A. Tinea Cruris (Jock Itch)

Definition: Common superficial fungal disorder of the groin and upper thighs.

Clinical Manifestations: Common in the groin and thigh region of post-pubescent males; the scrotum is spared. A raised border demarcates lesion. Often follows from prolonged use of an athletic supporter. Treat topically.

D. Tinea Pedis (Ringworm of the Feet/Athlete's Foot)

Definition: Fine vesiculopustular or scaly lesion that commonly are pruritic. The lesions can involve all areas of the foot.

Clinical Manifestations:

1. Fine vesiculopustular or scaly lesions with a predisposition to fissures and scaling between the toes.
2. Student frequently complains of severe itching of area(s).
3. The infection may spread to the soles of the feet.

4. Toenails may be infected and become dystrophic.
5. It may be accompanied by a spread to other parts of the body, especially the hands, or by a hypersensitivity reaction to the fungi with resulting vesicular eruptions on the palms of the hands, sides of the fingers, trunk and/or extremities.

Management: Topical medications are directed. Cool wet compresses to relieve itching. Proper foot hygiene.

Additional Considerations:

1. Students should not use public areas conducive to transmission (i.e., swimming pools, lockers) with active infection.
2. Need to evaluate the individual students' activities.

Y. Tuberculosis (Pulmonary)

Definition: Pulmonary tuberculosis (TB) is a bacterial disease affecting the lungs. Other parts of the body can also be affected, for example lymph nodes, kidneys, bones, joints, etc., this is called extra pulmonary tuberculosis. All cases of tuberculosis disease are initially treated with a least four anti-TB medications for a minimum of six months.

Etiology: Mycobacterium tuberculosis, an acid-fast bacillus (AFB).

Clinical Manifestations:

1. Tuberculosis infection may result after close contact with a person who has tuberculosis disease.
2. Early clinical manifestations that occur 1-12 months after initial infection may include one or more of the following: fatigue, night sweats, and low-grade fever, weight loss and/or progressive weakness, persistent sputum – productive cough.

Mode of Transmission: Infectious airborne droplets, from person with active pulmonary disease, usually released during coughing, sneezing, screaming, singing and/or spitting. Prolonged exposure to the tuberculosis organism is normally necessary for infection to occur.

NOTE: Because children rarely transmit the disease, the usual method of spread is adult-to-child.

Incubation Period: Four to 12 weeks after infection until significant skin test reaction or a demonstrable primary lesion. Infection may be latent for years.

Period of Communicability: As long as infectious tuberculosis bacilli are being discharged in sputum. Only an individual with **active** TB disease is capable of transmitting the disease.

Tuberculin Skin Testing: The intradermal Mantoux Purified Derivative (PPD) skin test is currently the most accurate and reliable test. It does not prove the presence of active infection. Tine tests should not be used. The disadvantage of the multiple puncture devices (i.e., tine test) is that the exact dose of antigen injected can be inconsistent and errors in reading the reaction are likely.

Tuberculosis skin testing in children: No routine skin testing of children for the presence of tuberculosis should be conducted, except as part of an epidemiological investigation in cooperation with or recommended by the local Department of Health Tuberculosis Control Program. Children should be tested by their primary health care provider based on risk assessment, as part of routine care.

Reporting Requirements: Tuberculosis is a reportable disease. As soon as school district becomes aware that a student, teacher or other member of the school staff has or is suspected of having tuberculosis disease, school authorities are required to report to the local Department of Health.

It is a responsibility of local Department of Health to evaluate and provide appropriate care for tuberculosis cases, tuberculosis suspects, contacts to infectious cases and tuberculin skin test reactors.

School Considerations:

1. If potential transmission of tuberculosis has occurred within the school, cooperation among the local Department of Health, school officials and school health personnel is necessary to determine the level of appropriate disease control investigation.
2. Students and/or school personnel who are taking treatment for latent TB infection (Usually Isoniazid for 9 months) prophylactic medication do not need to be excluded from the school setting. These individuals may be infected but do not have symptoms of the disease. They do **not** have the potential for transmitting the bacteria to others.
3. Students and/or school personnel who have been diagnosed as having active tuberculosis disease must be excluded from school until they are no longer infectious. A written statement from the primary care provider concerning their ability to return to the school setting should be requested.

Z. WEST NILE VIRUS

Definition: West Nile Virus (WNV) is a mosquito-borne infection that can cause serious illness, and in some cases, death.

Etiology: Arbovirus

Clinical Manifestations: It is estimated that 20% of the people who become infected will develop mild symptoms such as fever, headache and body aches, occasionally a skin

rash and/or swollen lymph glands. In many individuals, these symptoms are so mild that they go unnoticed or undetected.

The symptoms of severe infection (West Nile encephalitis or meningitis) include headache, high fever, neck stiffness, stupor, disorientation, coma, tremors, convulsions, muscle weakness and paralysis. Usually, symptoms occur from 3 to 14 days after exposure. There is no specific treatment for viral infections, other than to treat the symptoms and provide supportive care.

Risk Factors: All residents of areas where virus activity has been identified are at risk of getting West Nile Virus; persons over 50 years of age are at the highest risk for severe disease.

Mode of Transmission: WNV is primarily transmitted through the bite of an infected mosquito.

Incubation Period: 5-15 days.

VIII. HIPAA REGULATIONS

The Health Information Portability and Accountability Act (HIPAA) and Its Application to the School Setting.

HIPAA (The Health Information Portability and Accountability Act) is a federal law that imposes new standards for the protection of individual health information. It is important to distinguish between HIPAA and FERPA (The Family Educational Rights and Privacy Act). Educational records that are subject to FERPA are expressly exempted from HIPAA's coverage. Therefore, the confidentiality and privacy of school health records that are part of the student's educational record are governed solely by FERPA. The passage of HIPAA does NOT change that in any way. HIPAA does, however, affect the nature of the exchange of information from the student's health providers to the school. Previous informal exchanges between health providers and school health staff are no longer permitted; explicit written authorization is required from the parent or guardian in order for information to flow to the school. For example, immunization records require such authorization.

Within the school setting, FERPA continues to govern the exchange of health care information that is contained in the student's educational record. It is not necessary to obtain a release of information from a parent or guardian in order to share information with school staff for the purposes of insuring the best and most appropriate care for a student.

For additional information, please contact the New York State School Health Services Center at (585) 349-7630.

Application of HIPAA to a Student School Health Record

- Records from a health care provider (e.g., a medical record) require a signed release from the person(s) in parental relationship to the child that specifies to whom the information may be released and the duration of that release. The information in such a record may not be re-disclosed, which is also called secondary disclosure.

- This medical record upon arrival at the school does NOT shed its HIPAA status nor does it adopt a FERPA status.
- However, the information contained in the medical record can and should be used to form the basis of any required health plan for the individual child. For example, elements of the information may become enmeshed in the broader FERPA – governed health record.
- Regardless, nothing should be construed as allowing the medical record itself to become an open part of the student’s school health record.
- It is recommended that the medical record itself – the actual HIPAA-released document(s) – be kept in a sealed envelope, which may be annotated to indicate that the information contained therein forms the basis of whatever is included in the child’s health record. The date upon which the release expires should also be noted, understanding that the expiration of the release does not constitute permission to unseal the record.
- The identification of those persons to whom the record may be released needs to be clear and should be addressed with the parent/person in parental authority at the time the consent to release is obtained.
- No person, except the individual(s) to whom the information was released, should have access to the medical information at any time. The school district needs to have policies and procedures in place to ensure compliance with this access issue.
- Some notation regarding the individuals who have such access should be documented on the sealed envelope. The confidential medical record may be kept in the student’s health record or in an alternative secure location where it is accessible to appropriate school administration and health personnel.

VIII. Confidentiality, Record Keeping, and Documentation

A. Definition of Confidential Health Information

Confidential student health information is personal, sensitive information obtained most often by a health professional concerning the physical, developmental or mental health of an individual student.

B. Legal Provision for the Protection of Student School Records

The Family Educational Rights and Privacy Act (FERPA), is a federal law adopted in 1974 in response to reported abuses of confidentiality, denial of parental access, problems concerning correction or deletion of inaccurate or outdated material in student files and lack of consistency in record-keeping among school districts across the country. FERPA protects the privacy of students and their parents by restricting access to school records in which individual student information is kept. Only school officials with legitimate education interest, parents, and eligible students can directly access school records.

C. Information Included in Health Records

The Health record includes, but is not limited to, demographic information, emergency information, health history, individualized health care plans, immunization records, results and recommendation from examinations, screening or treatments, parent/guardian

referral records, progress notes, summary of relevant information from logs of student accidents, illnesses, and medications.

D. Parental Rights to Records

Parents or eligible students have the right to inspect and review all records maintained by the school and to request that a school correct records believed to be inaccurate or misleading. If the school decides not to amend the record, as requested, the parent or student then has the right to a formal hearing. If the school still decides not to amend the record, the parent or student has the right to place a statement with the record commenting on the contested information. The school must have written permission from the parent or eligible student to release any information from a student's record. The law allows disclosure of records, without consent, to school employees who have a need-to-know, to other schools to which a student is transferring and in certain other situations specifically listed in FERPA.

E. School District Retention of Health Records

Student's cumulative health record, including but not limited to health history; individualized health care plan; immunization record; results and recommendations from examination, screening, or treatment; parent or guardian referral and permission record; and teacher's comments.

- a. Summary report or individual records when **not posted to summary record:**
RETENTION: 0 after individual attains age 27

- b. Individual records when posted to summary record except blood and body fluids incident report:
RETENTION: 1 year after end of school year

- c. Individual immunization record, including authorization and/or parental consent:
RETENTION: 6 years, or 3 years after individual attains age 18, whichever is longer

NOTE: These records may be requested beyond their minimum legal retention period by persons needing proof of certain immunizations for college admission or other purposes. The State Archives recommends that school districts and BOCES evaluate the need to retain immunization records longer than the stated minimum retention period for these purposes.

- d. Blood and body fluids incident report, even when **posted to summary record:**
RETENTION: 0 after individual attains age 27

Log of students' accidents and illnesses during the school day:
RETENTION: 1 year after end of school year

NOTE: This retention period presumes that information contained in the log is also contained in the individual and/or summary health records covered by parts a. and/or b. of item no. 137, above. If this information is **not** posted to the student's individual and/or summary health records, then the log must be retained until the youngest student listed in it attains age 27.

Student's psychological or social assessment record file

NOTE: Institutional school districts should retain **all** these records until the student attains age 27.

- a. Report regarding student's ability, personality, family, and environmental influences:
RETENTION: 6 years after report written
- b. Source materials used in preparing report, including "protocols," tests and notes, for students **not** classified as special education: **RETENTION:** 1 year after report written
- c. Source materials used in preparing report, including "protocols," tests and notes, for students **classified** as special education:
RETENTION: 6 years

Inventory, storage, receipt and distribution records for vaccines and controlled substances (or other drugs or medication) administered to students and/or employees:

RETENTION: 5 years

Student health summary reports, covering all or groups of students, including school immunization survey summary and communicable disease summary report:

RETENTION: 3 years

Early intervention program records, including but not limited to case record and screening, assessment and referral records:

- a. Individual case record:
RETENTION: 7 years after discharge or last contact, but no less than 3 years after person attains age 18
- b. Screening, assessment and referral records, not found in individual case record:
RETENTION: 7 years

F. Health Office Logs

Although daily logs provide a mechanism for recording an accurate, chronological list of health office visits and may be helpful in compiling health office statistics, they are not required. Daily logs do not provide an accurate and/or broad picture of individual student health concerns. It is recommended that a separate, anecdotal record be kept in which individual health office visits are recorded. If daily logs are utilized, relevant information must be transcribed from the log to an individual's health record or the logs must be retained by the school district until the youngest student listed attains age 27 years.

G. Sharing of Student's Medical Issues with Staff

It is essential to treat all health-related information confidentially.

There may be a need to know of an existing health condition in order to modify an education plan or meet health and safety needs of a student. In accordance with law and local policies, school health personnel must determine which order to fulfill his/her professional responsibility. For instance, if a child has an allergy to bee stings, playground staff, bus drivers and individuals who attend field trips with the child; if a child has diabetes, information should be shared with cafeteria staff as well as others, but not with everyone who works in the school. Decisions about who should have access to health-related information should be made by school health personnel in conjunction with students, parents and physician. The health record itself does not have to be shared, but specific information and interpretation of that information should be provided by school health services staff to appropriate individuals.

H. Information Regarding Sensitive Issues Such As, Substance Abuse, Pregnancy, Abortion, STDS, and Mental Health Issues.

Districts must determine what, if any, procedures to develop that address sharing of sensitive information with others in the district and/or parents. In accordance with law and local policy, school health personnel must determine which health information is educationally relevant or may pose a risk to an individual student or others in the school and which school personnel would need to be apprised of the information. Overriding all concerns must be the safety of the student and the school community.

I. Requirements for Computerized Health Records

As with conventional Health Records, procedures to assure confidentiality of health records must be in place when computerized records are utilized. Electronic records should routinely be backed up to prevent loss, destruction or unauthorized alteration of information. It is not

necessary to print hard copies of records while a child is in attendance at a school, but a system for transferring records from building to building within a district or to a new school district if a student transfers must be in place. If information is transferred of the Internet, it should be encrypted or encoded to prevent access by outside parties. In the event that a record keeping system changes, consideration should be given to transferring all information to the new system and future availability of student records.

J. Faxing Medical Orders To The School

The use of facsimile copies or other electronic transmissions to transmit medical orders or records is permissible. Methods for assuring confidentiality of faxed records should be implemented. When the fax is used, it is not necessary for the prescribing practitioner to countersign the order at a later date.

SCHOOL DISTRICT FORMS & POLICIES



www.portchesterschools.org

Port Chester-Rye Union Free School District

113 Bowman Avenue
Port Chester, New York 10573
914.934.7913

Joseph G. Durney
District Director
Curriculum Office

Date:

TO:

From:

Phone
Fax

Email
Phone
Fax

REMARKS: ☐ Urgent ☐ For your review ☐ Reply ASAP ☐ Please Comment

The following student from your practice submitted a physical form to school this year without the required Weight Status Category (BMI%) designation indicated on the form. Weight status category must be determined by the provider.

Included in this transmission is a blank form with the date of birth and date of exam indicated for _____. I am asking that the required information (WSC) based on that exam be added and returned to me via the fax number above.

Should you have any questions regarding this request, please feel free to contact me.

Thank you for your assistance.

School Nurse

Confidentiality Statement: The information contained in this facsimile message is privileged and confidential. It is intended only for the use of the specific addressee listed above. If you are not the intended recipient, please note that this confidentiality statement pertains to you as well. Please deliver this to the addressee promptly. If you have received this facsimile in error or it cannot be delivered to the addressee please notify me IMMEDIATELY at _____. Thank you.



www.portchesterschools.org

Port Chester-Rye Union Free School District

113 Bowman Avenue
Port Chester, New York 10573
914.934.7913

Joseph G. Durney
District Director
Curriculum Office

New York State Education Law (Section 903-904) requires BMI and Weight Status reporting be included as part of the mandated school health exam. If this is not provided on the latest physical exam form, one time only, the district may request the required information be sent via “fax” on a blank physical exam form with the student’s name, date of birth and date of exam. Attach the new information form with the latest exam form and keep together in the student’s health folder.



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914.934.7913

Joseph G. Durney
District Director
Curriculum Office

BMI Opt Out Statement

New York State Education Law (Section 903 & 904) requires BMI and Weight Status reporting be included as part of the mandated school health exam. We will be reporting to the New York State Department of Health information about our student's weight status. If you choose to **NOT** have your child's weight status information reported please contact the school nurse in the school your child attends.



www.portchesterschools.org

Port Chester-Rye Union Free School District

113 Bowman Avenue
Port Chester, New York 10573
914.934.7913

Joseph G. Durney
District Director

Date _____

Dear Parent _____

As you were notified previously, your child _____ must be immunized against _____. The forms were to have been completed and returned to the school by _____. Despite reminders, the school has not received this information. Therefore, as of _____, we are excluding your child from school pending the receipt of proof of immunization.

If your child has not been immunized, please contact your doctor or clinic to set up an appointment. I remind you again, your child will not be permitted to attend school until the process has been completed.

Thank you for your cooperation in this matter.

Thank you,

Principal



www.portchesterschools.org

Port Chester-Rye Union Free School District

113 Bowman Avenue
Port Chester, New York 10573
914.934.7913

Joseph G. Durney
District Director

Notice of Exclusion from School Attendance

Student's Name: _____ Date: _____

School: _____ Teacher: _____ Grade: _____

Dear Parent or Guardian:

State law requires that every child entering school be vaccinated against Polio, Diptheria, Pertussis, Tetanus, Hepatitis B, Measles, Rubella, Mumps, and Varicella. Your child has not fulfilled these requirements as previously notified.

Regretfully, effective _____, we must exclude your child from further attendance at our school.

Your child may return to school when you are able to present evidence that the necessary immunizations have been given. If you have documentation of your child receiving the required immunizations, please bring these to the school immediately.

Thank you for your cooperation in this matter.



www.portchesterschools.org

Port Chester-Rye Union Free School District

113 Bowman Avenue
Port Chester, New York 10573
914.934.7913

Joseph G. Durney
District Director

IMMUNIZATION REQUEST LETTER TO PARENTS

Date:

Dear Parent/Guardian,

Required Immunizations for School Attendance for: _____
(Student's Name)

New York State Public Health Law, Section 2164 and Port Chester Public Schools requires that schools will not permit a child to attend school unless the parent provides the school with a certificate of immunization or proof from a physician, nurse practitioner or physician's assistant that the child is in the process of receiving the required immunizations. Additionally, all new entrants must have a **Tuberculosis Risk Assessment Questionnaire** completed by your child's health care provider. This attached form must be completed and submitted before attendance at school will be permitted.

Your child's needs these immunizations for school entry:

Your child will not be permitted to attend school without the necessary immunizations. The required immunizations can be obtained from your family health care provider.

A record of your child's immunizations from your health care provider or official copy of the immunization record from the child's previous school (a copy of the original immunization record from the healthcare provider – not a copy of the school health record) is acceptable. A NYSIIS/NYCIR record is also acceptable. The exact date each immunization was given must be included in the record.

If you have questions or concerns about immunizations, please contact the school health office.

School Nurse: _____ School: _____

Phone #: _____ Fax: _____ Email: _____

Sincerely

School Nurse



www.portchesterschools.org

Port Chester-Rye Union Free School District

113 Bowman Avenue
Port Chester, New York 10573
914.934.7900

Joseph G. Durney
District Director
Curriculum Office

Dear Parent/Guardian:

New York State Public Health Law, Section 2164 and Port Chester Public Schools requires that all students that attend school have updated and valid immunizations. Therefore per NYS DOH and upon review by the school nurse please be aware your child needs the following immunizations:

UPDATED IMMUNIZATION: _____

Invalid Immunization: _____

Your child will not be permitted to remain in school without these immunizations. Please contact your child's health care provider to make an appointment as soon as possible and provide the appointment date to the nurse along with your child's updated immunization record. If you have any questions or concerns about immunizations, please contact the school health office.

School Nurse: _____

School: _____

Phone: _____ FAX: _____ EMAIL: _____

Sincerely: _____



Port Chester-Rye Union Free School District

113 Bowman Avenue
Port Chester, New York 10573
914.934.7913

www.portchesterschools.org

Joseph G. Durney
District Director

Date: _____

Dear Parent / Guardian:

In order to keep our health records as accurate as possible, it is important that we are informed of each student's medical status.

Please have your doctor provide updated medical information on your child

_____ with regard to his/her _____.

It would be appreciated if this information could be returned to the Middle School Health Office as soon as possible.

Thank you for your time and cooperation in this matter.

Sincerely,

School Nurse

INTERVAL HEALTH HISTORY FOR SPORTS PARTICIPATION

Port Chester – Rye UFSD

Prior to the start of tryout sessions or practice at the beginning of each season, a health history review for each athlete must be conducted unless the student received a full medical examination within 30 days of the start of the season.

PART A, B, C and D TO BE COMPLETED BY THE PARENT OR GUARDIAN:

PART A Student: _____ Age: _____

Grade (check) 7 _____ 8 _____ 9 _____ 10 _____ 11 _____ 12 _____ Date of Birth: ____/____/____

Sport: _____ Level (check): Varsity ____ JV ____ Modified ____

Date of last health appraisal: ____/____/____ Limitations: Yes ____ No ____

PART B

NOTE: “YES” to any of these questions does not mean automatic disqualification from the athletic activity indicated. However, it will require a review and approval by the school physician before the student can report to practice or tryouts.

The answers to the questions on this form will be held in the school health office and will be kept confidential.

HISTORY SINCE LAST HEALTH APPRAISAL:

If the answer to any of the following questions is “YES”, please complete “PART C”.

- | | (CHECK) | |
|---|-----------|----------|
| 1. Any injuries requiring medical attention? | YES _____ | NO _____ |
| 2. Any illness lasting more than five (5) days? | YES _____ | NO _____ |
| 3. Taking medicine or under physician’s care at this time? | YES _____ | NO _____ |
| 4. Any feeling of faintness, dizziness or fatigue after exercise or exertion? | YES _____ | NO _____ |
| 5. Change in wearing glasses or contact lenses? | YES _____ | NO _____ |
| 6. Any surgical operations or fractures? | YES _____ | NO _____ |
| 7. Any treatment in a hospital or emergency room? | YES _____ | NO _____ |
| 8. Developed any allergies? | YES _____ | NO _____ |
| 9. Any Chronic disease? | YES _____ | NO _____ |

PART C

Describe the condition or situation below, if you answered “yes” to any question in Part B.

PART D – PARENTAL PERMISSION

I, the undersigned, clearly understand these questions are asked in order to decide if my child can safely participate in the sport names in PART A of this form. The answers are correct as of this date and he/she has my permission to participate.

SIGNED: _____ Date: ____/____/____

PLEASE RETURN TO THE SCHOOL HEALTH OFFICE

PART E – TO BE COMPLETED BY THE SCHOOL HEALTH OFFICE

Sports Participation (check):

_____ Approved

_____ Referred to School Physician

Signed _____
School Health Office

Date: ____/____/____

If referred to the School Physician (check):

Signed _____
School Physician

_____ Qualified
Date: ____/____/____

_____ Disqualified
Date: ____/____/____



www.portchesterschools.org

Port Chester-Rye Union Free School District

113 Bowman Avenue
Port Chester, New York 10573
914.934.7913

Joseph G. Durney
District Director

Authorization for Administration of Medication

A. To be completed by parent or guardian:

I request that my child _____, grade _____, receive the medication as prescribed below by their licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse or other designated person in the case of the absence of the school nurse, will administer the medication.

Signature(parent or guardian): _____

Address: _____

Telephone: Home: _____ Work: _____ Date: _____

B. To be completed by licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration: _____

Time to be taken during school hours: _____

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

Name of Licensed Prescriber and Title: _____

Prescriber's Signature: _____

Address: _____

See Back of this Page

**Self-Directed/Self Administer
Self- Medication Release Form**

School Year _____ Date:_____

Child's Name: _____ Self Directed __yes__no Self Administer __yes__no

has been instructed in the proper use of the following medication procedures:

We, (Heath Care Provider) _____ Signature _____ and

And (Parent or Guardian's) Signature _____

Request that (Child's name) _____ be permitted to carry, keep on their person, keep in their book bag, keep in their locker or PE locker the medication so prescribed. We feel he/she is able to:

****Identify the Correct medication**

****Identify the purpose of medication**

****Determine the correct dosage**

****Identify the time the medication is needed**

****Describe what will happen if medication is not taken**

Note: This form must be completed in addition to routine district medication form. Each decision for a student will be made on an individual basis



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Joseph G. Durney
District Director
Curriculum Office

Dear Parents/Guardian

New York State law requires that all new entrants (whether Pre-K or K), 2nd, 4th, 7th, & 10th graders and all students entering a school district for the first time have a physical examination during the _____ school year.

For your convenience, we are enclosing a physical form which includes immunization information for your health care provider to complete. We are requesting that your child's healthcare provider complete Body Mass Index information on the Health Appraisal Form. Please request that the provider complete that needed information in order to have a completed Health Appraisal on file at the school.

If your child has a physical scheduled during the school year, please notify the Health Office with the date of the scheduled physical exam. If the health appraisal form is not returned to the health office, it is understood your child will receive a physical exam by the Chief School Physician. If you have any questions, please call the Health Office at _____. Your physician may also fax the physical to _____.

Have a happy and healthy summer! See you in September.

Yours truly,

School Nurse

Enclosure



Port Chester-Rye Union Free School District

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Joseph G. Durney
District Director

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Student Name _____ Birthdate _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

I hereby authorize my child's physician(s) listed above to exchange the following information with District staff, including:

- | | |
|---|---|
| <input type="checkbox"/> School Nurse | <input type="checkbox"/> Immunizations/physical exams to comply with NYS regulations |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Psychological evaluations/reports |
| <input type="checkbox"/> Speech Therapist | <input type="checkbox"/> Medical clearances as needed following an injury or change in condition |
| <input type="checkbox"/> School Psychologist | <input type="checkbox"/> Medical orders required for therapy needs; evaluations |
| <input type="checkbox"/> School Social Worker | <input type="checkbox"/> Authorization for medications during the school day or on school trips |
| | <input type="checkbox"/> Medical condition/ treatment plans that may have an impact in the school environment |
| <input type="checkbox"/> Physician referral for services (OT, PT) | |
| <input type="checkbox"/> _____ | <input type="checkbox"/> Other _____ |

This information will be used to provide a safe and healthful environment and develop an appropriate program for this student at school. Enrollment is not contingent upon obtaining this release, however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment. This release expires on the last day of the enrollment of the above student in school and may be revoked at any time by sending the request to cancel this permission in writing to the address above. Such revocation will not affect any disclosure made prior to its receipt. Protected health information will not be disclosed without consent per FERPA regulations. **A copy of this release has been provided to me and will be sent to the appropriate provider when requests are made.**

☐ I waive my right to receive a copy of this notice.

(Signature of student over 18 or Parent/Guardian)**

(Date)

**If a student is under 18 years of age, parent or legal guardian must sign consent form. If other representative is signing, authority to act on student's behalf: _____

This form complies with all HIPAA regulations.



Port Chester-Rye Union Free School District

113 Bowman Avenue
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914.934.7913

Joseph G. Durney
District Director

Immunization Requirement for Students Entering 6th Grade

Dear Parent/Guardian,

Date:

Students who are entering 6th grade for the upcoming 2014-15 school year will require 2 additional immunizations:

- Tdap (described below)
- 2nd dose of Varicella- A health care provider's signed medical record indicating the student had varicella disease is acceptable proof of immunity.

Students who are entering 6th grade and who are 11 years of age or older must receive an immunization containing tetanus toxoids, diphtheria, and acellular pertussis (Tdap).

Students who are 10 years old and entering 6th grade will not be required to receive the Tdap until they turn 11 years old. At that time they must provide documentation of a booster dose of Tdap or provide proof of an appointment for the booster dose within 14 days.

The only two exemptions from this requirement are either:

- A medical exemption written by a physician
- A statement of religious exemption written by the parents/guardian of the student which must be approved by the superintendent or principal of the school.

If you have questions or concerns about immunizations, please contact the school health office.

Sincerely,

School Nurse _____

Telephone # _____ Fax # _____ Email: _____



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www.portchesterschools.org

Joseph G. Durney
District Director

Immunization Requirement for Students Entering 6th Grade

Dear Parent/Guardian,

Date:

New York State Law Section 2164 and Port Chester Union Free School District requires certain immunizations to enter 6th grade and attend school. Please check with your Health Care provider as soon as possible to make sure that your child has all the needed immunizations. They are listed below:

- **Varicella** (chickenpox)
2 doses – a health care provider's signed medical record indicating the student had varicella disease is acceptable proof of immunity.
- **Polio**
3-4 doses
- **Hepatitis B**
3 doses
- **DTP/DTaP/Tdap**
3 doses
- **Tdap**
- **MMR**
2 doses

If you have questions or concerns about immunizations, please contact the school health staff.

School Nurse: _____ School: _____

Phone#: _____ Fax: _____ Email: _____



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Joseph G. Durney
District Director

Immunization Requirement for Students Entering Kindergarten

Dear Parent/Guardian,

Date:

New York State Law Section 2164 and Port Chester Union Free School District requires certain immunizations to enter kindergarten and attend school. Please check with your health care provider as soon as possible to make sure that your child has all the needed immunizations. They are listed below. Additionally, all new entrants must have a **Tuberculosis Risk Assessment Questionnaire** completed by your child's health care provider. This attached form must be completed and submitted before attendance at school will be permitted.

Required Immunizations for Kindergarten

- **Polio**
3-4 doses
- **Hepatitis B**
3 doses
- **Diphtheria/Tetanus/Pertussis**
4-5 doses
- **Measles/Mumps/Rubella**
1 dose(**second dose required by age 7)
- **Varicella** (Chickenpox)
2 doses

Please send proof of immunization to the school nurse where your child will be attending kindergarten.

School Nurse:_____School:_____

Phone #:_____Fax:_____Email:_____



Distrito Escolar Port Chester-Rye Libre de Unión

113 Bowman Avenue
Port Chester, New York 10573

www.portchesterschools.org

Requisitos de Inmunización para los Estudiantes que Ingresan al Kindergarten

Querido Padre/Tutor,

Fecha:

La Sección de Ley del Estado de Nueva York 2164 y el Distrito Escolar de Port Chester Libre de Unión requiere ciertas vacunas para entrar al kindergarten y asistir a la escuela. Por favor, consulte con su proveedor de atención médica tan pronto como sea posible para asegurarse de que su hijo/a tiene todas las vacunas necesarias. A continuación se enumeran los requisitos. Además, todos los nuevos estudiantes deben tener un **Cuestionario de Evaluación de Riesgo de Tuberculosis** completado por el médico de su hijo/a. Este formulario adjunto debe ser completado y enviado antes que la asistencia a la escuela sea permitida.

Inmunizaciones Requeridas para Kindergarten

- **Polio**
3-4 dosis
- **Hepatitis B**
3 dosis
- **Difteria/Tétanos/Tos Ferina**
4-5 dosis
- **Sarampión/Papera/Rubeola**
1 dosis (**la segunda dosis se requiere a los 7 años)
- **Varicela**
2 dosis

Por favor, envíe la prueba de la inmunización a la enfermera de la escuela donde su hijo/a va a asistir kindergarten.



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Joseph G. Durney
District Director

Procedure for Parent Notification- Non Emergency

Public Health Law 680 Section 216, NYS Education Law 901 Article 19 and Port Chester-Rye Union Free School District Student Health Services Policy 5420: Parents will be notified of non emergency medical situations that have been reported to the nurse in a timely manner as follows:

Procedure:

1. All parents/guardians will be reached by phone call first by the school nurse and or a substitute nurse in her absence.
2. If a parent/guardian cannot be reached by phone, the school nurse will send home with the student the districts approved "Parent Notification Form".
- 3. All communication with parent/guardian will be documented by the school nurse in the nurse's notes on that student**



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Port Chester-Rye Union Free School District

113 Bowman Avenue
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Joseph G. Durney
District Director

Parent Notification Form

Name (Nombre) _____

Date (Fecha) _____

Your Child was seen today in the school health office: (Su hijo/a fue visto en la oficina de salud hoy)

Student Illness/Injury/Complaints (Condiciones/Síntomas):

- | | | |
|---|--|--|
| <input type="checkbox"/> Breathing(problems al respirar) | <input type="checkbox"/> Earache(dolor de oído) | |
| <input type="checkbox"/> Nausea/vomiting(nausea/vomito) | <input type="checkbox"/> Sore Throat(dolor de gargante) | <input type="checkbox"/> Tired(cansancio) |
| <input type="checkbox"/> Cough/cold (tos/ catarro) | <input type="checkbox"/> Eye Irritation(irritacion de ojo) | <input type="checkbox"/> Dizziness (vértigo) |
| <input type="checkbox"/> Headache(el dolor de cabeza) | <input type="checkbox"/> Pain (el dolor) | <input type="checkbox"/> Splinter (astilla) |
| <input type="checkbox"/> Stomachache (dolor de estomago) | <input type="checkbox"/> Diarrhea (diarrea) | <input type="checkbox"/> Abrasion (abrasión) |
| <input type="checkbox"/> Skin Discomfort(malestar de la piel) | <input type="checkbox"/> Hunger(hambre) | <input type="checkbox"/> Cut (cortadura) |
| <input type="checkbox"/> Nasal Congestion(congestión nasal) | <input type="checkbox"/> Foreign Object(objeto extraño) | <input type="checkbox"/> Bruise(el moretón) |
| <input type="checkbox"/> Bee Sting(picadura de avispa) | <input type="checkbox"/> Dental Injury(lesión dental) | <input type="checkbox"/> Swelling(hinchazón) |
| <input type="checkbox"/> Puncture (herida punzante) | <input type="checkbox"/> Rash (sarpullido) | <input type="checkbox"/> Bump (chichón) |
| <input type="checkbox"/> Nosebleed (sangrada nasal) | <input type="checkbox"/> Blister(la ampolla) | <input type="checkbox"/> Burn(la quemadura) |
| <input type="checkbox"/> Insect Bite(mordedura de insecto) | <input type="checkbox"/> Lost tooth(diente perdido) | <input type="checkbox"/> Other(otro) |
| <input type="checkbox"/> Muscle discomfort (molestias musculares) | | |
| <input type="checkbox"/> Menstrual cramps (dolor de menstruación) | | |
| <input type="checkbox"/> Mouth Irritation(irritación de la boca) | | |

First Aid and Follow Up Care Provided(Intervenciones Medicas y Tratamiento)

- | | |
|--|---|
| <input type="checkbox"/> Area rinsed/washed(área fue enjuagado/lavada) | <input type="checkbox"/> Bandage applied (venda fue aplicada) |
| <input type="checkbox"/> Ice applied(hielo fue aplicado) | <input type="checkbox"/> Rested (descansó) |

School nurse(enfermera) _____ Phone(teléfono) _____



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Port Chester-Rye Union Free School District

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Joseph G. Durney
District Director

Dear Health Care Provider:

The following is a list of activities provided in our physical education classes. Please indicate, by placing a “yes” or “no” next to each activity, if your patient _____
_____ Is qualified to participate in that activity. If your patient is not allowed to participate, please state the reason for disqualification.

Contact/Collision

Wiffle Ball _____
Football _____
Baseball _____
Basketball _____
Soccer _____
Softball _____
Field Hockey _____
Floor Hockey _____

Fitness

Weight Lifting _____
Yoga _____
Cardio Kickboxing _____
Pilates _____
Abdominal _____
Workouts _____
Stability Ball _____
Dumb Bells _____
Aerobics _____
Walking _____

Others

Badminton _____
Ping Pong _____
Fitness Testing _____
Running _____
Sit-ups _____
Push-ups _____
Flexibility _____
Circus Arts _____
Pickle Ball _____
Project _____
Adventure _____
Golf _____

Edurance

Track _____
Tennis _____
Volleyball _____

Reason for disqualification _____

Length of time to be disqualified _____

Health Care Provider's Stamp

Signature of Health Care Provider

Date:

Sincerely,

School Nurse



Port Chester-Rye Union Free School District

113 Bowman Avenue
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www.portchesterschools.org

Joseph G. Durney
District Director

Dear Parent/Guardian:

There is a New York State program that permits a few qualified students to participate on an athletic team beyond their grade placement. It is called the Selection/Classification Program.

Your child _____ (name) may be eligible to participate in _____ (sport) above normal grade level. In order to establish the appropriate eligibility, we must have your permission to begin the Selection/Classification screening process. This screening evaluates your child's physiological maturity, athletic performance abilities (physical fitness), and athletic skill in relationship to other student athletes at the specific participation level. The school physician will evaluate your child using the Tanner Scale, to determine his or her physiological maturity.

If your child can successfully meet the requirements of the Selection/Classification Program, he/she will be allowed to participate in an extended athletic career. Under normal circumstances, a student is only eligible for senior high school athletic competition in a sport for four consecutive seasons commencing with the students' entry into the ninth grade. However, by meeting the Selection/Classification requirements established by the New York State Education Department, your child's eligibility can be extended to permit:

- a) Participation during five consecutive seasons in the approved sport after entry into the eighth grade; or
- b) Participation during six consecutive seasons in the approved sport after entry into the seventh grade.

It is important for you and your child to understand that once the requirements are met and he/she is accepted as a member of the team, he/she cannot return to a lower level team (modified) in that sport in that season. Your child will be exposed to the social atmosphere that is inherent to older students and the high school environment.

Please feel free to contact me regarding this program or to discuss an aspect of your child's athletic placement. If you agree to allow your child's participation in this program, please sign and return the parental permission form to my office.

Sincerely,

Director of Physical Education / Athletics

PARENT/GUARDIAN STATEMENT

I understand the purpose and eligibility implications of the Selection/Classification Program. My son/daughter _____ (name) has my permission to participate in the Selection/Classification Program.

Parent/Guardian Signature _____ Date _____

**SELECTION AND CLASSIFICATION
Developmental Maturity Form****THIS SECTION TO BE COMPLETED BY THE DIRECTOR OF PHYSICAL
EDUCATION/ATHLETICS:**

Student's Name _____ Grade _____

Home Address _____

Date of Birth ____/____/____ Age ____ ☐ Male ☐ FemaleParental/Guardian Permission Form Received: ☐ YesDesired Level: ☐ Varsity ☐ Jr. Varsity ☐ Frosh ☐ ModifiedDesired Sport: _____ **REQUIRED RATING FOR
THIS SPORT & LEVEL:****THIS SECTION TO BE COMPLETED BY THE SCHOOL MEDICAL DIRECTOR:
(OR THE STUDENT'S LICENSED HEALTH CARE PROVIDER FOR REVIEW BY THE SCHOOL
MEDICAL OFFICER)****SCREENING PROCEDURES:**A. CIRCLE THE CURRENT DEVELOPMENTAL STAGE OF THE ATHLETE USING THE TANNER
SCALE:

1 2 3 4 5

B. ALTERNATIVE TO EXAM FOR FEMALES: IF SHE HAS HAD THE ONSET OF MENARCHE, SHE
QUALIFIES AS TANNER 5C. CHECK APPROPRIATE BOX BELOW, SIGN, DATE AND RETURN FORM TO THE DIRECTOR
OF PHYSICAL EDUCATION/ATHLETICS.

- ☐ Tanner score is appropriate for the sport and level indicated above
☐ Tanner score is not appropriate for the sport and level indicated above

SIGNED _____ EXAMINATION DATE ____/____/____
School Medical Director

PORT CHESTER ATHLETIC PARTICIPATION APPROVAL FORM

NAME _____ BIRTHDATE ____/____/____ Gr. ____ SPORT _____

ADDRESS _____ TEL. NO. _____

FAMILY DOCTOR _____ TEL. NO. _____

I hereby give permission for my son/daughter to participate in the indicated sport listed above during the school year _____.

I agree that he/she may travel by any conveyance approved by the Board of Education, to and from regularly scheduled school athletic contests. I understand that all transportation carriers are properly insured.

In addition, I hereby grant permission for my child to be examined by a school physician in accordance with the policy of the Port Chester Board of Education.

PUPIL HEALTH INFORMATION

Please check below (Yes or No) any of the following health problems. If yes, give approximate date:

Pneumonia _____

Injuries _____

Asthma _____

Operations _____

Allergies _____

Fractures _____

Diabetes _____

Speech Problem _____

Epilepsy _____

Visual Loss _____

Heart Problem _____

Hearing Loss _____

Rheumatic Fever _____

Other _____

Glandular Problem _____

My son/daughter is able _____, not able _____ to participate in all physical education and co-curricular activities. If not able, please specify reason: _____

Parent/Guardian Signature: _____ Date: _____

FOR SCHOOL ADMINISTRATION USE

Physical Examination Date: _____ Interview Date: _____

Approved for Play: Yes _____ No _____

If No – Reason _____

School Nurse's Signature

White Copy – Nurse Canary Copy – Coach Pink Copy – Director of Athletics



Port Chester-Rye Union Free School District

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Joseph G. Durney
District Director

Minimum Immunization Requirements for School Admission Port Chester-Rye Union Free School District

| Immunization | Requirement | Final |
|---------------------------|--|---|
| POLIO | 1 Doses | 3-5 (gr. K & 6) 3 (gr. 1-5,7-12) |
| DIPHTHERIA DTP DT DtaP | 1 Doses | 4-5 (gr. K-5) 3 (gr. 6-12) |
| MEASLES | 1 Dose **2 nd dose required by age 7 | 2 (gr. 1-12) 1 (gr. K) |
| MUMPS | 1 Dose | 1(gr. K-12) |
| RUBELLA | 1 Dose | 1(gr. K-12) |
| HEPATITIS B | 1 Doses child born on or after 1-1-93 | 3(gr. K-12) |
| VARICELLA | 1 Dose | 2 (gr. K & 6) 1 ((gr. 1-5, 7-12) |
| Tdap | 1 Dose for entering 6 th graders when they attain the age of 11 | 1 |
| TUBERCULOSIS SCREENING | The Port Chester –Rye UFSD requires Tuberculosis screening by licensed health care provider PRIOR to school entry according to district policy | |
| PHYSICAL EXAM | Completed, signed, and dated by a licensed health care provider according to the standards of the Port Chester School District | |

PORT CHESTER PUBLIC SCHOOLS

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____

Date of Birth: _____

School: _____

Gender: ☐ M ☐ F

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: _____

☐ No immunizations given today PPD: ☐ Positive ☐ Negative ☐ Not done Date: _____

☐ Immunizations given since last Health Appraisal: Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____

Dental Referral ☐ Yes ☐ No ☐ Not done **Significant**

Medical/Surgical History: ☐ See attached _____

Allergies: ☐ LIFE THREATENING ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____

☐ Seasonal ☐ Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Referral

Body Mass Index: _____

Weight Status Category (BMI Percentile):

☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th

☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

| | | | |
|--|---|---|--|
| Vision - without glasses/contact lenses | R | L | |
| Vision - with glasses/contact lenses | R | L | |
| Vision - Near Point | R | L | |
| Hearing <input type="checkbox"/> Pass 20 db sc both ears or: | R | L | |

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive:

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ☐ Yes ☐ No Student may self carry and self administer medication ☐ Yes ☐ No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION (WHERE APPROPRIATE) / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.

___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

☐ **Specify medical accommodations needed for school:** _____ ☐ Non

☐ **Known or suspected disability:** _____ ☐ Please monitor

☐ **Restrictions:** _____ ☐ Please monitor

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: _____

OPTIONAL INFORMATION, if known

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____ Parent Signature: _____ Date: _____



www.portchesterschools.org

Port Chester-Rye Union Free School District

113 Bowman Avenue
Port Chester, New York 10573
914.934.7913

Joseph G. Durney
District Director

TO BE COMPLETED BY PARENTS:

PORT CHESTER PUBLIC SCHOOLS PORT CHESTER, NY 10573 PUPIL HEALTH INFORMATION

STUDENT'S NAME _____ SEX: M ___ F ___ GRADE ___
LAST FIRST MIDDLE

ADDRESS _____ TELEPHONE _____

DATE OF BIRTH _____ PLACE OF BIRTH _____

FATHER'S/GUARDIAN'S NAME _____ CELL # _____

MOTHER'S/GUARDIAN'S NAME _____ CELL # _____

EMERGENCY CONTACT NAME _____ CELL # _____

NAME OF STUDENT'S PHYSICIAN _____ TELEPHONE # _____

PLEASE CHECK BELOW (YES OR NO) ANY OF THE FOLLOWING HEALTH PROBLEMS. IF YES, GIVE APPROXIMATE DATE.

ALLERGIES (PLEASE SPECIFY) _____ SERIOUS INJURIES _____

_____ SEIZURE DISORDER _____

ASTHMA _____ SPEECH PROBLEM _____

DIABETES _____ SURGERY _____

CURRENT MEDICATION _____ VISUAL LOSS _____

FRACTURES _____

HEARING LOSS _____

HEART CONDITION _____ OTHER _____

_____ MY SON/DAUGHTER IS ABLE TO PARTICIPATE IN ALL PHYSICAL EDUCATION AND CO-CURRICULAR ACTIVITIES.

_____ MY SON/DAUGHTER IS NOT ABLE TO PARTICIPATE IN ALL PHYSICAL EDUCATION AND CO-CURRICULAR ACTIVITIES DUE TO _____.

I UNDERSTAND A MEDICAL CERTIFICATE WILL BE REQUIRED FROM MY PHYSICIAN OR HEALTH FACILITY REGARDING THIS PROBLEM.

DATE _____ PARENT'S SIGNATURE _____

DEBE SER COMPLETADO POR LOS PADRES:

INFORMACIÓN DE SALUD DEL ALUMNO

SEXO: M____ F____ GRADO ____

DIRECCIÓN _____ TELÉFONO _____

FECHA DE NACIMIENTO _____ LUGAR DE NACIMIENTO _____

NOMBRE DEL PADRE/TUTOR _____ CELULAR # _____

| | |
|---------------------------|-----------|
| NOMBRE DE LA MADRE/TUTORA | CELULAR # |
|---------------------------|-----------|

NOMBRE DEL CONTACTO DE EMERGENCIA _____ CELULAR # _____

NOMBRE DEL MÉDICO DEL ESTUDIANTE _____ TELÉFONO # _____

SI LA RESPUESTA ES SÍ, escriba la fecha aproximada.

(POR FAVOR ESPECIFICAR) _____ TRASTORNO DE CONVULSIONES _____

ASMA PROBLEMA DEL HABLA

| DIABETES | CIRUGÍA |
|----------|---------|
|----------|---------|

| MEDICACIÓN ACTUAL | PÉRDIDA VISUAL |
|---|--|
| <p>1. Medicamentos:</p> <ul style="list-style-type: none"> 1.1. Anticoagulantes: Warfarina, Clopidogrel, Aspirina. 1.2. Antidoloríficos: Paracetamol, Ibuprofeno, Naproxeno. 1.3. Antidepresivos: Amitriptilina, Fluoxetina, Sertralina. 1.4. Antiepilepticos: Carbamazepina, Valproato de Sodio. 1.5. Antipsicóticos: Risperidona, Quetiapina. 1.6. Anticancerígenos: Quimioterapia (Cisplatino, Fluorouracilo). 1.7. Antidiabéticos: Insulina, Metformina. 1.8. Antipertensivos: Lisinapril, Amlodipino. 1.9. Anticardíacos: Digoxina, Furosemida. 1.10. Anticépticos: Antibióticos (Amoxicilina, Clindamicina). | <p>2. Grados de Pérdida Visual:</p> <ul style="list-style-type: none"> 2.1. Pérdida de visión periférica: Se refiere a la pérdida de la visión lateral o periférica, lo que puede afectar la capacidad de detectar objetos o personas que se acercan desde los lados. 2.2. Pérdida de visión central: Se refiere a la pérdida de la visión directa o central, lo que puede afectar la capacidad de leer, conducir o reconocer rostros. 2.3. Pérdida de visión nocturna: Se refiere a la dificultad para ver en condiciones de poca luz o de noche. 2.4. Pérdida de visión de colores: Se refiere a la dificultad para distinguir ciertos colores. 2.5. Pérdida de visión de profundidad: Se refiere a la dificultad para juzgar la distancia de los objetos. 2.6. Pérdida de visión de movimiento: Se refiere a la dificultad para detectar o seguir objetos en movimiento. 2.7. Pérdida de visión de tamaño: Se refiere a la dificultad para juzgar el tamaño de los objetos. 2.8. Pérdida de visión de forma: Se refiere a la dificultad para reconocer formas o figuras. 2.9. Pérdida de visión de contraste: Se refiere a la dificultad para distinguir entre tonos de gris o colores similares. 2.10. Pérdida de visión de detalle: Se refiere a la dificultad para ver detalles finos de los objetos. |

FRACTURAS

PÉRDIDA DE LA AUDICIÓN

| CONDICIÓN DEL CORAZÓN | OTROS |
|-----------------------|-------|
| 1 | 1 |
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| 99 | 99 |
| 100 | 100 |

MI HIJO/A PUEDE PARTICIPAR EN TODAS LAS ACTIVIDADES FÍSICAS Y CO-CURRICULARES.

MI HIJO/A NO PUEDE PARTICIPAR EN TODAS LAS ACTIVIDADES FÍSICAS Y CO-CURRICULARES
DEBIDO A _____.

ENTIENDO QUE SE REQUIERE UN CERTIFICADO MÉDICO DE MI MÉDICO O CENTRO DE SALUD CON RESPECTO A ESTE PROBLEMA.

FECHA _____ FIRMA DEL PADRE _____



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Port Chester-Rye Union Free School District

113 Bowman Avenue
Port Chester, New York 10573
914.934.7913

Joseph G. Durney
District Director

EMERGENCY HEALTH CARE PLAN

SEVERE ALLERGY TO: _____

Student's Name _____

DOB _____ Grade/Teacher _____

EMERGENCY TREATMENT

If student experiences mild symptoms of:

If an ingestion is suspected:

OR

Several hives
Itchy skin
Swelling

Treatment:

1. Send student to health office ACCOMPANIED.
2. Give _____ or _____ by mouth per MD order.
3. Contact parent or emergency contact person.
4. Stay with student, keep student quiet, and monitor systems, until parent arrives.
5. Watch student for more serious symptoms listed below.

Symptoms that progress can be life-threatening reactions: Severe allergic reaction

Hives spreading over body
Wheezing, difficulty swallowing/breathing, swelling (face, neck), tingling/swelling of tongue
Vomiting
Signs of shock (extreme paleness/gray color, clammy skin), loss of consciousness

Treatment:

1. Give Epi-Pen or Epi-Pen, Jr. immediately, hold against upper outer thigh through clothing if necessary.
2. Call 911 immediately.
3. Contact parents or emergency contact person. If parents are unavailable, school personnel should accompany the child to the hospital.

Directions for use of Epi-Pen

1. Pull off gray cap.
2. Place black tip against upper outer thigh.
3. Press hard into outer thigh, until it clicks.
4. HOLD in place 10 seconds, then remove.
5. Discard Epi-Pen in Sharps Container



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District Director

MEDICATION INCIDENT REPORT FORM

Name of Student: _____ Date of Report: _____

Telephone Number: (____) _____ Grade: _____ Gender: ☐ Male ☐ Female

Home Address _____
Street City State Zip

Date Error Occurred: _____ Time Noted: _____ ☐ AM ☐ PM
Month/ Day/Year

Name of Licensed Prescriber: _____

Medication: _____ Dose: _____ Route: _____ Time: _____

Describe the error and how it occurred. Use reverse side if necessary:

ACTION TAKEN:

| | | | |
|---|--------------------------|-----------|--|
| Licensed Prescriber Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No | Date (month/day/year) | Notified: | Time notified <input type="checkbox"/> AM <input type="checkbox"/> PM |
| Parent/Guardian Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No | Date (month/day/year) | Notified: | Time notified <input type="checkbox"/> AM <input type="checkbox"/> PM |
| Other Persons Notified: | | | |

Describe the outcome:

Name: _____ Title: _____



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Joseph G. Durney
District Director

Date: _____

Dear Parent/Guardian:

New York State Education Law requires all students in grades Kindergarten, 2, 4, 7, and 10 as well as new students to the district, must have a physical examination. As of this date, I have not received this report for your child.

On _____, our school physician, Dr. Henry Stampur, will be conducting physical exams here at school. If you wish your child to be examined by the school doctor, please indicate below. If not, please provide the date your child will be examined by his/her physician.

Sincerely,

School Nurse

I give permission for the school physician to examine my child.

Child's Name _____ Parent/Guardian Signature _____

My child will be examined by our family physician. Date of Exam _____

Child's Name _____ Parent/Guardian Signature _____



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Joseph G. Durney
District Director

Date: _____

Dear Parent/Guardian of _____;

This is to inform you that your child, _____, is scheduled to receive a physical exam from the school physician on _____.

We are conducting these physicals in accordance with New York State Law, which states that your student is required to have a recent physical on file. If your child has recently had a physical done by his/her private physician, please send it to the health office so that their health records can be updated and the above appointment can be cancelled.

Please contact me with any questions.

Thank you for your cooperation.

Sincerely,

School Nurse

Phone # _____



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Joseph G. Durney
District Director

DATE: _____

To the Parents/Guardian of _____:

I was not able to test your child's vision in school today because they did not have their glasses. Please have them bring their glasses to school everyday.

If you have any questions or concerns, please feel free to contact me.

Thank you.

Sincerely,

School Nurse



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Port Chester-Rye Union Free School District

113 Bowman Avenue
Port Chester, New York 10573
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Joseph G. Durney
District Director

Date _____

Dear Parent:

Your child had an accident in school today that caused a bump or hit on the head. Ice was applied and the child was observed by the School Nurse for any complications. No adverse symptoms were observed. Over the next 48 hours, you should continue to observe your child. If you should notice any of the following symptoms, please contact your physician or bring him/her to the emergency room.

- **Complaints of blurred or double vision**
- **Unrelieved headache**
- **Excessive drowsiness or difficulty waking the child**
- **Confusion**
- **Nausea and vomiting**
- **Weakness or numbness in legs or arms**

Thank you,

School Nurse



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Joseph G. Durney
Director del Distrito

Fecha _____

Queridos Padres:

Su hijo/a tuvo un accidente en la escuela hoy que causó un chichón o un golpe en la cabeza. Se le aplicó hielo y fue observado/a por la Enfermera de la Escuela por cualquier complicación. No se observaron síntomas adversos. Durante las próximas 48 horas, debe seguir observando a su hijo/a. Si usted nota alguno de los siguientes síntomas, consulte con su médico o llévelo/la a la sala de emergencias.

- Las quejas de la visión borrosa o doble
- Dolores de cabeza que no se alivian
- La somnolencia excesiva o dificultad para despertar al niño/a
- Confusión
- Náuseas y vómitos
- Debilidad o adormecimiento de las piernas o los brazos

Gracias,

Enfermera de la Escuela



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113 Bowman Avenue
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Joseph G. Durney
District Director

DATE:

Dear Parent / Guardian:

Your child, _____ was seen by the school physician for a physical examination today. He advises you to consult your health care provider regarding your child's weight.

According to the American Academy of Family Physicians and the American Academy of Pediatrics, your child falls into the overweight category.

Thank you,

School Nurse



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Port Chester-Rye Union Free School District

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Port Chester, New York 10573
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Joseph G. Durney
District Director

Date: _____

Dear Parent/Guardian:

Since your child _____ has recently visited a foreign country, he/she **MUST** have an updated Mantoux, PPD Test. This test must be done by _____ with the results given to the nurse as soon as the test is read.

Thank you for your cooperation.

Sincerely,

School Nurse

PLEASE RETURN FORM TO THE SCHOOL NURSE

_____ Was given a Mantoux PPD test on

_____. The test was read on _____

The result was _____.

Physician's Signature

Date



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Joseph G. Durney
District Director

MEMO TO: School Staff

FROM: School Health Office

SUBJECT: Infection Control Measures in the Classroom

It's that time of year again – the beginning of the dreaded **COLD** and **FLU** season. Runny noses, diarrhea, vomiting, etc. A good time to review procedures you follow on a daily basis to minimize the risk of infection for yourself and your students. You are definitely at an increased risk of infection for yourself and your students. You are definitely at a increased risk for Viral Infections due to the special needs of your students.

Do You:

Follow correct hand washing techniques?
Utilize washable toys and educational tools and wash them with soap and water daily?
Call the designated clean-up person (custodian) in the event of a blood/body fluid spill?

Remember:

“Prevention is worth a pound of cure”
“Clean hands are happy hands”
“An apple a day keeps the doctor away”

School Nurse

Date



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Joseph G. Durney
District Director

DETERMINATION OF SELF-DIRECTED STUDENTS (To be completed by Health Professional)

Name of Student: _____ Grade: _____
Classroom Teacher: _____
Medication: _____
Dose: _____
Time: _____
Reason for Medication: _____

THIS STUDENT:

| | | |
|--|------------|-----------|
| Recognizes his/her medication Comments: | YES | NO |
| Knows how much medication he/she takes Comments: | YES | NO |
| Knows what time his/her medication is needed during the school day Comments: | YES | NO |
| Knows why he/she takes this medication Comments: | YES | NO |
| Knows what happens when he/she doesn't take their medication Comments: | YES | NO |
| Knows when to refuse to take his/her medicine when appropriate Comments: | YES | NO |

I feel the above student is Self-Directed

Signature: _____

Date: _____

TUBERCULOSIS RISK ASSESSMENT QUESTIONNAIRE
(TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY)

| | | |
|-------------------------------|--------------------|---------------------|
| <u>PATIENT'S NAME:</u> | <u>DOB:</u> | <u>DATE:</u> |
|-------------------------------|--------------------|---------------------|

| | | |
|--|-----|----|
| 1. Has the student recently immigrated from a country with a high incidence of tuberculosis? <i>(Includes most countries of Asia, Africa, Eastern Europe, Central and South America)</i> | YES | NO |
| 2. Did the student travel to a high-incidence country for more than one month? <i>(e.g., where housing was with family members or local residents; not hotels, resorts, etc.)</i> | YES | NO |
| 3. Did the student have household contact with parents or others who immigrated or visited from a country with a high incidence of tuberculosis and tuberculin status unknown? <i>(Includes immediate and extended family, overnight guests, frequent visitors, and babysitters.)</i> | YES | NO |
| 4. Did the student have exposure to individuals in the past 5 years who are HIV infected, homeless, institutionalized, users of illicit drugs, incarcerated, or have known tuberculosis disease? <i>(Test all groups every 2-3 years)</i> | YES | NO |
| 5. Does the student have HIV infection (test yearly), diabetes, mellitus, chronic renal failure, malnutrition, reticuloendothelial disease, other immunodeficiencies or receiving immunosuppressive therapy? | YES | NO |
| 6. Has someone from a high risk country spent more than one month in the home of a student? | YES | NO |

***** If YES has been answered to any of the above questions, a tuberculosis skin test is indicated. *****

| | |
|----|--|
| NO | Patient has no risk factors and active tuberculosis is NOT suspected |
|----|--|

| | | | |
|-----|--|--------------------------------------|---|
| YES | <u>DATE PPD ADMINISTERED</u> _____ | <u>DATE PPD READ</u> _____ | <u>RESULTS (in mm)</u> _____ mm |
|-----|--|--------------------------------------|---|

TB TESTING RECOMMENDED?

IF THE TST IS POSITIVE, NOW OR PREVIOUSLY, THE FOLLOWING ARE REQUIRED

| | |
|--|-----------------------|
| <u>DATE OF POSITIVE PPD</u> | <u>DETAILS</u> |
| <u>CHEST X-RAY</u> <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <i>(describe)</i> | <u>DETAILS</u> |
| <u>CLINICAL EVALUATION</u> <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL <i>(describe)</i> | <u>DETAILS</u> |
| <u>TREATMENT</u> <input type="checkbox"/> DEFERRED <i>(describe)</i> <input type="checkbox"/> INITIATED <i>(describe)</i> | <u>DETAILS</u> |



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Joseph G. Durney
District Director

Date: _____

Dear Parent:

School will be ending soon which means your child's medication should be picked up by you from the health office. Medication cannot remain at school over the summer and must be returned to the parent. If this is not possible, the medication will be destroyed in a non-recoverable manner.

The Health Office will be open until June _____ from _____ for medication pick-ups. Please stop in at your convenience or call me at _____.

If your child requires the use of medication during school hours for the upcoming school year, you may pick up and complete the necessary forms from my office. The form(s) will need to be completed by a parent/guardian and the student's physician.

All completed forms and medications (medicine must be in original containers and labeled correctly) are to be brought to the Health Office at the beginning of the school year in September by the parent or guardian.

Please feel free to contact me with any questions or concerns.

Thank you for your cooperation.

Sincerely,

School Nurse



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Joseph G. Durney
District Director

Dear Parent or Guardian:

A recent hearing acuity test indicates that your child shows signs of hearing difficulty. To assist school personnel in making any necessary adjustment of the educational program, the following is recommended:

- _____ An exam by your child's physician.
- _____ A complete otological exam by a Otolaryngologist
(Ear, Nose, and Throat Doctor).
- _____ A Tympanogram (Impedence Meter).
- _____ A Pure Tone Audiogram.
- _____ A Middle Ear Functioning

.....
To Physician:

This pupil shows evidence of a hearing difficulty as a result of a threshold acuity screening test. Your medical and audiometric findings will be helpful in planning special educational services.
The following signs have been observed by school personnel:

Report of school's threshold acuity test:

| RIGHT | | | | | | | LEFT | | | | | | |
|-------|-----|------|------|------|------|------|------|-----|------|------|------|------|------|
| 250 | 500 | 1000 | 2000 | 3000 | 4000 | 6000 | 250 | 500 | 1000 | 2000 | 3000 | 4000 | 6000 |
| | | | | | | | | | | | | | |

Please send your audiometric and/or medical evaluations, including your recommendations to:

_____ SCHOOL NURSE

_____ SCHOOL



Joseph G. Durney
District Director

We (I), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the following specialized physical health care service for Management of Diabetes in school be administered to our (my) child. I will provide:

1. Provide the necessary supplies and equipment
2. Notify the school nurse if there is a change in pupil health status or attending physician
3. Notify the school nurse immediately and provide new consent for any changes in doctor's orders,

I authorize the school nurse to communicate with the physician when necessary.

I understand that I will be provided a copy of my child's completed Individual School Health care Plan.

Parent/Guardian Signature _____

Physician Authorization for Diabetes Management in School

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented. I understand that unlicensed designated school personnel under the training and supervision provided by the school nurse may perform specialized physical health care services. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed)

☐ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself. _____ Physician Initial

Physician Name _____

Physician Signature _____ **Date** _____ **Phone** _____

Reviewed by School Nurse (Signature) _____

Reviewed by Principal (Signature) _____ Date: _____





Joseph G.Durney
District Director

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PHYSICAL EDUCATION MEDICAL RECOMMENDATION FORM

TO DR: _____ DATE: _____

All students registered in the schools of New York State are required by New York State Education Law and Commissioner's Regulations to attend courses of instruction in physical education. These courses must be adapted to meet individual student needs if the student has medical limitations. This means that a student who is unable to participate fully in their physical education program must have activities modified to meet his/her individual needs.

Your patient, _____, is registered in this school district and has indicated an inability to participate fully in the physical education program. To assist us in designing a program adapted to meet his/her individual needs, would you kindly complete this form and return it to his/her school. Thank you for your cooperation!

Indicate with an **M** where a modification is recommended. Indicate with an **N** where no participation is recommended.

| | | |
|----------------|------------------|---------------------------|
| _____ Throwing | _____ Bending | _____ Pushing |
| _____ Catching | _____ Twisting | _____ Pulling |
| _____ Kicking | _____ Hitting | _____ Body contact |
| _____ Running | _____ Walking | _____ Water activities |
| _____ Lifting | _____ Jumping | _____ Out door activities |
| _____ Tumbling | _____ Stretching | _____ Other (specify) |

Modifications recommended: _____

This is to certify that I have examined the above patient and recommend that his/her physical education program be modified according to the above until
_____(Date)

Are there any exercises or activities you feel would be beneficial to the student in the recovery process?

Yes _____ No _____ If so, what? _____

Additional Physician's Remarks (on back)

(Physician's Signature)

(Date)

NOTE: This report will be attached to the student's health record with duplicates sent to the parent / guardian, physician education teachers, and director of physical education and Committee on Special Education when appropriate.

STUDENT INCIDENT REPORT

Please fully complete the form including codes Refer to reverse side of form for appropriate codes.

| | | | | | |
|---------------------------------------|--|------------------|--|----------------------------------|--|
| CODE | | | | | |
| School District/BOCES | | | | Name _____ | |
| | | | | | |
| Student | | Last Name | | First Name | |
| Name | | | | Alleged Incident Date | |
| | | | | Time | |
| | | | | | |
| Home Address / Telephone _____ | | | | D.O.B. ____ / ____ / ____ | |
| Building/ | | CODE | | Description | |
| Location | | | | of Location | |
| | | | | Grade | |
| | | | | | |

ALLEGED INCIDENT INFORMATION

Reported by _____ Date _____ Time _____

Describe Where Within Building/Location Alleged Incident Occurred and How:

BOCES Activities/Class: ☐ Yes or ☐ No
Person Supervising Student _____

Please Describe Alleged Injury (*Include part of body*):

Name/Address/Telephone of any Witnesses: (*Please indicate if none*)

Was first aid rendered? ☐ Yes or ☐ No

If yes, by whom/date/time

Did student remain in school
remainder of day/activity?

☐ Yes or ☐ No

Describe first aid _____

Did student receive medical
attention by a physician
or hospital?

☐ Yes or ☐ No

If Yes, describe medical attention. If unknown
please state.

Name/Address/Telephone # or physician or hospital _____

EMERGENCY CONTACT INFORMATION

Person Contacted / Relationship _____

Address _____ Telephone _____

Contacted by _____ Date _____ Time _____

If Emergency Contact Was Not Contacted, Please State Reason _____

Completed by Name: _____ Date _____ Time _____

Reviewed by Name: _____ Date: _____ Time _____



Port Chester-Rye Union Free School District

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Joseph G. Durney
District Director

Parent Notification Regarding Vision

PUPIL'S NAME _____ DATE OF EXAM _____
PARENT'S NAME _____ DATE OF BIRTH _____
ADDRESS _____ GRADE _____

Dear Parent or Guardian:

A recent evaluation indicates your child may have some eye difficulty. A complete eye examination is recommended to determine the need for professional care. Upon completion of exam, please return this form to the school nurse.

Thank you,

School Nurse

School

Date

Dear Examiner:

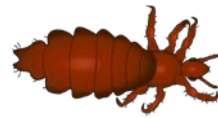
The following signs of eye difficulty have been noted by school personnel: _____

Report of Exam:

- (1) Diagnosis: (R) _____ (L) _____
- (2) Visual Activity (a) without (R) _____ (B) with (R) _____
correction (L) _____ correction (L) _____
- (3) Under what conditions should glasses be worn? _____
- (4) Have impact resistant lenses been recommended? Yes _____ No _____
- (5) Re-exam Date _____
- (6) For child with visual handicap: (a) Corrected near visual activity (R) _____ (L) _____
- (7) Peripheral vision with degree and location (R) _____ (L) _____
- (8) Should physical activities be limited? Yes _____ No _____

If yes, please specify _____

Date: _____ Examiner's Title and Signature



Dear Parents,

As many of you are aware, cases of head lice in our community are not unusual, and we continue to identify and monitor cases that are brought to our attention in the school community. Our goal is to raise awareness among parents about the issue, and to discuss strategies to avoid the spread of this health concern. Head lice are not a sign of poor hygiene and they do not transmit disease. Although they are an annoying problem, they do not cause harm. Family education continues to be the most successful method of controlling spread.

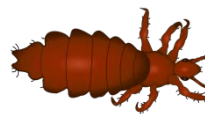
- Pediculosis, or head lice, is a condition that each year affects approximately six to 12 million children between the ages of three and 12 years of age, and about one in every 100 elementary school children. Head lice are parasites that are generally found on the scalp, around the ears, and at the back of the neck. The adult louse is about the size of a sesame seed, and can be a reddish brown color. Eggs, or nits, are smaller and silver in color.
- One of the most effective ways to address this situation is to disclose the presence of lice or nits on your child's head to the school nurse(s), because they are experienced in identification and monitoring for re-infestation. Even with proper treatment, re-infestation can occur. The louse has an average life cycle of 10 days, so monitoring for new nits needs to be done over that period of time.
- Additionally, lice do not "jump" head-to-head. Close head to head contact is required for them to travel. This usually occurs by sharing items that touch the head (hats, helmets, pillows, brushes, combs, *hair* accessories, mats, or stuffed animals). Frequently, children are exposed at sleepover parties, on vacation or at camp. One of the most common symptoms is head scratching. **If your children are scratching their heads, please check them. Even if they are not itching, we recommend checking your child weekly at home because lice can be present and the child may feel nothing.**
- When a case is identified, the school nurse will assess the circumstance. The nurse will check or have other building nurses check siblings who attend our schools. **The student' confidentiality is always maintained.**
- On the elementary level, the nurse may proceed to check the identified child's class if **deemed necessary**. **Mass surveillance of entire grades or schools is not a good use of the health office, results in students missing instructional time, and has not shown efficacy in identification of new cases.**
- The School District does not endorse any particular treatment or company, although many have been shown to work. We do recommend that you consult your health care provider about the best treatment for your family.

We encourage your questions and comments. Please feel free to contact your school nurse for further information.



Sincerely,

Jeanette Spinelli RN
Joe Durney



Queridos Padres,

Como muchos de ustedes saben, los casos de piojos en nuestra comunidad son bastante normales, y seguimos identificando y supervisando los casos que son traídos a nuestra atención en la comunidad escolar. Nuestro objetivo es concientizar a los padres sobre el tema, y discutir las estrategias para evitar la propagación de este problema de salud. Los piojos no son un signo de falta de higiene y ellos no transmiten la enfermedad. Aunque es un problema molesto, ellos no causan daño. La educación familiar sigue siendo el método más aceptado de controlar la propagación.

- Pediculosis, o piojos, es una condición que afecta cada año aproximadamente de seis a 12 millones de niños entre los años de tres y 12 años de edad, y aproximadamente uno en cada 100 niños de la escuela primaria. Los piojos son parásitos que generalmente se encuentran en el cuero cabelludo, alrededor de los oídos, y detrás del cuello. El piojo adulto es del tamaño de una semilla de sésamo, y puede ser de un color marrón rojizo. Los huevos, o liendres, son más pequeños y de color plateado.

Uno de los modos más eficaces para afrontar esta situación es dar a conocer la presencia de piojos o liendres en la cabeza de su hijo/a a la enfermera(s) escolar, porque ellos tienen la experiencia en la identificación y el seguimiento para la re-infestación. Incluso con el tratamiento apropiado, la re-infestación puede ocurrir. El piojo tiene un ciclo de vida medio de 10 días, por lo que el seguimiento de las nuevas liendres se necesita realizar durante ese período del tiempo.

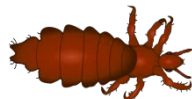
- Además, los piojos “no saltan” de cabeza a cabeza. Se necesita una cabeza estrecha de contacto para que ellos se movilen. Este generalmente ocurre al compartir los artículos que tocan la cabeza (sombreros, cascos, almohadas, cepillos, peines, accesorios de pelo, alfombras, o peluches). Con frecuencia, los niños están expuestos a fiestas de pijamas, vacaciones o campamento. Uno de los síntomas más comunes es rascarse la cabeza. **Si sus niños se rascan sus cabezas, por favor revíselos. Incluso si no les pica, recomendamos que revisen semanalmente a su hijo/a en casa porque los piojos pueden estar presentes y puede ser que el niño no sienta nada.**

Cuando un caso es identificado, la enfermera escolar evaluará la circunstancia. La enfermera comprobará o hará que otras enfermeras de la escuela verifiquen a los hermanos que asisten a nuestras escuelas. **La confidencialidad del estudiante siempre se mantiene.**

- En la escuela primaria, la enfermera puede proceder a verificar la clase del niño/a si se **considera necesario**. **La vigilancia masiva de todos los grados o las escuelas no es un buen uso de la oficina de salud, causa que los estudiantes pierdan tiempo educacional, y no ha demostrado eficacia en la identificación de nuevos casos.**

- El Distrito Escolar no respalda ningún tratamiento o empresa particular, aunque muchos han sido demostrados que funcionan. Recomendamos que consulte con su proveedor de asistencia médica sobre el mejor tratamiento para su familia.

Animamos sus preguntas y comentarios. Por favor no dude en ponerse en contacto con la enfermera escolar para más información.



**Atentamente,
Jeanette Spinelli RN
Joe Durney**



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Port Chester-Rye Union Free School District

113 Bowman Avenue
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Joseph G.
Durney
District Director
Curriculum Office

Bed Bug Protocol

If there is a suspicion based on evidence of bed bugs in schools, the school nurse should be contacted to investigate. If upon investigation, the school nurse finds evidence of bed bugs on a student, the evidence will be turned over to custodial staff for examination. It is critically important to maintain this evidence. Nurses have been provided information and direction on what warrants appropriate evidence. Nurses have also been advised to send students home where evidence of live or larvae bed bugs are present and to notify parents. Nurses will also tend to any health care needs of the student when warranted (bites, etc), and notify building and district health services administration. Teachers should be advised to refer suspicions to the school nurses.

Informational documentation should be provided to parents of students who are sent home after positive identification (see attached). It is reasonable to check siblings. At the discretion of the building administrator, an informational letter can be sent to parents in a class or on a grade level (see attached). Classroom checks of students are not recommended, and no student should be prevented from attending school unless live bedbugs are evidenced on their person.

Upon obtaining any suspected specimen, the buildings and grounds will contact a certified pest specialist and the following protocol is initiated:

- Specialized inspection to determine precise location of bed bug activity
- Chemically treat area (within legal limits) if necessary based on the recommendation of the certified pest consultant
- Preventive cleaning of all hard surfaces by wiping down, vacuuming all carpets, vacuuming corners of each room and all closets
- Use of portable steam machine on all hard surfaces, cubbies ,closets and rugs etc.
- Reinspection after two to three week period and if activity is identified we will repeat all the following steps



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Joseph G. Durney
District Director
Curriculum Office

Dear Parents/Guardians:

In keeping with our goal to raise awareness about certain environmental concerns and to discuss strategies to avoid any misinformation, this letter is for informational purposes and to help with any questions you may have on the subject of bedbugs and fleas. As always, feel free to call your school nurse with questions/concerns you may have. Family education continues to be the most successful method of controlling spread.

BED BUGS:

Bed bugs have spread far and wide throughout the country and affect every community regardless of population, income, ethnic/racial makeup. Anyone can bring bedbugs into the school environment. Children are not excluded if it is suspected they have bedbugs or bedbug bites. If bed bugs are suspected in school, classrooms will be inspected by a specialist. Many times what is presumed to be bed bugs are not. In general, insecticide treatments within the school will be avoided unless absolutely necessary. Bed bugs do not remain on a person. They can hide in cracks, crevices and may wander into clothing, pockets, cuffs, brief cases, book bags and anywhere else they find shelter. Education is essential in combating these pests.

FLEAS:

Fleas, either cat or dog, need a host to survive. Either type may feed upon a person. Only adult fleas blood feed. Generally flea bites are noticed around ankles. Simply laundering or changing clothes will be sufficient to eliminate fleas from a person. Because a child is not likely to infest others or the classroom environment, exclusion is not typically required. Again, education is essential.

For more information on bedbugs or fleas, please check the following websites National Association of School Nurses(www.nasn.org), New York State Department of Health(www.health.state.ny.us), Harvard School of Public Health(www.hsph.harvard.edu) or Westchester Government websites (www.westchestergov.org).

Sincerely,
Joe Durney
Jeanette Spinelli, RN



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Joseph G.
Durney
Director del Distrito
Curriculum Office

Queridos Padres / Tutores:

De acuerdo con nuestro objetivo de crear conciencia sobre determinados problemas ambientales y para discutir las estrategias para evitar la falta de información, esta carta es para fines informativos y para ayudar con cualquier pregunta que tenga sobre el tema de los chinches y pulgas. Como siempre, no dude en llamar a la enfermera de la escuela con preguntas o preocupaciones que pueda tener. La educación familiar sigue siendo el método más exitoso de controlar la propagación.

CHINCHES:

Los chinches se han extendido a lo largo y ancho de todo el país y afectan a todas las comunidades independientemente de la población, ingresos, étnicas o distribución por razas. Cualquier persona puede traer chinches en el entorno escolar. Los niños no están excluidos si se sospecha que tienen chinches o picaduras de chinches. Si se sospecha la existencia de chinches en la escuela, las aulas serán inspeccionadas por un especialista. Muchas veces lo que se supone que son chinches no lo son. En general, los tratamientos con insecticida dentro de la escuela se evitarán, a menos que sea absolutamente necesario. Los chinches no se quedan en la persona. Pueden esconderse en las grietas, hendiduras y puede caminar en la ropa, bolsillos, puños, maletines, mochilas y en cualquier otro lugar donde encuentran refugio. La educación es esencial en la lucha contra estas plagas.

PULGAS:

Las pulgas, ya sea de gato o perro, necesitan un huésped para sobrevivir. Cualquier tipo se puede alimentar de una persona. Sólo las pulgas adultas se alimentan de sangre. En general, las picaduras de pulgas se notan alrededor de los tobillos. Simplemente lavando o cambiándose de ropa será suficiente para eliminar las pulgas de una persona. Debido a que un niño no es probable que contamine a los demás o el ambiente del aula, la exclusión no es normalmente necesaria. Una vez más, la educación es esencial.

Para obtener más información sobre las chinches o pulgas, por favor, visita los siguientes sitios web de la Asociación Nacional de Enfermeras Escolares (www.nasn.org), Departamento de Salud del Estado de Nueva York (www.health.state.ny.us), la Escuela de Salud Pública de la Universidad de Harvard (www.hsph.harvard.edu) o sitios web del Gobierno de Westchester (www.westchestergov.org)

Atentamente,

Joe Durney
Jeanette Spinelli, RN

Port Chester – Rye Union Free School District
Automatic External Defibrillator (AED)
Implementation Protocol

The AED shall be applied to individuals who are determined by responding AED providers to have stopped breathing and are without a pulse. Teams of professional staff including teachers, administrators, nurses and coaching staff will receive training in the use of the AED in accordance with the American Red Cross (ARC) 'AED Essentials' curriculum. Upon application, the AED shall be powered up and the responding team member shall operate the AED in accordance with the ARC training.

Each AED trained team member shall receive annual update training. Further, quality assurance/quality improvement reviews will be conducted with team members involved whenever the AED is applied or used in the field.

Citizen access to the EMS is provided through the existing area 911-phone system. All professional staff have access to telephone service in all school facilities to access 911.

The school district will have one AED unit available for response in each school building. At the elementary schools this device will be maintained in the school in an alarmed cabinet. At the secondary schools a minimum of two AED units will be maintained in each building, one near the school nurses office and one near the Gymnasium/Athletics area. Team members will be trained in the location of the portable AED units to ensure rapid access whenever it is needed.

School nurses will be directed to complete a weekly inspection of the AED and necessary equipment. This inspection will include a check that the AED is operational, that appropriate pads are present and the package is sealed and not expired. Included with the AED unit will be a razor, towel, 4x4 bandage and latex gloves. The school nurse shall ensure all necessary items are present and accounted for.

All AED's will be maintained in accordance with manufacturers recommendations.

The school district currently requires school nurses to submit an incident report for injury aided case responses. This report includes:

- Name of responder, date and time of incident
- Name of patient, DOB, address, phone number and gender
- Nature of incident
- Hospital contacted
- First aid action taken

Port Chester – Rye Union Free School District
Automatic External Defibrillator (AED)
Implementation Protocol

Upon the use of an AED by a trained responding team member, the school district's written documentation shall also include:

- The estimated time from arrest to first AED shock
- The estimated time from arrest until the beginning of CPR
- Name of CPR initiator
- Number of shocks administered to the patient
- Patient outcome at the site

Each time the AED is applied an internal process of evaluation shall commence. This evaluation shall examine whether or not the AED was used in accordance to protocols and that the responding team members acted within the scope of their training. All responses where the AED was used shall be reported to a district administrator. The district has scheduled meetings to facilitate this process.

A district designated administrator shall review all medical aided AED cases in conjunction with Scott Moore, EMS administrator for the PC-Rye-Rye Brook EMS to ensure the AED is being applied where indicated. The designated administrator will provide Dr. Henry Stampur a report on the use of AED every six months. At that time, Dr. Henry Stampur will be invited to meet with all members of the responding teams to hold audits of the cases that are submitted to him. All unusual occurrences shall be immediately reported to Dr. Henry Stampur for review.

School Health Services

Date:

Dear Parent/Guardian:

The district's School Health Services program supports your student's academic success by promoting health in the school setting. One way that we provide care for your student is by performing the health screenings as mandated by the State of New York.

During this school year, the following screenings will be required or completed at school:

Vision

Distance acuity for all newly entering students and students in Kindergarten, Grades 1, 2, 3, 5, 7 and 10.

Near vision acuity, hyperopia and color perception screening for all newly entering students.

Hearing

Hearing screening for all newly entering students and students in Kindergarten, Grades 1, 3, 5, 7 and 10.

Scoliosis

Scoliosis (spinal curvature) screening for all students in Grades 5 -- 9.

Health Appraisals

A physical examination including Body Mass Index and Weight Status

Category Information is required for all newly entering students and students in Kindergarten, Grades 2, 4, 7 and 10.

Dental Certificates

A dental certificate is requested for all newly entering students and students in Kindergarten, Grades 2, 4, 7 and 10.

A letter will be sent home if there are any findings on the screening done at school that would cause concern or need medical follow-up. Please call the school's Health Office if you have any questions or concerns.

_____ School Nurse

_____ School Name

Health Office Phone Number _____



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Joseph G. Durney
District Director
Curriculum Office

Record Keeping

SED Recommendations for Recordkeeping:

- A paper copy of immunization records should be kept.
- A paper copy of the last physical until the next physical is received should be kept. School screenings if documented in the Electronic SIS do not need to be re-documented on the paper MR.

District Guidelines for Paper Recordkeeping

- Master Medication List
- Student Self Administration Form
- Student Self Directed Form
- Medication Delivery Form – to document administration of medication if electronic record is not used/accessible
- Original Medication and treatment orders
- Physical Education excused list
- Copies of the IHP
- Emergency Care Plan
- Evacuation plan for student with disabilities

Retention

- All “rules” related to paper records apply to electronic records
- Records retention information can be found @ following website:
<http://www.schoolhealthservicesny.com/uploads/records%20Retention%202004.doc>

RECORDS RETENTION AND DISPOSITION
SCHEDULE ED-1

Section 185.12, 8NYCRR (Appendix I)

FOR USE BY
SCHOOL DISTRICTS
BOCES
COUNTY VOCATIONAL EDUCATION AND EXTENSION BOARDS
TEACHER RESOURCE AND COMPUTER TRAINING CENTERS

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
New York State Archives
1988, revised 2004

HEALTH

- ♦ 1.[137] Student's cumulative health record, including but not limited to health history; individualized health care plan; immunization record; results and recommendations from examination, screening, or treatment; parent or guardian referral and permission record; and teacher's comments

- a. Summary record or individual records when **not posted to summary record:**

RETENTION: 0 after individual attains age 27

- b. Individual records when posted to summary record, except blood and body fluids incident report:

RETENTION: 1 year after end of school year

- c. Individual immunization record, including authorization and/or parental consent:

RETENTION: 6 years, or 3 years after individual attains age 18, whichever is longer

NOTE: These records may be requested beyond their minimum legal retention period by persons needing proof of certain immunizations for college admission or other purposes. The State Archives recommends that school districts and BOCES evaluate the need to retain immunization records longer than the stated minimum retention period for these purposes.

- d. Blood and body fluids incident report, even when posted to summary record:

RETENTION: 0 after individual attains age 27

- 2.[138] Log of students' accidents and illnesses during school day:
RETENTION: 1 year after end of school year

NOTE: This retention period presumes that information contained in the log is also contained in the individual and/or summary health records covered by parts a. and/or b. of item no. 137, above. If this information is not posted to the student's individual and/or summary health records, then the log must be retained until the youngest student listed in it attains age 27.

- 3.[139] Student's psychological or social assessment record file

NOTE: Institutional school districts should retain all these records until the student attains age 27.

- a. Report regarding student's ability, personality, family, and environmental influences:
RETENTION: 6 years after report written
 - b. Source materials used in preparing report, including "protocols," tests and notes, for students **not** classified as special education:
RETENTION: 1 year after report written
 - c. Source materials used in preparing report, including "protocols," tests and notes, for students classified as special education:
RETENTION: 6 years
- ♦4.[329] Inventory, storage, receipt and distribution records for vaccines and controlled substances (or other drugs or medication) administered to students and/or employees:
RETENTION: 5 years
- ♦5.[330] Student health summary reports, covering all or groups of students, including school immunization survey summary and communicable disease summary report:
RETENTION: 3 years
- ♦6.[457] Early intervention program records, including but not limited to case record and screening, assessment and referral records
- a. Individual case record:
RETENTION: 7 years after discharge or last contact, but no less than 3 years after person attains age 18
 - b. Screening, assessment and referral records, not found in individual case record:
RETENTION: 7 years



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Joseph G.
Durney
District Director
Curriculum Office

Date: September, 2010
To: School Nurses
From: Joe Durney
Subject: (New Format) On Call Nurse Schedule for 2010-2011
Contact: Marcie DeCarlo

The following is the "on call" nurse schedule for the 2010-2011 school year:

The following schools will cover each other for the full year.

| | |
|------------------|--------------------------------|
| Park/High School | Cindy Poletsky/Geri Cusamano |
| MS/Edison | Sue DePan/Regina Peniowich |
| JFK/ELC | Ava Konwiser/Jeanette Spinelli |

King Nurse must remain on site @ King St. for Special Nursing Service Coverage.

Please note that the on call nurse should coordinate their lunch with their assigned partner. On all nurses should take early lunch the week(s) that they are on call to ensure that they are available to cover for other district nurses who will take their lunch during the later time slot. Nurses are to be called for emergencies only. Jeanette Spinelli is the on-call nurse district wide and Corpus Christi. If on call nurse and district wide nurse are not available next closest school nurse should be called.

Thank you for your cooperation.

JD/mdc:
Donald K. Carlisle, Ed.D.
School Principals



www.portchesterschools.org

Port Chester-Rye Union Free School District

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Joseph G. Durney
District Director
Curriculum Office

Statement of Purpose:

In an effort to ensure the safety and well being of students, we present a structured program and protocol for the management of traumatic head injuries in the sports program consistent with contemporary standards in the field of educational interscholastic athletics.

Background Information

In the United States, the annual incidence of sports related concussion is estimated at 300,000. Estimates regarding the likelihood of an athlete in a contact sport experiencing a concussion may be as high as 19% per season. Although the majority of athletes who experience a concussion are likely to recover, an unknown number of individuals may experience chronic cognitive and neurobehavioral difficulties related to recurrent injury. Such symptoms may include chronic headaches, fatigue, sleep difficulties, personality change, sensitivity to light/noise, dizziness when standing too quickly and deficits in short term memory, problem solving and general academic functioning. This constellation of symptoms is referred to as "post concussion syndrome" and can be quite disabling for an athlete. In some cases, such difficulties can be permanent. In addition to post concussion syndrome, suffering a second blow to the head while recovering from an initial concussion can have catastrophic consequences as in the case of "second impact syndrome", which has lead to approximately 30-40 deaths over the past decade.

Athletes that are not fully recovered from an initial concussion are significantly vulnerable for recurrent, cumulative, and even catastrophic consequences of a second concussive injury. Such difficulties are prevented if the athlete is allowed time to recover from the concussion and return to play decisions are carefully made. No athlete should return to sport or other at risk participation when symptoms of concussion are present and recovery is ongoing. The best way to prevent difficulties with concussions is to manage the injury properly when it does occur.

The district procedure pertaining to suspected and/or diagnosed concussions for student-athletes participating in interscholastic athletics is as follows:

- With any positive sign/symptom, the student-athlete is held out of competition and practice.
- No student-athlete will be allowed to return-to-play (RTP) on the same day they show signs or symptoms of a concussion regardless if signs and symptoms return to normal.
- A student-athlete who is suspected of a concussion must be evaluated by a health care professional and must show written documentation of the evaluation before starting the district's RTP protocol.
- A student-athlete will only be allowed to fully participate in their sport after they have completed all stages of the district's RTP protocol (see attached) supervised by the athletic trainer.
- The Port Chester Union-Free School District physician will have the right to make final determination of all student-athletes RTP status.

Concussion Management Procedure

On-Field Evaluation

- Signs and Symptoms(S/S) Assessment (Noticed and recorded by coach) (See appendix A)
- Neurologic Exam (Performed by Certified Athletic Trainer (ATC)) – See Appendix D
- Mental Status Testing (Performed by ATC)
- Note any S/S requiring 'day of' referral to doctor (See appendix B)
- Note any S/S requiring immediate medical care (See appendix B)

Action:

With any positive sign/symptom, the athlete is held out of competition and practice.

Contact parents about child's condition. (Performed by coach or ATC)

No student-athlete will be allowed to RTP on the same day they show signs or symptoms of a concussion regardless if signs and symptoms return to normal.

The athlete should not be left alone, and regular monitoring for deterioration is essential over the initial few hours following injury.

Monitor athlete's vital sign and neurological status every five (5) minutes, until athlete's condition stabilizes and improves.

Return to play must follow a medically supervised process.

The cornerstone of proper concussion management is rest until all symptoms resolve and then a graded program of exertion before return to sport.

Follow-up Evaluation

- Within 24-72 hours of injury
 - Re-eval of S/S by health care professional using neurological exam (appendix D)
- Action: Rest until asymptomatic
- Once symptom free for at least 24 hours, student-athlete can begin the return to play protocol

If any concussion symptoms recur, the athlete must drop back to the previous level and try to progress after 24 hours of rest.

The student athlete should also be monitored for recurrence of symptoms due to mental exertion, such as reading, working on a computer, or taking a test.

Return to Play Protocol

The progression should be followed by all; coaches, healthcare providers, and parents, by using the basic steps below. To progress to the next step the student-athlete must be symptom-free. If the athlete has S/S, the progression must be stopped and the student's healthcare providers, coach, parent, and school health office notified. The number of days on each step may vary and duration questions referred to the health care providers. Typically, it is a seven day progression to full game play.

The athletic trainer or school nurse may refer the student-athlete back to the physician at any time for further evaluation.

Symptom Free Return to Play Progression

- 1. Aerobic Activity – No Contact**
- 2. Drills – No Contact**
- 3. Contact allowed**
- 4. Scrimmage/Game approval**

Stage 1 – rest until symptom-free (asymptomatic)

- Once the student-athlete is symptom-free for a full 24 hour period they may move on to stage 2

Stage 2 – fast walking/stationary bike 15-20 minutes under supervision of staff

- Any S/S's warrants stopping for the day and start Stage 2 over again after symptoms are gone for 24 hours
- If symptomatic post-exertion within 24 hours, rest until asymptomatic and start Stage 2 over again
- When asymptomatic for 24 hours after completion of Stage 2, proceed to Stage 3

Stage 3 – jogging/ running 20 minutes

- Any return in S/S's warrants stopping for the day and start Stage 3 again after the student-athlete is asymptomatic for 24 hours
- If symptomatic post-exertion with in 24 hours, rest until asymptomatic and start Stage 3 over again
- If athlete is asymptomatic for 24 hours proceed to Stage 4
- Consult with primary care physician if warranted

Stage 4 – Non-Contact Sports Drills for 30-45 minutes

- Any return in S/S's warrants stopping for the day and start Stage 4 again after the student-athlete is asymptomatic for 24 hours.
- If asymptomatic for 24 hours proceed to Stage 5

Stage 5 - Full Participation in practice without contact

- Any return in S/S's warrants stopping for the day and start Stage 5 again after the student-athlete is asymptomatic for 24 hours
- If symptomatic post-exertion with in 24 hours, rest until asymptomatic start again with Stage 5
- When asymptomatic for 24 hours proceed to Stage 6

Stage 6 - Full Practice No Restrictions

- Any return in S/S's warrants stopping for the day and start Stage 6 again after the student-athlete is asymptomatic for 24 hours
- When asymptomatic for 24 hours proceed to Stage 7
- Consult primary care physician if warranted
- If symptomatic post-exertion with in 24 hours, rest until asymptomatic start again with Stage 6

Stage 7 - Cleared for RTP No Restrictions for Competition by neuropsychologist and/or primary care physician and ATC

- If re-injured refer to primary care physician

Sample Concussion Procedure

The following is a sample of what could happen if and when a concussion occurs. Please note that there are a number of variables involved and every concussion is different.

Over Summer Vacation:

- Medical forms handed in to school nurse

Day 0 – Saturday

- Injury occurs involving the head
- Evaluated by coach (basic history of what happened, concussion checklist)
 - Student-athlete shows signs and symptoms of a concussion
 - Removed from activity
 - Referred to the ATC or EMS for evaluation
 - In absence of an ATC, parents are contacted and student-athlete is referred to a physician or EMS
- Evaluated by the ATC (detailed history, concussion checklist, neurological exam)
 - Student-athlete shows S/S of a concussion
 - Parents are contacted and updated
 - Referred to physician for evaluation and diagnoses
- Evaluated by physician
 - Diagnosed concussion

Day 1 – Sunday

- Rest
- Student-athlete shows S/S of a concussion

Day 2 – Monday

- Student-athlete returns to school with doctor's note restricting participation
 - Returns to doctor for clearance at appropriate date
- Student-athlete returns to school with doctor's note permitting participation
 - Evaluated by ATC
 - Still showing S/S of a concussion
 - Must be S/S free for full 24 hours before starting Return-to-Play (RTP) protocol

Day 3 – Tuesday

- Student-athlete sign and symptom free for 24 hours
 - Start stage one of RTP protocol
 - Student-athlete shows S/S of concussion
 - Student-athlete must be S/S free for 24 hours before starting stage one over again

Day 4 – Wednesday

- Rest

Day 5 – Thursday

- Student-athlete is S/S free for 24 hours
 - Start stage one of RTP protocol
 - No S/S

Day 6 – Friday

- Student-athlete starts stage two of RTP protocol

Day 7 – Saturday

- Student-athlete starts stage three of RTP protocol

Day 8 – Sunday

- Rest

Day 9 – Monday

- Student-athlete starts stage four of RTP protocol

Day 10 - Tuesday

- Student-athlete starts stage five of RTP protocol

Day 11 - Wednesday

- Student-athlete starts stage six of RTP protocol

Day 12 – Thursday

- Student-athlete starts stage seven of RTP protocol

Port Chester Protocol

The district procedure is to hold a student-athlete out of competition a minimum of seven (7) days starting the first day the student is symptom-free. Concurrent with a clearance from a physician, the student-athlete must also complete and pass the seven (7) stages of the Return to Play (RTP) Protocol. This procedure was developed using information from the National Athletic Trainers' Association Position Statement on Management of Concussions, area high schools and colleges' policies.

The athletic trainer or school nurse may refer the student-athlete back to the physician for further evaluation at any time.

The Port Chester Union Free School District physician reserves the right to make the final determination on approval of return to play for all student-athletes.

Appendix A

Symptom Checklist

Having one or two symptoms does not constitute a concussion. Every concussion is different and the entire situation should be considered.

Blurred Vision
Dizziness
Excess Sleep
Easily distracted
Fatigue
Feel “in a fog”
Feel “slowed down”
Headache
Inappropriate emotion
Irritability
Loss of consciousness
Loss of orientation
Memory problems
Nausea
Nervousness
Personality change
Poor balance
Poor concentration
Ringing in ears
Sadness
Seeing stars
Sensitivity to noise
Sleep disturbance
Vacant stare
Glassy eyes
Vomiting

Appendix B

Referral Checklist

Immediate Referral to ER by EMS

1. Deterioration of neurologic function (feeling, sensation, limb movement)
2. Decreasing level of consciousness
3. Decrease or irregularity in respirations
4. Decrease or irregularity in pulse
5. Unequal, dilated, or un-reactive pupils
6. Any signs or symptoms of associated injuries, spine or skull fracture or bleeding
7. Mental status changes: confusion or agitation
8. Seizure activity

Day of injury referral

1. Loss of consciousness on the field
2. Amnesia (lasting longer than 15 minutes)
3. Increase in blood pressure
4. Cranial nerve deficits
5. Vomiting
6. Motor deficits subsequent to initial on-field assessment
7. Sensory deficits subsequent to initial on-field assessment
8. Balance deficits subsequent in initial on-field assessment
9. Cranial nerve deficits subsequent to initial on-field assessment
10. Post-concussion symptoms that worsen
11. Additional post-concussion symptoms as compared with those on the field
12. Athlete is still symptomatic at the end of the game

Next Day Referral

1. Any of the findings in the day of injury category
2. Post-concussion symptoms worsen or do not improve over time
3. Increase in the number of post-concussion symptoms reported
4. Post-concussion symptoms begin to interfere with the athlete's daily activities (i.e. sleep, cognitive difficulties)

Appendix C

Concussion Home Instructions

The Port Chester Athletic Department believes that your son or daughter may have sustained a concussion. To make sure he/she recovers, please follow the following important recommendations:

1. Your son/daughter should be evaluated by a physician.
2. Please remind your son/daughter to report to the athletic trainer the next day they are at school for a follow-up evaluation.
3. Please review the items outlined on the enclosed Referral Checklist. If any of these problems develop prior to his/her visit, please contact the local emergency medical system or your family physician.
4. Follow the instructions outlined below if your physician has not given you other directions:

It is OK to:

- Use ice pack on head and neck as needed (15-20 mins)
- Eat a light diet
- Return to school
- Go to sleep
- Rest

There is NO need to:

- Check eyes with flashlight
- Wake up every hour
- Test reflexes
- Stay in bed

Do NOT:

- Drink alcohol
- Eat spicy foods
- Exercise
- Use ibuprofen or other anti-inflammatory medications (Advil, Motrin, Aleve)

Specific Recommendations:

Please feel free to contact the school's athletic trainer(s) if you have any questions. They can be reached at Cell:(914) 469-2919 or Office:(914) 939-7571, or email on weekends:

dsheridan@portchesterschools.org
asarkodie-mensah@portchesterschools.org

Appendix D

The Neurological Exam

The proper neurological exam, regardless of what type of physician performs it should also include a detailed history and also a basic test of cognitive function. Perhaps more important, the physical aspect of the exam should be a diligent, and detailed evaluation. It should include examination of the following parts:

- The movements and reactions of the eye.
- An examination of the eye using an ophthalmoscope.
- A test of smell, of each nostril. This is particularly important in concussion cases, as a compromised sense of smell can be an indicator of frontal lobe damage. Sadly, this is the part of the test most often neglected.
- The patient should be asked to whistle, smile and clench his teeth.
- Hearing should be tested.
- The muscles required to move the head around should be palpitated.
- The patient is asked to do the classic hand and arm movements, in order to elicit evidence of tremors, unilateral or bilateral motor weakness and to evaluate coordination and position sense.
- The neurological exam will also likely contain a rudimentary test of cognitive function, often the mini-mental status exam.

The focus of a neurological exam is usually the nervous system, with a particular emphasis on the cranial nerves. The Cranial nerves are nerves which branch off of the brain stem, and primarily control the functions which are within the head. The following are the cranial nerves:

- I. Olfactory - Smell. Insist that your neurologist checks this is you have any basis for concern.
- II. Optic - Vision.
- III. Oculomotor - Eye movement.
- IV. Trochlear - Eye movement.

- V. Trigeminal - Controls the muscle and senses of the face.
- VI. Abducens - Eye movement.
- VII. Facial - Taste, expression and facial and scalp movements.
- VIII. Vestibulocochlear - Hearing and vestibular system.
- IX. Glossopharyngeal - Gag reflex, taste, throat and sinus reflex.
- X. Vagus - throat, voice, gag reflex, coughing, dilations of the stomach.
- XI. Accessory - rotate head, shrug shoulder, raising chin.
- XII. Hypoglossal - muscles of the tongue.

SPECIAL TESTS

1. **100 minus 7 test** This tests one's ability to concentrate and critically think about the response. The individual is asked to start at 100 and subtract 7, then subtract 7 from that number, and so on. Note any problems.
2. **Finger to nose test** This tests depth perception and ability to focus on an object. Hold a finger in front of injured athlete. Ask person to reach out and touch it while alternating between the right and left hand. Note any problems.
3. **Rhomberg test** The athlete is asked to stand with the feet together, arms at side, and eyes closed while maintaining balance. Note any problems.
4. **Heel and toe walking** Ask the individual to walk on the toes, then heels. Note any swaying or inability to walk in a straight line.
5. **Exertion testing** Have athlete perform series of exercises. Push ups, knee bends, sprints, sit ups for 30 seconds. Note any problems.

The Port Chester UFSD Concussion Procedure has been endorsed and approved by the following people:

Joe Durney
District Director

Dr. Stampur
School Physician

Jeanette Spinelli, RN
District Nurse

Aimie Sarkodie-Mensah, ATC
Certified Athletic Trainer

David Sheridan, ATC
Certified Athletic Trainer

School Health Services Activities - New York State

What Do our School Nurses Do?

Management of Health Appraisals

Mandated Activities for School Health Services Staff

- Review and documentation of mandated Health Appraisals for new entrants to the district, Pre-Kindergarten, Kindergarten and in Grades 2, 4, 7 and 10
- Send parent letters to obtain Health Certificate 30 days after the commencement of the school year
- Assist the school medical director in completing Health Appraisals not returned to the school by the parent
- Document body mass index and weight status category reporting information and prepare for survey
- Documentation of dental certificate, if provided
- Adaptive physical education needs communicated to staff

School Health Activities Typically Overseen by the School Health Services Staff

- Sports Physicals
- Required annually for participation in school sports
- Modifications identified as needed for student participation i.e., protective equipment needs
- Sports Certification
- Completed for Fall, Winter and Spring sports seasons
- Oversight of selective classification
- Work Permits
- Provide proof of physical fitness for *work*
- Health Appraisal required within 12 months of application
- Committee on Special Education - CSE/CPSE
- Provide health related information to CSE on a need to know basis
- Attend CSE meetings as requested
- Student Weight Status Category Reporting
- Documentation of obesity related diseases if reported to school
- Organization of data
- Communicate "opt out" option to parents

School Health Services Activities – New York State

Health Screening

Mandated Activities for School Health Services Staff

- Vision Screening
 - o Distance acuity for new entrants and students in K and Grades 1, 2, 3, 5, 7 and 10
 - o Near vision acuity for new entrants
 - o Hyperopia for new entrants
 - o Color perception for new entrants
 - o Send referral as needed to parent or the person in relationship to the student
- Hearing Screening
 - o 20 db sweepcheck for new entrants and students in K and Grades 1, 3, 5, 7 and 10
 - o Threshold Screening for any student failing the 20db sweep check
 - o Acoustic Immittance Screening (if available)
 - o Send referral as needed to parent or the person in relationship to the student
- Scoliosis Screening
 - o For students in Grades 5 - 9
 - o Send referral as needed to parent or the person in relationship to the student

School Health Activities Typically Overseen by the School Health Services Staff

- Maintain equipment, including recalibration as needed

Immunizations

Mandated Activities for School Health Services Staff

- Receive and review immunizations from all students for school admission
- Receive parental requests for immunization exemptions
 - o Refer medical exemption requests to school medical director
 - o Refer religious exemption requests to school administration
 - 1. Provide information to parents regarding the importance of vaccinations
- Document immunizations on the cumulative health record
- Maintain an original copy of the student's immunization record

School Health Activities Typically Overseen by the School Health Services Staff

- Provide immunization forms to colleges and summer camp programs

School Health Services Activities – New York State

Survey and State Reporting

Mandated Activities for School Health Services Staff

- Immunization School Survey - NYS Department of Health
- Due annually on October 30th
- Reviews immunization compliance of all newly entering students
- Student Weight Status Category Reporting - NYS Department of Health
- Due annually on January 29th
- A sample (50%) of schools must report Student Weight Status of all students with mandated Health Appraisals
- Child Abuse Reporting
- Mandated reporters through Child Protective Services

School Health Activities Typically Overseen by the School Health Services Staff

- Statewide voluntary emergency medication and treatment data reporting
- Individual and/or district school health services data collection
- District Accident Reports

Medication Administration

Mandated Activities for School Health Services Staff

- Set up and maintain medication policies and delivery system
 - Prescription medications
 - Non prescription medications
 - Daily Medications
 - Medications given on an "as needed" basis
- Preparation of medication dosages for all students
- Administration of medications to non-self directed students
- Training of unlicensed staff to assist self directed students in taking their own medication
- Training of willing unlicensed staff to administer student specific doses of epinephrine and glucagon emergency medications as appropriate

School Health Activities Typically Overseen by the School Health Services Staff

- Administration of medications to self directed students
- Administration of emergency medications
- Planning for emergency medication administration in emergencies and building evacuations
- Documentation of healthcare provider orders and medication administration

School Health Services Activities – New York State

Provision of First Aid and Nursing Care

School Health Activities Typically Overseen by the School Health Services Staff

- Provide first aid and nursing care to students and staff as needed
 - o Illnesses
 - o Chronic Health Condition Management
 - o Injuries
 - o Substance Use Assessment
- Communication with healthcare providers as appropriate
- Notification of school administration and parents as appropriate
- Professional development attendance to remain current in the nursing profession
- Respond to medical emergencies as needed
- Provide nursing expertise in school emergency planning
- Office management
 - o Ordering of supplies
 - o Maintaining adequate and appropriate first aid and nursing care supplies

Communicable Disease Management

Mandated Activities for School Health Services Staff

- Reporting to Health Department of identified reportable communicable diseases
- Act as a liaison between school medical director, health department and school administration as needed
- Monitoring of students with immunization exemptions during an outbreak of a vaccine preventable disease
 - o Notification of parents as appropriate

School Health Activities Typically Overseen by the School Health Services Staff

- Monitoring of communicable diseases in the school setting
- Exclusion of students, where necessary, with contagious diseases or conditions

School Health Services Activities – New York State

Bloodborne Pathogen Training

School Health Activities Typically Overseen by the School Health Services Staff

- Staff training on Universal Precautions
- Preparation and distribution of Universal Precaution kits
- Consultation provided ongoing basis

Development of Healthcare Plans

School Health Activities Typically Overseen by the School Health Services Staff

- Development of Emergency Care Plans
 - o Obtain healthcare provider orders
 - o Review with parent, obtain signature to share plan at school
 - o Train unlicensed staff to administer the plan as needed
 - o Provide ongoing support to school staff

Development of Individualized Healthcare Plans

- o Obtain healthcare provider orders
- o Outline care to direct nursing response to complex medical condition

Signs and Symptoms
Of
Common Health Concerns
New York Statewide
School Health Services Center

www.schoolhealthservicesny.com

Phone: 585.349.763

Fax: 585.352.9131

*The pages in this chart list common symptoms of health issues and should only be used for
identifications purposes and not as a substitute for nursing or medical care.*

Please use in consultation with a school nurse.

Emergency Contact Information

School Name: _____

School Health Professional:_____

Phone Number:_____

Main Office Phone Number:_____

In the event of an Emergency during school hours, please contact:

In the event of an Emergency before or after school hours, please contact:

ALLERGIC REACTIONS

For Allergic Reactions: THINK F. A. S. T.

| | |
|---------------------|--|
| F ace: | itchiness, redness, swelling of face and tongue |
| A irway: | trouble breathing, swallowing or talking |
| S tomach: | pain, vomiting, diarrhea |
| T otal Body: | rash, itchiness, swelling, paleness, loss of consciousness |

Students with emergent health concerns should always be escorted to the Health Office, or supervised until the School Nurse or emergency care arrives.

ASTHMA

Some signs and Symptoms of Asthma:

- Wheezing
- Coughing
- Difficulty Breathing and/or shortness of breath

A Serious Asthma Episode may include:

- Breathlessness that may cause the student to speak in one-to-two word sentences or be unable to speak
- The student may stop an activity and be unable to start again.
- The student's neck muscles may tighten with each breath.
- Lips and nail beds may have a grayish or bluish color

Many students need to use their inhalers 15-30 minutes before physical education class to prevent asthma difficulties during periods of exercise.

Do not deny a student's request to come to the Health Office to use their inhaler.

Students with emergent health concerns should always be escorted to the Health Office, or supervised until the School Nurse or emergency care arrives.

HEAD INJURY

Following an injury to the head, the student should be observed for the following symptoms:

- Severe Headache
- Excessive drowsiness
- Nausea and/or vomiting
- Double vision, blurred vision pupils of different sizes
- Loss of muscle coordination such as falling down, walking strangely, or staggering
- Convulsions or seizures
- Unusual behavior: confusion, irregular breathing, dizziness, etc.
- Bleeding or Discharge from the ear

HEAT EXHAUSTION

- Symptoms:
 - Dehydration
 - Fatigue
 - Clammy skin
 - Headache
 - Nausea and/or vomiting
- Treatment:
 - Bring indoors or into shade
 - Loosen or remove clothing
 - Rub arms and legs down with cool water
 - Call physician or healthcare provider if student can't eat or drink

If left untreated, may escalate to Heat Stroke

HEAT STROKE

- Symptoms
 - Flushed, dry skin – no sweating seen
 - Temperature of 105 or higher
 - Severe, throbbing headache
 - Weakness, dizziness or confusion
 - Sluggishness or fatigue
 - Seizure
 - Decrease responsiveness
 - Loss of Consciousness
- Treatment:
 - THIS IS A MEDICAL EMERGENCY**
 - Call 911**
 - Get child indoors or into shade
 - Sponge or douse the student with cool water
 - Do NOT give fluids.

Students with emergent health concerns should always be escorted to the Health Office, or supervised until the School Nurse or emergency care arrives.

HYPERGLYCEMIA (HIGH BLOOD SUGAR)

| | |
|------------|--|
| Onset: | Gradual |
| Signs: | Drowsiness Extreme Thirst, Very frequent urination Flushed Skin Vomiting, fruity or wine-like odor to breath Heavy breathing Eventual stupor or unconsciousness |
| Causes: | Undiagnosed diabetes Insulin not taken Stress, injury or illness Too much food and/or drink |
| Treatment: | Pursue Emergency Care and take this person to the hospital |

Students with emergent health concerns should always be escorted to the Health Office, or supervised until the School Nurse or emergency care arrives.

New York Statewide School Health Services Center

HYPERGLYCEMIA (LOW BLOOD SUGAR)

| | |
|---------|--|
| Onset: | Sudden |
| Signs: | Staggering, poor coordination Anger, bad temper Pale Color Confusion, disorientation Sudden hunger Sweating Eventual Stupor or unconsciousness |
| Causes: | Failure to eat before strenuous exercise Delayed or missed meals or snacks |
| Treat: | Provide sugar. If the person can swallow without choking, offer any food or drink containing sugar (no diet drinks). |

**IF THE STUDENT DOESN'T FEEL BETTER IN 10-15 MINUTES, INITIATE
EMERGENCY CARE**

Students with emergent health concerns should always be escorted to the Health Office, or supervised until the School Nurse or emergency care arrives.



www.portchesterschools.org

Port Chester-Rye Union Free School District

113 Bowman Avenue
Port Chester, New York 10573
914.934.7900

Joseph G. Durney
District Director
Curriculum Office

Statement of Purpose:

In an effort to ensure the safety and well being of students, we present a structured program and protocol for the management of traumatic head injuries in the sports program consistent with contemporary standards in the field of educational interscholastic athletics.

Background Information

In the United States, the annual incidence of sports related concussion is estimated at 300,000. Estimates regarding the likelihood of an athlete in a contact sport experiencing a concussion may be as high as 19% per season. Although the majority of athletes who experience a concussion are likely to recover, an unknown number of individuals may experience chronic cognitive and neurobehavioral difficulties related to recurrent injury. Such symptoms may include chronic headaches, fatigue, sleep difficulties, personality change, sensitivity to light/noise, dizziness when standing too quickly and deficits in short term memory, problem solving and general academic functioning. This constellation of symptoms is referred to as "post concussion syndrome" and can be quite disabling for an athlete. In some cases, such difficulties can be permanent. In addition to post concussion syndrome, suffering a second blow to the head while recovering from an initial concussion can have catastrophic consequences as in the case of "second impact syndrome", which has lead to approximately 30-40 deaths over the past decade.

Athletes that are not fully recovered from an initial concussion are significantly vulnerable for recurrent, cumulative, and even catastrophic consequences of a second concussive injury. Such difficulties are prevented if the athlete is allowed time to recover from the concussion and return to play decisions are carefully made. No athlete should return to sport or other at risk participation when symptoms of concussion are present and recovery is ongoing. The best way to prevent difficulties with concussions is to manage the injury properly when it does occur.

The district procedure pertaining to suspected and/or diagnosed concussions for student-athletes participating in interscholastic athletics is as follows:

- With any positive sign/symptom, the student-athlete is held out of competition and practice.
- No student-athlete will be allowed to return-to-play (RTP) on the same day they show signs or symptoms of a concussion regardless if signs and symptoms return to normal.
- A student-athlete who is suspected of a concussion must be evaluated by a health care professional and must show written documentation of the evaluation before starting the district's RTP protocol.
- A student-athlete will only be allowed to fully participate in their sport after they have completed all stages of the district's RTP protocol (see attached) supervised by the athletic trainer.
- The Port Chester Union-Free School District physician will have the right to make final determination of all student-athletes RTP status.

Concussion Management Procedure

On-Field Evaluation

- Signs and Symptoms(S/S) Assessment (Noticed and recorded by coach) (See appendix A)
- Neurologic Exam (Performed by Certified Athletic Trainer (ATC)) – See Appendix D
- Mental Status Testing (Performed by ATC)
- Note any S/S requiring 'day of' referral to doctor (See appendix B)
- Note any S/S requiring immediate medical care (See appendix B)

Action:

With any positive sign/symptom, the athlete is held out of competition and practice.

Contact parents about child's condition. (Performed by coach or ATC)

No student-athlete will be allowed to RTP on the same day they show signs or symptoms of a concussion regardless if signs and symptoms return to normal.

The athlete should not be left alone, and regular monitoring for deterioration is essential over the initial few hours following injury.

Monitor athlete's vital sign and neurological status every five (5) minutes, until athlete's condition stabilizes and improves.

Return to play must follow a medically supervised process.

The cornerstone of proper concussion management is rest until all symptoms resolve and then a graded program of exertion before return to sport.

Follow-up Evaluation

- Within 24-72 hours of injury
 - Re-eval of S/S by health care professional using neurological exam (appendix D)
- Action: Rest until asymptomatic
- Once symptom free for at least 24 hours, student-athlete can begin the return to play protocol

If any concussion symptoms recur, the athlete must drop back to the previous level and try to progress after 24 hours of rest.

The student athlete should also be monitored for recurrence of symptoms due to mental exertion, such as reading, working on a computer, or taking a test.

Return to Play Protocol

The progression should be followed by all; coaches, healthcare providers, and parents, by using the basic steps below. To progress to the next step the student-athlete must be symptom-free. If the athlete has S/S, the progression must be stopped and the student's healthcare providers, coach, parent, and school health office notified. The number of days on each step may vary and duration questions referred to the health care providers. Typically, it is a seven day progression to full game play.

The athletic trainer or school nurse may refer the student-athlete back to the physician at any time for further evaluation.

Symptom Free Return to Play Progression

- 1. Aerobic Activity – No Contact**
- 2. Drills – No Contact**
- 3. Contact allowed**
- 4. Scrimmage/Game approval**

Stage 1 – rest until symptom-free (asymptomatic)

- Once the student-athlete is symptom-free for a full 24 hour period they may move on to stage 2

Stage 2 – fast walking/stationary bike 15-20 minutes under supervision of staff

- Any S/S's warrants stopping for the day and start Stage 2 over again after symptoms are gone for 24 hours
- If symptomatic post-exertion within 24 hours, rest until asymptomatic and start Stage 2 over again
- When asymptomatic for 24 hours after completion of Stage 2, proceed to Stage 3

Stage 3 – jogging/ running 20 minutes

- Any return in S/S's warrants stopping for the day and start Stage 3 again after the student-athlete is asymptomatic for 24 hours
- If symptomatic post-exertion with in 24 hours, rest until asymptomatic and start Stage 3 over again
- If athlete is asymptomatic for 24 hours proceed to Stage 4
- Consult with primary care physician if warranted

Stage 4 – Non-Contact Sports Drills for 30-45 minutes

- Any return in S/S's warrants stopping for the day and start Stage 4 again after the student-athlete is asymptomatic for 24 hours.
- If asymptomatic for 24 hours proceed to Stage 5

Stage 5 - Full Participation in practice without contact

- Any return in S/S's warrants stopping for the day and start Stage 5 again after the student-athlete is asymptomatic for 24 hours
- If symptomatic post-exertion with in 24 hours, rest until asymptomatic start again with Stage 5
- When asymptomatic for 24 hours proceed to Stage 6

Stage 6 - Full Practice No Restrictions

- Any return in S/S's warrants stopping for the day and start Stage 6 again after the student-athlete is asymptomatic for 24 hours
- When asymptomatic for 24 hours proceed to Stage 7
- Consult primary care physician if warranted
- If symptomatic post-exertion with in 24 hours, rest until asymptomatic start again with Stage 6

Stage 7 - Cleared for RTP No Restrictions for Competition by neuropsychologist and/or primary care physician and ATC

- If re-injured refer to primary care physician

Sample Concussion Procedure

The following is a sample of what could happen if and when a concussion occurs. Please note that there are a number of variables involved and every concussion is different.

Over Summer Vacation:

- Medical forms handed in to school nurse

Day 0 – Saturday

- Injury occurs involving the head
- Evaluated by coach (basic history of what happened, concussion checklist)
 - Student-athlete shows signs and symptoms of a concussion
 - Removed from activity
 - Referred to the ATC or EMS for evaluation
 - In absence of an ATC, parents are contacted and student-athlete is referred to a physician or EMS
- Evaluated by the ATC (detailed history, concussion checklist, neurological exam)
 - Student-athlete shows S/S of a concussion
 - Parents are contacted and updated
 - Referred to physician for evaluation and diagnoses
- Evaluated by physician
 - Diagnosed concussion

Day 1 – Sunday

- Rest
- Student-athlete shows S/S of a concussion

Day 2 – Monday

- Student-athlete returns to school with doctor's note restricting participation
 - Returns to doctor for clearance at appropriate date
- Student-athlete returns to school with doctor's note permitting participation
 - Evaluated by ATC
 - Still showing S/S of a concussion
 - Must be S/S free for full 24 hours before starting Return-to-Play (RTP) protocol

Day 3 – Tuesday

- Student-athlete sign and symptom free for 24 hours
 - Start stage one of RTP protocol
 - Student-athlete shows S/S of concussion
 - Student-athlete must be S/S free for 24 hours before starting stage one over again

Day 4 – Wednesday

- Rest

Day 5 – Thursday

- Student-athlete is S/S free for 24 hours
 - Start stage one of RTP protocol
 - No S/S

Day 6 – Friday

- Student-athlete starts stage two of RTP protocol

Day 7 – Saturday

- Student-athlete starts stage three of RTP protocol

Day 8 – Sunday

- Rest

Day 9 – Monday

- Student-athlete starts stage four of RTP protocol

Day 10 - Tuesday

- Student-athlete starts stage five of RTP protocol

Day 11 - Wednesday

- Student-athlete starts stage six of RTP protocol

Day 12 – Thursday

- Student-athlete starts stage seven of RTP protocol

Port Chester Protocol

The district procedure is to hold a student-athlete out of competition a minimum of seven (7) days starting the first day the student is symptom-free. Concurrent with a clearance from a physician, the student-athlete must also complete and pass the seven (7) stages of the Return to Play (RTP) Protocol. This procedure was developed using information from the National Athletic Trainers' Association Position Statement on Management of Concussions, area high schools and colleges' policies.

The athletic trainer or school nurse may refer the student-athlete back to the physician for further evaluation at any time.

The Port Chester Union Free School District physician reserves the right to make the final determination on approval of return to play for all student-athletes.

Appendix A

Symptom Checklist

Having one or two symptoms does not constitute a concussion. Every concussion is different and the entire situation should be considered.

Blurred Vision
Dizziness
Excess Sleep
Easily distracted
Fatigue
Feel “in a fog”
Feel “slowed down”
Headache
Inappropriate emotion
Irritability
Loss of consciousness
Loss of orientation
Memory problems
Nausea
Nervousness
Personality change
Poor balance
Poor concentration
Ringing in ears
Sadness
Seeing stars
Sensitivity to noise
Sleep disturbance
Vacant stare
Glassy eyes
Vomiting

Appendix B

Referral Checklist

Immediate Referral to ER by EMS

9. Deterioration of neurologic function (feeling, sensation, limb movement)
10. Decreasing level of consciousness
11. Decrease or irregularity in respirations
12. Decrease or irregularity in pulse
13. Unequal, dilated, or un-reactive pupils
14. Any signs or symptoms of associated injuries, spine or skull fracture or bleeding
15. Mental status changes: confusion or agitation
16. Seizure activity

Day of injury referral

13. Loss of consciousness on the field
14. Amnesia (lasting longer than 15 minutes)
15. Increase in blood pressure
16. Cranial nerve deficits
17. Vomiting
18. Motor deficits subsequent to initial on-field assessment
19. Sensory deficits subsequent to initial on-field assessment
20. Balance deficits subsequent in initial on-field assessment
21. Cranial nerve deficits subsequent to initial on-field assessment
22. Post-concussion symptoms that worsen
23. Additional post-concussion symptoms as compared with those on the field
24. Athlete is still symptomatic at the end of the game

Next Day Referral

5. Any of the findings in the day of injury category
6. Post-concussion symptoms worsen or do not improve over time
7. Increase in the number of post-concussion symptoms reported
8. Post-concussion symptoms begin to interfere with the athlete's daily activities (i.e. sleep, cognitive difficulties)

Appendix C

Concussion Home Instructions

The Port Chester Athletic Department believes that your son or daughter may have sustained a concussion. To make sure he/she recovers, please follow the following important recommendations:

5. Your son/daughter should be evaluated by a physician.
6. Please remind your son/daughter to report to the athletic trainer the next day they are at school for a follow-up evaluation.
7. Please review the items outlined on the enclosed Referral Checklist. If any of these problems develop prior to his/her visit, please contact the local emergency medical system or your family physician.
8. Follow the instructions outlined below if your physician has not given you other directions:

It is OK to:

- Use ice pack on head and neck as needed (15-20 mins)
- Eat a light diet
- Return to school
- Go to sleep
- Rest

There is NO need to:

- Check eyes with flashlight
- Wake up every hour
- Test reflexes
- Stay in bed

Do NOT:

- Drink alcohol
- Eat spicy foods
- Exercise
- Use ibuprofen or other anti-inflammatory medications (Advil, Motrin, Aleve)

Specific Recommendations:

Please feel free to contact the school's athletic trainer(s) if you have any questions. They can be reached at Cell:(914) 469-2919 or Office:(914) 939-7571, or email on weekends:

dsheridan@portchesterschools.org
asarkodie-mensah@portchesterschools.org

Appendix D

The Neurological Exam

The proper neurological exam, regardless of what type of physician performs it should also include a detailed history and also a basic test of cognitive function. Perhaps more important, the physical aspect of the exam should be a diligent, and detailed evaluation. It should include examination of the following parts:

- The movements and reactions of the eye.
- An examination of the eye using an ophthalmoscope.
- A test of smell, of each nostril. This is particularly important in concussion cases, as a compromised sense of smell can be an indicator of frontal lobe damage. Sadly, this is the part of the test most often neglected.
- The patient should be asked to whistle, smile and clench his teeth.
- Hearing should be tested.
- The muscles required to move the head around should be palpitated.
- The patient is asked to do the classic hand and arm movements, in order to elicit evidence of tremors, unilateral or bilateral motor weakness and to evaluate coordination and position sense.
- The neurological exam will also likely contain a rudimentary test of cognitive function, often the mini-mental status exam.

The focus of a neurological exam is usually the nervous system, with a particular emphasis on the cranial nerves. The Cranial nerves are nerves which branch off of the brain stem, and primarily control the functions which are within the head. The following are the cranial nerves:

- I. Olfactory - Smell. Insist that your neurologist checks this if you have any basis for concern.
- II. Optic - Vision.
- III. Oculomotor - Eye movement.
- IV. Trochlear - Eye movement.
- V. Trigeminal - Controls the muscle and senses of the face.
- VI. Abducens - Eye movement.
- VII. Facial - Taste, expression and facial and scalp movements.

- VIII. Vestibulocochlear - Hearing and vestibular system.
- IX. Glossopharyngeal - Gag reflex, taste, throat and sinus reflex.
- X. Vagus - throat, voice, gag reflex, coughing, dilations of the stomach.
- XI. Accessory - rotate head, shrug shoulder, raising chin.
- XII. Hypoglossal - muscles of the tongue.

SPECIAL TESTS

6. **100 minus 7 test** This tests one's ability to concentrate and critically think about the response. The individual is asked to start at 100 and subtract 7, then subtract 7 from that number, and so on. Note any problems.
7. **Finger to nose test** This tests depth perception and ability to focus on an object. Hold a finger in front of injured athlete. Ask person to reach out and touch it while alternating between the right and left hand. Note any problems.
8. **Rhomberg test** The athlete is asked to stand with the feet together, arms at side, and eyes closed while maintaining balance. Note any problems.
9. **Heel and toe walking** Ask the individual to walk on the toes, then heels. Note any swaying or inability to walk in a straight line.
10. **Exertion testing** Have athlete perform series of exercises. Push ups, knee bends, sprints, sit ups for 30 seconds. Note any problems.

The Port Chester UFSD Concussion Procedure has been endorsed and approved by the following people:

Joe Durney
District Director

Dr. Stampur
School Physician

Jeanette Spinelli, RN
District Nurse

Aimie Sarkodie-Mensah, ATC
Certified Athletic Trainer

David Sheridan, ATC
Certified Athletic Trainer

STUDENTS WITH HIV-RELATED ILLNESS

The Board of Education recognizes the public concern over the health issues surrounding Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus Infection (HIV). The Board also recognizes, based upon the current state of medical knowledge, that the virus associated with AIDS is not easily transmitted and there is no evidence that AIDS or the HIV virus can be transmitted by casual social contact in the open school setting.

The Board acknowledges the rights of those students diagnosed as having AIDS or HIV infection to continue their education as well as the rights of all students in the school district to learn and participate in school activities without being subjected to significant risks to their health. The Board also takes notice that under current law and regulations the disclosure of confidential AIDS and/or HIV related information must be strictly limited.

Accordingly, it is the policy of the Board of Education that no student shall be denied the opportunity to attend school, continue his/her education or take part in school-related activities solely on the basis of being diagnosed as having AIDS or HIV infection.

In accordance with current state law and regulations, it is also the policy of the Board of Education to prevent any student from being subjected to adverse or discriminatory treatment or stigma because he or she has been diagnosed as having AIDS or being HIV-infected.

The Superintendent of Schools is hereby directed to develop administrative regulations in regard to the education of students diagnosed as having AIDS or being HIV-infected.

The Superintendent also shall establish and implement, and all school personnel shall comply with, guidelines and routine sanitary hygiene procedures for dealing with all spills of blood and other body fluids in or on school premises and grounds. The Superintendent should consult public health officials and/or the school physician, as appropriate, for the most current methods and information pertaining to such procedures.

In addition, the Superintendent shall develop and, as needed, implement in-service education and training for all school personnel concerning AIDS and HIV infection and the routine sanitary hygiene procedures to be followed in the case of all spills of blood and other body fluids.

The Board shall, at least annually, re-examine its policy and procedures related to HIV-related illnesses. As new information regarding AIDS becomes available through the Public Health Service, the Board shall revise and, if appropriate, modify its policy and procedures when necessary. The Superintendent shall report to the Board, at least annually, on the status of each AIDS-infected individual.

STUDENTS WITH HIV-RELATED ILLNESS REGULATION

Confidentiality

A. *Definitions*

“HIV-related illness” means any clinical illness that may result from or be associated with HIV infection, including AIDS.

“Infected individual” applies to persons who have been diagnosed as having HIV-related illness or ARC (AIDS Related Complex) and to persons who are “asymptomatic carriers,” that is, persons who have been infected by the AIDS virus and are capable of transmitting it but who have not developed any outward symptoms of the disease.

“Protected individual” shall mean a person who is the subject of an HIV-related test or who has been diagnosed as having HIV-related illness.

“Capacity to consent” means an individual’s ability, determined without regard to such individual’s age, to understand and appreciate the nature and consequences of a proposed health care service, treatment or procedure, and to make an informed decision concerning such service, treatment or procedure.

B. *Confidentiality and Release of Information*

School officials and employees shall keep HIV-related information confidential, however obtained. The information shall not be disclosed to any person, unless the protected individual (or a person with capacity to consent) has completed and signed the Health Department Authorization for Release form (“Authorization Form”), a court order granted under Public Health Law §2785 has been issued, or the person to whom the information under Public Health Law (PHL) §2782 without a release form. Persons authorized to receive HIV information without a release include physicians providing care, agencies monitoring such care, and insurance companies for payment purposes. Disclosure to school personnel staff requires a release or court order.

If disclosure occurs pursuant to a signed release or order, the information shall only be released to those listed on such form or order, for the time period specified and only for the purpose stated on the form or order.

Such form shall be signed by the protected individual or when the protected individual lacks capacity to consent, a person authorized pursuant by law to consent to health care for the individual. Questions in regard to such capacity shall be referred to the school attorney.

C. *Testing*

No HIV-related testing of any student shall take place without first receiving the written informed consent of the person to be tested on a form approved by the State Health Department. Such consent shall only be given by an individual with capacity to consent as defined above.

D. *Penalties*

Persons who disclose confidential HIV information to unauthorized parties or who fail to obtain informed consent for the HIV test may be subject to a \$5,000 penalty and a criminal misdemeanor charge.

E. *Procedures*

1. The procedure set forth here shall be followed in any instance where the school district receives confidential HIV-related information concerning a student from the student and/or person in parental relation to the student without benefit of an Authorization Form or court order.
 - a. The Superintendent or building administrator to whom the information has been given shall request a meeting with the person in parental relation and/or the student for the purpose of discussing the student's condition, concerns and, should the situation arise, educational alternatives. Such alternatives may include homebound instruction during periods of short-term illness as well as provision of educationally related support services. At this point, school or public health personnel may be consulted provided that the appropriate Authorization Form is obtained. The person in parental relation and/or the student should be apprised of this and asked to sign such release form for personnel whose consultation is needed for delivery or appropriate educational services.
 - b. If a school officer or employee who has not been made privy to confidential HIV-related information pursuant to an Authorization Form or court order reasonably believes that a student may present a clear and imminent danger to an individual whose life or health may unknowingly be at significant risk as a result of contact with the person, he/she should express these concerns to the Superintendent of Schools who may attempt to obtain an Authorization Form from the individual or someone else with the capacity to consent. Should this request be refused, the Superintendent may recommend to the school board that the district seek an order for disclosure of confidential HIV-related information, pursuant to Public Health Law §2785.
2. The procedures set forth here shall be followed in any instance where the school district receives confidential HIV-related information concerning a student through the Authorization Form or through a court order.

- a. The Superintendent, or building administrator to whom the HIV-related information has been released, may request a meeting with the parent, or person in parental relationship, and the student for the purpose of discussing educational alternatives. Such alternatives may include homebound instruction during periods of short-term illness as well as provision of educationally related support services. The Superintendent or building administrator may enlist the expertise of the child's physician, or any school or public health personnel, provided that the appropriate release forms have been obtained. If a parent concurs in writing to the provision of educational alternatives, no referral to the Committee on Special Education (CSE) will be made.
- b.
 - (1) If a school officer or employee who has not been made privy to confidential HIV-related information pursuant to an Authorization Form or court order reasonably believes that a student may present a clear and imminent danger to an individual whose life or health may unknowingly be at significant risk as a result of contact with the person, he/she should express these concerns to the Superintendent of Schools. If the Superintendent has been given authority, through the Authorization Form, to inform such person(s) who may be at significant risk he/she should proceed to do so. If the Superintendent does not have the authority, he/she should attempt to obtain an Authorization Form from the individual or someone else with the capacity to consent. Should this request be refused, the Superintendent may recommend to the school board that the district seek an order for disclosure of confidential HIV-related information, pursuant to Public Health Law §2785.
 - (2) If a professional staff member of a school district who has been made privy to confidential HIV-related information pursuant to an Authorization Form or court order reasonably believes that a student may present a clear and imminent danger to an individual whose life or health may unknowingly be at significant risk as a result of contact with the person, he/she should make a referral of the student to the CSE, if appropriate. Staff are also expected to encourage students to seek advice from their physician and AIDS counseling centers and to behave responsibly by contacting those persons with whom they have engaged in behavior of significant risk.
3. If a professional staff member of a school district suspects that a student may have a disability, whether or not the staff member has been made privy to confidential HIV-related information, the staff member shall refer such student in writing to the CSE, or to the building administrator of the school

which the student attends, in accordance with Part 200.4 of the Commissioner's Regulations.

4. If a student has been referred to the CSE and the CSE reasonably believes either (a) that the student may present a clear and imminent danger to an individual whose life or health may unknowingly be at significant risk as a result of contact with the student, or (b) that the student has or is suspected of having a disability that the condition may be due, in whole or in part, to HIV-related illness, the CSE shall inform the Superintendent, who shall attempt to obtain an Authorization Form from the student or someone else with the capacity to consent. Should this request be refused, the Superintendent may recommend to the school board that the district seek an order for disclosure of confidential HIV-related information, pursuant to Public Health Law §2785.

When seeking the confidential information through either said Form or court order, the Superintendent shall attempt to have the person or court agree to disclose such information to the CSE, and may attempt to have the person or court agree to disclose such information to the classroom teacher(s) and any other personnel the Superintendent and the school attorney believe are appropriate.

5. If no such consent or court order is obtained, the district shall take no further action in this matter and shall instruct the appropriate officers or employees not to disclose information in regard to the case.
6. If confidential HIV-related information is obtained, it shall be disclosed only to those individuals listed on the form or pursuant to the court order and only for the purpose specified, for the specified time period.
7. At such time as the CSE receives confidential HIV-related information, it shall, on a case-by-case basis, review all of the medical information pertinent to the individual situation and make a determination as to whether the current mode of instruction and classroom setting for the student meets his or her current and ongoing needs or if it is appropriate. In making its determination, the CSE shall consider the following factors: (1) the physical condition of the student and any behavior which might increase the risk of transmission of the virus; and (2) the expected type of interaction with others in the school setting. The CSE may also consult with appropriate public health officials pursuant to article 27-F of the Public Health Law. Placement decision shall be based on the most current scientific and medical information available from federal, state and local sources.

In all other respects, the CSE shall carry out its responsibilities and make recommendations based upon the written evaluation setting forth the reasons for the recommendations, to the student, parent or guardian of the student and Board of Education as it would with any other student who has or is suspected of having a disability.

Because of the provisions in article 27-F of the Public Health Law permitting physicians to disclose confidential HIV-related information under certain circumstances, the school physician will be required to attend all meetings of the CSE in regard to students suspected or diagnosed as having HIV-related illness.

The CSE shall also have the authority to invite the appropriate professionals familiar with HIV- related illness to any meeting concerning the educational program for any such student, providing however, that such professional is named on a completed and signed Authorization Form or a court order granted under Public Health Law §2785.

The final decision to the admission, restriction or exclusion of infected students shall rest with the Board whose decision shall be based on the same standards applied to any other students with disabilities and after obtaining a recommendation from the CSE. If the Board proposes that the student be excluded or restricted, the parent or guardian shall be sent a written notice describing the proposed action. Upon the Board's decision to exclude or restrict placement of a child, every reasonable effort will be made to provide an alternative educational program such as home instruction or independent study. The Superintendent or his/her designee shall monitor students who are excluded.

8. If the student had previously been evaluated and been recommended for placement by the CSE, and thereafter the student is deemed dangerous to himself or others, a short-term suspension (of five days or less) may be imposed, or other protective procedures may be invoked. However, where parents choose to exercise their due process rights under the appeal procedures set forth in state and federal law, a student must remain in the current placement until appeal procedures are completed, or parental consent or court order for alternative placement is obtained.

If the student has not been evaluated and recommended for placement by the CSE, section 6 (above) shall apply.

9. Pursuant to Public Health Law article 27-F, a physician may, upon the consent of a parent or guardian, disclose confidential HIV-related information to a state, county or local health officer for the purpose of reviewing the medical history of a child to determine the fitness of the child to attend school.

Additional Matters

In the event of the presence of any contagious or communicable disease (such as chicken pox or measles, etc.) in the school population, which may constitute a risk to an infected individual, the Superintendent or the school nurse with authorization to obtain the confidential HIV-related information may inform the student, the student's parents or legal guardian about such risk. Any temporary decision or recommendation in such circumstances should be made by the individual's personal physician and the student's parents, in consultation with the Superintendent, school physician and nurse.

Adoption date: August, 1993

Cross-ref: 4315.1, AIDS Instruction
5420, Student Health Services
8123, Hygiene Precautions and Procedures

Ref: Public Health Law, Article 27-F
Education Law §4401; 4401-a
8 NYCRR §200
10 NYCRR §63

Adoption date: August, 1993

STUDENTS WITH HIV-RELATED ILLNESS EXHIBIT

*The University of the State of
New York Education Department*

*Approved by:
New York State Department of Health*

*Authorization for Release of
confidential HIV* Related Information
to the Superintendent of Schools and
the Board of Education*

OC-1 (6/89)

Confidential HIV Related Information means any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing this form. You may ask for a list of people who can be given confidential HIV related information even without this form.

If you sign this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form, and you can change your mind at any time.

If you experience discrimination because of the release of HIV related information, you may contact the New York State Division of Human Rights at (212) 870-9624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

| | | | |
|--|------|-------|----------|
| NAME OF PERSON WHOSE HIV RELATED INFORMATION WILL BE RELEASED | | | |
| NAME AND ADDRESS OF PERSON SIGNING THIS FORM (IF OTHER THAN ABOVE) | | | |
| STREET | CITY | STATE | ZIP CODE |
| RELATIONSHIP TO PERSON WHOSE HIV INFORMATION WILL BE RELEASED | | | |

| |
|-------------------------|
| NAME OF SCHOOL DISTRICT |
|-------------------------|

Name and addresses of the Superintendent of Schools and individual members of the Board of Education (Board of Trustees) of the above named school district who will be given HIV related information:

| | |
|-----------------------|------|
| SUPERINTENDENT'S NAME | |
| STREET | CITY |
| NAME | |
| STREET | CITY |

*Human Immunodeficiency Virus that causes AIDS (*Continued on Reverse*)

[illegible]

Reason for release of HIV related information

☐ To approve the recommendation of the _____ CSE as required by law.

☐ Other (explain in full, use additional sheet(s) if necessary _____

Time during which release is authorized

| | | | | | | | | | | |
|--|----------------------|----------------------|--------------|----------------------|----------------------|----------------------|----------------------|--------------|----------------------|----------------------|
| | <input type="text"/> | <input type="text"/> | FROM: | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | TO: | <input type="text"/> | <input type="text"/> |
| | <i>Month</i> | <i>Day</i> | | <i>Month</i> | <i>Day</i> | <i>Year</i> | | <i>Month</i> | <i>Day</i> | <i>Year</i> |

My questions about this form have been answered. I know that I do not have to allow release of HIV related information, and I can change my mind at any time.

Signature _____
Adoption date: August, 1993

Date _____

FIRST AID

School health personnel are responsible for giving first aid or emergency treatment in case of sudden illness or injury to a pupil or staff members. In case of a student's illness or injury, the school shall attempt to place the Student in the care of a parent, guardian, or person designated by the parent or guardian in such cases, as soon as possible, yet the school must retain jurisdiction over and responsibility for the student until this has been done.

The school physician shall develop and distribute Medical First Aid standing orders and procedures for the nurse or other personnel to follow in emergencies. These procedures shall incorporate the following requirements:

1. no treatment except first aid is permitted in school;
2. a master first aid kit shall be kept and properly maintained in each school, **on each school district personnel vehicle**, and each school bus;
3. no drugs shall be administered by school personnel unless authorized by a physician;
4. parents shall be asked to sign and submit an emergency medical authorization which shall indicate the procedure they wish the school to follow in the event of a medical emergency involving their child;
5. in all cases where the nature of an illness or an injury appears serious, the parent or guardian will be contacted if possible, and the instructions on the child's emergency card followed. In extreme emergencies, arrangements may be made for the child's immediate hospitalization whether or not the parent or guardian can be reached.

The district will follow SED directives and policies with respect to the use and maintenance of Automated External Defibrillation (AED) devices.

Ref: Education Law §§3023; 3212-a; 6527(4)(a); 6909

Ref: AED Policy

Adoption date: August, 1993

Revised: August 28, 2003

CONTAGIOUS DISEASES

The Board of Education believes that effective precautions and work practice controls are the best methods for the containment of potentially infectious materials and provide employees, students and others in the school community with the best protection against such exposure to contagious diseases.

The District shall establish and implement practices consistent with the Universal Precaution Procedure to safeguard against potentially infectious materials and/or contagious diseases.

Cross-ref: 5420, Student Health Services

Ref.: 29 CFR §1910.1030

Adoption date: August, 1993

Revised date: August 28, 2003

CONTAGIOUS DISEASES REGULATION

Consistent with federal regulations, the following guidelines are designed to protect members of the school community against exposure to potentially infectious materials.

A. Definitions

“Potentially Infectious Materials” means

1. the following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid; pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental proceedings, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.
2. any unfixed tissue or organ (other than intact skin) from a human (living or dead); and
3. HIV-containing cell of tissue cultures, organ cultures, and HIV-or HBV-containing culture medium of other solutions.

“Occupational Exposure” means reasonably anticipated skin, eye, mucous membrane, non-intact skin or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee’s duties.

“Exposure Incident” means a specific eye, mouth, other mucous membrane, non-intact skin or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee’s duties.

“Sharps” means any object that can penetrate the skin including, but not limited to, needles, staples, broken glass, capillary tubes, and exposed ends of dental wires.

“Universal Precautions” is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV (human immunodeficiency virus), HBV (hepatitis B virus), and other blood-borne pathogens.

“Work Practice Controls” means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique).

B. Universal Precautions Procedure

The district's **Universal Precautions Plan** contains at least the following elements:

Exposure Determination

The district shall prepare an exposure determination which shall contain the following:

1. a list of all job classifications in which all employees in those job classifications have "occupational exposure" (see Exhibit 8123.1 – E.1); and
2. a list of job classifications in which some employees have occupational exposure (see Exhibit 8123.1 – E.1); and

Methods of Compliance

1. Universal Precautions. Universal precautions shall be observed to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

Engineering and Work Practice Controls. Engineering and work practice controls shall be used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be used. The district shall:

- a. provide hand washing facilities which are readily accessible to employees or, when such facilities are not feasible, either an appropriate antiseptic hand cleaner in conjunction with clean cloth/paper towels or antiseptic towels. When antiseptic hand cleaners or towelettes are used, hand shall be washed with soap and running water as soon as feasible;
- b. examine and maintain or replace engineering controls on a regular schedule to ensure their effectiveness;
- c. prohibit the eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses in work areas where there is a reasonable likelihood of occupational exposure. In addition, food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on countertops where blood or other potentially infectious materials are present;
- d. require that all procedures involving blood or other potentially infectious materials be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances;
- e. require that employees wash their hands immediately after removal of gloves or other personal protective equipment, and wash their hands and any other exposed skin after contact with blood or other potentially infectious materials;
- f. dispose of contaminated sharps in appropriately labeled, puncture resistant, and leakproof containers.
- g. place potentially infectious materials in a properly labeled container which prevents leakage during collection, handling, processing, storage, transport, or shipping; and

- h. examine prior to shipment for servicing any equipment which may become contaminated with blood or other potentially infectious materials and decontaminate. If possible. An appropriate label shall be affected employees, servicing representatives, and/or manufacturer, as appropriate, shall be put on notice so that precautions will be taken.
2. Personal Protective Equipment. When there is occupational exposure, the district shall provide and require the use of, at no cost to the employee, appropriate personnel protective equipment such as, but not limited to, gloves, gowns, face shields or masks and eye protection or other ventilation devices. The district shall also clean, dispose, repair and replace personal protective equipment at no cost to the employee. Personal protective equipment will be considered “appropriate” only if it does not permit blood or other potentially infectious materials to pass through or reach the employee’s work under normal conditions of use and for the duration of time which the protective equipment shall be removed prior to leaving the work area and shall be placed in appropriately designated area or container for storage, washing, decontamination or disposal.
3. Cleaning, Laundering, and Disposal. The district shall clean, launder, and dispose of personal protective equipment at no cost to the employee.
4. Repair and Replacement. The district shall repair or replace personal protective equipment as needed to maintain its effectiveness, at not cost to the employee.

Housekeeping. The district shall ensure that the worksite is maintained in a clean and sanitary condition. The district shall determine and implement an appropriate written schedule for cleaning and method for decontamination based upon the location within the facility, type of surface to be cleaned, type of soil present, and tasks or procedures being performed in the area.

Hepatitis B Vaccination and Post-Exposure Evaluation and Follow-up

1. The district shall make available the hepatitis B vaccine and vaccination series to all employees who have occupational exposure, and post-exposure evaluation and follow-up to all employees who have had an exposure incident. The district shall ensure that all medical evaluations, hepatitis B vaccinations, and laboratory tests are available at no cost to the employee, at a reasonable time and place, and performed by or under the supervision of a licensed physician or other licensed healthcare professional (see Exhibit 8123.1-E-3, Memo to Staff).
2. Hepatitis B vaccination shall be made available after the employee has received the required training and within 10 working days of initial assignment to all employees who have occupational exposure unless the employee has previously received the complete hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.

3. The district shall not make participation in a prescreening program a prerequisite for receiving hepatitis B vaccination.
4. If the employee initially declines the hepatitis B vaccination, but at a later date while still covered under the standard decides to accept the vaccination, the district shall make available the hepatitis B vaccination at that time.
5. The district shall assure that employees who decline to accept the hepatitis B vaccination sign the appropriate statement (see Exhibit 8123.1-E.2, Decline/Consent Form).
6. An exposed employee's post-exposure medical evaluation and follow-up shall include at least the following elements:
 - a. documentation of the route(s) exposure, and the circumstances under which the exposure incident occurred;
 - b. identification and documentation of the source individual, unless the district can establish that identification is infeasible or prohibited by state or local law:
 - i. The source individual's blood shall be tested as soon as feasible and after consent is obtained in order to determine HBV and HIV infectivity. If consent is not obtained, the district shall establish that legally required consent cannot be obtained. When the source individual's consent is not obtained. When the source individual's consent is not required by law, the source individual's blood, if available, shall be tested and the results documented.
 - ii. When the source individual is already known to be infected with HBV or HIV, testing for source individual's known HBV or HIV status need not be repeated.
 - iii. Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.
 - c. collection and testing blood for HBV and HIV serological status;
 - d. post-exposure prophylaxis, when medically indicated, as recommended by the U.S. Public Health Service;
 - e. counseling, and
 - f. evaluation of reported illnesses.
7. The district shall insure that the healthcare professional responsible for the employee's Hepatitis B vaccination is provided a copy of the regulation. The district shall ensure that the healthcare professional evaluating an employee after an exposure incident is provided with the following information:
 - a. a copy of this regulation;
 - b. a description of the exposed employee's duties as they relate to the exposure incident;
 - c. documentation of the route(s) of exposure and circumstances under which exposure occurred;
 - d. results of the source individual's blood testing, if available; and

- e. all medical records relevant to the appropriate treatment of the employee including vaccination status which are the district's responsibility to maintain.
8. The district shall obtain and provide the employee with a copy of the evaluating healthcare professional's written opinion within 15 days of the completion of the evaluation;
9. Medical records required by this standard shall be maintained by the district (see Recordkeeping below).

Communication of Hazards to Employees

1. Warning labels shall be affixed to containers of regulated waste and other containers used to store, transport or ship potentially infectious materials.
2. The district shall ensure that all employees with occupational exposure participate in a training program which must be provided at no cost to the employee and during working hours. Annual training for all employees shall be provided within one year of their previous training.

Recordkeeping

1. Medical Records. The district shall establish and maintain an accurate record for each employee with occupational exposure. This record shall include:
 - b. the name and social security number of the employee;
 - c. a copy of the employee's hepatitis B vaccination status including the dates of all the hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination;
 - d. a copy of all results of examinations, medical testing, and following-up procedures;
 - e. a copy of the healthcare professional's written opinion; and
 - f. a copy of the information provided to the healthcare professional.

The district shall ensure that employee medical records are kept confidential and are not disclosed or reported without the employee's express written consent to any person except as required by applicable law or regulation.

2. Training Records. Training records shall include the following information:
 - a. the dates of the training session;
 - b. the contents or a summary of the training sessions;
 - c. the names and qualifications of persons conducting the training; and
 - d. the names and job titles of all persons attending the training sessions. Training records shall be maintained for three years from the date on which the training occurred.

Adoption date: August, 1993

Revised: August 28, 2003 (B on page 1 of Contagious Disease Regulation)

HYGIENE PRECAUTIONS AND PROCEDURES

The Board of Education, in order to promote and ensure the health and safety to all students and staff, adopts the following policy on hygiene and sanitary procedures for dealing with exposure to and contact with blood and other body fluids.

To prevent and/or minimize the transmission of contagious or communicable diseases or infections within the school community, all employees of the school district shall utilize appropriate precautions when providing first aid or otherwise dealing with situations that involve exposure to blood and other body fluids. Such precautionary measure will be followed uniformly in all instances and shall be applicable in all buildings and facilities throughout the school district.

The Superintendent of Schools is responsible for developing appropriate procedures to implement this policy and for informing all staff of such procedures and ensuring compliance with them. The failure by any employee to utilize such procedures may form the basis for disciplinary action.

Cross-ref: 5191, Students with HIV-Related Illness

Adoption date: August, 1993

HYGIENE PRECAUTIONS AND PROCEDURES REGULATION

The following procedures shall be followed by all employees when providing first aid or otherwise dealing with situations where there is the possibility for exposure to or contact with blood or other body fluids.

1. Except in extraordinary, life threatening circumstances, all employees must wear rubber gloves to prevent contact with blood or other body fluids when treating or cleaning open cuts, scrapes, abrasions, etc. or spills or blood or other body fluids.
2. All spills of blood or other body fluids should be cleaned up first with soap and water and then with a 10 percent (10%) solution of household bleach. Gloves shall be worn throughout the cleanup process.
3. If possible, feces should be disposed of in a toilet with normal flushing. All disposable materials, including gloves and contaminated material used in the cleanup process, should be placed in a plastic bag and sealed. The sealed plastic bag should then be placed in a second plastic bag and disposed of properly.
4. Mops and reusable items used to cleanup spills should be disinfected with the bleach solution and then washed out before storage or reuse.
5. Toys and/or other personal non-disposable items should be cleaned with warm, soapy water and disinfected with the bleach solution before reuse by another person or being stored away. It is recommended that all non-disposable items be double bagged until they can be cleaned.
6. All persons must wash their hands with soap and water after cleaning up any spill of blood or other body fluid.
7. A supply of rubber gloves, bleach solution and plastic bags ("hygiene kit") shall be maintained in all other locations within the school district where potential for direct exposure to blood or other body fluids exists. The school nurse shall periodically check the status of each hygiene kit in the building of facility for which she/he is responsible. Bleach solutions will be replaced at least once each semester *or as needed*. An additional supply of rubber gloves shall be maintained in the nursing office in each school building or in the appropriate supervisor's office at other locations.

Adoption date: August, 1993

Revised: August 28, 2003

CONTAGIOUS DISEASES EXHIBITS

1. Job Classifications in which employees have “occupational exposure”:
(Sec. 1910.1030)

- a. School Nurses
- b. Teachers and Teacher Aides in developmentally disabled settings

Category #1 employees will be invited to participate in the district-funded vaccination program.

2. Job Classification in which employees have “potential exposure”:

Coaches in a school athletic program.

Category #2 employees will be offered post vaccination.

HEPATITIS B VACCINATION PROGRAM

TO: School Nursing Staff
Staff Working with Developmentally Disabled Students
Maintenance Staff

FROM: Assistant Superintendent for *Special Services*

RE: **Hepatitis B Vaccination Program**

As an employee who may experience occupational exposure to bloodborne pathogens, the district invites you, at no personal expense, to participate in a vaccination program for Hepatitis B virus.

After carefully reading the attached material in Section A, which describes the benefits of being vaccinated, you are asked to complete Form 1 or 2.

If you decline to participate in the vaccination program at this time, please complete and return Form 1 to my office by _____.

If you decide to participate in the vaccination program, please complete and return Form 2 to my office by _____. If you decide to participate in the vaccination program you will need to make arrangements with your own doctor. Since this is being offered at no expense to the employee, please forward the bill from your doctor to _____.

Should you have any questions, please feel free to contact my office.

Adoption date: August 1993

Revised: August 28, 2003

STATEMENT OF EMPLOYEE'S DECISION NOT TO RECEIVE HEPATITIS B VACCINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

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Last name,

First

Middle

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Social Security Number

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Street Address

City

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County

State

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Signature

Date

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Witness

Date

STATEMENT OF EMPLOYEE'S DECISION TO RECEIVE HEPATITIS B VACCINATION

I have read and/or have had explained to me the information of the Hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge. I have had an opportunity to ask questions and all my questions have been answered to my satisfaction.

I understand that participation in this program is voluntary and my constant or refusal of vaccination does not waive any rights under my employment contract.

I believe that I have adequate knowledge upon which to base an informed consent.

The vaccination will consist of three (3) intramuscular does of vaccine in the arm over a six month period of time. There is no guarantee that I will not experience an adverse side effect from the vaccine.

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| Last name, | First | Middle |
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| Witness | Date |
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Adoption date: August, 1993

PORT CHESTER – RYE UFSD DISTRICT WELLNESS POLICY

Component 1: A Commitment to Physical Activity and Nutrition

The Board of Education of the Port Chester-Rye Union Free School District encourages students to be healthy by supporting wellness, good nutrition and regular physical activity as a part of the total learning environment. The school district supports a healthy environment where students learn and participate in positive dietary and lifestyle practices. By facilitating learning through the support and promotion of good nutrition and physical activity, schools contribute to the basic health status of students. Improved health optimizes student performance potential.

The school district provides a comprehensive learning environment for developing and practicing lifelong wellness behaviors. The entire school environment, not just the classroom, shall be aligned with healthy school district goals to positively influence a student's understanding, beliefs and habits as they relate to good nutrition and regular physical activity.

The school district supports and promotes proper dietary habits contributing to students' health status and academic performance. All foods available on school grounds and at school-sponsored activities during the instructional day should meet or exceed the school district nutrition standards. Foods should be served with consideration toward nutritional integrity, variety, appeal, taste, safety and packaging to ensure high-quality meals.

The school district will make every effort to eliminate any social stigma attached to, and prevent the overt identification of, students who are eligible for free and reduced-price meals. Toward this end, the school district may utilize electronic identification and payment systems; provide meals at no charge to income eligible children; and promote the availability of meals to all students.

The school district will develop a local wellness policy committee comprised of representatives of the board, parents, leaders in food/exercise authority and employees. The local wellness policy committee will develop a plan to implement and measure the local wellness policy and monitor the effectiveness of the policy. The committee will designate an individual to monitor implementation and evaluation of the policy. The committee will report annually to the board regarding the effectiveness of this policy.

Physical Education

The school district is committed to providing physical education in a safe and healthy environment that:

- is consistent with the New York State Commissioner's Regulation 135.4, to the extent possible;
- is taught by a certified physical education teacher;
- includes students with disabilities, students with special health-care needs may be provided in alternative educational settings; and,
- engages students in moderate to vigorous activity during at least 50 percent of physical education class time.

Recess Goals

Elementary schools should provide recess for students that:

- is at least 20 minutes a day;
- is preferably outdoors;
- encourages moderate to vigorous physical activity verbally and through the provision of space and equipment; and,
- discourages extended periods (i.e., periods of two or more hours) of inactivity.

When activities, such as mandatory school-wide testing, make it necessary for students to remain indoors for long periods of time, schools should give students periodic breaks during which they are encouraged to stand and be moderately active.

Physical Activity and Punishment

Employees will not use physical activity (e.g., running laps, pushups) or withhold opportunities for physical activity (e.g., recess, physical education) as punishment.

Integrating Physical Activity into Classroom Settings and Beyond

For students to receive the amount of daily physical activity mandated by New York State and for students to fully embrace regular physical activity as a personal behavior, students need opportunities for physical activity beyond the physical education class. Toward that end, the school district will:

- offer classroom health education that complements physical education by reinforcing the knowledge and self-management skills needed to maintain a physically active lifestyle and to reduce time spent on sedentary activities;
- discourage sedentary activities, such as watching television, playing computer games, etc.; and,

- provide opportunities for physical activity to be incorporated into other subject lessons and through available health services.

Component 2: Quality School Meals

School Meals

Meals served through the National School Lunch and Breakfast Programs will:

- meet, at a minimum, nutrition requirements established by local, state and federal law;
- offer a variety of fresh fruits and vegetables;
- serve only low-fat (1%) and fat-free milk and nutritionally equivalent non-dairy alternatives (as defined by the USDA); and,
- ensure that half of the served grains are whole grain.

Breakfast

To ensure that all children have breakfast, either at home or at school, in order to meet their nutritional needs and enhance their ability to learn, schools will:

- operate the breakfast program, to the extent possible;
- utilize methods to serve breakfasts that encourage participation, to the extent possible;
- notify parents and students of the availability of the School Breakfast Program, where available; and,
- encourage parents to provide a healthy breakfast for their children.

Free and Reduced-Priced Meals

The school district will make every effort to eliminate any social stigma attached to, and prevent the overt identification of, students who are eligible for free and reduced-price meals. Toward this end, the school district may:

- utilize electronic identification and payment systems;
- provide meals at no charge to income eligible children; and,
- promote the availability of meals to all students.

Meal Times and Scheduling

The school district:

- will provide students with at least 10 minutes to eat after sitting down for breakfast and 20 minutes after sitting down for lunch;
- should schedule meal periods at appropriate times.; should not schedule tutoring, club or organizational meetings or activities during mealtimes, unless students may eat during such activities;
- will schedule lunch periods to follow recess periods (in elementary schools) to the extent possible;
- will provide students access to hand washing or hand sanitizing before they eat meals or snacks; and,
- should take reasonable steps to accommodate the tooth-brushing regimens of students with special oral health needs (e.g., orthodontia or high tooth decay risk).

Qualification of Food Service Staff

Qualified nutrition professionals will administer the meal programs. As part of the school district's responsibility to operate a food service program, the school district will:

- provide continuing professional development for all nutrition professionals; and,
- provide staff development programs that include appropriate certification and/or training programs for child nutrition directors, nutrition managers and cafeteria workers, according to their levels of responsibility.

Sharing of Foods

The school district discourages students from sharing their foods or beverages with one another during meal or snack times, given concerns about allergies and other restrictions on some children's diets.

Component 3: Other Healthy Food Options

Foods Sold Outside the Meal (e.g. vending, a la carte, sales)

In schools, all foods and beverages sold individually outside the reimbursable meal programs (including those sold through a la carte [snack] lines, vending machines, student stores or fundraising activities) during the school day, or through programs for students after the school day, will meet the following nutrition and portion size standards:

Beverages

- **Allowed:** water or seltzer water without added caloric sweeteners; fruit and vegetable juices and fruit-based drinks that contain at least 50 percent fruit juice and that do not contain additional caloric sweeteners; unflavored or flavored low-fat or fat-free milk and nutritionally equivalent nondairy beverages (as defined by the USDA).
- **Not allowed:** soft drinks containing caloric sweeteners; sports drinks; iced teas; fruit-based drinks that contain less than 50 percent real fruit juice or that contain additional caloric sweeteners; beverages containing caffeine.

Foods

By September 1, 2007, a food item sold individually:

- will have no more than 35 percent of its calories from fat (excluding nuts, seeds, peanut butter and other nut butters) and 10 percent of its calories from saturated and trans fat combined;
- will have no more than 35 percent of its weight from added sugars; and,
- will contain no more than 230 mg of sodium per serving for chips, cereals, crackers, French fries, baked goods and other snack items; will contain no more than 480 mg of sodium per serving for pastas, meats and soups; and will contain no more than 600 mg of sodium for pizza, sandwiches and main dishes.

Portion Size

Limit portion sizes of foods and beverages sold individually to those listed below:

- one and one-quarter ounces for chips, crackers, popcorn, cereal, trail mix, nuts, seeds, dried fruit or jerky;
- one ounce for cookies;
- two ounces for cereal bars, granola bars, pastries, muffins, doughnuts, bagels and other bakery items;
- four fluid ounces for frozen desserts, including, but not limited to, low-fat or fat-free ice cream;
- eight ounces for non-frozen yogurt;
- twelve fluid ounces for beverages, excluding water and milk; and,
- the portion size of a la carte entrees and side dishes, including potatoes, will not be greater than the size of comparable portions offered as part of meals. Fruits and non-fried vegetables are exempt from portion-size limits.

Fundraising Activities

The school district encourages fundraising activities that promote physical activity. To support children's health and school nutrition-education efforts, school fundraising activities should encourage the use of foods and beverages that meet the above nutrition and portion size standards for foods and beverages sold individually.

Snacks

Snacks served during the school day or in after-school care or enrichment programs should make a positive contribution to children's diets and health, with an emphasis on serving fruits and vegetables as the primary snacks and water as the primary beverage. Schools should offer snacks based on timing of meals, children's nutritional needs, children's ages and other considerations. If eligible, schools that provide snacks through after-school programs will pursue receiving reimbursements through the National School Lunch Program.

Rewards

The school district will not use foods or beverages, especially those that do not meet the nutrition standards for foods and beverages sold individually, as rewards for academic performance or good behavior, and will not withhold food or beverages (including food served through meals) as a punishment.

Celebrations

Schools should evaluate their celebration practices that involve food during the school day and encourage foods or beverages that meet the nutrition standards for foods and beverages sold individually.

School-Sponsored Events

Foods and beverages offered or sold at school-sponsored events outside the school day will meet the nutrition standards for meals or for foods and beverages sold individually.

Food Safety

All foods made available on campus must adhere to food safety and security guidelines.

- All foods made available on campus comply with the state and local food safety and sanitation regulations. Hazard Analysis and Critical Control Points (HACCP) plans and guidelines are implemented to prevent food illness in schools.
- For the safety and security of the food and facility, access to the food service operations are limited to child nutrition staff and authorized personnel, as approved by Board of Education policy.

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Component 4: Pleasant Eating Experiences

The eating experience will:

- provide for affordable meals;
- be appealing and attractive to children;
- be served in clean and pleasant settings;
- provide for drinking fountains to be available for students to get water at meals and throughout the day;
- assist all students in developing the healthy practice of washing hands before eating;
- allow for enough time so students do not have to spend too much time waiting in line;
- provide eating time for each child after being served will be 10 minutes for breakfast and 20 minutes for lunch;
- have proper adult supervision who serve as role models to students by demonstrating proper conduct and voice level; and,
- accommodate the religious, ethnic, and cultural diversity of the student body.

Component 5: Nutrition Education

The school district will provide nutrition education and engage in nutrition promotion that:

- is offered at each grade level as part of a sequential, comprehensive, standards-based program designed to provide students with the knowledge and skills necessary to promote and protect their health;
- is part of not only health education classes, but also classroom instruction in subjects such as math, science, language arts, social sciences and elective subjects and through available health services;
- includes enjoyable, developmentally appropriate, culturally relevant participatory activities, such as contests, promotions, taste-testing, farm visits and school gardens;
- promotes fruits, vegetables, whole-grain products, low-fat and fat-free dairy products, healthy food preparation methods and health-enhancing nutrition practices;
- emphasizes caloric balance between food intake and physical activity;
- links with meal programs, other foods and nutrition-related community services; and,
- includes training for teachers and other staff.

Component 6: Marketing

- Students will receive positive, motivating messages, both verbal and non-verbal, about healthy eating and physical activity throughout the school setting. School personnel will help reinforce these positive messages.
- Schools will consider student need in planning for a healthy school nutrition environment.
- Students will be asked for input and feedback through the use of student surveys, and attention will be given to their comments.
- Schools will promote healthy food choices and will not allow advertising that promotes less nutritious food choices.
- Healthy eating and physical activity will be actively promoted to students, parents, teachers, administrators.

Communication with Parents

The school district will support parents' efforts to provide a healthy diet and daily physical activity for their children. The school district will:

- post nutrition tips on school web sites and provide nutrient analyses of school menus;
- encourage parents to pack healthy lunches and snacks and to refrain from including beverages and foods that do not meet the established nutrition standards for individual foods and beverages;

- provide information about physical education and other school-based physical activity opportunities before, during and after the school day;
- support parents' efforts to provide their children with opportunities to be physically active outside of school; and,
- include sharing information about physical activity and physical education through a web site, newsletter, other take-home materials, special events or physical education homework.

Food Marketing in Schools

By September 2007, school-based marketing will be consistent with nutrition education and health promotion. The school district will:

- limit food and beverage marketing to the promotion of foods and beverages that meet the nutrition standards for meals or for foods and beverages sold individually;
- prohibit school-based marketing of brands promoting predominantly low-nutrition foods and beverages;
- promote healthy foods, including fruits, vegetables, whole grains, and low-fat dairy products; and,
- market activities that promote healthful behaviors.

Component 7: Implementation and Monitoring and Policy Review

The Superintendent of Schools or his/her designee will ensure implementation and compliance with this policy.

A District Wellness Team will be established to:

- conduct a baseline assessment of the school's existing nutrition and physical activity environments and practices. The results of those school-by-school assessments will be compiled to identify and prioritize needs for the site based wellness functions.
- survey, on an annual basis, students, staff, and parents and provided the summary report to the Board of Education, school wellness personnel, and food service personnel in the school district; and
- report on the most recent USDA School Meals Initiative (SMI) review findings and any resulting changes. If the school district has not received a SMI review from the state agency within the past five years, the school district will request from the state agency that a SMI review be scheduled as soon as possible.
- develop a summary report every three years on school district-wide compliance with the school district's established wellness policy, based on input from schools within the school district. As part of that review, the school district will review the nutrition and physical activity practices and the provision of an environment that supports healthy eating and physical activity. The school district, revise the wellness policy and develop work plans to facilitate their implementation.

In each school:

- the principal will ensure, through the establish of a school based wellness function, implementation and compliance in the school;
- the principal will report on the school's implementation and compliance using the format in the related Regulation;
- food service staff will ensure implementation and compliance; and
- the food service director will report on implementation and compliance using the format in the related Regulation.

Ref: P.L. 108-265 (Child Nutrition and WIC Reauthorization Act of 2004)
 42 USC §§1758(f)(1); 1766(a) (Richard B. Russell National School Lunch Act)
 42 USC §1779 (Child Nutrition Act)
 7 CFR §210.10; 210.11 (National School Lunch Program participation requirements – standards for lunches, snacks, and competitive foods)
 7 CFR §220.8 (School Breakfast Program participation requirements – nutrition standards)

Adoption date:

XI. School Health Office Activity Calendar

September

- Emergency form distribution and data entry
- Notify parents of students whose immunizations are not in compliance
- Generate health records for all new entrants
- Confidential list to Administration and Guidance Counselors
- Inform Physical Education teachers and Guidance Counselors of medical excuses
- New entrant's physicals/Transition physicals/Sports physicals
- Audio screenings on 10th graders receiving sports physical examinations
- Conduct sport interval health histories
- Working paper physical examinations
- Confirm grades of all students and file charts appropriately
- Head Lice checks
- Develop emergency medical care plans
- Develop individualized health care plans
- Daily Log
- Monthly Report

October

- Update student health records & review immunizations for compliance
- Notify parents of students whose immunizations are not in compliance
- Generate health records for all new students
- Inform physical education teachers and guidance counselors of medical excuses
- New entrant's physicals/Transition physicals/Sports physicals
- Conduct sport interval health histories
- State Immunization Survey
- Mandated physical examination begin (grades K, 2, 4, 7, & 10)
- Begin Height, Weight, Vision, and Scoliosis (>8years old) Screenings for mandated grades
- Referral letters for findings on physical exam and/or screenings
- Daily Log
- Monthly Report

November

- New entrant's physicals/Transition physicals/Sports physicals
- Generate health records for all new entrants
- Inform physical education teachers and guidance counselors of medical excuses
- Notify parents of students whose immunizations are not in compliance
- Conduct sport interval health histories
- Mandated physical examinations continue
- Height, Weight, Vision, and Scoliosis screenings continue
- Referral letters for findings on physical exam and/or screenings
- Send communicable disease letter to parents
- Infection Control Measures Letter to Teachers

- Daily Log
- Monthly Report

December

- Continue activities of previous months
- Budget
- Daily Log
- Monthly Report

January

- Continue activities of previous months
- Send letters to families regarding mandated physicals for September of next school year (K, 2, 4, 7, & 10)
- Daily Log
- Monthly Report

February

- Continue activities of previous months
- Daily Log
- Monthly Report

March

- Continue activities of previous months
- Daily Log
- Monthly Report

April

- Continue activities of previous months
- Daily Log
- Monthly Report

May

- Continue activities of previous months
- Good Touches-Bad Touches Teaching
- Daily Log
- Monthly Report

June

- Continue activities of previous months
- Send letters home requesting updated medical information (in order to generate confidential list for upcoming year)
- Medication consent forms for upcoming year
- Letter home for pick-up of medications
- Transfer files to appropriate schools within the district
- Daily Log
- Monthly Report