



School Nursing Manual

Nursing Policy Manual

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Section 1

Introduction

Introduction

*I see God in every human being. When I wash the leper's wounds, I feel
I am nursing the Lord himself. Is it not a beautiful experience?
Mother Teresa*

Being a nurse in a Catholic School is a unique blessing and opportunity. Each day, the work consists of meeting the increasingly complex health needs of the children and faculty within the building. Catholic Schools within the Archdiocese of Baltimore (AOB) vary in size, demographics of their student populations, staffing logistics and a host of other factors.¹ As school nurses are likely the only health care professionals within the building, their role is a vital component to the health and safety of students and staff. School nurses are important contributors to the education productivity, academic success and spiritual enrichment of the students served.

The AOB School Nursing Manual has been assembled to provide the dedicated nurses of Catholic schools with an information bank of many standard protocols, policies, and resources. The Manual includes many of the Maryland State Department of Health and Mental Hygiene guidelines that pertain to school health management and student care. It is by no means a complete compilation of all the resources currently available online or within the healthcare and nursing field. Periodically, as possible, this Manual may be updated to provide school nurses additional reference materials and resources.

This Manual is informational only, and nurses themselves should stay up to date with the latest policies and procedures regulating their profession, and, of course, should rely on their professional judgment, knowledge, and training when providing care to students at their respective school.

If you, as a school nurse within the AOB's religious jurisdiction, have questions related to this Manual, please contact the AOB's Department of Schools at 410-547-5515 or the Department of Risk Management at 510-547-5424

¹ All schools and parishes are owned and operated by separately incorporated legal entities. Thus, any school nurse working at a school within the AOB's religious jurisdiction is an employee or agent of only the school or location at which they are actually employed. And this Manual does not create any employment or agency relationship between any person or entity and the AOB or any of its employees or agents.

Section 2

Role of School Nurse in Catholic Schools

Role of School Nurse in Catholic School, Job Description, Qualifications

Nursing Position

Role:

A school nurse is a specialized professional who advances the well-being, academic success, spirituality and achievement of students. Within their roles, school nurses promote safety and health, intervene with both actual and potential health issues/problems, and actively collaborate with others to build student and family capacity for adaptation, self-management, self-advocacy, and learning (as defined by the National Association of School Nurses.)

Within Catholic schools, the nurse functions as part of a multi-disciplinary team in an effort to identify, assess, plan, implement and evaluate the health needs within the school community. In this role, the nurse will actively involve administration, parents, staff members, students and community liaisons with an emphasis toward prevention, promotion of health, appropriate utilization of health services, and health education. School nurses also support school attendance. When warranted, they may alert families and assist with identifying special health needs. If appropriate, they can work with other health care professionals to provide health care plans in an effort to reduce interruptions in student learning and absenteeism.

A school nurse's duties include (but are not limited to) dispensing medication as needed, maintaining health records, and working to ensure compliance with state and county health requirements.

All school nurses working more than a 5 hour day must take a 30 minute lunch break.

Typical Job Responsibilities:

- Provide nursing assessment and treat injuries and illnesses
- Dispense medication as necessary and as prescribed
- Schedule/perform hearing and vision testing
- Collaborate with other school nurses

Section 2

- Maintain student health records in accordance with the Health Department of Maryland and the Department of Catholic Schools, AOB requirements (including the use of PowerSchool)
- Maintain a clean and safe health office/suite/room (e.g., supplies, secure medication and health record storage, etc.)
- Report injuries and health related risk issues to the Archdiocese and the Department of Risk Management when appropriate to do so
- Disseminate health information to parents as appropriate and necessary
- Share and/or disseminate health information as needed to administration, faculty, staff and students
- Educate and maintain staff certification on blood borne pathogens, anaphylactic allergies, the use of stock epinephrine, diabetes and any other medical condition that may require emergency treatment in school
- Coordinate care plans and special accommodations for students
- Maintain CPR certification
- Participate in a crisis management committee and coordinate a medical emergency response team
- Maintain the health room and all school health related equipment and supplies
- Assist in the development of a school health services budget
- Coordinate medical management of students for field trips
- Attend continuing education programs
- Attend AOB nurse meetings
- Maintain confidentiality in all areas of responsibility
- Maintain a substitute RN list for administration in the event of emergency, planned or unplanned absences from work
- Oversee the Certified Medication Technicians (if there is one at school)
- Perform other duties as assigned

Typical Qualifications:

- Registered nurse, currently licensed and in good standing in the state of Maryland
- Prior experience working with a diverse age group/population
- Successful prior work experience
- Have completed the Delegating Nurse curriculum as outlined by the Maryland Board of Nursing (or be willing to complete the DN curriculum in a timely manner)
- Current CPR certification
- Excellent references

More information on school health within the State of Maryland can be found at www.mdschoolhealthservices.

.07 School Health Services Standards — For All Students.

A. Physical Examination.

(1) A physical examination is required of each child entering the Maryland public school system for the first time. The examination shall be completed within the period of 9 months before entrance or 6 months after entrance. The physical examination form designated by the Department of Education and the Maryland Department of Health shall be used to meet this requirement.

(2) The physical examination shall be completed by a physician or certified nurse practitioner.

(3) For each school year each public school shall report to the local board of education or local health department the number of children entering the public school system for the first time who have not had a physical examination because of the lack of access to health care, insufficient financial resources, or any other reason, including a religious reason, as the public school deems appropriate.

(4) An effort should be made to facilitate students and their families in obtaining a physical examination. However, if a student is unable to obtain a physical examination, the student may not be excluded from school.

(5) For each school year the local board of education or local health department shall report the number of children who have not had a physical examination and the reason or reasons for not obtaining the physical examination to the Maryland Department of Health.

B. Review of Students' Health Records. The initial review of students' health records may be conducted by the designated school health professional or a school health services aide. The review of records shall include a review of the student's health history, health screening reports, physical examination form as designated by the Department of Education and the Maryland Department of Health, dental examination records, and other health reports. During the record review, the designated school health services professional or school health services aide shall document whether the student has a primary care provider. Students with health problems or concerns identified during the initial review of records by the school health services aide shall be referred to the designated school health services professional for a health appraisal.

C. Health Appraisal. A health appraisal for students identified through the review of records as having health problems or concerns shall be conducted by the designated school health services professional. The health appraisal may include health observations, interviews, and conferences with parents/guardians, students, educators, and other health professionals. Health appraisals shall be conducted as follows:

(1) The health appraisal shall take place not later than 6 months after the date of entry to a school system and after that as indicated in §C(2), of this regulation.

(2) The health appraisal of students with identified health problems shall be repeated as frequently as deemed necessary by the designated school health services professional.

(3) Screening of students shall be carried out according to mandated or recommended screening programs established by the Department of Education and the Maryland Department of Health. These shall include:

(a) **Hearing and Vision Screening Tests.** The local board of education or local health department shall provide and fund hearing and vision screenings for all students in the public schools. The local health department shall provide and fund hearing and vision screenings for all students in any private school that has received a certificate of approval under Education Article, §2-206, Annotated Code of Maryland, and students in any nonpublic educational facility in this State approved as a special education facility by the Department.

(b) Unless evidence is presented that a student has been tested within the past year, these hearing and vision screenings shall be given in the years that a student enters a school system, enters the first grade, and enters the eighth, or ninth grade. Additional screenings may be required under the policies adopted by the local board of education or local health department.

(c) The results of the hearing and vision screenings shall be made a part of the permanent record file of each student and given to the parents of any student who fails the screenings and reported to the local board of education or the local health department. If a student fails the screenings, the parent/guardian shall report on the recommended services received by the student to the local board of education or local health department on an approved form.

(d) The local board of education or local health department shall report to the Maryland Department of Health the results of the hearing and vision screenings and, to the extent practicable, the number of students receiving the recommended services.

(e) Students may be exempt from these hearing and vision screenings if the parent/guardian objects in writing on the ground that it conflicts with the tenets and practice of a recognized church or religious denomination of which the parent/guardian is a member.

(4) When a health problem has been identified through the health appraisal process, the designated school health services professional or designee shall notify and assist students, or parents/guardians, or both, in selecting recommended services.

(5) For students without a usual source of care, the designated school health services professional or designee shall assist the student/family to identify a primary care provider.

(6) The designated school health services professional shall be responsible for follow-up.

(7) The designated school health services professional or the school health services aide shall inform appropriate school personnel of students who have health problems which may impede learning or require special care, or both.

D. Health Counseling.

(1) The designated school health services professional shall offer health counseling after the identification of a health need.

(2) If any additional counseling services are required, the designated school health services professional shall assist students and families in selecting the additional counseling services.

E. Communicable Diseases.

(1) A school shall comply with the Maryland Department of Health's immunization requirements in accordance with COMAR 10.06.04.

(2) The principal or the principal's designee shall notify the local health department of all suspected or diagnosed cases of reportable communicable diseases in compliance with Health-General Article, Title 18, Annotated Code of Maryland. The local health department shall assist the local board of education in implementing a plan for preventing the spread of the reported disease.

(3) The local health department and the local board of education, following State guidelines, shall jointly develop written policies and procedures for dealing locally with outbreaks of nonreportable communicable diseases such as scabies, pediculosis, and athlete's foot.

F. Physical Education Program.

(1) The designated school health services professional shall be available for consultation in planning, implementing, and evaluating those aspects of the physical education program which specifically relate to the health and safety of the participants.

(2) Before participating in interscholastic sports, students shall have a physical examination in compliance with COMAR 13A.06.03.02I. A copy of the results of the physical examination shall be kept in the school health record.

(3) In compliance with COMAR 13A.06.03.04B(3), all coaches shall be required to enroll and complete a one-credit course in the prevention and care of athletic injuries.

Section 3

PowerSchool, Record Keeping, Absences, and Confidentiality

PowerSchool

To help schools maintain student healthcare records in a timely and efficient manner, all students' office visits, immunization records, and health screenings must be entered into the Student Information System (PowerSchool). This includes all students currently enrolled at the school, with the expectation that any new students entering the school will be added into the school's secure, health file within PowerSchool in a timely manner. Only staff who have been granted Health Access by the school nurse are able to enter this information. With the exception of notations regarding allergies, which are noted with a distinct symbol and can be seen by a classroom teacher, all health related information and health suite visits are confidential to the designated health care professional or his/her designee.

Please see sections 3.0a, 3.0b, 3.0c, and 3.0d for information on documenting student health information into PowerSchool.

If your school is using an alternative Student Information System, the expectation for timely documentation should still apply.

Office Visits in PowerSchool

ALL students who visit the health suite should have their office visit entered into the Student Information System (PowerSchool). This is to be performed in as timely a manner as possible by the school nurse or her/his designee.

If your school is using an alternative Student Information System, the expectation for timely documentation should still apply.

Directions:

archbalt.powerschool.com/admin

Enter username and password (This information can be obtained from your Local Administrator.)

1. Main Menu > Select Student > Health > Office Visit Tab

[Start Page](#) > [Student Selection](#) > Health

Health

4 10017801 SI

Immunizations

Screenings

Office Visits


Grade Level Entry Certifications

Section 3.0a

2. Add > Fill out information on screen > Add

Add Office Visit

Visit Details

Visit Type	<input type="text"/>	<input type="checkbox"/> Contact with Parent	
Provider Name	Sunda Cramer	Provider Type	<input type="text"/>
Visit Date *	06/13/2017 	Visit Time In	🕒 10:14 AM
		Visit Time Out	🕒

Visit Reasons

Issue/Visit Reason	Assessment
<input type="text"/>	<input type="text"/>
512 characters left	512 characters left

Outcome & Actions

Visit Outcome

3. Submit

****Office Visits can be edited by clicking on the date of the office visit and editing any information****

Immunizations in PowerSchool

All students' immunization records should be entered into the Student Information System (PowerSchool). This includes all students currently enrolled at the school, with the expectation that any new students entering the school will be added into the school's secure, health file within PowerSchool in a timely manner. Only staff who have been granted Health Access are able to enter this information. With the exception of notations regarding allergies, which are noted with a distinct symbol and can be seen by a classroom teacher, all health related information and health suite visits are confidential to the designated health care professional or his/her designee.

If your school is using an alternative Student Information System, the expectation for timely documentation should still apply.


Directions:

Go to: archbalt.powerschool.com/admin

Enter in username and password (This information can be obtained from your Local Administrator.)

1. Main Menu > Select Student > Health > Immunization Tab

[Start Page](#) > [Student Selection](#) > [Health](#)

Health 

4 10017801 SI

Immunizations

Screenings


Office Visits

Grade Level Entry Certifications

Section 3.0b


2. Click on the empty box of the immunization to enter. Enter in date.

Vaccine		
	1st	2nd
DTP	<input type="text"/>	<input type="text"/>
DTP (Age 5+)	<input type="text"/>	<input type="text"/>
Polio	<input type="text"/>	<input type="text"/>
HIB	<input type="text"/>	<input type="text"/>
HIB (Age 5+)	<input type="text"/>	<input type="text"/>
MMR (Age 2-4)	<input type="text"/>	<input type="text"/>

MM/DD/YYYY 

No Date

Certificate Type:

County Form 

3. Enter initials in Description of Change box

Description Of Change * Use this field to record rationale for the changes being made.

4. Submit

Section 3.0b

For exempted vaccinations click on the vaccination and choose the exemption type, then follow steps 3 and 4.

HIB	<input type="button" value="OP"/> <input type="button" value="EX"/>		
HIB (Age 5+)	<input type="button" value="OP"/>		
MMR (Age 2-4)	<input type="button" value="OP"/> <input type="button" value="EX"/>		
MMR (Age 5+)	<input type="button" value="OP"/>		
Varicella (Age 2-4)	<input type="button" value="OP"/>		
Varicella (Age 2-4)			
Out of compliance <input type="checkbox"/>			
Exemption Type:			
None			
Comment:			
511 characters left			
Tdap	<input type="button" value="OP"/>		

Section 3.0b

HIB	<input type="checkbox"/> OP <input type="checkbox"/> EX
HIB (Age 5+)	<input type="checkbox"/> OP
MMR (Age 2-4)	<input type="checkbox"/> OP <input type="checkbox"/> EX
MMR (Age 5+)	<input type="checkbox"/> OP
Varicella (Age 2-4)	<input type="checkbox"/> OP
Varicella (Age 2-4)	
Out of compliance <input type="checkbox"/>	
Exemption Type:	
None ▼	
Comment:	
<div style="border: 1px solid gray; height: 60px;"></div>	
511 characters left	
Tdap	<input type="checkbox"/> OP

Health Screenings in PowerSchool

Students' vision and hearing screenings should be entered into the Student Information System (PowerSchool). If the student has a waiver, this information also needs to be noted in PowerSchool. The only staff who can access this screen are those staff members who have been given previous access in the health section and school nurses.

Directions:

Go to: archbalt.powerschool.com/admin

Enter username and password (This information can be obtained from your Local Administrator.)

Screenings Available:

- Hearing
- Oral Health
- Scoliosis
- Tuberculosis
- Vision & Color
- Vital Sign/Biometrics

To do enter individual student data:

1. Main Menu > Select Student > Health > Screenings Tab > Add Screening or Add Waiver

Immunizations Screenings Office Visits Grade Level Entry Certifications

Screening Records

2.

Type	Date	Outcome	Comments
No records found.			

Add Waiver ▾ Add Screening ▾

- Hearing Screening
- Oral Health Screening
- Scoliosis Screening
- Tuberculosis Screening
- Vision and Color Screening
- Vital Signs/Biometrics Screening

Click on the screen to enter > Fill in information > Add

Section 3.0c

Add Hearing Screening



Screening Details

Screening Provider Name

Screening Date *

06/13/2017



Screening Provider Type



Grade Level *

4th Grade



Hearing Test

Right Ear Test Result



Left Ear Test Result



Test Type



Hearing Referral Date

MM/DD/YYYY



Hearing Aid

256 characters left

Test Conducted Late

Outcome & Comment

Screening Outcome



Comment

3. Submit

Section 3.0c

To enter mass screening data:

1. Main Menu > Click on the grade level or group of students > Drop down from right hand side on bottom Health Screenings

The screenshot shows a software interface with a top navigation bar containing 'Students', 'Staff', and 'Parents'. Below this is a search bar with a magnifying glass icon, an 'Advanced' checkbox, and a 'View Filter' link. A grid of letters (A-Z) and grade levels (PK3, PK4, K, 1-8, M, F, All) is visible. A 'Current Student Selection (65)' section is highlighted. On the right, a 'Group Functions' dropdown menu is open, listing categories: Student Screens, Attendance (Attendance Change, Search By Grades/Attendance, Search For Perfect Attendance), Enrollment (Enrollment Summary, Mass Enroll Special Program, Re-Enroll in School, Transfer Out Of School), Export (Export Using Template, List Students, Quick Export), and Functions (Fee Functions, Health Screenings, ID/Password Assignment). The 'Health Screenings' option is checked with a green checkmark. At the bottom right of the dropdown, there are buttons for 'Select By Hand' and 'Health Screenings'.

2. Enter in the screening information > Next

▼ Select Students and Screening Type

The screenshot shows a form titled 'Select Students and Screening Type'. It has two main sections: 'Student Selection' and 'Screening Information'. Under 'Student Selection', there are radio buttons for 'Current Selection (65)' (selected) and 'By Class (0)'. Under 'Screening Information', there is a date field for '06/13/2017' with a calendar icon, a dropdown menu for 'Screening Type' set to 'Hearing', and a 'Default Values' button. Below these are several checkboxes for columns to display: 'Screening Provider Name', 'Screening Date', 'Screening Provider Type', 'Right Ear Test Result', 'Left Ear Test Result', 'Test Type', 'Hearing Referral Date', 'Hearing Aid', 'Test Conducted Late', 'Screening Outcome' (checked), and 'Comment'. At the bottom, there is a note: 'Screenings are entered one student at a time. Click Next to begin entering student screenings' followed by a 'Next' button.

3. Scroll to bottom of page > Click empty box next to student name > Fill in information in pull down box

[View All Screenings](#)

Screening Details

Screening Provider Name

Screening Date 06/13/2017

Grade Level


Screening Provider Type

Hearing Test

Right Ear Test Result

Left Ear Test Result

Test Type

Hearing Referral Date MM/DD/YYYY 

Hearing Aid

Cancel **Save and Close** **Save and Next**

4. Save and click Next to go to next student or Save and Close to close screen

Emergency Medical Information in PowerSchool

Students' emergency medical information should be entered into the Student Information System (PowerSchool). The only staff who can access this screen are those staff members who have been given previous access in the health section and school nurses.

If your school is using an alternative Student Information System, the expectation for timely documentation should still apply.

Directions:

archbalt.powerschool.com/admin

Enter username and password (This information can be obtained from your Local Administrator.)

1. Main Menu > Select Student > Emergency Contact/Medical

[Start Page](#) > [Student Selection](#) > [Emergency Contact/Medical](#)

Emergency Contact/Medical


-1 10019611 ASRS

Contact #1

Contact Name (Last, First)

Section 3.0d

2. Under emergency contact information> enter student emergency health information

Contact #	Contact Name (Last, First)	Relationship
	<input type="text"/>	<input type="text"/>
	Phone	Phone Type
	<input type="text"/>	<input type="text"/>
Doctor	<input type="text"/>	<input type="text"/>
Dentist	<input type="text"/>	<input type="text"/>
Special Medical Considerations	<input type="text"/>	
Allergies	<input type="text"/>	
Immunizations	Polio MMR DPT	
	<input type="text"/>	<input type="text"/>
Medical Alert Text	<input type="text"/>	
Alert Expires (date)	0/0/0  (0/0/0 to never expire)	

Submit

3. Submit

Record Keeping

Please see the attached table that contains retention periods for various types of records.

Of particular note:

- Student health records must be retained until the student attains the age of majority plus 3 years (i.e, age 21) or for 5 years after the record is made, **whichever is later**.
- Student injury reports must be retained until the student attains the age of 21, then destroyed.
- Staff exposure records under OSHA should be retained for the duration of employment plus 30 years.

Please also note the following excerpts from the *Policy Manual for Elementary Schools for the Archdiocese of Baltimore* under the Administration, Student Services and Health sections. This manual is generally maintained in the Administrative offices of each school. Nurses are to be familiar with policies on record keeping, admission procedures as they relate to health, absences, vaccination requirements, and student injury.

- ADM 4.1- Emergency information for each student is kept on file in the school.
- HE 1.0- The school maintains a health file for each student for the duration of enrollment.
- HE 3.0- Principals notify their local health department in cases of student absences due to a reportable communicable disease.
- HE 6.0- The principal must develop an adequate plan to ensure the health and safety of students, staff and visitors.

Last Updated January 2018

SCHOOL RECORDS

ADMINISTRATIVE RECORDS		
Records Title / Description	Retention Period	Type Of File
Accreditation Files (<i>reports, notes, correspondence, evaluations, personnel record, etc., relating to accreditation by the Maryland State Department of Education and County Superintendent of Schools</i>)	Retain State Accreditation Files permanently. Retain County Superintendent of Schools Accreditation Files seven years, then destroy.	Administrative. Administrative value ceases.
Administrator's Working Papers (<i>notes, correspondence, memoranda, etc.</i>)	Annual review.	Administrative value ceases.
Annual Reports	Permanent.	Administrative. Historical.
Architectural Drawings and Specifications	Permanent.	Administrative. Historical.
Booster Club Minutes	Permanent.	Historical.
Budget Files (<i>budgets, notes, memos, correspondence, etc.</i>)	Retain seven years, then destroy.	Administrative value ceases.
Business Files (<i>correspondence, vouchers, paid bills, receipts, etc.</i>)	Retain seven years, then destroy.	Administrative value ceases.
Bus Schedules	Retain until superseded.	Administrative value ceases.
Calendars (<i>for school events</i>)	Permanent.	Historical.
Class Lists	Permanent.	Administrative.
Class Rank List	Permanent.	Administrative.
Class Schedules	Retain until superseded.	Administrative value ceases.
Construction Files (<i>contracts, correspondence, specifications, architectural drawings, etc.</i>)	Permanent.	Administrative. Historical.
Correspondence-Official (<i>concerning school policy, administration, diocesan directives, etc.</i>)	Permanent.	Administrative. Historical.
Correspondence-Routine	Annual Review.	Administrative value ceases.
Equipment and Instructional Resource File (<i>catalogs, brochures, articles, memos</i>)	Retain until superseded.	Administrative value ceases.
Equipment File (<i>catalogs, instructions, warranties, manuals, inspection certificates, etc.</i>)	Retain until superseded.	Administrative value ceases.
Faculty Meeting Minutes	Permanent.	Historical.
Faculty Schedules	Retain until superseded.	Administrative value ceases.
Grade Reports	Permanent.	Administrative value ceases.
Grant Files (<i>correspondence, memoranda, applications, reports, etc.</i>)	Retain seven years after completion of grant activity, then destroy.	Administrative value ceases.
Guidance Counselor Files (<i>correspondence, notes, student files, memos, etc.</i>)	Merge student files with permanent student files. All other material, annual review.	
History File (<i>historical sketches, photographs, newspaper clippings, letters</i>)	Permanent. If not available, administrators should create and maintain a school history file.	Historical.

<i>and extra-curricular activities record, etc.)</i>	retained permanently by the parish school).	
Student Health Records	Retain until the student attains the age of majority plus 3 years (i.e., age 21) or for five years after the record is made, whichever is later.	Administrative. Legal.
Student Handbook	Permanent.	Administrative. Historical.
Student Injury Reports	Retain until age of student is 21, then destroy.	Administrative value ceases.
Student Organization Records (<i>minutes, reports, by-laws, photos, etc.</i>)	Permanent.	Historical.
Student Publications (<i>yearbooks, histories, newsletters, etc.</i>)	Permanent.	Historical.
Student Reading Certificates	Retain until superseded.	Administrative value ceases.
Student Registration Forms	Retain in Student File if student attends school. Destroy forms if student does not enroll or attend.	Administrative. Administrative value ceases.
Subject Files (<i>correspondence, memos, reports, printed material, etc.</i>)	Annual review.	Administrative value ceases.
Teacher's Register (<i>attendance record submitted to the County Superintendent of Schools</i>)	Permanent.	Administrative. Historical.
Testing Materials Files (<i>schedules, reports, completed examinations, forms, and printed material relating to SRA</i>)	Retain final reports permanently. Retain other materials until superseded.	Administrative. Administrative value ceases.
Text Book Inventory	Retain until superseded.	Administrative value ceases.
Vehicle Records (<i>licenses, letters, maintenance and mileage reports, etc.</i>)	Retain until superseded, then destroy.	Administrative value ceases.

PERSONNEL RECORDS

Records Title / Description	Retention Period	Type Of File
Professional Certificates	Retain until superseded.	Administrative value ceases.
Employment contracts	Retain seven years after employment separation, then destroy.	Administrative value ceases.
Job Descriptions	Retain until superseded.	Administrative value ceases.
Payroll Records	Retain seven years, then destroy.	Administrative value ceases.
Personnel Files (<i>applications, certificates, resumes, correspondence, grade transcripts, evaluations, contracts</i>)	Retain seven years after employment separation, then destroy. *Exception is exposure records under OSHA, which should be retained for the duration of the employee's employment plus 30 years.	Administrative value ceases.
Substitute Teacher Applications	Retain three years, then destroy.	Administrative

Insurance Claims Files (<i>correspondence, claims, policies</i>)	Permanent.	Legal. Administrative.
Lesson Plans	Retain until superseded.	Administrative value ceases.
Library Schedules	Retain until superseded.	Administrative value ceases.
Memoranda and Directives from the Diocesan Superintendent of Schools	Permanent.	Administrative.
Parent's Newsletters	Permanent.	Historical.
Parent-Teacher Bulletins	Permanent.	Administrative. Historical.
Parent-Teacher Conference Files (<i>memos, correspondence, schedules</i>)	Retain until superseded.	Administrative value ceases.
Parent-Teacher Organization Minutes	Permanent.	Administrative. Historical.
Permanent Student Card	Permanent.	Administrative. Historical.
Photographs (<i>school activities, facilities, etc.</i>)	Permanent.	Historical.
Principal's Working Papers (<i>notes, correspondence, memoranda, etc.</i>)	Annual Review.	Administrative value ceases.
Promotion Lists	Retain until superseded.	Administrative value ceases.
Property Inventory (<i>audio-visual materials, science equipment, musical instruments, athletic equipment, etc.</i>)	Retain until superseded.	Administrative value ceases.
Reading Group Lists	Retain until superseded.	Administrative value ceases.
Records Disposal Authorization Forms	Permanent.	Administrative.
Records Retention Schedule	Retain until superseded, then destroy.	Administrative value ceases.
Reports to the Archdiocese's Catholic Schools Office	Permanent.	Administrative. Historical.
Retention Lists (<i>lists of students prohibited from advancing to the next grade</i>)	Retain until superseded.	Administrative value ceases.
School Board Files (<i>minutes, resolutions, correspondence, memoranda, regulations</i>)	Permanent.	Administrative. Historical.
School Board Minutes	Permanent.	Administrative. Historical.
Scrapbooks (<i>newspaper clippings, letters, programs, photographs, etc.</i>)	Permanent.	Historical.
Student Absence List and Forms	Retain until superseded, then destroy.	Administrative value ceases.
Student Files-Elementary School (<i>permanent student card, registration forms, immunization record, evaluations, grade reports, photographs, transcripts, memoranda, test reports, sacramental record, sports and extra-curricular activities record, etc.</i>)	Retain permanently unless student transfers-- files will be transferred to the student's next school (permanent Student Card still retained permanently by the parish school).	
Student Files-Secondary School (<i>permanent student card, registration forms, immunization record, evaluations, grade reports, photographs, transcripts, memoranda, test reports, sacramental record, sports</i>)	Retain permanently unless student transfers-- files will be transferred to the student's next school (permanent Student Card still	Administrative.

Lot Maps Quarterly	Permanent.	Administrative. Historical.
Report	Retain one year, then destroy. (Retain permanently if an annual report is not prepared.)	Administrative value ceases.
Paid Bills	Retain seven years, then destroy.	Fiscal value ceases.
Receipts	Retain seven years, then destroy.	Fiscal value ceases.
Rules and Regulations	Permanent.	Administrative. Historical.

RELIGIOUS EDUCATION RECORDS

Records Title / Description	Retention Period	Type Of File
Annual Report	Permanent.	Administrative.
Business File (<i>paid bills, vouchers, cancelled checks, receipts, etc.</i>)	Retain seven years, then destroy.	Administrative value ceases.
Class Lists	Retain until superseded.	Administrative value ceases.
Collection Record (<i>contributions</i>)	Retain seven years, then destroy.	Fiscal value ceases.
Family Record (<i>provides names of parents, names and number of children, parish, sacramental history, etc.</i>)	Retain until superseded, then destroy.	Administrative value ceases.
Instructional Equipment File	Retain until superseded, then destroy.	Administrative value ceases.
Registration Forms	Retain one year, then destroy.	Administrative value ceases.
Religious Education Files (<i>lesson plans, catalogs, instructional materials</i>)	Annual review.	Administrative value ceases.
Schedules (<i>classes, teachers</i>)	Retain until superseded.	Administrative value ceases.
Student Card (<i>provides student name, birth date, sacramental history, etc.</i>)	Permanent.	Administrative. Historical.
Student Files (<i>registration forms, progress reports</i>)	Retain seven years after termination of student, then destroy.	Administrative value ceases.
Subject Files (<i>memoranda, budgets, correspondence, notes</i>)	Annual review.	Administrative value ceases.
Tuition Record	Retain seven years, then destroy.	Fiscal value ceases.

PUBLICATIONS

Records Title / Description	Retention Period	Type Of File
Anniversary Booklets	Permanent.	Historical.
Annual Reports of the Parish	Permanent.	Administrative. Historical.
Newsletters	Permanent.	Historical.
Other Publications (<i>histories of the parish, parish organizations, programs, etc.</i>)	Permanent.	Historical.
Parish Bulletins	Permanent.	Historical.
Promotional or Information Pamphlets or Books	Permanent.	Historical.



ADM 4.1

Emergency information for each student is kept on file in the school.

Purpose:

- To ensure that parents (or designated contact person) can be contacted in case of an emergency.

Commentary/Procedural Points:

- The information includes:
 - student's name
 - parents' or guardians' names, addresses, pertinent phone numbers, and e-mail addresses.
 - names, addresses, phone numbers of alternate contact persons
 - name and phone number of physician
 - special health information for the student
- If the designated persons are unable to be contacted, the school calls the police for assistance in reaching one of these persons.

References:

- Local Crisis Management Plan

February 8, 2008



HE 1.0

The school maintains a health file for each student for the duration of enrollment.

Purpose:

- To comply with applicable laws and regulations

Commentary/Procedural Points:

- The following information is maintained in the health file, if applicable:
 - copy of physician's physical report, if required
 - immunization record
 - vision and hearing results
 - dental report
 - authorization for medications and individual health plans
 - injury reports
 - documentation of communicable diseases
 - health inventory form
- Health records are to be stored in a locked location separate from the cumulative folders.
- Records may only be accessed by authorized personnel.
- Principals should encourage parents to share information with the school about any new or existing medical conditions, medications, or treatments which may affect the child's well-being.
- When a pre-kindergarten operates in a separate building, the health records for these students must be maintained in the building where the program is conducted.

References:

- Applicable laws and regulations

October 10, 2013



HE 3.0

Principals notify their local health department in cases of student absences due to a reportable communicable disease.

Purpose:

- To prevent the spread of communicable disease in the school

Commentary/Procedural Points:

- Before the student returns to school, a release card from the local health department or a letter from a licensed healthcare practitioner must be provided, indicating that the health department regulation has been met.
- Notes from parents/guardians are not accepted as assurance that the health department regulation has been met.
- The local health department has listings of the types of diseases and procedures for possible *school* closings and the communications to notify the school families and general public.

References:

- *Communicable Disease Summary - Guide for Schools and Child Care Settings*; provided to schools by Maryland State Department of Health

January 12, 2005



HE 6.0

The principal must develop an adequate plan to ensure the health and safety of students, staff, and visitors.

Purpose:

- To ensure a safe environment

Commentary/Procedural Points:

- The plan must be communicated to the staff and parents.
- Principals are responsible for determining an appropriate response to any individual who appears to have an injury or an illness.
- Completion of an accident report is mandatory for all injuries.
- The school maintains a daily log documenting illnesses, injuries and administration of medication.
- Parents are notified of instances of injury or illness, as necessary.
- In case of a serious injury, the principal communicates with the Department of Catholic Schools and the Archdiocesan Office of Risk Management.
- This plan is communicated to parents upon request

References:

- AOB forms:
 - Head Injury Report to Parent
 - Minor Injury Report to Parent
 - Report to Parent of Health Room Visit

http://www.marylandpublicschools.org/MSDE/divisions/studentschoolsvcs/student_services_and_school_health_services/

October 10, 2013

Student Absences

Students in Maryland private schools, like Catholic schools, must comply with Maryland State law concerning compulsory attendance. Students are required to attend school regularly throughout the school year, and parents are required to send in written documentation of the reason for their student's absence upon their return to school. Regular school attendance is expected in order for students to achieve their academic potential. Attendance is recorded and permanently retained as part of a student's permanent record.

The School Nurse is to meet with the Principal or the designated Administrator regarding any students who have excessive absences, or have health problems that will be or are causing a student to miss an excessive amount of school. The School Nurse will work with the school's administration to develop a plan to help these students maintain academic success. Families of students with health issues that require excessive absences may be referred to Home and Hospital Services.

More than 20 days absent per year is considered excessive and the Principal must notify the appropriate Associate Superintendent.

Parents have a maximum of 20 days from the time their child starts school to provide the school with the child's immunization record. If there is no verification of immunization presented, the student is to be excluded from school immediately.

Exempted students (i.e., those students granted an immunization exemption by the school following the presentation of the proper documentation and verifications required by the school) are to be excluded from school if there is an outbreak of the disease (s) for which they are not immunized.

In the case of a student absence due to a reportable communicable disease, the student must be released by a licensed health care provider in accordance with Health Department regulations before returning to school. More information can be found in the "Communicable Disease" section of this Manual.

Home and Hospital Services:

When a student has a chronic or intermittent health problem, parents should contact the Local Education Agency (LEA) for Home and Hospital Services if this health problem will be or is causing the student to miss an excessive amount of school. The parents should contact the LEA of the student's county of residence. Please refer to the list of Home and Hospital Coordinators included in this section.

To receive Home and Hospital Services, the student must be enrolled in their local public school. After contacting the LEA, parents must enroll their student in the local public school and withdraw the student from the Catholic School.

These services are rendered under:

Code of Maryland Regulation (COMAR) 13A.03.05.01, which states: "These regulations, which establish a minimum requirement, apply to the provision of instructional services to public school students who are unable to participate in their school of enrollment due to a physical or emotional condition."

More information and a current list of local school system contacts can be found by visiting:

<http://www.marylandpublicschools.org/about/Pages/DSFSS/SSSP/HomeHospital/index.aspx>

Also appended to this Section are the following excerpts from the *Policy Manual for Elementary Schools for the Archdiocese of Baltimore*. This manual is generally maintained in the Administrative offices of each school.

- SS 1.0 - Students in Catholic School must comply with Maryland State law concerning compulsory attendance.
- SS 1.1- A school must maintain written documentation for all absences.
- HE 2.0- All students in Catholic Schools must be immunized in accordance with Maryland State Law.
- HE 3.0- Principals notify their local health department in cases of student absences due to a reportable communicable disease.



SS 1.0

Students in Catholic Schools must comply with Maryland State law concerning compulsory attendance. The law requires regular attendance during the entire school year. Students are held accountable for time(s) they are absent from school. A principal may excuse a student for a necessary absence.

Regular school attendance is expected in order for students to achieve their academic potential. Each student's attendance is carefully recorded and permanently retained. Therefore, absence for reasons such as a vacation is strongly discouraged. Excessive absence has a serious impact on the student's academic performance.

Purpose:

- To ensure the continuous development and progress of the child's education.

Commentary/Procedural Points:

- Unlawful absences are considered truant. The school informs parents that if truancy persists, the public authorities will be notified.
- More than 20 days absence per year is considered excessive. The school establishes local regulations regarding the consequences for excessive absenteeism and outlines these policies in the Parent/Student Handbook. These cases are brought to the attention of the appropriate Associate Superintendent.
- A student can only be marked "Present" if he is physically in school.
- When a student has a chronic or intermittent health problem, parents should contact the Local Educational Agency (LEA) for Home and Hospital Services.
- For home hospital services, the parent must enroll the student in the local public school.



SS 1.1

A school must maintain written documentation for all absences.

Purpose:

- To ensure proper maintenance of the student's permanent record.

Commentary/Procedural Points:

- The decision for a student to be absent from the school is the responsibility of the parent.
- Parents are pre-advised of the consequences of unscheduled absences.
- The school's policy regarding assignments and make-up work is communicated to parents on an annual basis.
- The school's policy regarding the impact of absences(s) on receiving awards or other honors is communicated on an annual basis.
- School requires and maintains written absentee notes from parents or guardians for the duration of the school year.

References:

- Local Parent/Student Handbook

January 12, 2005



HE 3.0

Principals notify their local health department in cases of student absences due to a reportable communicable disease.

Purpose:

- To prevent the spread of communicable disease in the school

Commentary/Procedural Points:

- Before the student returns to school, a release card from the local health department or a letter from a licensed healthcare practitioner must be provided, indicating that the health department regulation has been met.
- Notes from parents/guardians are not accepted as assurance that the health department regulation has been met.
- The local health department has listings of the types of diseases and procedures for possible *school* closings and the communications to notify the school families and general public.

References:

- *Communicable Disease Summary - Guide for Schools and Child Care Settings*; provided to schools by Maryland State Department of Health

January 12, 2005



HE 2.0

All students in Catholic schools must be immunized in accordance with Maryland State Law.

Purpose:

- To ensure the safety and well being of all members of the school community

Commentary/Procedural Points:

- Immunization records must be maintained at the school for each student.
- Schools inform parents that the child may have up to a maximum of twenty (20) calendar days from the time the child starts school to obtain the immunization record, get needed doses of vaccine, or get started on the vaccination series. If there is no verification of immunization record presented within twenty (20) calendar days of entry, the student is to be excluded until the record is obtained.
- In case of religious objection or medical contraindication for one or more immunizations, form DHMH 896 must be submitted and kept on file.
- Exempted students are to be excluded from school if there is an outbreak of the disease(s) for which they are not immunized.

References:

- Maryland Department of Health and Mental Hygiene Immunization requirements

January 12, 2005

Confidentiality

All schools must comply with the Family Educational Rights and Privacy Act (FERPA), which is a federal law designed to protect the privacy of student education records.

Please see the attached table outlining and comparing the requirements of FERPA and HIPPA (the Health Insurance Portability and Accountability Act).

Please note that outside providers who are HIPPA compliant must have a signed release of information form on file. A sample of such form is located in the commonly used form section of this manual.

Please also see the following excerpt from the *Policy Manual for Elementary School in the Archdiocese of Baltimore*:

ADM 5.0-Policies and procedures for protecting the right of privacy of students and their parents regarding school records are written and stated clearly in the parent/student handbook.



ADM 5:0

Policies and procedures for protecting the right of privacy of students and their parents regarding school records are written and stated clearly in the parent/student handbook.

Purpose:

- To ensure that the school's policies comply with the Family Educational Rights and Privacy Act (FERPA) i.e. to provide parents and eligible students access to school records directly related to the students; to permit parents and eligible students to request amendment of those records on the grounds that they are inaccurate, misleading, or otherwise in violation of the student's privacy or other rights; to obtain the written consent of parents or eligible students before releasing personally identifiable information about the students contained in educational records to third parties, with certain exceptions; and to notify parents and eligible students of these rights annually.
- To ensure that the school's policies and practices comply with the Code of Conduct of the Archdiocese, particularly as they relate to the privacy of financial and administrative records.

Commentary/Procedural Points:

- Schools shall give full rights under FERPA to a custodial and non-custodial parent (unless the school has been provided with certified copy of a court order denying such access) and to any other person acting as a parent in the absence of a parent (i.e. a step-parent or a grandparent with whom the child lives).
- The term "educational records" means those records that are directly related to a student and maintained by the school.
- The term "educational records" does not include: records of instructional, supervisory, and administrative personnel (and personnel ancillary to those persons) that are kept in the sole possession of the maker of the record, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record; records that

Comparison of FERPA and HIPAA Privacy Rule for Accessing Student Health Data Fact Sheet

Public health agencies view schools and education agencies as important partners in protecting children and adolescents from health threats. Sharing data between schools and public health agencies may, in some instances, be the only realistic and reliable method for getting the information necessary to conduct public health activities, such as tracking immunization rates. Federal privacy protections for student education records have created confusion and difficulties for public health efforts to conduct ongoing and emergency public health activities in schools. This document compares key aspects of the Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule related to the use and disclosure of information. The following chart provides only a snapshot of the rights, duties, and limitations imposed by FERPA and HIPAA. Please see the [ASTHO Public Health Access to Student Health Data Issue Brief](#) and the text of the federal laws and regulations for more detailed information.

	FERPA	HIPAA Privacy Rule
Privacy Rights Conferred	<ul style="list-style-type: none"> • FERPA prevents the disclosure of personally identifiable information (PII) in a student's education record without the consent of a parent or eligible student (aged 18 or older) unless an exception to the law's general consent requirement applies. • FERPA also grants parents and eligible students the right to review the student's education records maintained by the school and request correction of records they believe to be inaccurate or misleading. 	<ul style="list-style-type: none"> • The HIPAA Privacy Rule prohibits covered entities from disclosing protected health information (PHI) to any third parties, unless the individual who is the subject of the information (or the individual's personal representative) authorizes it in writing or the rule otherwise permits the disclosure. • Disclosure is required to be made to the individual/representative.
Persons or Entities Covered	<p>FERPA applies to the following entities:</p> <ul style="list-style-type: none"> • All educational institutions (e.g., elementary, high school, college) and agencies that receive any funds for programs administered by the U.S. Department of Education (ED) are covered by FERPA. • FERPA also applies to "non-school" entities that do not have students but receive funding from ED. • All public schools and school districts, most public and private post-secondary institutions (e.g., colleges), and any other programs receiving ED funds are covered by FERPA. • Private and religious elementary and secondary schools are not subject to FERPA because they generally do not receive funding from ED. 	<p>The Privacy Rule applies to the following entities as defined by the rule:</p> <ul style="list-style-type: none"> • "Covered entity," which is a health plan, healthcare clearinghouse, or any healthcare provider who transmits health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA. • A school that is not covered by FERPA may be a covered entity if it provides health services for which it transmits health information electronically, such as submitting claims for payment from a health plan. • "Business associate" is a person or organization not employed by the covered entity that performs certain activities for a covered entity that involve the use or disclosure of individually identifiable health information. • "Hybrid entity" is an entity that conducts both covered and noncovered activities. State and local health departments and schools can be hybrid entities if they provide healthcare services to patients for which they transmit health information electronically.
Information Covered	<p>FERPA covers the following types of information and records:</p> <ul style="list-style-type: none"> • "Personally identifiable information" (PII) which includes name, address, personal identifiers like Social Security number or date of birth, or other information that could be used alone or in combination to identify a student. • "Education record" is defined as records that are: (1) directly related to a student and (2) maintained by an educational agency or institution or by a party acting on behalf of the agency or institution. 	<p>The Privacy Rule covers the following types of information and records:</p> <ul style="list-style-type: none"> • "Protected health information" (PHI), which is individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media—electronic, paper, or oral. • PHI includes demographic data; common identifiers (e.g., name, address, birth date, Social Security number); information relating to the individual's past, present, or future physical or mental health condition,

	FERPA	HIPAA Privacy Rule
	<ul style="list-style-type: none"> A student's health records, including immunization information and other records maintained by a school nurse, are considered part of the student's education record and are protected from disclosure under FERPA. A school may disclose "directory information" about a student without consent. Directory information includes information such as a student's name, address, telephone number, date and place of birth, honors and awards, and dates of attendance. Schools must tell parents and eligible students about directory information and allow them a reasonable amount of time to request that the school not disclose directory information about them. 	<p>healthcare provided to him or her, or payment for healthcare; and data that identifies the individual or which could be reasonably used to identify the individual.</p> <ul style="list-style-type: none"> Employment records maintained by a covered entity for its own employees are excluded from the definition of PHI. Education records covered by FERPA are also specifically excluded from the definition of PHI.
Accessing Data <i>With</i> Consent	<ul style="list-style-type: none"> Under FERPA, health agencies can access education records—including student health data maintained by the school or a person acting on its behalf—if the school has received written consent from a parent or eligible student. ED notes that such releases are advisable for health agencies wishing to use PII to track absences or immunization rates before an emergency is recognized. ED has developed sample consent forms for schools and health agencies to use. 	<ul style="list-style-type: none"> Under the Privacy Rule, health agencies can obtain PHI from covered entities if the agency receives written consent from the patient or their representative.
Accessing Data <i>Without</i> Consent: Exceptions and Generally Permitted Uses	<ul style="list-style-type: none"> FERPA contains a number of exceptions that allow schools to disclose PII from a student's education record without consent of a parent or an eligible student. FERPA exceptions have generally been narrowly construed by ED to err on the side of protecting the student's privacy and may present challenges for health agencies in accessing student health data. 	<p>Under the Privacy Rule, a covered entity is permitted to use and disclose PHI without an individual's authorization for the following purposes or situations:</p> <ul style="list-style-type: none"> For treatment, payment, and healthcare activities like quality assessment or evaluations. Informal opportunities to agree or object such as providing information for hospital directories or notifications to family members. Disclosures incident to an otherwise permitted use and disclosure. The use or disclosure of limited data sets for the purposes of research, public health, or healthcare operations. Public interest and benefit activities. There are a dozen "public purposes" identified in the rule under the public interest and benefit permitted use. These include public health activities and addressing serious threats to health and safety. (See discussion of each below.)
De-Identified and Limited Data	<ul style="list-style-type: none"> Schools can provide health agencies with access to student health and other relevant data if the information does not contain PII. ED notes that, in instances like the H1N1 influenza pandemic or other outbreaks, a school may share general information about the number of students absent from the school without prior written consent. However, if absentee data to be shared includes PII and no FERPA exception applies, then the school must obtain written consent before sharing the data with health officials. De-identified data must not allow the recipients to identify the students through either single or multiple releases of data or by combining the data with other information. 	<ul style="list-style-type: none"> The Privacy Rule does not restrict the use or disclosure of de-identified health information. The rule also allows the release of limited data sets—in which specific identifiers about the patient or household have been removed—for public health, research, and other purposes. Users of limited data sets must complete a data use agreement covering the protection of remaining PHI in the data. This exception permits health agencies to access limited health data about children and adolescents that are not covered under FERPA.
Public Health Activities	<ul style="list-style-type: none"> FERPA does not contain a "public health exception" akin to the one found in HIPAA. Because education records covered by FERPA are expressly excluded from the Privacy Rule, public 	<p>The Privacy Rule contains a robust exception which allows public health authorities to receive PHI without prior consent of a patient or his or her representative. Covered entities may disclose PHI to:</p>

	FERPA	HIPAA Privacy Rule
	<p>health authorities cannot use HIPAA's public health exception to access school education records covered under FERPA without consent unless a FERPA exception applies.</p>	<ul style="list-style-type: none"> Public health officials authorized by law to collect or receive such information for preventing or controlling disease, injury, or disability. Public health or other government officials authorized to receive reports of child abuse and neglect. Entities subject to FDA regulation regarding FDA-regulated products or activities for purposes such as adverse event reporting, tracking of products, product recalls, and post-marketing surveillance. Individuals who may have contracted or been exposed to a communicable disease when notification is authorized by law.
Emergencies and Threats to Health or Safety	<ul style="list-style-type: none"> FERPA permits disclosure without written consent in specified emergency situations if the information is necessary to protect the health and safety of the student or other individuals. Disclosure of PII in student education records may be made to "appropriate parties," which include health agencies. ED has narrowly construed the emergency exception so that it must be limited to the time period of the emergency; disclosures made for general emergency preparedness activities are <i>not</i> covered under the emergencies exception. This exception would not apply where a threat of a possible or eventual emergency exists but the likelihood of its occurrence is unknown. Each school or education agency is responsible for making a case-by-case determination that the release of PII is necessary to address an "articulable and significant threat." ED will defer to the judgment of the school or agency in making the determination that there was a "rational basis" regarding the nature of the emergency and the appropriate parties to whom the disclosure was made. 	<ul style="list-style-type: none"> The Privacy Rule has a specific exception for disclosure of PHI in emergencies in addition to its broad public health exception. The rule allows covered entities to disclose PHI that they believe is necessary to prevent or lessen a serious and imminent threat to a person or the public, when such disclosure is made to someone they believe can prevent or lessen the threat (including the target of the threat). HHS notes that PHI can be released without disclosure to public officials responding to a bioterrorism or other public health threat or emergency.
Data Not Maintained by School	<ul style="list-style-type: none"> If a person or entity is employed by or acts on behalf of the school by providing health services (whether at the school or off-site) under contract or otherwise under the "direct control" of a school and maintains student health records, then these records are considered education records under FERPA as if the school was maintaining the records directly. However, if a person or entity provides health services directly to students and is not employed by, under contract to, or otherwise acting on behalf of a school, then the resulting health records are not deemed to be part of the education record covered by FERPA, even if the services are provided at the school site. 	<ul style="list-style-type: none"> If a school's education records are not covered under FERPA—as is generally the case for private elementary and secondary schools—they may be subject to HIPAA as a covered entity if they transmit health information electronically. In this scenario, the school is a covered entity and student health records are PHI under the Privacy Rule. One of the rule's permitted uses, such as a public health activity, would have to apply before the records are released without consent. If the records are not covered under FERPA or HIPAA, state or local privacy laws may still apply.
Affect on State Law	<ul style="list-style-type: none"> Any state law or regulation that conflicts with FERPA and its regulations are preempted by the federal law. If a school determines that it cannot comply with FERPA because of a conflict with state or local laws, it must notify ED and the agency will review the conflicting law and any interpretations of it made by the state and provide guidance to the requesting entity regarding FERPA's applicability to the situation. 	<ul style="list-style-type: none"> In general, a state law or regulation that conflicts with HIPAA and the Privacy Rule is preempted by the federal law. The Privacy Rule contains exceptions that allow differing state requirements to control if the state law: (1) relates to privacy of individually identifiable health information and provides greater protections or rights than the Privacy Rule; (2) requires the reporting of disease, injury, child abuse, birth, or death, and for public health surveillance, investigation, or intervention; or (3) requires certain reporting by health plans, such as for management or financial audits or evaluations. States can also request a determination that a conflicting state law will not be preempted by HIPAA if the state can demonstrate one of the conditions listed

	FERPA	HIPAA Privacy Rule
		in the rule, including, but not limited to, that the conflicting provision serves a compelling public health, safety, or welfare interest, and, if the conflicting provision relates to a privacy right, that the intrusion into privacy is warranted given the public interest being served.
Enforcement	<ul style="list-style-type: none"> • FERPA does not include a private cause of action; individual parents or students may not bring a lawsuit to enforce the act's provisions or to seek redress for violations of the act. • Persons who believe their rights under FERPA have been violated may file a complaint with the ED's Family Policy Compliance Office (FPCO), which investigates the complaint. • FPCO is authorized to, among other things, revoke funding for institutions found in violation of FERPA and its regulations. 	<ul style="list-style-type: none"> • The Privacy Rule does not authorize individuals to sue for violations; individuals must direct their complaints to HHS's Office for Civil Rights (OCR), which then investigates the complaint. • In cases of noncompliance, the Secretary is directed to resolve the matter by informal means. • If the matter cannot be resolved informally, the Secretary may issue written findings of noncompliance that may be used as a basis for initiating a civil action or a criminal case. • Violators that knowingly and improperly disclose identifiable health information are subject to civil monetary and criminal penalties.

Sources

- Family Educational Rights and Privacy Act, as amended. Codified at 20 U.S.C. §1232g.
- Family Educational Rights and Privacy Act Regulations. 34 C.F.R. Part 99.
- Health Insurance Portability and Accountability Act of 1996, as amended. Codified at 42 U.S.C. §1320d et seq, and §300gg; and 29 U.S.C. §1181 et seq.
- U.S. Dept. of Health and Human Services. *Standards for Privacy of Individually Identifiable Health Information*. 45 C.F.R. Parts 160, 164.
- U.S. Dept. of Education. Final Rulemaking "Family Educational Rights and Privacy." 76 F.R. 75604. December 2, 2011.
- U.S. Dept. of Education. "Family Educational Rights and Privacy Act (FERPA) and the Disclosure of Student Information Related to Emergencies and Disasters." June 2010. Available at <http://www2.ed.gov/policy/gen/guid/fpcg/pdf/ferpa-disaster-guidance.pdf>. Accessed January 31, 2012.
- U.S. Dept. of Education. "Family Educational Rights and Privacy Act and H1N1." October 2009. Available at <http://www2.ed.gov/policy/gen/guid/fpcg/pdf/ferpa-h1n1.pdf>. Accessed January 31, 2012.
- U.S. Dept. of Education and U.S. Dept. of Health and Human Services. "Joint Guidance on the Application of the Family Educational Rights and Privacy Act and the Health Insurance Portability and Accountability Act of 1996 to Student Health Records." November 2008. Available at <http://www2.ed.gov/policy/gen/guid/fpcg/doc/ferpa-hipaa-guidance.pdf>. Accessed January 31, 2012.
- U.S. Dept. of Health and Human Services, Office for Civil Rights. "HIPAA—Frequently Asked Questions" webpage. Available at www.hhs.gov/ocr/privacy/hipaa/fag/index.html. Accessed January 31, 2012.
- U.S. Dept. of Health and Human Services. "Summary of the HIPAA Privacy Rule" website. Available at www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html. Accessed January 31, 2012.
- ASTHO. "Accessing School Health Information for Public Health Purposes" Position Statement (2006). Available at www.astho.org/Display/AssetDisplay.aspx?id=146. Accessed January 31, 2012.
- Chaikind H. et al. Congressional Research Service. *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions* (RL31634). January 24, 2005. Available at www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3163401242005.pdf. Accessed January 31, 2012.

This document was compiled in June-December 2011 and reflects the laws and programs current then. It reflects only portions of the laws relevant to public health emergencies and is not intended to be exhaustive of all relevant legal authority. This resource is for informational purposes only and is not intended as a substitute for professional legal or other advice. The document was funded by CDC Award No. 1U38HM000454 to the Association of State and Territorial Health Officials; Subcontractor PI Elliott, Logan Circle Policy Group LLC.

Section 4

Immunizations, Health
Inventory, Blood Lead
Testing Requirements

Immunization Requirements

In accordance with Maryland State Law, all students must receive all age-appropriate immunizations. The record of vaccinations/immunizations should be maintained at each school for students. The policy drafted by the Archdiocese of Baltimore Department of Schools is as follows:

- *All immunization records must be kept on file at the school, as well as documented and updated, as needed, in PowerSchool.
- *Schools will inform parents that a child may have up to a maximum of twenty (20) calendar days from the time a child starts school to obtain the immunization record, get needed doses of vaccine, or get started on the vaccination series. If there is no verification of immunization record presented within twenty (20) calendar days of entry, the student is to be excluded from school immediately until the record is obtained.
- *In case of religious objection or medical contraindication for one or more immunizations, form DHMH 896 **MUST** be properly completed and submitted by the student's parent or legal guardian, and kept on file by the school.
- *Students exempted from vaccinations are to be excluded from school if there is an outbreak of the disease(s) from which they are not immunized.

The following two pages contain the current school year's Maryland Vaccine Requirements for children. Please note that these requirements are updated yearly and students are expected to be in compliance with the current school year's requirements from the Maryland Department of Health and Mental Hygiene.

See the included excerpt from the *Policy Manual for Elementary School for the Archdiocese of Baltimore*:

HE 2.0- All students in Catholic schools must be immunized in accordance with Maryland State Law.



Vaccine Requirements For Children
Enrolled in Preschool Programs and in Schools — Per DHMH COMAR 10.06.04.03
Maryland School Year 2017 - 2018 (Valid 9/1/17 - 8/31/18)

Required cumulative number of doses for each vaccine for PRESCHOOL aged children enrolled in educational programs							
Vaccine	DTaP/DTP/DT ¹	Polio ²	Hib ³	Measles, ^{2,4} Mumps, Rubella	Varicella ^{2,4,5} (Chickenpox)	Hepatitis B	PCV ³ (Prennar TM)
Current Age of Child							
Less than 2 months	0	0	0	0	0	1	0
2 - 3 months	1	1	1	0	0	1	1
4 - 5 months	2	2	2	0	0	2	2
6 - 11 months	3	3	2	0	0	3	2
12 - 14 months	3	3	At least 1 dose given after 12 months of age	1	1	3	2
15 - 23 months	4	3	At least 1 dose given after 12 months of age	1	1	3	2
24—59 months	4	3	At least 1 dose given after 12 months of age	1	1	3	1
60 - 71 months	4	3	0	2	1	3	0
Required cumulative number of doses for each vaccine for children enrolled in KINDERGARTEN - 12 th grade							
Grade Level Grade (Ungraded)	DTaP/DTP/Tdap/DT/Td ^{1,6}	Tdap ⁶	Polio ²	Measles, ^{2,4} Mumps, Rubella	Varicella ^{2,4,5} (Chickenpox)	Hepatitis B	Meningococcal
Kindergarten, Grade 1, 2 & 3 (5-7 yrs)	4 or 3	0	3	2	2	3	0
Grades 4 - 6 (8- 11 yrs)	3	0	3	2	1 or 2	3	0
Grade 7, 8, 9 & 10 (12-14 yrs)	3	1	3	2	1 or 2	3	1
Grades 11-12 (15-18+ yrs)	3	0	3	2	1 or 2	3	0

* See footnotes on back for 2017-18 school immunization requirements.

**Vaccine Requirements For Children
Enrolled in Preschool Programs and in Schools
Maryland School Year 2017 - 2018 (Valid 9/1/17 - 8/31/18)**

FOOTNOTES

Requirements for the 2017-18 school year are:

- 2 doses of Varicella vaccine for entry into Kindergarten, 1st, 2nd AND 3rd Grade
- 1 dose of Tdap vaccine for entry into 7th, 8th, 9th AND 10th grades
- 1 dose of Meningococcal vaccine for entry into 7th, 8th, 9th AND 10th grades

Instructions: On the chart locate the student's age or grade and read from left to right on the chart to determine the **NUMBER** of required vaccinations by age or grade. Dosing or spacing intervals should not be considered when determining if the requirement is met, only count the number of doses needed. MMR and Varicella vaccination dates should be evaluated (See footnote #4).

1. If DT vaccine is given in place of DTP or DTaP, a physician documented medical contraindication is required.
2. Proof of immunity by positive blood test is acceptable in lieu of vaccine history for hepatitis B, polio and measles, mumps, rubella and varicella, **but revaccination may be more expedient.**
3. Hib and PCV(PrevnarTM) are not required for children older than 59 months (5 years) of age.
4. All doses of measles, mumps, rubella and varicella vaccines should be given on or after the first birthday. However, upon record review for students in preschool through 12th grade, a preschool or school may count as valid vaccine doses administered less than or equal to four (4) days before the first birthday.
5. One dose of varicella (chickenpox) is required for a student younger than 13 years of age. Two doses of varicella vaccine are required for students entering Kindergarten, 1st, 2nd and 3rd grade and for previously unvaccinated students 13 years of age or older. Medical diagnosis of varicella disease is acceptable in lieu of vaccination. Medical diagnosis is documented history of disease provided by a health care provider. Documentation must include month and year.
6. Four (4) doses of DTP/DTaP are required for children less than 7 years old. Three (3) doses of tetanus and diphtheria containing vaccine (any combination of the following — DTP, DTaP, Tdap, DT or Td) are required for children 7 years of age and older. One dose of Tdap vaccine received prior to entering 7th grade is acceptable and should be counted as a dose that fulfills the Tdap requirement.
7. Polio vaccine is not required for persons 18 years of age and older.



HE 2.0

All students in Catholic schools must be immunized in accordance with Maryland State Law.

Purpose:

- To ensure the safety and well being of all members of the school community

Commentary/Procedural Points:

- Immunization records must be maintained at the school for each student.
- Schools inform parents that the child may have up to a maximum of twenty (20) calendar days from the time the child starts school to obtain the immunization record, get needed doses of vaccine, or get started on the vaccination series. If there is no verification of immunization record presented within twenty (20) calendar days of entry, the student is to be excluded until the record is obtained.
- In case of religious objection or medical contraindication for one or more immunizations, form DHMH 896 must be submitted and kept on file.
- Exempted students are to be excluded from school if there is an outbreak of the disease(s) for which they are not immunized.

References:

- Maryland Department of Health and Mental Hygiene Immunization requirements

January 12, 2005

Health Inventory Forms and Blood Lead Testing Requirements

For Pre-Kindergarten - 12th Grade:

A physical examination by a physician or certified nurse practitioner must be completed within nine months prior to enrolling in school for the first time, or within six months after starting school for the first time. Both parts of the Health Examination Form must be submitted, with the second part completed and signed by a physician or nurse practitioner.

A blood lead test certificate or signed waiver is required for all students who reside in a designated at risk area as defined in the provided reference document when first entering Pre-Kindergarten, Kindergarten, and 1st Grade.



Maryland Schools Record of Physical Examination

To Parents or Guardians:

In order for your child to enter a Maryland Public school for the first time, the following are required:

- **A physical examination by a physician or certified nurse practitioner must be completed within nine months prior to entering the public school system or within six months after entering the system.** A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement. (<http://www.dsd.state.md.us/comar/comarhtml/13a/13a.05.05.07.htm>)
- **Evidence of complete primary immunizations against certain childhood communicable diseases is required for all students in preschool through the twelfth grade.** A Maryland Immunization Certification form for newly enrolling students may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend school. This form can be found at:
[https://phpa.health.maryland.gov/OIDEOR/IMMUN/Shared%20Documents/Maryland%20immunization%20Certification%20Form%20\(DHMH%20896%20-%20February%202014\).pdf](https://phpa.health.maryland.gov/OIDEOR/IMMUN/Shared%20Documents/Maryland%20immunization%20Certification%20Form%20(DHMH%20896%20-%20February%202014).pdf).
- **Evidence of blood testing is required for all students who reside in a designated at risk area when first entering Pre-kindergarten, Kindergarten, and 1st grade.** The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at:
https://phpa.health.maryland.gov/OEHFP/CHS/Shared%20Documents/Lead/MarylandDHMHBloodLeadTestingCertificateDHMH4620_revised3.24.2016c.pdf.

Exemptions from a physical examination and immunizations are permitted if they are contrary to a students' or family's religious beliefs. Students may also be exempted from immunization requirements if a physician/nurse practitioner or health department official certifies that there is a medical reason not to receive a vaccine. Exemptions from Blood-Lead testing is permitted if it is contrary to a family's religious beliefs and practices. The Blood-lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

The health information on this form will be available only to those health and education personnel who have a legitimate educational interest in your child.

Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.

If your child requires medication to be administered in school, you must have the physician complete a medication administration form for each medication. This form can be obtained at <http://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SHS/medforms/medicationform404.pdf>. If you do not have access to a physician or nurse practitioner or if your child requires a special individualized health procedure, please contact the principal and/or school nurse in your child's school.

Maryland State Department of Health and Mental Hygiene

Maryland State Department of Education

Records Retention - This form must be retained in the school record until the student is age 21.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade
Address (Number, Street, City, State, Zip)			Phone No.	
Parent/Guardian Names				
Where do you usually take your child for routine medical care?			Phone No.	
Name:		Address:		
When was the last time your child had a physical exam? Month		Year		
Where do you usually take your child for dental care?			Phone No.	
Name:		Address:		
ASSESSMENT OF STUDENT HEALTH				
To the best of your knowledge has your child any problem with the following? Please check				
	Yes	No	Comments	
Allergies (Food, Insects, Drugs, Latex)				
Allergies (Seasonal)				
Asthma or Breathing Problems				
Behavior or Emotional Problems				
Birth Defects				
Bleeding Problems				
Cerebral Palsy				
Dental				
Diabetes				
Ear Problems or Deafness				
Eye or Vision Problems				
Head Injury				
Heart Problems				
Hospitalization (When, Where)				
Lead Poisoning/Exposure				
Learning problems/disabilities				
Limits on Physical Activity				
Meningitis				
Prematurity				
Problem with Bladder				
Problem with Bowels				
Problem with Coughing				
Seizures				
Serious Allergic Reactions				
Sickle Cell Disease				
Speech Problems				
Surgery				
Other				
Does your child take any medication?				
No Yes Name(s) of Medications: _____				
No Yes Treatment _____, etc.)				
Does your child require any special procedures? (catheteriz				
No Yes				
Parent/Guardian Signature _____ ation, etc.)				
Date: _____				

PART II - SCHOOL HEALTH ASSESSMENT
To be completed **ONLY** by Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade
--------------------------------------	-------------------------	-----------	----------------	-------

1. Does the child have a diagnosed medical condition?
No Yes _____

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".
No Yes _____

3. Are there any abnormal findings on evaluation for concern?
Evaluation Findings/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider or a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis.
No Yes ~ _____
(A medication administration form must be completed for medication administration in school).

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
No Yes _____

7. Screenings	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

PART II - SCHOOL HEALTH ASSESSMENT - continued

To be completed **ONLY** by Physician/Nurse Practitioner

(Child's Name) _____ has had a complete physical examination and has:

no evident problem that may affect learning or full school participation problems noted above

Additional Comments:

Physician/Nurse Practitioner (Type or Print)

Phone No.

Physician/Nurse Practitioner Signature

Date

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

If you are enrolling a child in **child care, pre-kindergarten, kindergarten or first grade**, you must complete and submit this form (COMAR 10.11.04.05, 13A.17.03.02.D). **PLEASE PRINT CLEARLY.**

CHILD'S NAME _____ / _____ / _____
 LAST FIRST MIDDLE
 CHILD'S ADDRESS _____ / _____ / _____
 ADDRESS CITY STATE ZIP
 SEX: MALE FEMALE BIRTHDATE _____ / _____ / _____

PARENT _____ / _____ / _____ OR
 GUARDIAN _____ / _____ / _____
 ADDRESS CITY STATE ZIP

CERTIFICATION INFORMATION

Complete Box A if the child has had blood lead testing, Box B if testing was not required (see conditions in Box B), OR Box C if testing declined on religious grounds.

BOX A

Check at least one:

- This child was born **on or after** January 1, 2015 **AND** lives in Maryland.
- This child was born before January 1, 2015 **AND** is enrolled in Medicaid EPSDT.
- This child was born before January 1, 2015 **AND** has lived in an "at risk" ZIP code (see list on reverse).
- This child was born before January 1, 2015 **AND** has at least one risk factor for lead exposure, as determined by the health care provider.

RECORD OF BLOOD LEAD TEST RESULTS

Test #1. _____ Date: _____
 Test #2. _____ Date: _____
 Comments: _____

Person completing form: Health Care Provider/Designee OR
 School Health Professional/Designee

Printed Name: _____
 Signature: _____
 Date: _____
 Office Address _____

 Phone: _____

BOX B

BLOOD LEAD TESTING NOT REQUIRED

- This child does not and has never lived in an at-risk area (see ZIP codes on facing page) **AND** was born before January 1, 2015.

Parent or Guardian Name (Print) _____
 Signature _____
 Parent or Guardian
 Date: _____

BOX C

Complete the section below if the child is exempt from lead testing on religious grounds. A lead risk assessment questionnaire must be administered by a health care provider if the child is exempt from lead testing on religious grounds:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

To be completed by Parent or Guardian:
Parent or Guardian Name (Print) _____
 Signature _____
 Parent or Guardian
 Date: _____

To be completed by a Health Care Provider:
 Lead risk poisoning risk assessment questionnaire done: YES NO

Printed Name: _____
 Signature: _____
 Date: _____

HOW TO USE THIS FORM

The documented tests should be the tests at 12 months and 24 months of age. Two test dates are required if the 1st test was done prior to 24 months of age. If the 1st test is done after 24 months of age, one test date is required. The child's **primary health care provider** may record the test dates directly on this form (check marks are not acceptable) and certify them by signing or stamping the signature section. A **school health professional or designee** may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record. A list of children (including home contact information) whose parent/guardian does not comply with the requirement to provide evidence of blood lead testing, must be forwarded to the Local Health Department in the jurisdiction where the child resides.

Maryland Childhood Lead Poisoning Targeting Plan At Risk Areas by ZIP Code (for children born BEFORE January 1, 2015)

<u>Allegany</u>	<u>Baltimore Co. (Cont.)</u>	<u>Frederick . (Cont)</u>	<u>Montgomery (Cont)</u>	<u>Queen Anne's</u>
ALL	21239	21757	20812	21607
	21244	21758	20815	21617
<u>Anne Arundel</u>	21250	21762	20816	21620
20711	21251	21769	20818	21623
20714	21282	21776	20838	21628
20764	21286	21778	20842	21640
20779	<u>Baltimore City</u>	21780	20868	21644
21060	ALL	21783	20877	21649
21061		21787	20901	21651
21225	<u>Calvert</u>	21791	20910	21657
21226	20615	21798	20912	21668
21402	20714		20913	21670
		<u>Garrett</u>		
<u>Baltimore Co.</u>	<u>Caroline</u>	ALL	<u>Prince George's</u>	<u>Somerset</u>
21027	ALL		20703	ALL
21052		<u>Harford</u>	20710	<u>St. Mary's</u>
21071	<u>Carroll</u>	21001	20712	20606
21082	21155	21010	20722	20626
21085	21757	21034	20731	20628
21093	21776	21040	20737	20674
21111	21787	21078	20738	20687
21133	21791	21082	20740	
21155		21085	20741	
21161	<u>Cecil</u>	21130	20742	<u>Talbot</u>
21204	21913	21111	20743	21612
21206		21160	20746	21654
21207	<u>Charles</u>	21161	20748	21657
21208	20640		20752	21665
21209	20658	<u>Howard</u>	20770	21671
21210	20662	20763	20781	21673
21212			20782	21676
21215	<u>Dorchester</u>	<u>Kent</u>	20783	
21219	ALL	21610	20784	
21220		21620	20785	
21221	<u>Frederick</u>	21645	20787	
21222	20842	21650	20788	<u>Washington</u>
21224	21701	21651	20790	ALL
21227	21703	21661	20791	
21228	21704	21667	20792	<u>Wicomico</u>
21229	21716		20799	ALL
21234	21718	<u>Montgomery</u>	20912	<u>Worcester</u>
21236	21719	20783	20913	ALL
21237	21727	20787		

Section 5

Vision and Hearing

Hearing and Vision

Maryland law provides guidelines for hearing and vision screenings for students (the guidelines currently are located in Section 7-404 of the Education Article of the Maryland Annotated Code). Under the law, each county board or county health department “shall provide hearing and vision screenings for all students in the public schools”. The article further notes that “each county health department shall provide and fund hearing and vision screenings for all students,” which, includes students in parochial and other private schools. Within the Archdiocese of Baltimore’s religious jurisdiction, there are many county health departments currently providing hearing and vision screening, including Baltimore and Anne Arundel Counties. Unfortunately, while the vision and hearing screenings are State mandated requirement, funding for the program must come from each County. Budgetary challenges impacts each county’s ability to coordinate and assist parochial and private schools with such vital screenings. In many cases, the actual planning, implementation, and financing of hearing and vision screening of students is among the responsibilities of each individual Catholic school and is generally coordinated by the school nurse.

Following the outline of the Maryland statute, it is recommended that the following students have the required hearing and vision screenings:

- Any new students to the school who have not provided adequate documentation of a screening within the past year.
- At a minimum, all students are to be screened the year they enter the school (Pre-K and Kindergarten), 1st grade, and 8th grade or 9th grade.
- 3rd or 4th grade is often additionally screened if funding is possible.
- Any student with a suspected hearing or vision problem as reported by school staff or parent/guardian.

The results of the screening become part of the student’s permanent record and should be noted in PowerSchool in the health section under the child’s name. Parents/guardians will be notified **only if** their child is referred for follow-up care. In Baltimore and Anne Arundel Counties, the technician performing the screening will send a letter to the parent/guardian of students who require follow-up.

Section 5

Any questions or clarification about whether the county in which your school is located assists with hearing and vision screening can be addressed by the applicable local County Health Department. (See contact information in the “communicable disease” section of this Manual.)

Last Updated January 2018

*** Current through October 1, 2017, of the 2017 Regular Session of the Maryland General Assembly. ***

EDUCATION
DIVISION II. ELEMENTARY AND SECONDARY EDUCATION
TITLE 7. PUBLIC SCHOOLS
SUBTITLE 4. HEALTH AND SAFETY OF STUDENTS

Md. EDUCATION Code Ann. § 7-404 (2017)

§ 7-404. Hearing and vision screening tests

(a) County boards or health departments to provide screenings. --

(1) Each county board or county health department shall provide hearing and vision screenings for all students in the public schools.

(2) Each county health department shall provide and fund hearing and vision screenings for all students:

(i) In any private school that has received a certificate of approval under § 2-206 of this article; and

(ii) In any nonpublic educational facility in this State approved as a special education facility by the Department.

(b) When administered. --

(1) Unless evidence is presented that a student has been tested within the past year, the screenings required under subsection (a) of this section shall be given in the year that a student enters a school system, enters the first grade, and enters the eighth or ninth grade.

(2) Further screening shall be done in accordance with:

(i) The bylaws adopted by the State Board; or

(ii) Policies adopted by a county board or a county health department.

(c) Records. -- The results of the hearing and vision screenings required by this section shall be:

(1) Made a part of the permanent record file of each student;

(2) Given to the parents of any student who fails the screenings; and

(3) Reported to the county board or the county health department.

(d) Report. -- On a form provided by the county board or the county health department, a parent or guardian shall report to the county board or the county health department on the recommended services received by a student who failed the screenings.

(e) Report to Maryland Department of Health. -- The county board or the county health department shall report to the Maryland Department of Health the results of the hearing and vision screenings and, to the extent practicable, the number of students receiving the recommended services.

(f) Adoption of standards, rules, and regulations. -- In cooperation with the Maryland Department of Health, the Department of Education shall adopt standards, rules, and regulations to carry out the provisions of this section.

(g) Students excepted. -- A student whose parent or guardian objects in writing to hearing and vision screening on the ground that it conflicts with the tenets and practice of a recognized church or religious denomination of which he is an adherent or member may not be required to take these screenings.

Section 6

Student Injury Reports

Student Injury Reports

It is a top priority of the Office of Risk Management (ORM) to provide resources to schools and school nurses. Student safety is the primary concern during all school activities, and preventing injuries is the main objective. In the unfortunate event of an injury occurring to a student while on school property or arising out of school sponsored activities off premises, certain reporting procedures to check for and ensure insurance coverage must be adhered to.

If:

- Follow up treatment is probable beyond that provided in the health suite;
- Circumstances surrounding the proximate cause of the injury are unusual or questionable;
- Parents are contentious or making allegations involving negligence; or
- Nurse's discretion deems reporting appropriate

Then:

Enter all visit information in PowerSchool including "ORM" in the "Issue/Visit Reason" field to indicate action is needed by the Office of Risk management.

Visit Reasons

Issue/Visit Reason	<input type="text" value="ORM-"/>
---------------------------	-----------------------------------

507 characters left

In addition to entering the visit in PowerSchool, the Report of Student Injury Form **may** also be faxed or emailed to the Office of Risk Management.

Section 6

For incidents involving non-employee visitors please complete the *General Liability Loss Notice*, and for incidents involving employees please complete the *Workers Compensation First Report of Injury*. These reports can be found at:

<https://www.archbalt.org/office-of-risk-management/internet-claims-reporting/>

If immediate attention is necessary, contact the Office of Risk Management directly at:

Cathy O'Brien, Risk Management Associate

Cathy.obrien@archbalt.org

(443)263-1950 direct office line

(410)456-2288 cell

(410)547-3153 fax

Or

Tom Alban, Risk Manager

Talban@archbalt.org

(410)547-5424 direct office line

(410)591-5717 cell

(410)547-3153 fax

****It is always important that no commentary should be used in any of the reports. Please document facts only (for example, what happened, where, when, etc.), and do not include any opinions, personal views, or comments in any report or other written documentation. ****

Last Updated January 2018



ARCHDIOCESE OF BALTIMORE
DEPARTMENT OF MANAGEMENT SERVICES
OFFICE OF RISK MANAGEMENT

REPORT OF STUDENT INJURY

NAME OF CHILD:	_____	GRADE:	_____	GENDER	_____
NAME OF PARENT GUARDIAN:	_____				
ADDRESS	_____				
CITY:	_____				
STATE:	_____				
ZIP:	_____				
TELEPHONE	_____				

DAY/DATE OF ACCIDENT	_____
CIRCUMSTANCES	_____

FOLLOW-UP CARE:	_____

NAME OF SCHOOL	_____
SUBMITTED BY:	_____
DATE:	_____
E-MAIL ADDRESS:	_____
PHONE NUMBER:	_____

Submit to:	Cathy O'Brien, Risk Management Associate
	Fax: 410-547-3153
	E-mail cathy.obrien@archbalt.org

1. Please refer to Student Injury Reporting and Submission Guidelines for information on completion of this form.

Section 7

Communicable Disease

Communicable Diseases

All schools should comply with the Maryland Department of Health's immunization requirements as stated in Section 4 of this Manual.

Please reference the *Communicable Disease Summary* located in this section for information on common communicable diseases, as well as guidance for excluding children from school.

The principal or the principal's designee shall notify the local health department of all suspected or diagnosed cases of reportable communicable diseases. The local health department will assist the school in implementing a plan for preventing the spread of the reported disease. Please see the list of local Maryland health departments located in this section.

All reportable communicable diseases should also be reported to the Office of Risk Management.

Please also see HE 3.0 "Principals notify their local health department in cases of student absences due to a reportable communicable disease," from the *Policy Manual for Elementary Schools for the Archdiocese of Baltimore*



Communicable Diseases Summary

A Guide for School Health Services Personnel,
Child Care Providers and Youth Camps

Revised: November 2011

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

If you have questions about anything in this Summary, or other questions about communicable diseases:

Please call your local health department or the Maryland Department of Health and Mental Hygiene, Office of Infectious Disease Epidemiology and Outbreak Response (IDEOR) at 410-767-6700,

OR

Please check the DHMH website at <http://ideha.dhmh.maryland.gov/SIPOR/> for additional information.

Acknowledgements: The following contributed to the content, review and production of this document:

- Maryland Department of Health and Mental Hygiene (DHMH), Infectious Disease and Environmental Health Administration (IDEHA), Office of Infectious Disease Epidemiology and Outbreak Response (IDEOR)
- Maryland Department of Health and Mental Hygiene (DHMH), Family Health Administration (FHA), Center for Maternal and Child Health, School Health Services Program
- Maryland State Department of Education (MSDE), Division of Student and School Support, School Health Services Program
- American Academy of Pediatrics (AAP), Maryland Chapter
- Medical and Chirurgical Faculty of Maryland (MedChi), Public Health Committee, Maternal and Child Health Subcommittee
- Medical and Chirurgical Faculty of Maryland (MedChi), Infectious Disease Committee

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Use of this document:

The intent of this document is to provide general guidance to school health services personnel, child care providers, youth camp owners/operators about common communicable diseases. It is not intended for use as a diagnostic guide. Please consult a health care provider for any situations which require medical attention. This guidance is to be used in conjunction with School Health Services (SHS) guidance and local health department (LHD) policies and procedures, and applies to individual or sporadic cases of the communicable diseases described below. Outbreaks or unusual situations may require additional control measures to be instituted/implemented in consultation with your local health department. The procedures in this document represent measures specific to school, child care or youth camp settings. References to SHS Guidelines are intended for use by schools in programs serving school-aged children.

If a child's health care provider (HCP) provides exclusion recommendations which conflict with these guidelines, please consult with your local health department. If parents have additional questions, they should contact their HCP or local health department.

This document is intended to guide the development of specific local policy and procedures regarding management of communicable diseases in schools, child care, and youth camps. These policies and procedures should be implemented in collaboration and in consultation with local health departments, school health services programs, local child care authorities and youth camp regulatory authorities.

Definitions:

Outbreak: In general, an outbreak is defined as an increase in the number of infections that occur close in time and location, in a facility, such as a school, child care center, or youth camp, over the baseline rate usually found in that facility. Many facilities may not have baseline rate information, if you have questions, please contact your local health department about whether a particular situation should be considered an outbreak. In some cases, the health department may require longer exclusions than stated in this guide in response to an outbreak.

Reportable disease/condition: Maryland statute, Maryland Code Annotated, Health-General ("Health-General") §18-201 and §18-202, and Maryland regulation, Code of Maryland Regulations ("COMAR") 10.06.01.04 "Communicable Diseases" and 10.16.06.25 "Certification for Youth Camps", require that health care providers, school and child care personnel, masters of vessels or aircraft, medical laboratory personnel, owners/operators of food establishments, and owners/operators of youth camps, submit a report in writing or notification by telephone of diagnosed or suspected cases of specified diseases to the Commissioner of Health in Baltimore City or the health officer in the county where the provider cares for that person. A list of reportable diseases and conditions can be found at <http://ideha.dhuh.maryland.gov/reportable-diseases.aspx>

Infection control measures: Includes the use of one or of combinations of the following practices. The level of use will always depend on the nature of the anticipated contact:

- Handwashing, the most important infection control method
- Use of protective gloves, latex-free gloves are recommended*
- Masks, eye protection and/or face shield
- Gowns
- Proper handling of soiled equipment and linen
- Proper environmental cleaning
- Proper disposal of sharp equipment (e.g., needles)
- Isolation in a separate area for those who cannot maintain appropriate cleanliness or contain body fluids

* Latex allergy is recognized as an issue for some children, especially those with multiple past surgeries. Latex-free gloves are preferred.

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Fever: For the purposes of this guidance, fever is defined as a temperature >100.0° F orally; an oral temperature of 100° F is approximately equivalent to 101° F rectally or temporally (Temporal Artery Forehead scan), or 99.5° F axillary (armpit).

Diarrhea: Loose or watery stools of increased frequency that is not associated with change in diet.

Vomiting: Two or more episodes of vomiting in a 24 hour period.

General Considerations:

Exclusion: Children may be excluded for medical reasons related to communicable diseases or due to program or staffing requirements. In general, children should be excluded when they are not able to fully participate with the program, or in the case of child care settings, when their level of care needed during an illness is not able to be met without jeopardizing the health and safety of the other children, or when there is a risk or spread to other children that cannot be avoided with appropriate environmental or individual management. For exclusion, all applicable COMAR regulations should be followed; for youth camps, specifically COMAR 10.16.06.31 "Exclusion for Acute Illness and Communicable Disease".

Fever: A child may have a fever for many reasons. If a child has a fever, all applicable COMAR regulations should be followed. In addition, any child with a fever and behavior changes or other symptoms or signs of an acute illness should be excluded and parents notified. Once diagnosed, exclusion due to fever should be based on disease-specific guidelines or other clinical guidance from the child's health care provider. Also, it is important to be sure the appropriate method for measuring temperature is used based on the age or developmental level of the child.

An unexplained fever in any child younger than 3 months requires medical evaluation. Fever in an infant the day following an immunization known to cause fever, may be admitted along with health care provider recommendations for fever management and indications for contacting the health care provider. Instructions from the health care provider should include: the immunizations given, instructions for administering any fever reducing medication, and medication authorizations signed by the parent and the health care provider.

Diarrhea: Diarrhea may result in stools that are not able to be contained by a diaper or be controlled/contained by usual toileting practices. An infectious cause of diarrhea may not be known by the school, child care facility, or camp at the time of exclusion or return. Documentation of the cause of diarrhea should be sought.

A child with diarrhea should be excluded if:

- Stool is not able to be contained in a diaper or in the toilet, or child is soiling undergarments
- Stool contains blood
- Child is ill or has any signs of acute illness
- Diarrhea is accompanied by fever
- Child shows evidence of dehydration (such as reduced urine or dry mouth)

With appropriate documentation, a child with diarrhea may be readmitted to care, school, or camp when:

- An infectious cause of diarrhea (see chart) has been treated and the child is cleared by a health care provider, in conjunction with the local health department, if necessary
- The diarrhea has been determined by the local health department to not be an infectious risk to others

Vomiting: An infectious cause of vomiting may not be known by the school, child care facility, or camp at the time of exclusion or return. Documentation of the cause of vomiting should be sought. Child should be excluded until vomiting resolves or until a health care provider clears for return (is not contagious).

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BITES, ANIMAL	N/A	Redness, pain, swelling, drainage around area bitten. May develop fever, lymph node enlargement.	Direct contact.	N/A	No, exclusion is not routinely recommended as long as student/child does not meet any other exclusion criteria. It is strongly recommended that there be medical follow-up. For school age children, see SHS "Guide for Emergency Care in Maryland Schools, 2005". For preschool age children, contact the child's health care provider.	After immediate needs of bitten victim(s) are taken care of, notify local health department and appropriate local authority (police, sheriff, animal control) immediately by telephone. [Also, see section for "Rabies".]
BITES, HUMAN	N/A	Redness, pain, swelling, drainage around area bitten. May develop fever, lymph node enlargement.	Direct contact.	N/A	No, exclusion is not routinely recommended as long as student/child does not meet any other exclusion criteria. It is strongly recommended that there be medical follow-up. For school age children, see SHS "Guide for Emergency Care in Maryland Schools, 2005". For preschool age children, contact the child's health care provider.	After immediate needs of bitten victim(s) are taken care of, notify Responsible authority and parent/guardian. Assess immunization status of children involved, including tetanus and Hepatitis B vaccination. [Also, see SHS "Bloodborne Pathogens Control And Handling Body Fluids in the School Setting, 2007".]

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CHLAMYDIA <i>(Chlamydia trachomatis)</i>	Usually 7-14 days; up to 30 days.	May be asymptomatic; genital infection can include: purulent discharge, painful urination, lower abdominal pain. Symptoms of conjunctival infection include painful, swollen eyelids.	Sexual contact: genital, oral, anal. Conjunctivitis: from infected mother to infant.	Variable, but can be a long time, if not treated.	No, exclusion is not routinely recommended.	A case or outbreak must be reported to the local health department. All cases should be referred to a health care provider for assessment (including potential for gonorrheal co-infection) and possible treatment. This infection in a young child may possibly be an indicator of sexual abuse. COMAR 10.16.06.35 requires camp operator to report child abuse. <i>[Also, see SHS "Guide for Emergency Care in Maryland Schools, 2005" section for "Child Abuse and Neglect".]</i>
CMV <i>(Cytomegalovirus, Human herpesvirus 5)</i>	Variable, can be within 3-12 weeks.	Non-specific febrile illness; asymptomatic infections common. In adolescents and adults, may see fever, sore throat, fatigue, swollen glands, and mild hepatitis. In immunocompromised, may see pneumonia, colitis, retinitis.	Through mucosal contact with infected secretions or excretions (such as urine, saliva, feces, blood and blood products, breast milk, semen, cervical secretions).	Variable, may be many months or episodic for several years.	No, exclusion is not routinely recommended. Control measures: Emphasize washing hands often, especially after toileting and after diapering and handling any children less than 2 years old.	A pregnant woman or a woman who is considering pregnancy should talk to her doctor if she cares for infants or young children, or handles urine or saliva in any home or occupational setting. Pregnant women do not necessarily need to be excluded from such situations

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COMMON COLD	12 hours to 5 days; usually 2 days.	Runny nose, watery eyes, sneezing, chills, sore throat, cough, and general body discomfort lasting 2-7 days. May also have a low-grade fever.	Direct contact with an ill person or respiratory droplets; also by contact with hands or articles contaminated with nose or throat secretions.	Variable, depending on cause; average 24 hrs before to 5 days after symptoms have started.	No, unless child meets other exclusion criteria. Do not exclude solely on the presence of runny nose regardless of the color or consistency of the nasal discharge, or presence of cough. Control measures: Emphasize covering nose and mouth when coughing/sneezing; using facial tissue to dispose of nose or throat secretions; washing hands often and not sharing eating utensils.	Many different viruses can cause the common cold.
CONJUNCTIVITIS, INFECTIOUS (Infectious Pink Eye)	Caused by bacterial or viral agents.	White or yellow discharge, accompanied by pink or red conjunctivae, redness and swelling of the lids, and matted, sticky lids.	Direct contact or through contaminated hands followed by contact with eyes; contaminated swimming pools are rarely a source of infectious pink eye.	Variable, depending on cause, from several days to weeks.	Yes, until cleared for return with documentation from a health care provider, after taking antibiotics for 24 hours, or until symptoms have resolved. Control measures: Emphasize hand hygiene.	Refer any newborn with conjunctivitis to a health care provider. NOTE: Exclusion not necessary for allergic conjunctivitis (watery eye discharge, without fever, pain, red lids, and with or without pink eye or injected conjunctivae) if evaluated and documented by a health care provider.

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DIARRHEAL ILLNESS: UNKNOWN CAUSE	Varies according to causative agent.	Varies according to causative agent. Symptoms may include nausea, vomiting, diarrhea, stomach cramps, headache, blood and/or mucus in stool, fever.	Usually spread from person-to-person by fecal-oral route; from ingesting contaminated food or water.	Duration of clinical symptoms or until causative agent is no longer present in stool.	Exclude until diarrhea has resolved and child is diarrhea-free for at least 24 hours; or until cleared by medical provider. Control measures: Emphasize hand hygiene; observe exclusion period especially for those in activities at high risk for transmission: child care attendees, food service workers, those who care for the very young or elderly, health care workers, etc.	Report individual cases according to state health department "List of Reportable Diseases and Conditions". An outbreak must be reported to the local health department.
DIARRHEAL ILLNESS: CAMPYLOBACTER	Usually 2-5 days; range 1-10 days.	Diarrhea with or without blood, abdominal pain, fever, cramps, malaise, nausea and/or vomiting.	Spread from person-to-person by fecal contact, contact with infected pets, or from ingesting contaminated foods such as raw or undercooked meats, unpasteurized milk, or untreated water.	Usually 2-3 weeks in untreated cases, up to 7 weeks.	Yes, if symptomatic until cleared by local health department after further testing. Contact local health department for guidance.	A case or outbreak must be reported to the local health department.
DIARRHEAL ILLNESS: E. COLI O157:H7 and other STEC (Shiga Toxin-producing E. coli)	Usually 3-4 days; range 1-10 days.	Severe abdominal pain, diarrhea with or without blood and vomiting.	Spread from person-to-person by fecal-oral route or ingesting under-cooked beef, un-pasteurized milk or juices, raw fruits or vegetables, or contaminated water.	Usually 1-3 weeks.	Yes, if symptomatic until cleared by local health department. Contact local health department for guidance.	A case or outbreak must be reported to the local health department.

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DIARRHEAL ILLNESS: <i>GIARDIA</i>	Usually 7-10 days; range 3 days to 4 weeks.	Acute watery diarrhea with abdominal pain, bloating, frequent loose and pale greasy stools, fatigue and weight loss.	Spread from person-to-person by fecal-oral route or ingestion of contaminated recreational/ drinking water.	Entire period of infection, often months.	Yes, until treated. If not treated, contact local health department for guidance about exclusion criteria. Control measures: Hand hygiene by staff and children should be emphasized, especially after toilet use or handling of soiled diapers; dispose of feces in a closed container; disinfection of feces-soiled articles.	A case or outbreak must be reported to the local health department.
DIARRHEAL ILLNESS: <i>NOROVIRUS</i>	Usually 24-48 hours; range 12-72 hours.	Nausea, vomiting, abdominal cramps, diarrhea, fever, headache.	Spread from person-to-person by fecal contact or from ingesting contaminated foods. Commonly from contaminated surfaces, objects. Possible transmission via aerosolized particles.	At least 48 hours after symptoms resolve. Sometimes longer.	Yes, until 48 hours after resolution of symptoms. Control measures: Emphasize handwashing after use of bathroom or changing diapers and thorough environmental cleaning.	An outbreak must be reported to the local health department.
DIARRHEAL ILLNESS: <i>ROTAVIRUS</i>	Range approx. 1-3 days.	Vomiting, fever and watery diarrhea.	Spread from person-to-person by fecal-oral route. Possible airborne transmission.	At least 48 hours after symptoms resolve. Sometimes longer in persons with weakened immune systems.	Yes, until 48 hours after resolution of symptoms. Control measures: Vaccine-preventable. Emphasize handwashing after use of bathroom or changing diapers and thorough environmental cleaning.	An outbreak must be reported to the local health department. NOTE: Vaccine available as of 2007.

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DIARRHEAL ILLNESS: SALMONELLA	Usually 12-36 hours; range 6-72 hours.	Diarrhea, fever, abdominal cramps, nausea, vomiting, headache.	Ingestion of contaminated foods, including poultry, beef, fish, eggs, dairy products or water; also contact with infected reptiles.	Throughout the course of infection; extremely variable, usually several days to several weeks.	Yes, for children in child care if not toilet trained, whether symptomatic or not. Asymptomatic school age children generally do not need to be excluded. Contact local health department for guidance.	A case or outbreak must be reported to the local health department.
DIARRHEAL ILLNESS: SHIGELLA	Usually 1-3 days; range 1-7 days.	Abdominal cramps, fever, diarrhea with blood and mucous; also watery diarrhea. Sometimes nausea or vomiting.	Direct or indirect fecal-oral transmission from a symptomatic patient or asymptomatic carrier; ingestion of contaminated water or food.	During acute infection and up to 4 weeks after illness.	Yes, for those who are symptomatic until cleared by local health department after further testing. Contact local health department for guidance.	A case or outbreak must be reported to the local health department.
DIPHTHERIA (<i>Corynebacterium diphtheriae</i>)	Usually 2-5 days; range 1-10 days.	Patches of grayish membrane with surrounding redness of throat, tonsils, nose, and/or mucous membranes. May include nasal discharge, sore throat, low grade fever, hoarseness, barking cough. Less common sites of infection: skin, eyes, ears, and vagina.	Spread from person-to-person by contact with respiratory secretions or skin lesions. Rarely, transmission may occur from articles soiled with discharges from lesions of infected persons.	Variable; usually 2-4 weeks or until 5 days after antibiotic therapy has been started.	Yes, until cleared by local health department. Contact the local health department for further guidance. Control measures: Vaccine-preventable. Vaccination is the key preventive measure.	A case or outbreak must be reported immediately to the local health department by telephone. Rarely seen in Maryland.

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FIFTH DISEASE (Erythema infectiosum, Parvovirus B19)	Variable, 4-20 days.	Red, patchy facial rash ("slapped cheek") that may spread to rest of body in lace-like pattern. Cold-like symptoms may precede rash. May be asymptomatic.	Spread from person-to person by respiratory secretions; by contaminated blood or blood products; from mother to fetus.	Most infectious before the onset of rash in most cases.	<p>No, exclusion is usually not necessary. Contact health care provider and/or local health department about special recommendations for infected persons with chronic anemia at risk for hemolytic complications (such as sickle cell disease), weakened immune systems, or for pregnant women.</p> <p>Control measures: Encourage hand washing and disinfection of surfaces, high-contact items, such as doorknobs, and items shared among children.</p>	An outbreak must be reported to the local health department. Pregnant women exposed to a case of Fifth disease should consult with their health care provider.

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GONORRHEA (<i>Neisseria gonorrhoeae</i> , <i>Gonococcus</i>)	1-14 days, sometimes longer.	Males: Cloudy or creamy discharge from penis, pain with urination. Females: usually no symptoms, but may have vaginal discharge, urinary frequency, abdominal pain. Both genders: throat and anorectal infections (although uncommon) may produce discharge, localized pain. (Gonococcal infection can infrequently cause achy, swollen joints; a skin rash; fever; and other symptoms.	Spread from person-to-person by genital, oral or anal sexual contact.	Variable, but can be a long time, if not treated.	No, exclusion is not routinely recommended. Cases should contact a health care provider, and referred to the local health department for follow-up.	A case or outbreak must be reported to the local health department. All cases should be referred to a health care provider for assessment (including potential for chlamydial co-infection) and possible treatment. This infection in a young child may possibly be an indicator of sexual abuse. COMAR 10.16.06.35 requires camp operator to report child abuse. <i>[Also, see SHS "Guide for Emergency Care in Maryland Schools, 2005" section for "Child Abuse and Neglect".]</i>
HAEMOPHILUS INFLUENZAE type B (HIB) DISEASE	Unknown; may be 2-4 days.	Various, depending on site of infection: ear, eye, skin, lungs, joints, or spinal fluid spaces.	Airborne droplets produced by coughing or sneezing or contact with nose or throat discharges of an ill person or carrier; or by direct person-to-person contact.	Non-communicable 24-48 hours after the start of appropriate antibiotic treatment. Contact local health department for guidance.	Yes, exclude for 24 hours after the initiation of antibiotic therapy. Control measures: Vaccine-preventable. Vaccination is the key preventive measure. Contact local health department for recommendations about the need to exclude those who are unvaccinated, or administer prophylaxis to contacts.	A case or outbreak must be reported to the local health department immediately by telephone.

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HAND, FOOT AND MOUTH DISEASE (various Coxsackie-viruses)	Usually 3-5 days. Lesions may persist from 7-10 days	Fever, cold symptoms, rash on palms, fingers and soles, sores in mouth. Occasionally appear on the buttocks.	Spread through direct person to person contact with nose, and throat discharges, and feces of an infected person.	Highly contagious during the acute phase. Shedding in stool may continue for several weeks.	No, unless meets other exclusion criteria, "hand to mouth" behavior uncontrollable, not able to contain secretions, or draining sores cannot be covered. Control measures: Avoid person-to-person contact with ill person. Emphasize washing hands often and not sharing eating utensils, also for caretaker of ill infants and diapered children. Wash or discard items of clothing contaminated with nose or throat discharges or with fecal material.	An outbreak must be reported to the local health department.
HEPATITIS A	Usually 28 days after exposure; range 15-50 days.	Early symptoms: fatigue, loss of appetite, stomach pain, diarrhea, nausea, vomiting, fever, dark urine. Later symptom: jaundice (yellow skin and eyes). Some cases are mild. Children may be asymptomatic.	Spread from person-to-person by fecal contact; or from ingesting food or water containing the virus.	Usually a 3-week period: from 1 week before onset of early symptoms to 1 week after onset of jaundice. Prolonged viral excretion (up to 6 months) has been documented in infants and children.	Yes, for at least 2 weeks after the onset of early symptoms or 1 week after onset of jaundice. Control measures: Vaccine-preventable. Emphasis on hand-washing after use of bathroom or changing diapers and (if necessary) improved disinfection. Food handlers or servers should refrain from preparing or serving food for 2 weeks after onset of early symptoms.	A case or outbreak must be reported to the local health department.

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HEPATITIS B	Usually 60-90 days; range 45-180 days.	Dark urine, fatigue, loss of appetite, nausea, vomiting, often followed by jaundice. Joint pain may be present. Some cases are mild. Children may be asymptomatic.	Spread by exposure to infected blood; injection drug use; from mother to infant during pregnancy or birth; sexual contact; and through other body fluids.	Several weeks before onset of symptoms and during course of acute disease. Persons with a positive hepatitis B surface antigen (HBsAg) test are considered communicable, even years after initial infection.	No, exclusion is not routinely recommended unless the individual is not able to resume activities. However, exclusion could be considered in cases in which a child's medical condition (oozing sores or rash, bleeding) or behavior (scratching, biting) increases likelihood of exposing others. Contact local health department for further guidance. Control measures: Vaccine-preventable. Vaccination is the key preventive measure	A case or outbreak must be reported to the local health department. Pregnant women who are HBsAg positive should be referred to their health care provider.
HEPATITIS C	Ranges from 2 weeks to 6 months; commonly 6-9 weeks.	Loss of appetite (weight loss), nausea, vomiting, jaundice, dark urine, fatigue, & vague abdominal discomfort may occur. However, may be asymptomatic.	Exposure to infected blood: primarily parenterally (through injection drug use, accidental contaminated sharps exposure). Sexual and perinatal transmission appear rare. Rarely through other body fluids.	One or more weeks before the onset of symptoms; some persons become carriers and remain infected indefinitely.	No, exclusion is not routinely recommended unless the individual is not able to resume activities. However, exclusion could be considered in cases in which a child's medical condition (oozing sores or rash, bleeding) or behavior (scratching, biting) increases likelihood of exposing others. Contact local health department for further guidance.	A case or outbreak must be reported to the local health department.

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HERPES SIMPLEX VIRUS (Cold Sores, Fever Blisters, genital herpes sores, skin lesions)	Usually 2-12 days	Oral herpes: sores or blisters on the lips or mouth. Genital herpes: painful sores or blisters in the genital area. Herpes gladiatorum: Sores on exposed areas of skin.	Spread from person-to-person by direct contact with saliva, sores, or blisters, such as touching, kissing, or having sex; perinatally.	Virus can be recovered from lesions 2-7 weeks after primary infections and up to 5 days in reactivation lesions	Oral herpes: No, unless child with oral herpes is drooling and can not contain secretions or meets other exclusion criteria. Genital herpes: No, unless meets other exclusion criteria. Herpes gladiatorum: Yes, exclusion from contact sport participation that requires skin-skin contact. Control measures: Handwashing and avoid touching lesions. Cover lesions if possible. Disinfection of sporting equipment after use. Avoid sharing sports equipment that comes in contact with skin.	Pregnant women with herpes should consult a health care provider. Stress handwashing and not touching lesions. An outbreak must be reported to the local health department.
HIV (Human Immunodeficiency Virus) infection, includes AIDS	Variable; 1-3 months from infection to detection of antibodies. Median incubation in infected infants is shorter than adults	May be asymptomatic for many years. Symptoms in later stages of HIV infection are variable.	Spread from person-to-person through sexual contact; exposure to HIV-infected blood or body fluids (e.g., dirty needles); from mother to infant during pregnancy, or birth.	Soon after onset of infection and persists throughout life. Infectivity is high during first months; increases with viral load; worsening of clinical status; and presence of other sexually transmitted infections. Treatment may reduce communicability.	No, unless meets other exclusion criteria, has weeping and oozing sores that can not be covered, bleeding condition where blood can not be contained; if so, consult local health department. Control measures: Responsible sexual behavior (abstinence or condom use). Avoidance of blood and sharps exposures.	Staff who routinely provide acute care should wear gloves and use good handwashing technique. Standard precautions should be followed by all health care personnel. <i>[Also, see SHS "Bloodborne Pathogens Control And Handling Body Fluids in the School Setting, 2007".]</i>

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INFLUENZA (Seasonal)	Usually 1-3 days.	Cough, fever, headache, muscle aches, runny nose, sore throat. Less frequently, GI symptoms.	Person to person by droplets or direct contact with infected articles.	24 hours before the onset of symptoms and up to 7 days in young children.	Yes, until without fever for 24 hours, or if meets other exclusion criteria. Follow local health department recommendations. Control measures: Vaccine-preventable. Emphasize respiratory etiquette and frequent handwashing.	An outbreak must be reported to the local health department. Do not use salicylates (such as aspirin) during illness.
IMPETIGO ("SKIN INFECTIONS", Staphylococcal or Streptococcal skin infections)	Variable. Usually 4-10 days.	Blister-like skin lesions, which later develop into crusted sores with an irregular outline.	Direct contact with draining sores or by touching articles contaminated with blister fluid.	Usually not contagious after 24 hours of treatment.	No, if lesion can be covered. Yes, if lesion cannot be covered. If antibiotic therapy indicated, exclude until 24 hours of antibiotic therapy has been completed, or otherwise cleared by HCP (in some cases, antibiotic use may not be indicated for treatment). If no antibiotics indicated, exclude until lesion is healed. For contact sports: Yes, if lesion cannot be covered, regardless of whether antibiotics started, until lesion is healed. Control measures: Avoid touching lesions. Emphasize frequent handwashing. Conduct routine environmental cleaning.	Cases with lesions should avoid contact with newborns. <i>[See also sections for "Staphylococcal Infection" and "Streptococcal Infection."]</i>

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LICE, BODY <i>(Pediculus corporis)</i>	6-10 days from laying of eggs to hatching of nymphs.	Intense itching, worse at night. Lice live in seams of clothing and may or may not be visible.	Direct contact with an infested person or contact with objects used by an infested person, especially clothing.	As long as lice are alive on infested person or object. Eggs viable on clothing 1 month. Adult lice viable away from host up to 10 days.	Yes, at the end of the program/activity/school day. Skin may need treatment with pediculicide -- if one is used, exclude for 24 hours after first treatment is completed. Control measures: Bathe with soap and water. Wash clothing and bedding in hot water and dry on high heat or dust clothing with a pediculicide.	An outbreak must be reported to the local health department. Body lice may transmit serious infections.
MEASLES <i>(Rubeola)</i>	Usually 8-12 days from exposure to onset of symptoms. Average interval between appearance of rash after exposure is 14 days; range 7-18 days.	Sudden onset of chills followed by sneezing, runny nose, conjunctivitis, photophobia, fever, cough. Rash usually appears first behind the ears or on forehead/ face; blotchy, unusually dusky red rash over face, trunk, and limbs. Small white spots (Koplik's spots) inside mouth.	Direct contact with infectious droplets or, less commonly, by airborne spread. Highly contagious among unvaccinated children in school, child care or camp settings.	1-2 days before onset of symptoms (3-5 days before rash) to 4 days after appearance of the rash. Immuno-compromised children can be contagious for the duration of the illness.	Yes, until 4 days after the onset of rash in otherwise healthy children and for the duration of illness in immunocompromised children. Contact local health department for further guidance on management of cases and contacts. Control measures: Vaccine-preventable. Vaccination is the key preventive measure.	A case or outbreak must be reported to the local health department immediately by telephone. Pregnant women exposed to a case should see a health care provider for evaluation.

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MENINGITIS, VIRAL or ASEPTIC (including Enterovirus, Measles, Herpes, Adenovirus)	Varies depending on specific viral agent. Usually within 3-10 days later.	Fever, severe headache, stiff neck, bright lights hurting the eyes, drowsiness or confusion, and nausea and vomiting may occur. Meningitis symptoms are an emergency that should be assessed immediately by a health care provider.	Varies depending on specific viral agent. Most common cause: Enteroviruses, most often spread through direct contact with respiratory secretions.	Depends on the viral agent causing illness, but usually (Enteroviruses) 3 days after infected until about 10 days after developing symptoms.	Yes, until cleared for return by health care provider or local health department. Contact local health department for guidance. Contacts of cases generally do not need to be seen by a health care provider or given preventive medications. Control measures: Emphasize handwashing after use of bathroom, changing diapers, and before handling or eating food or drink.	A case or outbreak must be reported to the local health department. Most viral infections do not require treatment; however, some may require specific antiviral therapy.
MENINGITIS, BACTERIAL (<i>Haemophilus influenzae</i>, <i>Neisseria meningitidis</i>, <i>Streptococcus pneumoniae</i>, <i>Listeria</i>)	Varies depending on specific bacterial agent, but usually 2-10 days, commonly 3-4 days.	Fever, stiff neck, headache, vomiting, and rash may occur. Meningitis symptoms are an emergency that should be assessed immediately by a health care provider.	Direct contact, including respiratory droplets from nose and throat of infected people, but it varies depending on the bacterial agent causing illness.	Depends on the bacterial agent causing illness.	Yes, until cleared by health care provider in conjunction with local health department. Contact local health department for guidance. Some agents may require antimicrobial therapy. Some contacts of cases may need preventive antibiotics. Control measures: Vaccine-preventable for some types of bacteria that can cause meningitis (<i>Haemophilus influenzae</i> , <i>Neisseria meningitidis</i> , <i>Streptococcus pneumoniae</i>). Vaccination is the key preventive measure.	A case or outbreak must be reported to the local health department.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
MENINGOCOCCAL DISEASE <i>(Neisseria meningitidis)</i>	Usually 3-4 days; range 1-10 days.	Sudden onset with fever, vomiting, intense headache, and stiffness of the neck. A rash may appear on the body. Other symptoms sometimes seen with non-meningitis forms of the disease.	Spread by close contact with droplets and discharge from nose, throat or saliva of an infected person. Illness highly contagious in child care settings.	Usually 24 hours after the initiation of appropriate therapy	Yes. Refer case to health care provider. Control measures: Follow local health department recommendations for prophylaxis and surveillance for close contacts, including household, child care contacts, others with saliva contact with case. A vaccine is available for certain types of meningococcal disease, and is required by law for certain risk groups. Vaccination is the key preventive measure.	A case or outbreak must be reported to the local health department immediately by telephone.
MOLLUSCUM CONTAGIOSUM	Usually 2-7 weeks; range 7 days to 6 months.	Smooth surfaced, spherical papules on skin, sometimes appears in linear orientation, can be itchy. In children, lesions most often seen on face, trunk, extremities.	Usually through direct contact. Possible sexual transmission or via fomites. Some autoinoculation.	Unknown. Probably as long as lesions persist.	No, exclusion not routinely recommended. For contact sports or sports with shared equipment that comes in contact with skin (such as gymnastics, etc.): No, as long as lesions/bumps can be covered with clothing or a watertight bandage.	An outbreak must be reported to the local health department. Genital lesions in a young child may possibly be an indicator of sexual abuse. COMAR 10.16.06.35 requires camp operator to report child abuse.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
MONONUCLEOSIS, INFECTIOUS (Epstein-Barr virus)	Usually 30-50 days.	Fever, sore throat, swollen lymph nodes, sometimes rash. Neurologic complications include: meningitis, encephalitis, myelitis.	Spread by close personal contact via saliva; also may be transmitted by blood transfusion.	Prolonged; may be up to a year or more. Some may be long-term carriers.	General exclusion: No, exclusion not routinely recommended. Contact sports: Yes, until acute illness is resolved and cleared by a health care provider. Control measures: Use general hygienic measures, including handwashing to prevent salivary contamination from infected individuals; minimize contact with saliva (such as, avoiding drinking beverages from a common container).	An outbreak must be reported to the local health department. Regarding contact sports, health care provider must clear athletes to reduce risk of splenic rupture.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
MUMPS	Usually 16 to 18 days; range 12 to 25 days.	Fever, swelling, tenderness of the salivary gland; may be asymptomatic. Parotid glands most frequently affected. Meningitis may occur. In males after puberty, testicular involvement may occur.	Spread by droplet contact and direct contact from nose and throat discharge of an infected person. Highly contagious among unvaccinated children in school, child care, or camp settings.	From 3 days before salivary gland enlargement to 5 days after.	Yes. Exclude case for 5 days after onset of parotid gland swelling. Refer case to health care provider and contact local health department for guidance managing contacts of cases. Control measures: Vaccine-preventable. Vaccination is the key preventive measure.	A case or outbreak must be reported to the local health department.
PERTUSSIS (Bordetella pertussis, Whooping Cough)	Usually 7-10 days; range 5- 21 days.	Acute onset of cough becomes repeated and violent within 1-2 weeks, can persist for several months. Characteristic thick mucus and vomiting after coughing. May not have the typical inspiratory "whoop". Fever may be low-grade or absent.	Spread by close contact with infected persons via aerosolized droplets.	Beginning from just before onset of symptoms to up until 3 weeks after start of symptoms.	Yes, consult with local health department. Confirmed cases should be excluded until completion of 5 days of recommended antibiotics. Untreated cases should be excluded 21 days from the date cough began. Control measures: Vaccine-preventable. Vaccination is the key preventive measure.	A case or outbreak must be reported to the local health department immediately by telephone. Highly contagious among unvaccinated children in school, child care, or camp settings. Infants, elderly and immunocompromised individuals at increased risk for complications.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
PINWORMS (<i>Enterobius vermicularis</i>)	The life cycle of the worm is 2-6 weeks.	Perianal itching (usually worse at night), irritability, disturbed sleep, secondary infection of the scratched skin.	Transfer of <i>Enterobius</i> eggs from fingers of infected person to mouth of uninfested person.	Eggs are communicable in the environment at room temperature about 2-3 weeks.	No, exclusion is generally not recommended. Control measures: Encourage frequent hand-washing. Keep nails short; discourage nail biting and perianal scratching. Daily for several days after treatment: change to clean underwear and bed sheets after bathing, wash linens in hot (131°F) water, clean and vacuum living and sleeping areas.	This should be handled and on a case-by-case basis by the appropriate school or regulatory authority.
PNEUMOCOCCAL DISEASE (<i>Streptococcus pneumoniae</i>)	Varies depending on type of infection. May be as short as 1-3 days.	Various symptoms, depending on location of infection: ear, eye, sinus, lungs, blood, joints, or spinal fluid spaces. May cause meningitis.	Person-to-person transmission through contact with respiratory droplets.	No longer communicable 24-48 hours after initiation of appropriate antibiotics.	No, exclusion is not routinely recommended. Contact local health department for further guidance. Control measures: Vaccine-preventable. Vaccination is the key preventive measure.	Outbreaks or cases of invasive disease must be reported to the local health department.
POLIO	3-6 days for mild (nonparalytic) cases; 7-21 days for paralytic cases.	Infection may be asymptomatic, cause mild illness (fever, malaise, headache, vomiting), or severe illness (meningitis, muscle paralysis, death).	Spread by contact with nose or throat discharge, or by fecal-oral contamination.	Shortly before onset of clinical illness to several weeks after. Children are contagious as long as virus is excreted in feces, usually for several weeks.	Yes, exclude case until health department approves readmission. Contact local health department for guidance of acute cases and contacts. Control measures: Vaccine-preventable. Vaccination is the key preventive measure.	A case or outbreak must be reported to the local health department immediately by telephone.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
RABIES (and RABIES EXPOSURE)	Varies: days to years	<p>Human: Apprehension, fever, difficulty swallowing, hypersalivation, muscle weakness, hydrophobia, sensory changes (e.g. tingling) or paralysis, delirium, convulsions, death due to respiratory paralysis.</p> <p>Animal: Unusual behavior changes (stupor or aggression), increased salivation, paralysis. Death in 2-7 days from onset of illness.</p>	Primarily via bite from a rabid animal. Non-bite exposures include scratches, abrasions, and saliva contamination of open wounds or mucous membranes, or organ transplantation.	Human-to-human bite transmission does not generally occur. In dog and cats, approximately 3-7 days before clinical signs appear and throughout course of disease.	<p>No, exclusion is not recommended for rabies exposure alone.</p> <p>Control measures: Do not let children play with strange, unknown animals or have contact with wild animals, especially bats. If a person is exposed to a possibly rabid animal, immediately wash wound thoroughly with soap and water for several minutes. Seek emergency medical attention immediately, if child was bitten. For school age children, see SHS "Guide for Emergency Care in Maryland Schools, 2005". For preschool age children, contact the child's health care provider. Contact local health department to assess need for post-exposure prophylaxis.</p>	<p>Any case or suspected exposure must be reported immediately by telephone to local law enforcement and local health department. Confine biting animal (if it is safe to do so) or as advised by local law enforcement, and local health department or animal control, for possible testing or quarantine.</p> <p><i>[Also, see section for "Bites, Animal".]</i></p>

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
RINGWORM OF SCALP <i>(Tinea capitis)</i>	Usually 10-14 days.	Patchy areas of dandruff-like scaling and hair loss; many separate blisters, with pus in them with little hair loss; or a soft, red, swollen area of scalp.	Contact with the skin of an infected person or animal, or by contact with contaminated surfaces or objects such as combs, furniture, clothing, and hats. People may be asymptotically infected yet able to transmit disease.	May persist on contaminated materials for a long time if untreated.	Yes, until oral treatment has been initiated. Yes, exclude from contact sports involving skin-skin contact. Control measures: Cover lesions if necessary to prevent direct contact. Disinfect sports equipment that comes in contact with skin. Avoid sharing sports equipment that comes in contact with skin. Examine household, child care, school, camp, and animal contacts; treat if infected. Do not share combs, brushes, hair ornaments, hats, or linens while being treated. Haircuts or shaving the head is not needed. Selenium-containing shampoo twice a week limits shedding of fungus. Head lesions may not be able to be covered. This should be handled on a case-by-case basis.	Recommended treatment for ringworm of the scalp is oral medications because topical medications are not effective against ringworm of the scalp. Topical medications are considered effective for non-scalp ringworm.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
RINGWORM OF SKIN OR BODY <i>(Tinea corporis)</i>	Usually 4-10 days.	Lesions are usually circular or ring-like, slightly red with a raised edge, and appear on the face, trunk, or extremities. May itch.	Contact with lesions or with contaminated surfaces such as floors, showers, or benches.	While lesions are visible. Fungus may persist for long periods on contaminated surfaces.	<p>No, as long as lesions can be covered, and oral or topical treatment has been initiated. Routine exclusion is not recommended.</p> <p>Yes, exclude from contact sports involving skin-skin contact.</p> <p>Control measures: Cover lesions to prevent direct contact. Disinfect sports equipment that comes in contact with skin. Launder towels, linens and clothes in hot water. Refer school, child care, or camp contacts to their health care provider. Examine skin for resolution of lesions.</p>	Topical medications are considered effective for non-scalp ringworm.
ROSEOLA (Human herpesvirus 6, Exanthem subitum, Sixth Disease)	Usually 10 days; range 5-15 days.	Fever, rash (small flat pink spots or patches) usually on the chest, back, abdomen, neck and arms, not usually itchy.	Direct contact with salivary secretions.	Unknown.	<p>No, unless meets other exclusion criteria.</p> <p>No specific control or preventive measures indicated.</p>	An outbreak must be reported to the local health department.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
RSV (Respiratory Syncytial Virus)	Usually 4-6 days; range 2-8 days.	Acute respiratory tract illness.	Direct or close contact with contaminated secretions (via droplets or objects).	Period of viral shedding usually 3-8 days, but may last longer in young infants and those who are immunosuppressed.	No, unless meets other exclusion criteria. Follow local health department recommendations. Control measures: Cohort those with respiratory illness, emphasize handwashing hygiene, contact precautions where indicated.	An outbreak must be reported to the local health department.
RUBELLA (German measles)	Usually 16-18 days; range 14-23 days.	Mild illness with low fever, mild rash, usually associated with enlargement of nodes on the back of the neck. Rash usually follows 5-10 days later; may resemble measles, scarlet fever, or fifth disease.	Spread by droplet contact and direct contact from nose and throat discharge of an infected person, and possibly from blood and urine; from mother to infant during pregnancy.	Maximal communicability is from a few days before to 7 days after onset of rash. Those children with congenital rubella syndrome may be infectious for up to 1 year. Highly communicable.	Yes, exclude for 7 days after rash onset. With outbreaks, exclude unimmunized individuals until they are immunized. Contact local health department for guidance. Control measures: Vaccine-preventable. Vaccination is the key preventive measure.	A case or outbreak must be reported to the local health department immediately by telephone. Infection during pregnancy may have serious consequences for the fetus. For recommendations for children with congenital rubella syndrome, contact local health department. Caregivers of these infants should be aware of the potential hazard of the infants to susceptible pregnant contacts.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
SCABIES	2-6 weeks before onset of itching; 1-4 days for those reinfested.	Rapid onset of red papular rash, with or without white scaling, involving the fingers, wrists, elbows, knees, abdomen and other skin surfaces. Intense itching, especially at night. A classic burrow, mite, or egg seen on skin scraping is diagnostic.	Person-to-person through direct skin-to-skin contact such as holding hands or sexual contact or through direct contact with contaminated clothes, bedding, and personal articles.	Until mites or eggs are destroyed, usually after 24 hours of effective therapy. Mites usually die if away from host for more than 2-3 days.	Yes, until after treatment is administered, usually the overnight. Treat case with scabicide and follow medical advice from health care provider. Treat household and close contacts at same time as case. Clothing, bedding and other personal articles used in the 3 days before treatment should be laundered using hot cycles of washer and dryer, or dry-cleaned.	An outbreak must be reported to the local health department. Mites do not transmit any other communicable disease. Itching may persist for weeks following effective treatment due to allergic reaction; bacterial infections of skin can result from scratching.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
STAPHYLOCOCCAL INFECTION ("Staph", Impetigo), including MRSA, (Methicillin-resistant <i>Staphylococcus aureus</i>)	Variable and indefinite	Skin and soft tissue infections, such as impetigo, boils, or skin abscesses, occasional invasive disease (ex: wound infections, bloodstream infections, pneumonia)	Direct person to person contact, usually on hands. Possible transmission via air, contaminated surfaces, objects. Non-intact skin increases risk.	As long as purulent lesions continue to drain but sporadic cases occur due to asymptomatic carrier state.	<p>No, if lesion can be covered.</p> <p>Yes, if lesion cannot be covered. If antibiotic therapy is indicated exclude until 24 hours of antibiotic therapy has been completed, or otherwise cleared by HCP (in some cases, antibiotic use may not be indicated for treatment). If no antibiotic therapy indicated, exclude until lesion is healed.</p> <p>For contact sports: Yes, if lesion cannot be covered, regardless of whether antibiotics have been started, until lesion is healed.</p> <p>Control measures: Avoid touching lesions. Emphasize frequent handwashing. Conduct routine environmental cleaning.</p>	<p>Colonization alone with Staph, including MRSA, is not a reason for exclusion. Contact local health department for guidance.</p> <p>An outbreak must be reported to the local health department. Antibiotic treatment may not be indicated for every case of Staph infection, including MRSA.</p> <p><i>[Also, see section for Impetigo ("Skin Infections").]</i></p>

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
STREPTOCOCCAL INFECTION (Strep Throat, Scarlet Fever, Impetigo)	1-3 days, can be up to 5 days; variable for skin infections	Fever and sore throat/tonsillitis with tender, enlarged lymph nodes. Scarlet fever -- sore throat, fever, plus a red rash that feels like sandpaper and lasts 2-5 days. Tongue may appear strawberry-like. When rash fades, skin peels from tips of fingers and toes.	Spread from person to-person by respiratory droplets, by direct contact and rarely by contact with objects contaminated with nose or throat secretions. Carriers capable of spreading illness. May be foodborne via contaminated milk or eggs.	10-21 days if untreated. Until 24 hours after start of antibiotic treatment.	Yes, exclude case until 24 hours after start of antibiotic treatment. Control measures: Emphasize respiratory etiquette ("cover your cough") and frequent handwashing.	An outbreak must be reported to the local health department. Early recognition and treatment can prevent serious complications. <i>[Also, see section for Impetigo ("Skin Infections").]</i>
SYPHILIS	Usually about 3 weeks; range 10 days to 3 months.	May be asymptomatic; painless ulcer on genitals, anus, or mouth. Rash on palms and soles, generalized rash, or generalized lymph node swelling appear in secondary stage.	Spread by genital, oral or anal sexual contact with an infected person; from mother to infant during pregnancy or at delivery.	Up to one year if untreated but recurrences of lesions may persist.	No, exclusion not routinely recommended, however, should be managed by a health care provider. Case should be treated with antibiotics, and sexual contacts examined and treated with preventive antibiotics.	A case or outbreak must be reported to the local health department. Untreated, syphilis (even with no initial symptoms) can cause serious damage to heart, brain and other organs. This infection in a young child may possibly be an indicator of sexual abuse. COMAR 10.16.06.35 requires camp operator to report child abuse. <i>[Also, see SHS "Guide for Emergency Care in Maryland Schools, 2005" section for "Child Abuse and Neglect".]</i>

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
TICKBORNE ILLNESSES: (<i>Anaplasmosis, Ehrlichiosis, Lyme Disease, Rocky Mountain Spotted Fever, etc.</i>)	Usually 7-10 days; range 3-32 days after tick bite.	Fever, headache, lack of appetite, nausea, vomiting, muscle aches, chills. Possible rash, conjunctivitis, or meningoencephalitis.	Tick bite; rarely through blood transfusion	No documented person-to-person transmission.	No, exclusion is not necessary. Control measures: Avoid exposure to ticks; wear protective light-colored, long sleeve shirts and pants; use insect repellents; conduct tick checks. Remove embedded ticks promptly with tweezers. Consult a health care provider if symptoms occur.	A case must be reported to the local health department. Tick-borne diseases carry the risk of more severe and/or chronic illness for immunocompromised persons. Pregnant women bitten by a tick should consult with their health care provider.
TUBERCULOSIS (TB, <i>Mycobacterium tuberculosis</i>)	Generally 2-10 weeks after exposure to someone with active TB who is infectious.	Fever, weight loss, malaise, cough and night sweats are common, but some individuals have no symptoms at all. Children younger than 5 years are more likely to present with weight loss, malaise, and failure to thrive.	Airborne: via activities such as coughing, speaking and singing.	A person diagnosed with active TB on appropriate antibiotics will become non-infectious in a few weeks on average; however, a person's response to treatment will vary depending on their general health and the severity of their TB disease when diagnosed. In contrast, a person with latent TB infection cannot infect others and treatment is not mandatory.	Yes, until treatment is started and cleared by local health department. The local TB Control Program will determine when a person with active TB disease may return; and will determine control measures in the school, child care, or camp setting. Children diagnosed with latent TB infection cannot infect others and should not be excluded. Children who have received BCG vaccine may still become infected with TB, and should not be excluded from any testing that the local health department does as part of an investigation of possible TB contacts.	A person with or suspected to have active TB disease must be reported immediately by telephone to the local health department. Facility must cooperate fully with the local health department in testing any other children, faculty, staff, and child care providers to determine if TB transmission has occurred. Requirements for TB testing of new students may vary from one jurisdiction to another. Consult local health department for further details.

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
TYPHOID FEVER (<i>Salmonella typhi</i>)	Depends on infectious dose and on host factors, but usually 7-14 days; range 3 days to over 60 days.	Fever, headache, red ('rose') spots on the body; lack of heart rate elevation with fever; constipation more often than diarrhea.	Spread from direct person-to-person contact, or by contaminated food or water.	For as long as infected person carries in feces or urine, if untreated can be months, if carriers can be years.	Yes, for those who are symptomatic, until cleared by local health department after further testing. Contact local health department for guidance. Control measures: Vaccine-preventable. Encourage hand hygiene after toilet use, after diapering children, and before preparing or eating food.	A case or outbreak must be reported immediately by telephone to the local health department immediately by telephone.
VARICELLA ZOSTER VIRUS: CHICKENPOX (Primary varicella zoster virus infection)	Usually 14-16 days from exposure to rash, but may range from 10-21 days.	Slight to moderate fever and skin rash consisting of fluid-filled bumps (vesicles). In "ordinary" infections, "new" vesicles can continue to appear for 4-7 days. Rash is itchy; scratching can produce skin abrasions and lead to secondary infection.	Person-to-person, by respiratory or airborne droplet spread (produced by talking, coughing, or sneezing) or by direct contact with vesicle fluid or respiratory sections, or with mucous membranes of infected persons. Highly contagious. However, a susceptible person may acquire chickenpox infection if exposed to the vesicle fluid of someone with shingles.	Usually, in a "normal" case of varicella in an otherwise healthy child, period of communicability is from 1-2 days before rash appears, to when all lesions are completely crusted over (approximately 5 days). Persons who are susceptible to varicella should be considered to be infectious from 8-21 days after exposure. Persons with weakened immune systems may be communicable for longer periods.	Yes, until all lesions are completely dried or crusted over, usually 5 days after the onset of the rash. Lesions that can be fully covered are of little risk to susceptible persons. Control measures: Vaccine-preventable. Vaccination is the key preventive measure. Contact local health department for more specific recommendations, such as vaccination of unvaccinated or incompletely vaccinated individuals. Disinfect articles handled by, or contaminated with respiratory secretions or vesicular fluid from infected persons.	Reports outbreaks to local health department. Advise student's parent or guardian, or staff member, to contact health care provider after varicella exposure of neonate, during pregnancy, or of a person with a weakened immune system. [Also, see section for "Varicella zoster virus: Shingles".] [Also, see SHS "Guide for Emergency Care in Maryland Schools, 2005" section for "Rashes".]

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Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Exclusion (Yes or No) and Control Measures	Other Information
<p>VARICELLA ZOSTER VIRUS: SHINGLES (also known as zoster; reactivation of prior infection with varicella zoster virus)</p>	<p>Reactivation of latent herpes zoster virus infection may occur years after primary infection (chickenpox) and may occur after vaccination with live virus varicella vaccine.</p>	<p>Vesicles with a red base appearing in the distribution of a peripheral sensory nerve ("dermatome"). Vesicles associated with either itching or severe pain. Scarring, loss of function may occur.</p>	<p>May also be associated with prior varicella vaccination. Zoster occurs due to reactivation of latent varicella/zoster virus.</p> <p>NOTE: Fluid within zoster vesicles is infective, and indirect transmission of virus particles from vesicle fluid on contaminated clothing or other articles may occur.</p>	<p>From appearance of shingles vesicles until all vesicles are dried or crusted over -- about five days to a week.</p>	<p>Yes, until all lesions are completely dried and crusted over, or fully covered. Contact local health department for specific recommendations for contacts.</p> <p>Control measures:</p> <p>Varicella vaccine (see above) not shingles vaccine may be used in some circumstances to prevent cases of primary chickenpox in people exposed to shingles. Contact local health department for more specific recommendations.</p> <p>Disinfect articles handled by, or contaminated with vesicular fluid from infected persons.</p>	<p>Report outbreaks to local health department. Persons on cancer chemotherapy or who are HIV-infected may be at higher risk.</p> <p><i>[Also, see section for "Varicella zoster virus: Chickenpox".]</i></p> <p><i>[Also, see SHS "Guide for Emergency Care in Maryland Schools, 2005" section for "Rashes".]</i></p>

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ADDITIONAL INFORMATION: INFESTATIONS COMMONLY SEEN IN SCHOOLS, CHILD CARE, AND YOUTH CAMPS

Parasite	Symptoms	How do infestations occur?	Exclusion (Yes or No) and Control Measures	Additional information
BED BUGS <i>(Cimex lectularius)</i>	Itchy, skin welts occur a day after the bite. The medical concern is usually limited to itching and inflammation of the welts. Infestations may cause anxiety and loss of sleep. If badly affected, seek medical care promptly.	Bed bugs are usually carried into the home unknowingly. People carry them on luggage, clothing, beds, and furniture, especially used beds and sofas. Once inside the home, they spread from room to room. Can live for months without food or water.	If bed bugs are found on a child, the child should not be sent home early or excluded immediately. Control measures: Clothing may be placed in disposable plastic bags and then taken directly into the washer and/or dryer. For infestations of facilities, it is recommended to enlist the services of a professional pest control firm.	For additional information, refer to: < http://deha.dhmdh.maryland.gov/pdf/bed_bugs_fact_sheet_maryland_dhmdh.pdf >
LICE, HEAD <i>(Pediculus capitis)</i>	Often none. Itching possible. Nits (eggs) are tightly attached to hair shaft near the scalp, often near nape of neck and behind the ears. Crawling lice rarely seen.	Direct contact with infested person's hair or occasionally their clothing, combs, brushes, carpets, or linens. Lice do not jump from person to person. Adult lice viable away from host up to 2 days.	Yes, at the end of the program/activity/school day, until after first treatment is completed. Children should not be sent home early or excluded immediately. For nits, routine exclusion not recommended. "No-nit" policies not recommended. Control measures: Notify parent/guardian to treat child with a pediculicide. Follow manufacturer's recommendation for treatment and remove nits. Do not share combs, brushes, hair ornaments, hats, or linen. Examine close contacts for lice and treat. Wash clothing, bedding, and towels in hot water and dry on high heat or dry clean or place in tightly closed plastic bag for 14 days. Vacuum furniture and rugs.	Exclusion or readmission can be determined by local policy, or on a case-by-case basis. Lice do not transmit any communicable diseases, but bacterial infections of skin can result from scratching. This should be handled and on a case-by-case basis by the local school system or regulatory authority.

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<i>Gonococcus</i>	See Gonorrhea
<i>Haemophilus influenzae</i> Type B (HIB Disease).....	12
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Herpes Simplex Virus (HSV).....	15
HIV (Human Immunodeficiency Virus).....	15
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Meningitis, Bacterial.....	18
Meningitis, Viral.....	18
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<i>Mycobacterium tuberculosis</i>	See Tuberculosis

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

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<i>Neisseria meningitidis</i>	See Meningococcal Disease
Norovirus	9
Parvovirus B19	See Fifth Disease
<i>Pediculus corporis</i>	See Lice, Body
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Pink Eye	See Conjunctivitis, Infectious
Pinworms	22
Pneumococcal Disease	22
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Rabies	23
Ringworm, Body	25
Ringworm, Scalp	24
Ringworm, Skin	25
Rocky Mountain Spotted Fever	See Tickborne Illnesses
Roseola	25
Rotavirus	9
RSV (Respiratory Syncytial Virus)	26
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Rubeola	See Measles
<i>Salmonella</i> spp	10
<i>Salmonella typhi</i>	Typhoid Fever
Scabies	27
<i>Shigella</i> spp	10
Sixth Disease	See Roseola
"Skin Infections" (see also Impetigo)	16
Staphylococcal Infection	28
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Streptococcal Infection	29
<i>Streptococcus pneumoniae</i>	See Pneumococcal Disease
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<i>Tinea corporis</i>	See Ringworm, Skin or Body
Typhoid Fever	31
Varicella Zoster Virus: Chickenpox	31
Varicella Zoster Virus: Shingles	32
Whooping Cough	See Pertussis

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Diarrhea	4
Fever	4
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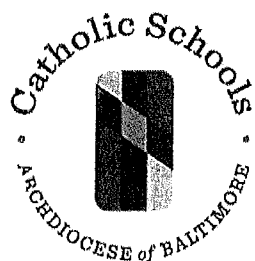
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Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

NOTES:

- *Periods of exclusion are intended for cases in school, child care, and youth camp settings*
- *Check with local health department for recommended control measures and prevention steps*
- *Additional information on these and other diseases can be found on the Internet at <www.cdc.gov> or <<http://ideha.dhmh.maryland.gov/SIPOR/>>*
- *A Directory of Local Health departments may be found at <<http://ideha.dhmh.maryland.gov/local-health-departments.aspx>>*



HE 3.0

Principals notify their local health department in cases of student absences due to a reportable communicable disease.

Purpose:

- To prevent the spread of communicable disease in the school

Commentary/Procedural Points:

- Before the student returns to school, a release card from the local health department or a letter from a licensed healthcare practitioner must be provided, indicating that the health department regulation has been met.
- Notes from parents/guardians are not accepted as assurance that the health department regulation has been met.
- The local health department has listings of the types of diseases and procedures for possible *school* closings and the communications to notify the school families and general public.

References:

- *Communicable Disease Summary - Guide for Schools and Child Care Settings*; provided to schools by Maryland State Department of Health

January 12, 2005

Table 3

MARYLAND LOCAL HEALTH DEPARTMENTS

Addresses & Telephone Numbers for Infectious Disease Reporting

* Telephone (T) or Pager (P) Number for After Hours and Weekend Reporting

JURISDICTION	ADDRESS	JURISDICTION	ADDRESS
ALLEGANY Ph. 301-759-5112 Fax 301-777-5669 *T 301-759-5000	PO Box 1745 12501 Willowbrook Road SE Cumberland MD 21501-1745	HARFORD Ph. 410-612-1774 Fax 410-612-9185 *T 443-243-5726	1321 Woodbridge Station Way Edgewood MD 21040
ANNE ARUNDEL Ph. 410-222-7256 Fax 410-222-4004 *T 443-481-3140	Communicable Disease & Epi. 1 Harry S. Truman Parkway Room 231 Annapolis MD 21401	HOWARD Ph. 410-313-1412 Fax 410-313-6108 *T 410-313-2929	8930 Stanford Blvd Columbia MD 21045
BALTIMORE CITY Ph. 410-396-4436 Fax 410-625-0688 *T 410-396-3100	1001 E. Fayette Street Baltimore MD 21202	KENT Ph. 410-778-1350 Fax 410-778-7913 *T(410) 708-5611	125 S. Lynchburg Street Chestertown MD 21620
BALTIMORE CO. Ph. 410-887-6011 Fax 410-377-5397 *T 410-832-7182	Communicable Disease, 3rd Floor 6401 York Road Baltimore MD 21212	MONTGOMERY Ph. 240-777-1755 Fax 240-777-4680 *T 240-777-4000	2000 Dennis Avenue Suite 238 Silver Spring MD 20902
CALVERT Ph. 410-535-5400 Fax 410-414-2057 *P 443-532-5973	PO Box 980 975 Solomon's Island Road Prince Frederick MD 20678	PR. GEORGE'S Ph. 301-583-3750 Fax 301-583-3794 *T 240-508-5774	3003 Hospital Drive Suite 1066 Cheverly MD 20785-1194
CAROLINE Ph. 410-479-8000 Fax 410-479-4864 *T 443-786-1398	403 South 7th Street Denton MD 21629	QUEEN ANNE'S Ph. 410-758-0720 Fax 410-758-8151 *T 410-758-3476	206 N. Commerce Street Centreville MD 21617
CARROLL Ph. 410-876-4900 Fax 410-876-4959 *T 410-876-4900	290 S. Center Street Westminster MD 21158-0845	ST. MARY'S Ph. 301-475-4316 Fax 301-475-4308 *T 301-475-8016	PO Box 316 21580 Peabody Street Leonardtown MD 20650
CECIL Ph. 410-996-5100 Fax 410-996-1019 *T 410-392-2008	John M. Byers Health Center 401 Bow Street Elkton MD 21921	SOMERSET Ph. 443-523-1740 Fax 410-651-5699 *T 443-614-6708	Attn: Communicable Disease 7920 Crisfield Highway Westover MD 21871
CHARLES Ph. 301-609-6810 Fax 301-934-7048 *T 301-932-2222	PO Box 1050 White Plains MD 20695	TALBOT Ph. 410-819-5600 Fax 410-819-5693 *T 410-819-5600	100 S. Hanson Street Easton MD 21601
DORCHESTER Ph. 410-228-3223 Fax 410-901-8180 *P 410-221-3362	3 Cedar Street Cambridge MD 21613	WASHINGTON Ph. 240-313-3210 Fax 240-313-3334 *T 240-313-3290	1302 Pennsylvania Avenue Hagerstown MD 21742
FREDERICK Ph. 301-600-3342 Fax 301-600-1403 *T 301-600-1603	350 Montevue Lane Frederick MD 21702	WICOMICO Ph. 410-543-6943 Fax 410-548-5151 *T 410-543-6996	Attn: Communicable Disease 108 E. Main Street Salisbury MD 21801-4921
GARRETT Ph. 301-334-7777 Fax 301-334-7771 Fax 301-334-7717 *T 301-334-1930	Garrett Co. Community Health Ctr. 1025 Memorial Drive Oakland MD 21550-4343 (Fax for use during emergencies)	WORCESTER Ph. 410-632-1100 Fax 410-632-0906 *T 443-614-2258	PO Box 249 Snow Hill MD 21863

Table 4 MARYLAND STATE HEALTH DEPARTMENT (DHMH) OFFICES

Addresses & Telephone Numbers for Infectious Disease Reporting

* Telephone (T) or Pager (P) Number for After Hours and Weekend Reporting

OFFICE	ADDRESS
CENTER FOR HIV SURVEILLANCE, EPIDEMIOLOGY & EVALUATION Ph. 410-767-5939 Fax Do NOT Fax *P 410-716-8194 (For use when Local Health Department is unavailable.)	Maryland DHMH 500 North Calvert Street, 5 th Floor Baltimore, MD 21202 ATTN: CHSE
CENTER FOR SEXUALLY TRANSMITTED INFECTION PREVENTION Ph. 410-222-6690 Fax 410-528-6098 *P 410-716-8194 (For use when Local Health Department is unavailable.) sti@dnhm.state.md.us	Maryland DHMH 500 North Calvert Street, 5 th Floor Baltimore MD 21202 ATTN: CSTIP
CENTER FOR TUBERCULOSIS CONTROL AND PREVENTION Ph. 410-767-6698 Fax 410-383-1762 *P 410-716-8194 (For use when Local Health Department is unavailable.)	Maryland DHMH 500 North Calvert Street, 5 th Floor Baltimore MD 21202 ATTN: TB Control
INFECTIOUS DISEASE EPIDEMIOLOGY & OUTBREAK RESPONSE BUREAU Ph. 410-767-6700/6709 Fax 410-225-7615 *T 410-795-7365 (For use when Local Health Department is unavailable.)	Maryland DHMH 201 West Preston Street, 3 rd Floor Baltimore MD 21201 ATTN: PHPA/OIDEOR/Unit 26

Section 8

Head Injury Protocol

Head Injury Protocol

Students who are suspected of having sustained a head injury in the school setting must be carefully evaluated by trained personnel in order to correctly identify those individuals who need immediate medical intervention and to reduce the risk of further injury. The potential for head injury can occur any time a student's head comes into contact with a hard object or when the student receives a blow or jolt to the head. Head injury may also occur from a blow to the body that causes the head and brain to move rapidly up and down or from side to side. Where appropriate and possible, students who sustain a head injury outside of the school setting and the school has been made aware of the injury, should be monitored and recommended for follow up care as necessary.

The Archdiocese of Baltimore has developed a protocol that schools can implement in the event a student is suspected of having sustained a head injury.

To protect student privacy, a completed *Suspected Head Injury Assessment Forms* and *Concussion Signs and Symptoms Checklist* should be maintained as a confidential education record.

Contained in this section are:

1. A Suspected Head Injury Protocol;
2. A Suspected Head Injury Assessment Form; and
3. A Concussion Signs and Symptoms Checklist.

Protocol for Suspected Head Injuries:

Background: Students who are suspected of having sustained a head injury in the school setting must be carefully evaluated by trained personnel in order to correctly identify those individuals who need immediate medical evaluation and, to prevent the possibility of further trauma or injury. The potential for head injury can occur anytime a student's head comes into contact with a hard object, or when the student receives a blow or jolt to the head. Head injury may also occur from a blow to the body which causes the head and brain to move rapidly back and forth or side to side.

The Archdiocese of Baltimore has developed a protocol and recommendations to assist school nurses, faculty and staff in the event a student is suspected of having sustained a head injury. These guides include: documents to aide in assessment and communication and head injury awareness education for students, parents/guardians, faculty and staff. Informational materials also are available on how to train staff on head injury awareness and regarding return to school protocols for students diagnosed with a concussion.

To maintain confidentiality and ensure privacy, this protocol, the *Suspected Head Injury Assessment Form*, and the *Concussion Signs and Symptoms Checklist* are intended for use by appropriately trained school professionals (e.g., school nurses, athletic trainers, coaches, athletic directors, and school administrators).

Note, this protocol is adapted from documents created by the U.S. Department of Health and Human Services Centers for Disease Control and Prevention.

Protocol:

1. Students suspected of having sustained a head injury should be evaluated by the School Nurse or "trained school personnel". In this context, "trained school personnel" would include any of the following individuals: School Nurse (who by definition must be an RN), certified athletic trainers, certified athletic directors, and employees or volunteers that have received proper training by completing a recognized head injury/concussion training program.
2. If a School Nurse or trained school staff member is available, he/she should be alerted of the suspected injury by a supervising adult.
3. If the student is unresponsive, convulsing or seizing, vomiting repetitively, slurring speech, experiencing weakness, numbness or decreased coordination or, if one pupil is larger than the other, school staff should immediately activate EMS by calling 911. Refer to *Danger Signs* on the *Suspected Head Injury Assessment Form*
4. If the student is able to safely ambulate to the Health Room, they will do so directly, escorted by a responsible adult or classmate. Students suspected of having sustained a head injury should not be left alone.
5. The School Nurse or trained school staff member should assess the nature of the injury including the cause and force of the hit, bump, jolt or blow to the head.
6. The School Nurse or trained school staff member should assess the student's memory of the incident, paying close attention to memory lapses of events leading up to or immediately following the injury.
7. If a witness is available, he/she should assist in determining the accuracy of the student's account.
8. The School Nurse or trained school staff member should administer first aid as needed.
9. The School Nurse or trained school staff member should interview the victim and complete the *Suspected Head Injury Assessment Form* and *Concussion Signs and Symptoms Checklist*.
10. The School Nurse or trained school staff member should contact the applicable parent/guardian to report the incident, and the assessment and status of injured student.
11. In the absence of symptoms, the School Nurse may determine that the student is able to return to class.
12. If the student returns to class, the School Nurse should make a plan with the student for alerting the Nurse in the event symptoms develop during the school day.
13. The School Nurse should plan follow-up same day visit(s) to the Health Room for reassessment.

14. The School Nurse should notify appropriate teacher(s) and School Administrator(s) of the incident.
15. Teachers, administrators and staff should alert the School Nurse to any signs or symptoms of concussion observed or reported by the student.
16. The School Nurse completes *Suspected Head Injury Assessment Form* and the *Concussion Signs and Symptoms Checklist* to include documentation of communication with parents/guardians, teachers/administrators, additional assessments made following the first 30 minutes, vital signs if indicated, and interventions, e.g., first aid.
17. The School Nurse should sign the *Suspected Head Injury Assessment Form* and the *Concussion Signs and Symptoms Checklist*, make and maintain a copy in the student's health record, and send the original home along with *Know Your Concussion ABCs Fact Sheet for Parents*.
18. Parents/guardians should sign the completed *Concussion Signs and Symptoms Checklist* and return it to the school's nurse.
19. The School Nurse should maintain the signed *Concussion Signs and Symptoms Checklist* in the student's health record.
20. If the student is referred for medical evaluation, the School Nurse should complete a *Report of Accident on School Grounds Form* and send it to the Office of Risk Management.
21. The School Nurse should complete additional documentation as needed or required by law.
22. The School Nurse should receive and implement follow-up health care evaluation(s) and return to school care plans, and communicate with and support students and faculty in providing academic accommodations and activity restrictions if indicated.

Suggested procedure for assessing, documenting and reporting students who have possibly sustained a head injury during the school day, on school grounds:

1. Refer to the *Suspected Head Injury Assessment Form*. Begin by assessing the student using the *Head Injury Danger Signs Checklist*. If the student has one or more of the indicated symptoms, the student should be seen by emergency medical health care providers immediately. If the student requires immediate care, contact the parent/guardian and/or emergency services to arrange for emergency health care delivery. The student should be continuously monitored until discharged for emergency care. Provide first aid as needed. Complete the *Suspected Head Injury Assessment Form* and provide a copy to the parent/guardian (a second copy may be provided to the emergency health care professional by the parent/guardian or, by school personnel.)
2. Complete a *Report of Student Injury* form for any student who is injured on school grounds who is referred for medical evaluation/treatment. This form may be obtained from the Office of Risk Management.
3. If the student does not have one or more of the symptoms referenced on the *Head Injury Danger Signs Checklist*, administer the *Concussion Signs and Symptoms Checklist* and provide first aid as needed. The *Concussion Signs and Symptoms Checklist* indicates that the student should be assessed at least three times in thirty minutes. Do not return the student to class prior to completing the checklist at "0", "15" and "30" minutes.
4. If the student shows one or more signs of a concussion based on the completed checklist, contact the parent/guardian to arrange for the student to be further evaluated by their health care professional. Continue to monitor the child using the checklist until the parent/guardian arrives to take the child for a medical evaluation.
5. Complete the *Report of Student Injury* form for any student who is injured on school grounds and is referred for medical evaluation/treatment. This form may be obtained from the Office of Risk Management.
6. If after administering the *Concussion Signs and Symptoms Checklist* over 30 minutes, the student does not show symptoms indicating the need for referral to their health care provider, the student may return to class. Complete the *Suspected Head Injury Assessment Form*. Contact the parent/guardian to report the event, assessment, interventions and student disposition.
7. Share a copy of the completed *Suspected Head Injury Assessment Form* with the parent/guardian of any student for whom the form has been completed. Parents/guardians should be notified that it is appropriate to share a copy of the form with the student's health care provider(s), and a second copy of the form may be provided for this purpose.

8. Provide a copy of the CDC form titled "***Heads Up to Schools: Know Your Concussion ABCs, A Fact Sheet for Parents***" for the parent/guardian. (http://www.cdc.gov/headsup/pdfs/schools/tbi_factsheets_parents-508-a.pdf)
9. Provide a copy of the CDC form titled "***Acute Concussion Evaluation Care Plan – School Version***" for the parent/guardian of any student referred for medical evaluation of a suspected head injury (for the student's health care provider's consideration in planning for the student's return to school). (http://www.cdc.gov/concussion/headsup/pdf/ACE_care_plan_school_version_a.pdf)

Suggested procedure for assessing, documenting and reporting students who indicate they have or, may have sustained a head injury outside of school or, on a previous school day:

1. Refer to the ***Suspected Head Injury Assessment Form***. Begin by assessing the student using the ***Head Injury Danger Signs Checklist***. If the student has one or more of the indicated symptoms, the student should be seen by emergency medical health care providers immediately. If the student requires immediate care, contact the parent/guardian and/or emergency services to arrange for emergency health care delivery. The student should be continuously monitored until discharged for emergency care, and provided first aid as needed. Complete the ***Suspected Head Injury Assessment Form*** and provide a copy to the parent/guardian. A copy of the completed ***Suspected Head Injury Assessment Form*** may be provided to the emergency health care professional by the parent/guardian or by school personnel.
2. Complete the ***Report of Student Injury*** form for any student who is injured on school grounds who is referred for medical evaluation/treatment. This form may be obtained from the Office of Risk Management.
3. If the student's symptoms indicate that the student does not require immediate attention from his/her physician or emergency services per the ***Head Injury Danger Signs Checklist***, administer the ***Concussion Signs and Symptoms Checklist*** and ask about his/her sleep patterns. Drowsiness, sleeping more or less than usual, or difficulty falling asleep may be signs of concussion. If the student does not demonstrate signs or symptoms of concussion per the ***Concussion Signs and Symptoms Checklist*** and denies a change in sleep patterns, the child may be returned to class. If the student indicates he/she is experiencing an alteration in normal sleep patterns, assess the student for symptoms listed on the ***Concussion Signs and Symptoms Checklist***. If the student does show one or more signs of a concussion based on the completed checklist, contact the parent/guardian to arrange for the student to be further evaluated by a health care professional, and continue to monitor the child using the checklist until the parent/guardian arrives to take the student for medical evaluation.
4. Complete the ***Report of Student Injury*** form for any student who may have been injured on school grounds and is referred for medical evaluation/treatment. Send the report to the Office of Risk management. This form may be obtained from the Office of Risk Management.
5. If after assessing the student for symptoms listed on the ***Concussion Signs and Symptoms Checklist*** the student does not show symptoms indicating the need for referral for medical evaluation, the student may return to class. The ***Suspected Head Injury Assessment Form*** should be completed and the parent/guardian contacted to report the visit, assessment, interventions, and student disposition.
6. Share a copy of the completed ***Suspected Head Injury Assessment Form*** with the parent/guardian of any student for whom the form has been completed. Parents/guardians should be notified that it is appropriate to share a copy of the form with the student's health care provider(s), and a second copy of the form may be provided for this purpose.
7. Provide a copy of the CDC form titled "***Heads Up to Schools: Know Your Concussion ABCs, A Fact Sheet for Parents***" for the parent/guardian. (http://www.cdc.gov/headsup/pdfs/schools/tbi_factsheets_parents-508-a.pdf)
8. Provide a copy of the CDC form titled "***Acute Concussion Evaluation Care Plan – School Version***" with the parent/guardian of any student referred for medical evaluation of a suspected head injury (for the student's health care provider's consideration in planning for the student's return to school). (http://www.cdc.gov/concussion/headsup/pdf/ACE_care_plan_school_version_a.pdf)

Training and Educational Resources:

To improve prevention, recognition and responses to a suspected head injury or sports-related concussion, education on suspected head injury and concussion awareness should be incorporated by schools into their annual faculty and staff

training sessions. Principals are responsible for arranging such trainings. Listed below are links to educational and training materials developed by the CDC, which may be useful to enhance the training experience.

For School Nurses:

<http://www.cdc.gov/headsup/schools/nurses.html>

For School Professionals:

http://www.cdc.gov/headsup/pdfs/schools/tbi_classroom_tips_for_teachers-a.pdf

[http://www.cdc.gov/concussion/pdf/TBI_factsheet TEACHERS-508-a.pdf](http://www.cdc.gov/concussion/pdf/TBI_factsheet_TEACHERS-508-a.pdf)

<http://www.cdc.gov/headsup/resources/training.html>

[http://www.cdc.gov/headsup/pdfs/custom/headsupconcussion fact sheet for schools.pdf](http://www.cdc.gov/headsup/pdfs/custom/headsupconcussion_fact_sheet_for_schools.pdf)

For Coaches:

<http://www.cdc.gov/headsup/highschoolsports/coach.html>

[http://www.cdc.gov/headsup/pdfs/youthsports/headsupconcussion in sports script-a.pdf](http://www.cdc.gov/headsup/pdfs/youthsports/headsupconcussion_in_sports_script-a.pdf)

For Parents and Athletes:

http://www.cdc.gov/headsup/pdfs/youthsports/parent_athlete_info_sheet-a.pdf

<http://www.cdc.gov/headsup/youthsports/parents.html>

PowerPoint Presentations:

[http://www.cdc.gov/concussion/pdf/ys_toolkit ppt.pdf](http://www.cdc.gov/concussion/pdf/ys_toolkit_ppt.pdf)

Suspected Head Injury Assessment Form

Directions: This form is to be completed if a student is reported to have a potential head injury (whether sustained at school or whether the student reports a head injury was sustained outside of school) and no documentation is provided indicating he/she has been evaluated for potential immediate care needs (see the Protocol for Suspected Head Injuries).

Student Information:

Student's Name: _____ Student's Grade: _____

Date/Time Injury Occurred: _____

Description of injury (Include information about any loss of consciousness and duration, memory loss, seizures following injury, prior concussions if any):

Head Injury Danger Signs Checklist:

Directions: Observe and interview the student, and place a check next to all symptoms that apply. The student should be seen with immediacy by a health care professional and the parent contacted immediately if one or more of the following symptoms apply.

- One pupil (the black part in the middle of the eye) larger than the other
- Drowsiness or cannot be awakened
- A headache that gets worse and does not go away
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Difficulty recognizing people or places
- Increasing confusion, restlessness, or agitation
- Unusual behavior
- Loss of consciousness (even a brief loss of consciousness should be taken seriously)

If none of the above listed *Danger Signs* are present, complete the *Concussion Signs and Symptoms Checklist*

Resolution of Injury and Disposition of Student (Check all that apply):

- Student departure for emergency medical care: Time _____
- Student returned to class: Time _____
- Student sent home: Time _____
- Student referred to health care professional with experience in evaluating for concussion.
- Parent/Guardian contacted: Time _____
- Notified appropriate school personnel:
 - Building administrator
 - Coach, Trainer, or Athletic Director
 - Teacher(s) _____
 - Other _____
- Notes: _____

***Parent/Guardian, it is advisable to continue to monitor the student referencing the symptoms listed on the *Concussion Signs and Symptoms Checklist* and seek medical attention if signs or symptoms present.**

Concussion Signs and Symptoms Checklist

Student Name _____ Date/Time _____

Directions: If at any time during assessment the student develops one or more of the symptoms listed on the **Head Injury Danger Signs Checklist** refer the child immediately for emergency medical care.

To complete the **Concussion Signs and Symptoms Checklist** interview the student and assess for the symptoms of concussion listed in the "Observed Symptoms" column. Place a check mark for each symptom observed in the column marked "0 Minutes" next to the symptom observed. If one or more of the boxes are checked after the initial observation, contact the parent/guardian as the student should be referred to a health care professional with experience in evaluating for concussion. Continue to monitor the student using the checklist until the parent/guardian arrives. If the student shows no observed symptoms after the initial completion of the checklist at 0 minutes, continue to administer the checklist at 15 minutes after the initial observation and again 30 minutes after the initial observation. If during any of these subsequent observations one or more symptoms of concussion is observed, contact the parent/guardian as the student should be referred to a health care professional with experience in evaluating for concussion. If after thirty minutes the student shows no symptoms of concussion, the student may be returned to class.

Observed Symptoms	0 minutes	15 Minutes	30 Minutes	___ Minutes
Appears dazed or stunned				
Is confused about events				
Repeats questions				
Answers questions slowly				
Can't recall events <i>prior</i> to injury				
Can't recall events <i>after</i> injury				
Loss of consciousness (even briefly)				
Shows behavior or personality changes				
Forgets class schedule or assignments				
Headache or "pressure" in head				
Nausea or vomiting				
Balance problems or dizziness				
Fatigue or feeling tired				
Blurry or double vision				
Sensitivity to light				
Sensitivity to noise				
Numbness or tingling				
Does not "feel right"				
Difficulty thinking clearly				
Difficulty concentrating				
Difficulty remembering				
Feeling more slowed down				
Feeling sluggish, hazy, foggy or groggy				
Irritable				
Sad				
More emotional than usual				
Nervous				

Signature of School Professional completing this form:

 Title: _____ Date: _____
Parent Signature:
 _____ Date: _____

Section 9
General Use
Epinephrine Program

Program for General Use of Epinephrine, and for Students with a Known Risk for Anaphylaxis or Other Adverse Allergic or Immune Response

General Use Epinephrine Program

According to the most current statistics, every 3 minutes a food allergy reaction sends someone to the emergency department. That is more than 200,000 emergency department visits per year. Moreover, this number includes only food allergies and only those adverse reactions that result in emergency department visits. Other exposures, such as insect bites, fabrics, detergents and other environmental stimulants, can trigger anaphylaxis. While not all schools have the available resources to implement such a program, schools should strongly consider seeking out the needed resources to implement a general use epinephrine pen program.

If your school wishes to proceed with the implementation of a general use epinephrine pen program, the Archdiocese of Baltimore has created a General Use Epinephrine Program for review and adoption. Please note that under Maryland Law (currently Section 7-426.3 of the Education Article of the Maryland Annotated Code), any general use epinephrine program requires the oversight of a licensed healthcare professional.

To access the latest version of the Archdiocese's program please visit:
<http://www.archbalt.org/risk/>.

Students with a Known Risk for Anaphylaxis or Other Adverse Allergy or Immune Response

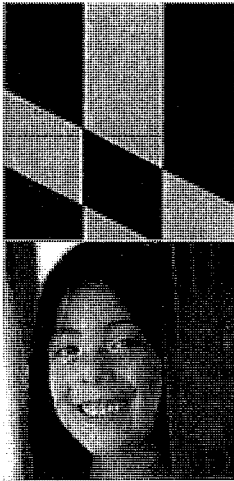
Students with a known risk for anaphylaxis should have their own supply of epinephrine (please refer to the document *Management of Students at Risk for Anaphylactic Reaction, August 2009* located in this section). Also included with

Section 9

this section is the FARE emergency care plan, and a self-carry and self-administration of auto-injectable epinephrine evaluation.

School Nurses should participate in the creation and management of reasonable accommodations for students with a known risk for other adverse allergy or immune response, whether from food or otherwise, where possible and appropriate.

Last Updated April 2018



MANAGEMENT OF STUDENTS AT RISK FOR ANAPHYLACTIC REACTION

MARYLAND STATE SCHOOL HEALTH SERVICES GUIDELINE

AUGUST 2009

Maryland State Department of Education
Student Services and Alternative Programs
Branch
200 West Baltimore Street
Baltimore, Maryland 21201
Phone: 410-767-0311
TTY/TDD: 410-333-6442

Maryland Department of Health
and Mental Hygiene, Center for
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Foreword

There is a strong relationship between academic achievement and a child's physical, emotional and mental health. This link is the foundation for providing school health services as an important component of a school program. School health services provide primary prevention aimed at keeping students in schools through appropriate screenings, early identification of children at risk for physical, emotional and mental health concerns, and case management of students with chronic health concerns.

The Annotated Code of Maryland, Education Article, §7-401 requires the Maryland State Department of Education (MSDE) and the Maryland Department of Health and Mental Hygiene (DHMH) to jointly develop public standards and guidelines for school health programs. The guidelines developed under §7-401 contain recommendations for minimum standards of care and current best practices for the health service topics addressed. The following guideline was developed in accordance with that requirement and is based on the expressed needs of the local school health services programs. It is intended that these guidelines will be used by the local school systems in developing local school health services policies and procedures as a means to assist local school health services programs in providing consistent and safe care to the students of Maryland. Specific laws and regulations that direct school nursing practice or other health services are identified in the guidelines.

To implement these guidelines, local school systems and local health departments should consult with the Maryland State Department of Education and the Department of Health and Mental Hygiene who will:

- Assist and provide technical assistance to local school health programs to support their efforts to plan for students with special health needs;
- Provide training to all appropriate school staff regarding issues related to students with special health needs including, but not limited to, planning, maintaining a safe environment, and medication administration issues; and
- Monitor the implementation of school health services programs including but not limited to programs and policies related to students and staff with special health needs.

Introduction

Allergic reactions are an immune system hypersensitivity to a particular substance called an allergen. For many allergic individuals, exposure to an allergen results in mild symptoms. However, for some, allergic reactions can be severe and result in potentially life-threatening medical conditions. The most dangerous symptoms include breathing difficulty and a drop in blood pressure or shock, both of which are potentially fatal. Anaphylaxis refers to this type of severe allergic reaction. Anaphylaxis may affect students with both known allergies and those without known allergies.

Students with a diagnosis of anaphylaxis, or who are at risk for anaphylaxis do not necessarily require daily care in the health suite and are encouraged to participate in all school activities. Students with a history of anaphylaxis, or who are identified as having severe allergic disease and are at risk for anaphylaxis, require health care plans to meet their needs in the event of an emergency as well as policies and procedures in place to reduce the risk of allergen exposure. Epinephrine injection is the emergency medical treatment for anaphylaxis. Each child with a diagnosis of anaphylaxis or at risk for anaphylaxis should have at least one individual auto-injector epinephrine available in school.

Planning is an essential part of the care for students with a diagnosis of anaphylaxis or at risk for anaphylaxis. The school nurse requires communication, collaboration, coordination, and cooperation between the school, family, student, and community health care provider to effectively plan. Local school system policy is also important to the process of planning and implementing procedures to address student safety.

The safety of students with life-threatening allergies requires five key activities: 1) allergy awareness, 2) planning, 3) allergen exposure avoidance measures, 4) treatment strategies, and 5) training. School health services staff, other school staff, parents, and students all have responsibilities within each of these key areas. Managing allergies in school is a team effort among the health care provider, family, student, and school.

The guidelines that follow address the needs of students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis as documented by a health care provider. Guidelines for those who may experience anaphylaxis with an unknown history of anaphylaxis or allergic reactions are contained in another document, *Guidelines for the Emergency Management of Students with Unknown History of Anaphylaxis or Severe Allergic Reactions*.

Purpose

1. To provide guidelines to school health staff for planning and for addressing the needs of students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis as documented by a health care provider.
2. To provide guidelines for the management of students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis as documented by a health care provider.
3. To provide guidance on allergen exposure risk reduction through education, training, and environmental assessments and controls, and
4. To define the roles and responsibilities of school health services staff, school administrators, school food service staff, and other school staff, parents/guardians and students in the planning and management of students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis as documented by a health care provider.

Definition

Anaphylaxis is a sudden, severe, potentially life-threatening allergic reaction that affects multiple organ systems of the body. Anaphylaxis requires immediate medical attention as it can be fatal if not reversed within seconds or minutes of coming in contact with the allergen. Allergens such as insect stings or bites, foods, latex, medications and other allergens are common causes of anaphylaxis, but it may also be idiopathic or exercise-induced. Anaphylaxis usually occurs immediately (seconds or minutes) but also may occur several hours after allergen exposure. Symptoms progress rapidly, making it a medical emergency. The signs and symptoms of an anaphylactic reaction include, but are not limited to, those listed in Table 1.

Table 1

SIGNS and SYMPTOMS OF AN ANAPHYLACTIC REACTION	
Organ System	Sign(s)/Symptom(s)
<i>Mouth/Throat</i>	Itching, tingling, or swelling of lips, tongue, or mouth; blue/grey color of lips; hacking cough; tightening of throat; hoarseness; difficulty swallowing
<i>Nose/Eyes/ears</i>	Hay fever-like symptoms: runny, itchy nose; redness and/or swelling of eyes; throbbing in ears
<i>Skin</i>	Facial flushing; hives and/or generalized itchy rash; swelling of face or extremities; tingling; blue/grey discoloration
<i>GI</i>	Nausea, abdominal cramps, vomiting, diarrhea
<i>Lung</i>	Shortness of breath; wheezing; short, frequent, shallow cough; difficulty breathing
<i>Heart</i>	Thready or unobtainable pulse; low blood pressure; rapid pulse, palpitations, fainting; dizziness; pale, blue, or gray color of lips or nail beds
<i>Mental</i>	Uneasiness; agitation; unconsciousness
<i>Other</i>	Any other symptom specific to an individual's response to a specific allergen

NOTE: Not all signs and symptoms need be present in anaphylaxis.

Emergency Management of Anaphylactic Reaction

Adrenaline (epinephrine) is a quick-acting hormone that works to relieve and prevent all of the physiological processes that occur with anaphylaxis. The use of auto-injector epinephrine is recommended in the emergency treatment of an anaphylactic reaction since it does not require manipulation or handling of a syringe, nor calculation or measurement of a dosage. There are more than one epinephrine auto-injector products available for use. Staff responsible for administering emergency medications for anaphylactic reactions must be familiar with the operation of all types of devices used by the students in the school building.

When a person is having or is suspected of having an anaphylactic reaction:

1. Rapidly assess Airway, Breathing, and Circulation (ABC's) and begin CPR as necessary;
2. Follow emergency plan completed by the student's health care provider. This may include administration of diphenhydramine and/or auto-injector epinephrine;
3. Directions for use of auto-injector epinephrine:
 - a. Pull off safety cap or caps (depending on manufacturer there may be one or two caps to be removed to allow the injector to be discharged);
 - b. Make sure thumb or fingers do not contact tip of auto-injector;
 - c. Apply injector directly against the thigh, but may administer through clothing, if necessary;**
 - d. Place tip on thigh at right angle to leg. Always give in the antero-lateral aspect of the thigh (outside of the mid-thigh);
 - e. Press firmly into the thigh until the auto-injector mechanism discharges the medication, and hold in place for 10 seconds;
 - f. Remove the injector and discard in a biohazard container; and
 - g. Massage the injection area for 10 seconds.
4. **Call 911** after giving epinephrine and notify dispatcher that epinephrine has been given for an anaphylactic reaction, and that paramedics are needed to provide and continue administration of epinephrine if needed;
5. Assist student into a comfortable position. Lay the student on their back as long as airway swelling does not make breathing uncomfortable or difficult in that position. Light-headedness or loss of consciousness indicate low blood pressure which necessitate lying the student flat and elevating the legs;
6. Loosen restrictive clothing. Give nothing by mouth. Reassure and assist to keep student calm;
7. Stay with the student until 911 personnel arrive and accept care responsibilities;

SPECIAL NOTE: IT IS RECOMMENDED THAT ANYONE RECEIVING EPINEPHRINE BE TRANSPORTED TO A HOSPITAL BY PARAMEDICS TO PROVIDE ANY ADDITIONAL MEDICAL CARE THAT IS NEEDED. EMS WILL DETERMINE TRANSPORTATION NEEDS AFTER THEIR ASSESSMENT AS PART OF THEIR CARE RESPONSIBILITIES.

8. Notify parent/guardian or student's emergency contact;
9. Follow local school system emergency policy regarding 911 calls;
10. Complete documentation of the incident, including the time of epinephrine administration, the suspected precipitating cause, and 911 and parent notifications according to any local documentation guidelines;
11. Send documentation of the event, including vital signs, interventions and student's identifying information to the hospital with EMS personnel according to local policy; and
12. Maintain a copy of the above documentation for the health record according to local policy.

The Nursing Appraisal/Assessment

Data Collection

It is essential that the school nurse be informed of all aspects of medical, educational, and social issues regarding students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis as documented by a health care provider. The school nurse collects information from a review of medical and educational records (i.e., the school health record, the Student Record Card, emergency health card, and the student cumulative education record). It is necessary that the school nurse obtain the needed medical information related to the student's health condition from the parent/guardian and the student's health care provider. This should include:

- Written documentation from the student's health care provider regarding the specific allergies and interventions to be implemented in case of an exposure or reaction;
- Up-to-date and accurate history of allergic reactions and allergens from parents and health care providers and student as appropriate; and
- Other relevant health information and assessments from the student's health care provider.

The school nurse should seek additional information from the following sources if needed:

- Student interview;

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- Teaching staff; and
- Classroom observation(s).

The school nurse should maintain for students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis an updated file that contains:

- Current health care provider orders;
- An initial and annually reviewed health appraisal or nursing assessment;
- A current emergency care plan if not included in the individualized health care plan; and
- Current emergency contact information and numbers, updated at least annually.

Health Appraisal and Nursing Assessment

The school nurse should assess the special health needs of students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis as documented by a health care provider using local standard assessment procedures and the procedures outlined in the *Maryland State School Health Services Guidelines: Nursing Appraisal/Assessment of Students with Special Health Needs*. The school nurse should use the information obtained in the nursing appraisal and assessment to develop a written individualized health plan. The school nurse should develop that plan with input from the student's parent/guardian and their health care provider(s). The plan should outline the student's needs and the specific interventions appropriate to meet those needs. The school nurse should be cognizant of policies regarding the release of records, information sharing, and confidentiality. Identifying information, information specific to the student's allergies, history of anaphylaxis, risk of anaphylaxis, and treatment needs should include, but not limited to the following;

Identifying Information/Contact Information

- Name of parents/guardians, address, phone number, and emergency contacts;
- Student's date of birth (DOB) and grade;
- Primary care provider's name and phone number; and
- Name and phone number of allergy specialist (if the student is under the care of one).

Medical History/ Allergy History

A very important part of the medical history is a thorough assessment of the current allergy status and treatment. The allergy/anaphylaxis specific information along with other relevant medical history may include the following:

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- Current diagnosed medical conditions;
- Current medication and treatment orders for allergies and other identified conditions, and the indications for their use;
- Emergency medications and the indication for their use;
- Side effects of all current medications;
- Family history of allergies and anaphylaxis;
- Development of disease, progress of disease, and initial anaphylaxis diagnosis;
- Current allergens (foods, insect stings, etc) type and severity of reaction to each allergen, and management and treatment for reactions to each allergen and typical response to interventions;
- History of anaphylaxis emergencies and frequency and circumstances of allergen exposures;
- History of emergency department visits;
- Number of days of school missed in the past year;
- Limitation of activities;
- Family and student's understanding of the condition and its management;
- Ability of family and student to cope with the condition;
- Interactions with peers and teachers in the past;
- Written copy of health care provider's orders and anaphylaxis management plan;
- Written copy of health care provider's allergen exposure avoidance recommendations;
- Student's understanding and demonstration of medication administration technique; and
- Level of independence with medication/treatment including ability to possess and self-administer medication.

Students who obtain school meals as part of any United States Department of Agriculture (USDA) school meal program (i.e. school breakfast program or school lunch program) are entitled to meal modifications because of their special health need. In order to plan for meal/food accommodations, the following additional information is required for both free and reduced

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priced meals as well as full price meals. USDA regulations 7CFR Part 15b requires substitutions or modifications in school meals for children whose disability restricts their diet. A child with a disability or special health need must be provided food substitutions when a statement signed by a licensed health care provider supports the need. The health care provider statement must identify or provide:

- The child's disability or special health need;
- An explanation of why the disability or health need restricts the child's diet;
- The major life activity affected by the disability or health need;
- The food or foods to be omitted from the child's diet; and
- The food or choice of foods that must be substituted.

School Environment

The school nurse should work in collaboration with school administrators and other school staff to assess the school environment in order to identify and address possible allergen exposure risks and barriers to emergency treatment. A comprehensive emergency plan for individual students should include consideration of classroom, cafeteria, and other areas of the school, school-sponsored events, and school buses. For example, the school nurse may work with school staff to identify areas for reducing the risk of exposure to allergens for students with anaphylactic reactions such as:

- Classrooms- allergens in the classroom such as craft materials, other classroom teaching materials, and food items brought into the classroom;
- Cafeteria- food ingredients in each menu items that should be avoided, plan for food substitutions if necessary, review procedures in cafeteria or other food service areas to avoid cross-contamination food handling and distribution, and hand washing practices that may reduce exposure of students to food allergens;
- School-sponsored activities– potential exposure to allergens on field trips, recess, and other school sponsored activities and implementation of emergency plans; and
- School bus– recognizing allergic reactions; implementing bus emergency plans and procedures.

Accommodations

Accommodations for individual students should be developmentally appropriate and school specific. A copy of the nurse's final assessment should be placed in the student's health record and should be shared with the parents/guardian and health care provider. As the student advances through the school system, his/her needs may change, therefore, accommodations will need to

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change accordingly. Accommodations to reduce the risk of allergen exposure may include, but are not limited to;

- Removal/replacement of classroom teaching materials that pose an exposure risk; and
- Modification of school/classroom policies on food brought in to the school by parents for celebrations or other events.

Annotated Code of Maryland, Section 7-426.1 requires principals to designate a nut or other allergen-free table in the cafeteria for students with nut or other food allergies.

Individualized Health Plans and Emergency Plans/Protocols

Based on nursing judgment, an individualized health plan (IHP) may need to be developed. The school nurse may develop an IHP that addresses the unique aspects of the school setting and should include the student's routine and emergency medication as ordered by the student's health care provider, as well as the health care provider's recommendations for allergen avoidance/allergen exposure risk reduction. The IHP includes the nursing diagnoses and desired student outcomes. Documentation of school nurse interventions and evaluation of student outcomes are recorded on the IHP.

The school nurse should review and update the IHP at least annually. The following information gathered from the nursing assessment should be considered when developing individualized health care plans for students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis as documented by a health care provider:

- Severity of disease;
- Identification of allergens, allergen avoidance strategies, and allergen elimination strategies;
- Developmental considerations;
- Barriers to best practice management;
- Parental concerns and expectations;
- Student concerns;
- Classroom jobs, projects, and special events that may involve food or allergen exposure;
- Classroom, bus, and cafeteria environment and accommodations;
- Plan to alert and train school staff regarding student allergies and expected role in allergen avoidance and emergency plan implementation;

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- Schedule- physical education, lunch, recess, field trips, transportation to and from school, other school-sponsored activities;
- Emergency care including provisions for a student exposed to allergens, such as emergency medication administration protocol/emergency care plan, an adult escort to the office/health room, contacting the parents/guardians, and health care provider;
- Knowledge of student's allergy by appropriate school staff, including substitutes, and accompanying staff training;
- Educational needs and accommodations;
- Medication administration, including self administration;
- Student's ability to identify need for interventions; and
- Storage of and access to emergency medication and/or equipment including light and temperature exposure precautions.

Emergency Plans

The school nurse should develop an emergency plan for all students with a diagnosis of anaphylaxis or at risk for anaphylaxis as documented by a health care provider. This plan should be developed to communicate how and where the auto-injector epinephrine should be placed to be secure and immediately accessible to all designated school personnel and the emergency protocol in the event of an allergen exposure. This plan should include, but not be limited to;

- Health care provider's orders and nursing interventions;
- The health care provider's emergency orders/ specific emergency interventions needed;
- Emergency contact information that is updated as changes occur;
- What should be done if a nurse is not available;

NOTE: The Maryland Nurse Practice Act (Title 10, Subtitle 27, Code of Maryland Regulations) allows delegation of certain nursing functions. The decision as to whether the student's health care needs may be delegated is based on the delegation criteria outlined in the Maryland Nurse Practice Act and the professional judgment of the school nurse. The school nurse must also determine the appropriate personnel/staff to which the responsibility for administering epinephrine by auto injector should be given.

* Each jurisdiction should have a procedure or protocol that addresses what to do in the event that the parent has not provided an epinephrine auto-injector.

- Signs and symptoms for which emergency care may be needed that are specific to an individual student's typical allergic reaction history;
- Who and when to call 911;
- How auto-injector epinephrine will be stored to assure appropriate temperature and light exposure precautions and to allow immediate availability of the medication to students and staff for those students who do not possess and/or self-administer their medication;
- How many and in what locations auto-injector epinephrine devices are needed in the school; and
- School staff that will be designated to administer auto-injector epinephrine in the event of an allergen exposure.

Facilitating immediate access to epinephrine auto-injector to avoid treatment delay is the objective for the determination of the location(s) for the epinephrine auto-injector and how many are needed. When planning, the following should be considered:

- Size and layout of the school building;
- Feasibility for having an auto-injector located at multiple sites within the building;
- Feasibility for having the auto-injector safely passed from teacher to teacher as the student moves throughout the building (e.g. a fanny pack); and
- Ways a student can securely carry the injector for immediate access by the student or for use by a trained adult who is present with the student (e.g. a fanny pack).

SPECIAL NOTE: THE EFFECTS OF EPINEPHRINE INJECTION MAY WEAR OFF RAPIDLY AND PLACE THE STUDENT AT RISK FOR RECURRENCE OF SYMPTOMS. THEREFORE, SCHOOL NURSES SHOULD DISCUSS WITH THE FAMILY THE NEED TO HAVE A SECOND AUTO-INJECTOR AVAILABLE.

Communication

The school nurse should share a copy of the emergency plan with the parent/guardian and appropriate school management team/staff (including bus drivers), and place a copy in the student's health record. School staff who have direct contact with the student should have immediate access to the emergency care plan at all times in a manner determined by the school nurse and the school staff in order to allow immediate access while also protecting the student's confidentiality.

The school nurse should communicate to the school food service manager on site necessary cafeteria accommodations needed by students with food allergies, diagnosis of anaphylaxis or have health conditions that place them at risk for anaphylaxis to foods. The school nurse should determine needs in collaboration with the parent/guardian and health care provider.

It is important that parents and health care providers are aware of the school health services guidelines used to guide the development and implementation of care plans. Local school health programs should develop policies and procedures for making the guidelines available to parents and health care providers and on how to communicate the content of individualized health plans to parents.

Self-Carry/Self-Administration of Medications

Students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis as documented by a health care provider who are developmentally capable and have received appropriate and adequate instruction should be encouraged to possess and to self-administer their epinephrine auto-injector. This requires the health care provider to complete a medication order form for the school and indicate that the student can possess and self-administer the medication. Section 7-421 of the Education Article, Annotated Code of Maryland, states: "The school nurse shall assess the student's ability to demonstrate the skill level necessary to ensure proper and effective use of the medication in school." The school nurse should assess each student's:

- Ability to communicate to school staff when an allergen exposure has occurs;
- Ability to use correct technique to self-administer epinephrine;
- Ability to recognize when to use the auto injector; and
- Developmental ability to perform this task in a responsible manner.

The school nurse should review annually with the student the correct procedures for storing and administering the auto-injector epinephrine and discuss with parents the need for a back up auto-injector epinephrine device to be stored in the health room.

Case Management and Care Coordination

Some students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis as documented by a health care provider may need a designated school case manager to coordinate his/her care.

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The school nurse is often the case manager for these students, but another student services staff member or Individualized Education Plan (IEP) or 504 team member may be designated as the case manager. The school nurse serves as the liaison between the health care team, school staff, administration, pupil services staff, parents/guardians, food service managers, and the student regardless of who is the designated case manager. The school nurse can also refer the student and/or family for counseling, support groups, and access to medical care.

Effective case management requires coordination between all persons involved in the care of the student. Each person or team member has a specific set of responsibilities for the care of the student:

Parent Responsibilities

Parents are an integral part of the process of planning, care, and coordination of care for all students with a diagnosis of anaphylaxis or who are at risk of anaphylaxis as documented by a health care provider. In addition, the Annotated Code of Maryland, Education Article, §7-426 designates parents with certain responsibilities. It is important that school nurses and parents/guardians work collaboratively to provide for the health and safety of students with a diagnosis of anaphylaxis or at risk for anaphylaxis as documented by the health care provider. School nurses should seek to involve the student's parent/guardian to the fullest extent possible. To that end, the parent/guardian is responsible for the following:

- Provide the school with emergency contact information that is accurate and updated as needed;
- Provide the school with complete and accurate medical information related to the student's allergic condition. This information includes, but is not limited to;
 - Up-to-date and accurate history of allergic reactions;
 - Types of allergens and triggers;
 - Written health care provider documentation of the student's allergic condition; and
 - A written list of food or other allergies;
- Work with the school nurse to develop the plan of care for the student with allergies and risk of anaphylaxis to the best of their ability;
- Supply and maintain at least one non-expired auto-injector epinephrine device annually at the beginning of the school year, along with the appropriately completed written medication order;
- Work with the school nurse and health care provider to obtain additional epinephrine auto-injectors based on need;
- For students who self-carry, monitor the proper storage (i.e. away from light and high temperatures) and routinely check the expiration dates of epinephrine auto-injectors; and

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- Provide the recommended and preferred medical identification bracelet/necklace indicating allergic condition.

NOTE: Each jurisdiction should have a procedure or protocol that addresses what to do in the event that the parent has not provided an epinephrine auto-injector.

NOTE: If transport times are prolonged in the local school areas, it is recommended that parents provide two auto-injector epinephrine devices in case a second dose is needed prior to arrival of local emergency personnel.

Student Responsibilities

Coordinating and managing the care of students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis as documented by a health care provider requires the school nurse to communicate to the student their role in the planning process. Student participation in planning must be developmentally appropriate. Student responsibilities must also be developmentally appropriate and may include, but are not limited to;

- Avoiding known allergens;
- Immediately informing school staff in the event of an exposure;
- Acting responsibly when possessing and self-administering medications, specifically, not to misuse medication; and
- Participate in care planning.

School Responsibilities

The Annotated Code of Maryland, Education Article, §7-426 specifies certain school and school administrator responsibilities for the care of students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis as documented by a health care provider. School administrators should work closely with school nurses in planning for these students. The school administrator and school nurse should collaborate in gathering, maintaining, and reviewing school-wide information required to meet the needs of these students. School nurses should provide aggregate data to the school administrator regarding the number and type of allergies and anaphylaxis risks in the student population, and the needed accommodations.

The school administrator must be aware of students with a diagnosis of anaphylaxis or at risk for anaphylaxis as documented by a health care provider, and work with the school nurse to support the effective implementation of health care plans for these students. Implementation of the health care plans includes supporting reasonable accommodations that are based on the school nurse's assessment, healthcare provider orders, and the unique needs of each individual student.

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The school administrator:

- Supports the school nurse's training, education and awareness activities, which include, but are not limited to;
 - Providing staff training in allergen exposure risk reduction, recognition of signs and symptoms of an anaphylactic reaction, and the use of epinephrine auto-injectors;
 - Planning for implementation of student emergency care plans on school sponsored events;
 - Providing outreach and education for parents, other caregivers, and the general school community;
 - Making auto-injector epinephrine as accessible as possible to avoid treatment delay; and
- Supports the school nurse in regards to adherence to the parent/guardian responsibilities.

School Staff Responsibilities

Other school team members may contribute to the management of students with a diagnosis of anaphylaxis or at risk for anaphylaxis as documented by the health care provider in ways that include, but are not limited to;

- Bus Drivers Respond to an emergency as instructed and trained; communicate problems or concerns with the transportation office, school nurse and school administrator.
- Coaches/Advisors for School Sponsored Activities Respond to an emergency during athletic or other activities as instructed and trained; communicate problems or concerns to the school nurse and school administrator.
- Food Services Staff Make meal substitutions or modifications in school meals according to USDA requirements, assist with dietary accommodations as necessary; share food ingredient lists with school nurse.
- School Counselor Assist with disability awareness, support groups/counseling.
- Pupil Personnel Worker/
School Social Worker Assist with transportation issues, home teaching and attendance issues.
- School Psychologist Assist with any needed behavioral strategies.

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- Teachers Respond to an emergency as instructed and trained, communicate problems or concerns with school nurse and school administrator.

Outreach and Education

School-wide outreach and education regarding allergy awareness and allergen avoidance measures within the school is recommended. School nurses should provide parent/guardian of students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis as documented by a health care provider information regarding resources. (See resource list at the end of the guideline for a list of parent/guardian resources.)

The school nurse should provide or arrange for all appropriate school staff to receive training on anaphylaxis. The school nurse should apprise all appropriate school staff who have responsibility for the student during the school day of the child's allergies and specific interventions needed. The school nurse may share student-specific information when necessary to protect the health of the students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis as documented by a health care provider. Training may include, but is not limited to;

- Definition of allergies and anaphylaxis;
- Classroom accommodations;
- Cafeteria accommodations;
- Transportation accommodations;
- Accommodations for school-sponsored activities;
- Allergen avoidance and allergen exposure risk reduction;
- Symptoms to report to the school nurse (i.e. symptoms of anaphylactic reaction);
- Confidentiality protections;
- Review of the individual emergency plan/protocol;
- Maintenance of emergency plans/protocols with information provided to staffing substitutes, e.g., classroom, school health, transportation, and food services staff;
- Medication information related to storage, access, locations, and administration technique; and
- Education for school visitors or volunteers with student contact, as needed per local policy.

The school nurse should document the provision and the receipt of training for each staff member who attended.

Education Planning

A nursing assessment is a recommended part of the process for determining special accommodations for students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis as documented by a health care provider (e.g. change in school placement, concurrent or intermittent home teaching, or adaptations to physical education class). For more specific information regarding education planning, please refer to *Role of the School Nurse in Implementing 504 and Individualized Education Plans*.

School-Sponsored Activities

If a school-sponsored activity is planned, the assigned personnel should give sufficient notice to the school nurse so that preparation can be made and a plan can be developed for ensuring the safety of students with a diagnosis of anaphylaxis or who are at risk for anaphylaxis as documented by a health care provider. Prior to the school-sponsored activity, the school nurse should ensure the teacher/staff member in charge has copies of the emergency care plan for the student.

Monitoring/Evaluation

The school nurse should evaluate and monitor anaphylaxis management. The school nurse must assess the student's response to and the effectiveness of the emergency plan and IHP to meet the student's health and educational needs on an ongoing basis and make appropriate adjustments.

GLOSSARY

ABC's: The acronym for "Airway, Breathing, and Circulation" used in the assessment of an ill individual by a health care provider or first responder.

Accommodations: Changes or adjustments in a work or school site, program, or job that makes it possible for an otherwise qualified employee or student with a disability to perform the duties or tasks required as required under 29 C.F.R. pt. 1630 app. § 1630.2(o) (1997).

Allergen: A substance that causes an allergic reaction.

Allergen avoidance and exposure risk reduction: Actions or activities documented in an individualized health care plan that specifically addresses the interventions needed to reduce the risk that an allergic person will come in contact with an allergen that puts them at risk for anaphylaxis or other allergic symptoms.

Anaphylaxis: A constellation of life threatening symptoms affecting multiple systems in the body that results from an allergic reaction to an allergen and requires immediate medical attention. It can be fatal if not reversed within seconds or minutes of coming in contact with the allergen.

Auto injector: A medication delivery device designed to automatically administer an injectable medication (e.g. epinephrine) that does not require manipulation or handling of a syringe or needle nor the measurement of the medication dose.

CPR: The acronym for "Cardiopulmonary Resuscitation". CPR is done in response to an airway, breathing, or circulatory emergency in an attempt to maintain oxygenation to the brain and vital organs until normal body functions are restored or rescue personnel arrives.

Delegation: The act of assigning certain nursing tasks (in accordance with the Maryland Nurse Practice Act) to a certified nursing assistant (CNA), a certified medication assistant, or an unlicensed individual by a registered nurse or licensed practical nurse.

Emergency Plan: a document that specifies the actions needed to manage a student's specific, medical condition in the event of a medical emergency.

Epinephrine: a hormone normally secreted in response to stress used chiefly as a heart stimulant, to constrict the blood vessels, to maintain blood pressure and to prevent or counteract the physiologic response to an allergen during an allergic or anaphylactic reaction.

Health Appraisal: The process by which a designated school health services professional identifies health problems that may interfere with learning. These may include health observations, interviews, and conferences with parents/guardians, students, educators, and other health professionals.

Individualized Health Plan: A type of nursing care plan that is developed by the school nurse utilizing the data from a nursing appraisal/assessment that is specific for a student with a chronic health condition and is designed to meet the student's unique health care needs. The individualized health plan should include an emergency care plan when needed. In some cases it may be appropriate for the individualized health plan to only contain care to be provided in an emergency.

Maryland School Health Services Guideline-Management of Students at Risk for Anaphylactic Reaction

Nurse Practice Act: A statute enacted by the legislature of any state or by the appropriate officers of the district. The act delineates the legal scope of the practice of nursing within the geographical boundaries of the jurisdiction.

Nursing Assessment: The act of gathering and identifying data that assists the nurse, the client, and the client's family to identify the client's health concerns and needs. (Nurse Practice Act, Annotated Code of Maryland, Health Occupations Article, Title 8, COMAR Title 10, Subtitle 27.)

School Nurse: A registered nurse currently licensed by the Maryland Board of Nursing who works in a school setting.

Self-Administration: The application or consumption of medication by an individual in a manner directed by the health practitioner without additional assistance or direction (Sec §7-421, Annotated code Of Maryland).

Self-Carry: The possession of a medication on an individual's person to allow quick access to and administration of the medication and to allow self-administration when specified.

RESOURCES

- **American Academy of Allergy, Asthma, & Immunology:** <http://www.aaaai.org/>
- **American College of Asthma, Allergy & Immunology:** <http://allergy.mcg.edu/home.html>
The American College of Asthma, Allergy & Immunology is an information and news service for patients and parents of patients.
- **Asthma & Allergy Foundation of America:** <http://www.aafa.org> The Asthma and Allergy Foundation of America is a patient organization dedicated to improving the quality of life for people with asthma and allergies through education, advocacy and research. This site contains resources and continuing education programs for health care professionals.
- **The Food Allergy & Anaphylaxis Network (FAAN):** <http://www.foodallergy.org/> The Food Allergy & Anaphylaxis Network. FAAN serves as the communication link between the patient and others. Their mission is to raise public awareness, to provide advocacy and education, and to advance research on behalf of all those affected by food allergies and anaphylaxis.
- **USDA, Food and Nutrition Services:** <http://www.usda.gov>. *Accommodating Children with Special Dietary Needs in the School Nutrition Programs: Guidance for School Food Service Staff.* Fall 2001.
- **Safe@School® Partners, Inc:** www.foodallergysmart.org Safe@School Partners, Inc. is a 501c3 nonprofit organization whose mission is to support schools, camps and daycares in their efforts to keep food-allergic students safe at school. Their primary service is the provision of food allergy safety training to schools, camps and child cares sites.



Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No

**PLACE
PICTURE
HERE**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.

If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

**OR A
COMBINATION**
of symptoms
from different
body areas.



- 1. INJECT EPINEPHRINE IMMEDIATELY.**
- 2. Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

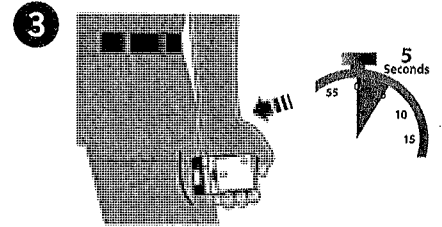
Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____



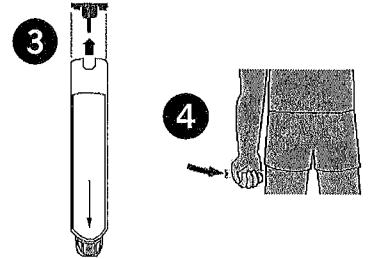
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



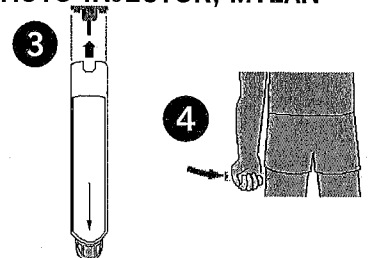
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



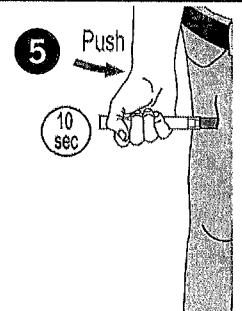
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____
 DOCTOR: _____ PHONE: _____
 PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____
 PHONE: _____
 NAME/RELATIONSHIP: _____
 PHONE: _____

Self-carry and Self-Administration of Auto-Injectable Epinephrine Evaluation

Student _____ Date of Birth _____

Grade _____ Homeroom/Teacher _____

Name of Medication _____

Current medication form on file with parent signature and health care provider signature authorizing self-carry and self-administration of the medication ____ Yes ____ No

Interview Date _____ Health Room Staff _____

Reviewed with teacher _____ Date _____

1. Student is capable of identifying individual medication ____ Yes ____ No
2. Student is knowledgeable of purpose of medication ____ Yes ____ No
3. Student is able to identify specific symptoms/triggers that indicate need for medication
____ Yes ____ No
4. Student is knowledgeable about medication dosage/frequency ____ Yes ____ No
5. Student demonstrates proper administration of medication ____ Yes ____ No
6. Student has plan for access to medication at all times ____ Yes ____ No (where it is to be kept
during class, recess, gym)
7. Student is knowledgeable about how to access assistance for self if needed in an
emergency. ____ Yes ____ No
8. Spare auto-injectable epinephrine to be kept in health room ____ Yes ____ No
9. Student is aware that any inappropriate use or sharing with others may result in
parental notification and limiting the right to carry medication. ____ Yes ____ No
10. The student is aware that they have to notify nearby school staff and the health room
immediately if the medication is used, and that emergency services will be notified
____ Yes ____ No.

The student has completed the self-carry and self-administration evaluation and has demonstrated appropriate self-administration and level of responsibility to self-carry their medication.

_____ Health Room Signature

_____ Student Signature

_____ Date

Copy of form in student health file.

Section 10

Head Lice

Head Lice

Protocol for Head Lice (*Pediculosis capitus*)

Background: The identification and treatment of head lice is complicated by misdiagnosis, misinformation, mismanagement and myths. Common myths include the need to exclude children from school, the need to remove all visible nits, the need for comprehensive environmental cleaning, that head lice live for long periods of time, and that schools are a common location for lice transmission (National Association of School Nurses, 2014).

Head lice cause no medical harm, transmit no disease, are not a sign of poor hygiene and, can be effectively eradicated. Because in-school transmission of lice is considered to be rare, children who present with head lice may remain in school but, be discouraged from having head-to-head contact with others. (Frankowski & Bocchini, 2010). Sharing of hair brushes, combs, hats and hair accessories is also discouraged though inanimate objects are insignificant in harboring and transmitting head lice or their eggs.

The CDC recommends students go home at the end of the day, receive the appropriate treatment and return to school after initial treatment. Successful treatment kills live lice and, includes the manual removal of lice, nymphs and nits. The American Academy of Pediatrics and the National Association of School Nurses guidelines recommend no healthy child should be excluded from or, miss school because of head lice, and no-nit policies for return to school should be discontinued.

Life Cycle of the louse is divided into three phases. Lice begin as nits (eggs) which are laid by female lice and attached to the base of the hair shaft with a glue-like secretion to the base of the hair shaft nearest the scalp. Nits are very small, difficult to see and may often be confused with dandruff, debris or hair product.

The second stage begins 6-7 days later as the egg hatches to release the nymph. The nit's shell remains attached to the hair shaft. Nymphs resemble adult lice but are very small (0.5-0.8 mm). Nymphs feed on the scalp in the area where they hatched and mature in about 7 days.

In the third phase the mature louse grows to about the size of a sesame seed (2-4mm), it is a wingless, parasitic insect with 6 clawed legs. It lives only on the scalp, neck

and, sometimes eyebrow hairs of their human host. The mature louse moves only by crawling; it is unable to hop, jump or fly.

Adult head lice are small (2-4mm) wingless, parasitic insects able to live only on the scalp and neck hairs of their human host. Lice can live for up to 30 days on an infested head. Lice move by crawling; they cannot hop or fly. Head lice are spread most commonly by direct contact with a person who has an active infestation. Without the warmth and food provided by the host scalp, the louse will not be able to reproduce and will die within one to two days; their nits cannot hatch and usually die within a week (CDC, August 2016).

The Archdiocese of Baltimore has developed = recommendations for school nurses, faculty and staff to follow in the management of their students with head lice in the school setting. These recommendations include: guidelines for the detection, surveillance, and eradication of head lice (the suggested guidelines also consider community standards and the impact). Educational resources which comply with current scientific knowledge and best practices in the management of pediculosis in the school setting also are listed in this section.

The goals of any guidelines in this area should be to:

1. Support families in identifying and eradicating head lice;
2. Maintain school attendance and minimize disruption of learning; and
3. Preserve the privacy and confidentiality of all students as possible.

SUGGESTED PROCEDURES FOR HEAD LICE DETECTION AND MANAGEMENT IN SCHOOL

Guiding Principles

1. Procedures for the implementation of head lice surveillance and control are based on current scientific research and National Association of School Nurses published best practices.
2. The National Association of School Nurses (NASN) recommends that children found with live head lice should remain in class but, be discouraged from head-to-head contact with other children.
3. The primary goals of the School Nurse in controlling infestations are to identify children with head lice and to break the cycle of re-infestation.
4. School staff is trained by the School Nurse in head lice management procedures.

5. In compliance with FERPA and/or to maintain privacy and confidentiality, information about head lice infestation is to be shared only on a “need to know” basis as deemed appropriate by the School Nurse.
6. Consideration should be given to the student’s ability to understand whether or not they have head lice and if sharing this information is developmentally appropriate.
7. Full Classroom screenings for head lice are not best practice. Evidence-based research does not support the efficacy and cost-effectiveness of classroom or school-wide screening nor do these screenings decrease the incidence of head lice infestation among children. (CDC, 2016).

Possible Observations/Symptoms

1. Tickling feeling on scalp, especially occipital (back of the head) and post auricular (behind ears).
2. Frequent itching/scratching of scalp triggered by lice saliva and excrement.
3. Irritability.
4. Difficulty sleeping, lice tend to be most active in the dark.
5. Alteration to skin integrity, cutaneous scalp infection related to scratching.
6. No symptoms, many children with head lice are asymptomatic.
7. Nits, “glued” to hair shaft usually within 0.25 inch (6.35 mm).
8. Live, crawling lice.

Management

Students presenting with symptoms of head lice infestation should report to the School Nurse for assessment.

When a student is found to have live lice:

1. The parent/guardian is notified and information related to detection and elimination of head lice and nits is provided at that time and/or, sent home with the student in a sealed envelope. Best practice is to contact the parent/guardian personally if possible.
2. It is **not** mandatory for the student to be sent home from school; however, it is acceptable for the parent/guardian to pick up the student for early dismissal for prompt evaluation and treatment.

3. The parent/guardian is instructed that the student must be treated promptly and properly with pediculocide-containing over-the-counter or prescription medication and lice/nit combing before returning to school. Proper treatment includes the removal of all live lice and visible nits.
 - A. Parent/guardian is advised to follow the pediculocide product manufacturer's recommendations for treatment and re-treatment.
 - B. School Nurse provides education and instruction on proper lice eradication procedures as possible.
4. Parent /guardian communicates to School Nurse that student has been treated with a pediculocide product and combing/nit-picking or provides documentation from a health care provider stating the student does not have head lice infestation or viable nits.
5. Evidence of treatment with a pediculocidal product and/or notification of evaluation by student's healthcare provider may be requested by the School Nurse.
6. The School Nurse may require re-inspection of the student's head upon return to school.
 - A. If live lice and/or nits are found:
 1. Parent/guardian is notified and advised to continue combing and nit-picking at least daily for the next two weeks and continue to follow the pediculocide product manufacturer's instructions for treatment/retreatment.
 2. Student may be referred to his/her primary healthcare provider for additional evaluation and treatment for possible resistant cases.
 - B. Follow-up head checks may be done by the School Nurse to confirm lice management and eradication.

When a student is found to have nits but, *no live lice* are detected:

1. Parent/guardian is notified and information related to detection and elimination of head lice and nits is provided at that time and/or sent home with the student in a sealed envelope. Best practice is to contact the parent/guardian personally if possible.

2. Parent/guardian is advised to do focused lice combing and nit-picking and inspect for live lice at least daily for the next two weeks.
3. School Nurse may re-inspect the student's head. If future checks reveal an increased number of nits or live lice, the parent/guardian is contacted and the student is referred for treatment. Follow the protocol above for "When a student is found to have live lice".

Additional Considerations:

If live lice or nits are detected it is best practice to:

1. Determine if the student has siblings. If yes, then check the siblings in the immediate school.
2. Advise parent/guardian to check family members and to notify family, friends and acquaintances, with whom infested members have been recently close including sleep over parties, overnight camping trips, etc., to inspect for lice and to take precautionary measures to avoid family infestation.

Classroom environment:

1. Instruct students to avoid head-to-head contact and not to share personal items such as pillows, hair brushes, combs, accessories, hats, etc.
2. Routine cleaning and vacuuming of classrooms and all upholstered furniture should be completed.
3. Stuffed animals and pillows can be bagged for two weeks, though inanimate objects are insignificant vessels in the harboring or transmitting of head lice or their eggs.
4. No environmental pesticide treatments (pesticide bombs) are to be used.
5. It is advisable for students with long hair to wear their hair in "contained" hair styles such as ponytails, buns, braids, etc.
6. The School Nurse can use professional judgment to determine when extraordinary measures are necessary to respond to extraordinary cases.

7.

Notification Procedures:

1. Notification of the presence of head lice is to be done on an individual, case-by-case basis to the parent/guardian of an infested student. Classroom-wide notifications to families are not recommended with typical head lice cases.
2. In the rare case a student is to be excluded (see Exclusion Procedures), a notice will be given to the parent in person or a phone contact will be attempted and documented. If there is concern about the delivery of the notification, it can be sent by certified mail.
3. In very unusual cases, it may be appropriate in the professional opinion of the School Nurse and in consultation with the School Principal to consider a general parent/guardian notification for a high number of identified cases of head lice in a classroom or the school building.

4.

Exclusion Procedure:

1. In the rare case that a student has either chronic head lice infestation or severe head lice infestation that is disruptive to the learning environment, the School Nurse will be consulted.
2. If in the nurse's professional judgment it is determined that exclusion of the student needs to be considered, the nurse will consult with the Principal.
3. With chronic head lice infestation cases, the nurse will secure documentation of repeated and unsuccessful head lice management measures.
4. The return of a student after exclusion will be predicated on a head check by the School Nurse with evidence of progress in head lice management and eradication of the head lice (such evidence will look like elimination of live lice and a decrease in the number of nits).
5. It may be appropriate in the judgment of the School Nurse to monitor progress of lice management over a period of time and to support the family in eradication of the infestation.

Recurrent and/or Apparent Non-Responsive Cases

1. The School Nurse may refer persistent or repeated cases to the student's primary healthcare provider for additional evaluation and treatment.
2. The School Nurse and/or Principal may refer chronic or recurrent cases of lice infestation to the local Child Protective Services office if there is evidence that parents/guardians are unwilling or unable to complete the procedures necessary to eradicate the lice.

Documentation

Standard documentation procedures as required for all Health Room visits and notifications should be followed for interventions and communications related to pediculosis identification, education and surveillance.

Outdoor Education and Overnight Field Trip Considerations:

Some outside facilities may have head lice policies and procedures that are not in alignment with these suggested procedures. When a facility presents with requirements that are counter to the school's procedures, the School Nurse or informed staff member should consult with that facility and advise them of the school's procedures. After consultation with the facility, parents/guardians will be advised of any provisions related to head lice prior to attending an event at that facility.

Tools and Resources

www.cdc.gov/parasites/lice/head/treatment.html,

www.HeadfirstLiceLessons.org

Lice Lessons is an educational initiative focused on dispelling common head lice misperceptions, providing information about the value of engaging healthcare professionals and building awareness of new treatment options. The portfolio of tools and resources available are designed to help school nurses, often on the frontlines in the battle against head lice, reduce fear and stigma and help parents navigate treatment choices. There are both English and Spanish language versions available on the website

Lice lessons can be found by visiting:

<https://www.nasn.org/nasn/programs/educational-initiatives/lice-lessons>

References

American Academy of Pediatrics. <https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Offers-Updated-Guidance-on-Treating-Head-Lice.aspx> June 26, 2010

Buter, Leslie A. RN, BSN, & Sutherland, Nancy N. RN, MEd. Informal Parent Survey of Parent Attitudes Around Head Lice Notification, October, 2010.

Centers for Disease Control and Prevention.

www.cdc.gov/parasites/lice/head/treatment.html, August 19, 2016

Cole, Marjorie, RN MSN. 2005. Managing Head Lice in the School Setting (PowerPoint). National Assembly of School Nurses Listserve.

Exclusion of Children with Head Lice or Nits from Child Care (white Paper)
July 22, 2010. Washington State Department of Early Learning

Frankowski, B.L. & Bocchini, J.A. (2010) Clinical Report-Head Lice *Pediatrics* 126(2) 392-403

Head Lice. Identify Us. 2010. Frequently Asked Questions

Infectious Disease Control Guide for School Staff; Washington State Department of Health; Office of Superintendent. of Public Instruction. June 2004.

National Association of School Nurses. (2011), Pediculosis in the School Setting. *Position Statement.* <http://www.nasn.org/Default.aspx?tabid=237>

National Guideline Clearinghouse. (2008) Guidelines for the diagnosis and treatment of pediculosis capitus (head lice) in children and adults.
http://www.guideline.gov/summary/summary.aspx?doc_id=12784&nbr=006586&string=pediculosis

Pollack, R. (2009) Head Lice Information. Statement from Harvard School of Public Health. <https://www.hsph.harvard.edu/headlice.html>

SCHLRN List Serve: Cross State Lice Procedures Inquiry/Responses (anecdotal information from practicing School Nurses). 11.29.2010

Sciscione, Patricia & Krause-Parello, Cheryl A. No Nit Policies in Schools: Time for Change, *The Journal of School Nursing*, February 2007

HEAD LICE 101



To Start with:

- **DO NOT PANIC!** Head lice are *not* an emergency and, in most cases, do not pose any health risk. However, misuse of pesticides and use of unlabeled treatments (ex., kerosene) *can* pose a health risk.
- Head lice **CANNOT** live off a human host for more than 24-48 hours. Head lice **CANNOT** live on pets. Head lice **CANNOT** reproduce in carpets, furniture or other household furnishings.
- **PESTICIDE SPRAYS DO LITTLE OR NOTHING TO CONTROL LICE.** *NEVER* treat your home, car, furniture, beds, pillows, or clothing with pesticides (e.g. 'licebombs,' flea bombs, sprays, etc.) in an attempt to control head lice. You will expose yourself and your family to unnecessary pesticide risk.
- Head lice are very common among all races and classes of people. More than 12 million people, mostly children and school personnel, get head lice per year. **ANYONE** can get head lice they **DO NOT** imply a lack of cleanliness.
- Direct head-to-head contact with an infested person is the main way head lice are transmitted, but they may also be transmitted by sharing hats, scarves, headphones, combs and other hair accessories.
- If a lice shampoo is warranted, ask your doctor or pharmacist for specifics on the product and **follow all label instructions exactly.** Misapplications can be ineffective and dangerous as well.

Lice cannot hop, jump or fly, but they can crawl rapidly.

So what are head lice anyway?

Head lice are small, wingless parasitic insects. They are typically 1/6-1/8 inch long, brownish in color with darker margins. The claws on the end of each of their six legs are well adapted to grasping a hair strand. Female head lice glue their grayish-white to brown eggs (nits) securely to hair shafts. The eggs are resistant to pesticides, and they are difficult to remove without a special 'nit-comb.'

A child cannot "Catch Nits." Nits are laid and cemented to hair shaft by live lice.



What about Treatment?

1. Use a medicine that your health care provider or pharmacist recommends. After treatment, removal of nits is necessary.
 2. For nit removal, work in a well lit area or use a flashlight or hand lens.
 3. Use a grooming comb or hairbrush to remove tangles. A hair detangle spray or other hair conditioner may aid in this process.
 4. Divide the hair into sections and fasten off the hair that is not being worked on.
 5. Use a lice comb to detect and remove lice and nits. Or manually remove by pinching the nit and pulling it off the hair shaft.
 6. Go through hair sections from the scalp to the end of the hair. Nits are usually found close to the scalp.
 7. Dip the comb in a cup of hot, soapy water or use tape to remove lice, nits, or debris from comb.
 8. Move on to the next section until the entire scalp and all hair has been checked.
9. Screen the person every day for 10 days and regularly thereafter.

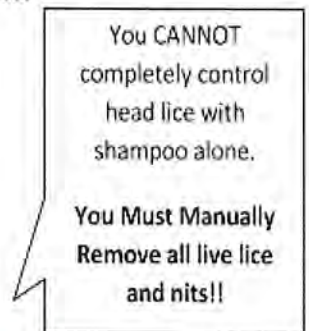


PLEASE MAKE SURE TO NOTIFY THE HEATHROOM IF YOUR CHILD HAS LICE
Students may be checked by school nurse before returning to school after treatment.

Your child may return to class after they have been properly treated for lice.

What about my house?

- To kill lice on bedding, clothes, etc., wash and dry them as you would ordinarily.
- **NEVER** add any pesticide. Vacuum materials that cannot be washed.
- For carpets, furniture, and car upholstery vacuum them thoroughly and wipe smooth surfaces with a damp cloth.
- Place items that cannot be washed or dried, such as stuffed animals, in a tightly sealed plastic trash bag for 10 days.
- To kill lice on brushes, combs, or hair accessories, wash them with hot, soapy water, and remove all nits/lice



commonly spread on hairbrushes, etc.).

How can my family prevent head lice?

- Teach your children to avoid direct head-to-head contact and, though lice are not objects, not to share hats, helmets, scarves, headphones, and grooming items (combs,
- Watch for signs of head lice. Frequent head itching or complaints of itchy, tingling head/scalp, irritability and, lack of sleep are common signs. **Lice are easier to eliminate when caught early.**

Section 11

Staff Training

Staff Training

Although teachers and staff are not expected to take the role of a healthcare professional, it is important that they receive information about how to adequately get aid to students who are experiencing a medical crisis.

All staff should receive blood borne pathogens training yearly, as required by OSHA. In addition, staff should receive training in the use of epinephrine auto injectors and inhalers, and training in identifying the signs of an allergic reaction.

Staff who will have regular contact with students with a specific medical condition should be educated about that student's condition and any appropriate precautions, warning signs, or necessary responses.

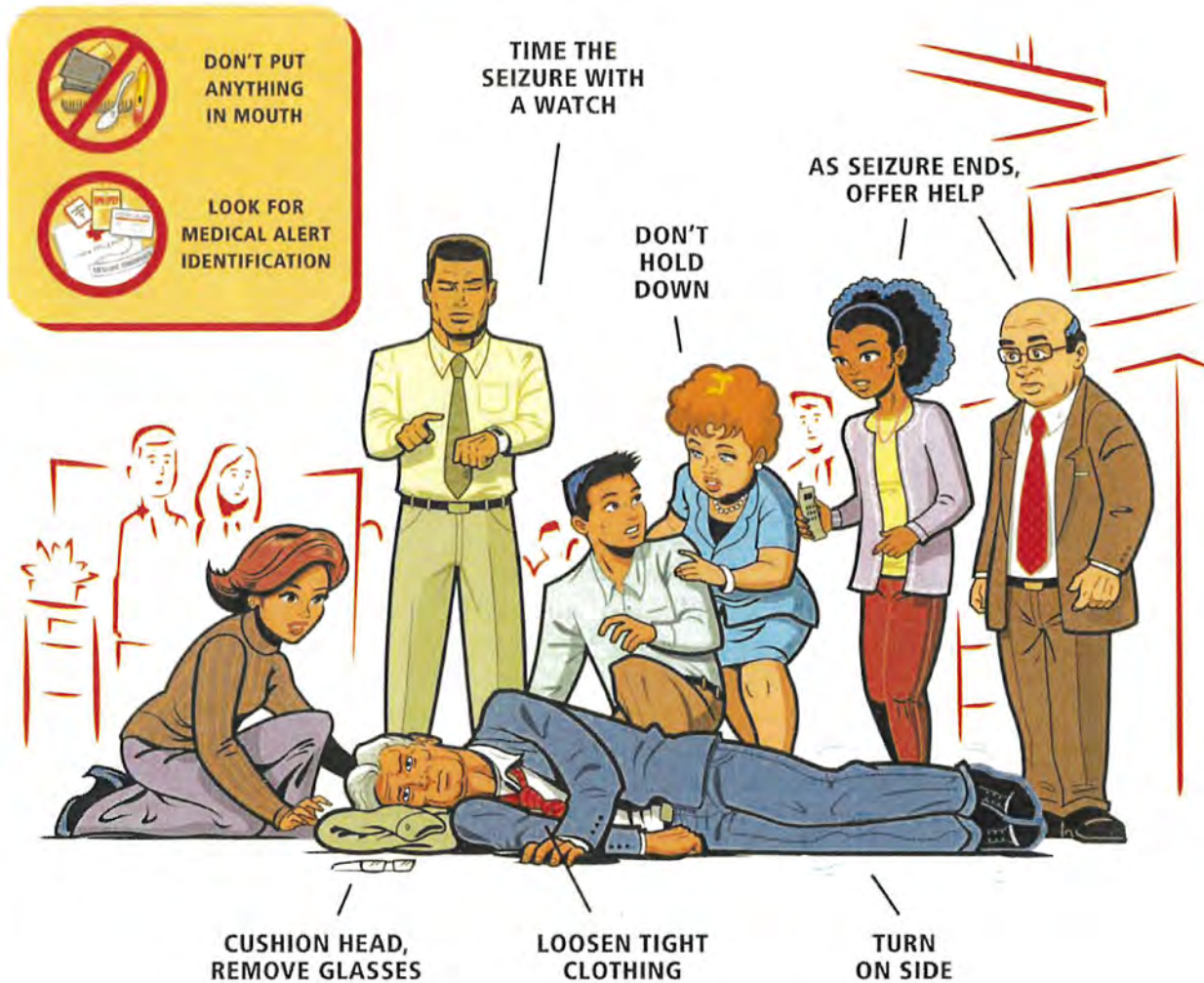
It is also recommended that staff should be given emergency response information regarding anaphylaxis and seizures regardless of whether they have a student with a known condition, as these emergencies can occur in students with no prior history of a condition.

To align with Code of Maryland Regulation 13A.05.05.09, at least one adult in each school, other than the designated school health services professional and the school health services aide, shall be currently certified in adult or pediatric cardiopulmonary resuscitation (CPR) or both, as well as first aid. One certified person shall be available on site during the school day. A copy of this Regulation can be found in this section.

All schools should keep a copy of *Guidelines for Emergency Care in Maryland Schools 2015 Edition* on site. This book is published by the Maryland State Department of Education and Maryland Department of Health and Mental Hygiene, and is available on the Maryland School Health Services' website.

First Aid for Seizures

(Convulsive, generalized tonic-clonic, grand mal)




Most seizures in people with epilepsy are not medical emergencies. They end after a minute or two without harm and usually do not require a trip to the emergency room.

But sometimes there are good reasons to call for emergency help. A seizure in someone who does not have epilepsy could be a sign of a serious illness.

Other reasons to call an ambulance include:

- A seizure that lasts more than 5 minutes
- No "epilepsy" or "seizure disorder" identification
- Slow recovery, a second seizure, or difficulty breathing afterwards
- Pregnancy or other medical diagnosis
- Any signs of injury or sickness

 **EPILEPSY FOUNDATION**[®]
Not another moment lost to seizures[™]
1-800-332-1000 • www.epilepsyfoundation.org





Recognize and Respond to Anaphylaxis

For a suspected or active food allergy reaction

FOR ANY OF THE FOLLOWING SEVERE SYMPTOMS

-  **LUNG:** Short of breath, wheezing, repetitive cough
-  **HEART:** Pale, blue, faint, weak pulse, dizzy
-  **THROAT:** Tight, hoarse, trouble breathing/swallowing
-  **MOUTH:** Significant swelling of the tongue, lips
-  **SKIN:** Many hives over body, widespread redness
-  **GUT:** Repetitive vomiting, severe diarrhea
-  **OTHER:** Feeling something bad is about to happen, anxiety, confusion

OR MORE THAN ONE MILD SYMPTOM

-  **NOSE:** Itchy/runny nose, sneezing
-  **MOUTH:** Itchy mouth
-  **SKIN:** A few hives, mild itch
-  **GUT:** Mild nausea/discomfort

1 INJECT EPINEPHRINE IMMEDIATELY

2 Call 911
Request ambulance with epinephrine.

Consider Additional Meds

(After epinephrine):

- » Antihistamine
- » Inhaler (bronchodilator) if asthma

Positioning

Lay the person flat and raise legs. If breathing is difficult or they are vomiting, let them sit up or lie on their side.

Next Steps

- » If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- » Transport to and remain in ER for at least 4 hours because symptoms may return.

Do not depend on antihistamines. When in doubt, give epinephrine and call 911.

.09 School Health Services Standards — Emergency Services.

A. Personnel Qualifications. At least one adult in each school, other than the designated school health services professional and the school health services aide, shall be currently certified both in the First Aid Program of the American National Red Cross or its equivalent, and in adult or pediatric cardiopulmonary resuscitation (CPR), or both. One certified person shall be available on site during the regular school day and at all school-sponsored athletic events.

B. Emergency Care Procedures.

(1) A guide for emergency care management shall be developed and distributed by the local health department and the local board of education to each school, and copies shall be placed in multiple locations.

(2) An emergency information card shall be maintained for each student, and shall be updated at least annually.

(3) Emergency evacuation plans shall be developed in consultation with the fire department, and shall include provisions for physically handicapped students and students with other special health needs.

Section 12

Medication

Medication

One of the most common responsibilities of a School Nurse is dispensing medication. It is part of the Nurse's role to insure that medications are administered in a supervised and safe environment. As per standard policy:

- If medication must be given during school hours, written instructions from the student's doctor/licensed health care practitioner regarding administration should be given to designated school personnel.
- Unauthorized personnel do not dispense medication.
- Before and after school care must maintain its own supply of medication and related forms.
- Written authorization/instructions from the student's doctor/licensed health care practitioner regarding required medication is to be submitted annually, or as needed, and is kept on file in the student's physical health file as long as the student is enrolled in the school.
- During a school-sponsored field trip, designated school personnel transport and dispense medication.
- All medications must be kept under lock and key and inventory must be properly monitored.
- If a medication is missing from the school, parent/guardian must be notified and a police report must be filed.
- Under special circumstances, individual students may be authorized by their physician/licensed health care provider to carry and self-administer emergency medications (e.g. inhalers, epi-pens).

Schools should adhere to the *Maryland State School Health Services Guideline: Administration of Medication in Schools, (January 2006; Reference Updated March 2015)*, a copy of which is located in this section.

ADMINISTRATION OF MEDICATION IN SCHOOLS

MARYLAND STATE SCHOOL HEALTH SERVICES GUIDELINE

JANUARY 2006
(Reference Updated March 2015)

Maryland State Department of Education
Student Services and Strategic Planning
Branch
200 West Baltimore Street
Baltimore, Maryland 21201
Phone: 410-767-0311
TTY/TDD: 410-333-6442

Maryland Department of Health and
Mental Hygiene Center for Maternal
& Child Health
201 West Preston Street
Baltimore, Maryland 21201
Phone: 1-877-463-3464
TTY/TTD: 1-800-735-2258



MARYLAND SCHOOL HEALTH SERVICES GUIDELINE

Foreword

There is a strong relationship between academic achievement and a child's physical, emotional and mental health. This link is the foundation for providing school health services as an important component of a school program. School health services provide primary prevention aimed at keeping students in schools through appropriate screenings, early identification of children at risk for physical, emotional and mental health concerns, and case management of students with chronic health concerns.

The Annotated Code of Maryland, Education Article, § 7-401 requires the Maryland State Department of Education (MSDE) and the Maryland Department of Health and Mental Hygiene (DHMH) to jointly develop public standards and guidelines for school health programs. The following guideline is developed in accordance with that requirement and is based on the expressed needs of the local school health services programs. It has been reviewed by the Maryland Board of Nursing, the Maryland Board of Pharmacy, the Maryland Chapter of the American Academy of Pediatrics, and the Committee on School Health. These guidelines contain recommendations for minimum standards of care and current best practices for the health service topics addressed. It is intended that these guidelines will be used by the local school systems in developing local school health services policies and procedures as a means to assist local school health services programs in providing consistent and safe care to the students of Maryland. Specific laws and regulations that direct school nursing practice or other health services are identified in the guidelines.

The Maryland State School Health Council serves as an advisory council to both departments and as such, the council's School Health Services Subcommittee serves as the committee that develops and reviews these guidelines along with the specialists from MSDE and DHMH. School Health Services Program supervisors/coordinators also review and participate in the guideline development process. To those dedicated school health services professionals and administrators, our thanks.

Introduction

The administration of medication in the school setting is a service that is provided to promote wellness and decrease absenteeism. When there is a need for a student to receive medication in school, safe and proper administration is essential. To assist local school systems (LSSs), schools, and local health departments, the Maryland State Department of Education, the Department of Health and Mental Hygiene, and the Maryland State School Health Council developed the following Guideline for the administration of medication in schools. These guidelines were approved by the Maryland Board of Nursing and reviewed by the Maryland Board of Pharmacy.

Prescription Medication

All prescription medication to be given in school must be ordered by a person authorized to prescribe medication. In Maryland an authorized prescriber is a physician, nurse practitioner, certified midwife, podiatrist, physician's assistant or dentist, (Section 12-101(b), Health Occupations, Annotated Code of Maryland). It is recommended that an approved medication administration/authorization form be developed (see example of state form in Appendix). The locally approved medication administration/authorization form should contain the following information:

- Date of order;
- Name of student;
- Diagnosis;
- Name of medication to be administered;
- Dosage;
- Time of administration;
- Route of administration;
- Duration of medication order;
- Possible side effects;
- Special requirements such as "take with food"; and
- Whether or not medication may be self-administered.

The locally approved medication administration/authorization form must be signed by the authorized prescriber and the parent /guardian. A stamp with the prescriber's signature is acceptable; however a printed name stamp is not acceptable. A written parent/guardian authorization must accompany each medication order. An order should be renewed annually even if the order is for a prn (as needed) medication. The authorization should be filed in the student's school health record.

Verbal orders from an authorized prescriber may be taken only by a registered nurse (RN) or a licensed practical nurse (LPN). This order shall be recorded by the nurse in the student's health record and must be followed up within a locally determined number of days, by a written order from the prescriber. If unable to obtain the written order, the nurse should attempt to contact both the prescriber and parent/guardian. If the written order is not received within the locally determined number of days, administration of the medication must be discontinued in school.

Faxed medication orders for the administration of medication may be accepted when submitted on a written, locally approved authorization form and signed by an authorized prescriber. The parent should sign the form within a locally determined number of days.

Parental Consent

Written parental consent is required for each medication ordered and for each new order (even if the medication was previously given in school). Parental consent is required as a part of the authorization. As with the medication orders, parental consent must be renewed annually.

In the case of verbal orders from an authorized prescriber, verbal consent from the parent must be obtained and documented, to be followed by the written consent within a locally designated number of days. Parental consent forms should be filed in the student's school health record.

Labeling, Storage, and Disposal

The medication container shall accompany all medications to be administered in school. Parents/guardians may request two containers (one for school and one for home) from the pharmacist when getting a prescription filled. Medications should be brought to the school by the parent or responsible adult, especially for elementary school students. However, if this is not possible, the parent/guardian should inform the school nurse, principal, or designee by telephone that his/her child is bringing the medication to school and how much medication is in the container. This eliminates any question about how much medication should have been in the container when the child reached the school. The amount of medication received should be checked by the school nurse, school administrator, or designee and documented as soon as the parent/guardian delivers the medication. Alternatives to this procedure can be determined by the local SHS program provided that the students health & safety is not jeopardized.

The medication container shall be labeled with the following:

- Name of student;
- Name of medication;
- Dosage of medication to be given;
- Frequency of administration;
- Route of administration;
- Name of physician/authorized prescriber ordering medication;
- Date of prescription; and
- Expiration date.

In compliance with the School Health Standards (COMAR 13A.05.05.05--.15), all medication must be stored in a locked cabinet. Medications that must be refrigerated must be stored in a locked box in the refrigerator. Access to medication locked in the designated space shall be under the authority of the designated school health professional, the principal, and/or designee.

All medication must be removed from the school premises one week after the expiration date, upon appropriate notification of medication being discontinued, or at the end of the school year. If not retrieved by a parent or responsible adult, unused and unclaimed medication should be disposed of by flushing. Empty asthma inhalers may be disposed of in the trash. Sharps (needles and lancets) must be disposed of in a puncture-proof container. Disposal of this container and other medical waste must follow Occupational Safety and Health Administration (OSHA)/Maryland Occupational Safety and Health (MOSH). Bloodborne Pathogens Standard found in the Code of Federal Regulations (29CFR1910.1030).

Administration of Medication

The designated school health professional, in collaboration with the school administrator, implements the medication policy. School staff and parents shall be informed annually of the medication policies and procedures.

The following are recommended in the administration of medication:

- The parent/guardian should give the first dose of any new prescription or over-the-counter medication, except for prn emergency medications (e.g. Epi-Pen); and a record must be maintained each time a medication is administered.
- The record shall include: student's name, date and time of administration, dosage, and signature of person administering the medication.
- A plan should be developed by the physician, parent, and school nurse for students who self-administer. A physician must authorize self-administration of medication. The school nurse must **evaluate and approve** the student's ability and capability to self-administer medication. The plan shall address how to keep a record of administrations.
- It must be determined by the school nurse whether a student who self administers medication is responsible to self carry their medication. The developmental ability of the student, the need to have ready access to emergency medication and the safe storage of medication must be taken into account when making this decision.

Narcotics

If a narcotic must be administered in school, the guideline for prescription medications should be followed with the following modifications:

- The parent/guardian shall bring the medication to school;
- The amount of the drug received shall be immediately counted and recorded by the school health professional or designee, witnessed by a responsible employee;
- Narcotics shall be counted on a scheduled basis by the designated school health professional and witnessed by a responsible employee. This count should be reconciled with the prior count and medication administration record;
- The school nurse should maintain no more than a 30 day supply of narcotics; and
- There must be a new order and parent authorization every 30 days EXCEPT if the narcotic is to be given prn. If the narcotic is to be given prn and for more than thirty days, the designated school health professional should contact the parent or prescriber to confirm the continued need for the medication, especially in cases where the medication is classified as a narcotic.

Over-the-Counter (OTC) Medications

Administration of OTC medication must be conducted in accordance with the guideline for prescription medication. The only exception is if the local school system and local school health services program has adopted "physician directed nursing protocols" for the administration of OTC medication in compliance with Board of Nursing regulations. If the local school system and local school health services program has adopted "physician directed nursing protocols" the following should be incorporated in the policy:

- The LSS and the Health Services Program shall identify which OTC medications are to be administered under its policy;
- Parental consent is required annually for the administration of the identified OTC medications;
- Administration of the identified OTC medications must be part of a nursing protocol which has been approved by the LSS, the supervisor of health services, and the medical director;
- Only RNs may make the assessment and the decision to administer an OTC medication (therefore the LSS and the Health Services Program's "physician directed nursing protocols", may only be used in schools that are staffed by a fulltime RN); and
- Medications administered under the LSS and the Health Services Program's "physician directed nursing protocols" are not to be given for a problem/health concern diagnosed by the child's primary care physician. The guideline for prescribed medication must be followed when this occurs. In the absence of an order from an authorized prescriber for a medication that is included in the "physician directed nursing protocols", the LSS and the Health Services Program's "physician directed nursing protocols" may be followed if parental permission is obtained. A student's specific medication order from an authorized prescriber shall take precedence over the LSS and the Health Services Program's "physician directed nursing protocols". OTC medication must be brought to school in an original, unopened container.

Homeopathic and Herbal Medications

Homeopathic and herbal medicines should be administered in accordance with the guideline for prescription drugs.

Delegation of Medication Administration to Unlicensed Staff

Plans for the administration of medications in the absence of the nurse shall be developed collaboratively by the school nurse and the school administrator. The decision regarding delegation of medication administration should be considered in conjunction with other school duties, such as lunch and recess supervision. Such comprehensive planning will ensure that the most appropriate person is assigned to each task and that medication administration is completed in a safe manner.

Criteria for Personnel Selected to Administer Medication in the Absence of the School Nurse: In all cases, the person to whom the administration of medications is delegated should meet criteria set forth in COMAR 10.27.11. and COMAR 10.39.04 which includes:

- In the judgment of the nurse, the task delegated can be properly and safely performed by the unlicensed individual or certified medication technician without jeopardizing the client's welfare.
- That the person is competent to perform the task assigned.

Additionally, the person should:

- Be an employee and agree to this responsibility;
- Have good attendance;
- Be familiar with the students in the school;
- Possess good organizational skills;
- Handle stress in a calm manner;
- Have coverage/assistance available for regularly assigned job duties during peak times when medications must be given (usually between 11:00 a.m.-1:00 p.m.); and
- Be in a quiet environment which allows for safe and effective administration of medications.

Since the majority of medication doses are scheduled for administration between the hours of 11:00 a.m. and 1:00 p.m., plans must include considerations for the person's lunch.

COMAR 10.27.11.05G and COMAR 10.39.04 requires that persons administering medications under the direction of a nurse be appropriately trained and supervised. The School Health Medication Administration Training Program is the approved program for school staff. This training provides instruction in the administration of oral medications. Administration of medication by any other route requires that the delegating nurse train the unlicensed person on a one-to-one basis. Records of the date and nature of the initial training and every two year re-certification must be maintained. At the conclusion of the training, the school administrator and nurse should make a final decision as to the appropriateness of the assignment for the individuals trained.

School systems must make plans for periodic direct supervision by registered nurses of personnel assigned responsibility for medication administration. Registered nurses should maintain records of this supervision.

Each person assigned routine responsibility for medication administration should have at least one person designated as an alternate to substitute in the case of absence. Selection and training of alternates should follow the same Medication Technician training process outlined above.

Persons assigned responsibility for medication administration should have regular opportunities to administer medications in order to reinforce training and ensure that skills are maintained.

Medication administration is not an appropriate assignment for an unlicensed school volunteer.

Administration of Medication on School-Sponsored Activities

Medications should be administered to students on school-sponsored trips only when absolutely necessary. Timing of doses should be adjusted to occur outside of the school-sponsored activity period if medically appropriate. Medications may be administered on school-sponsored trips only when previously administered and a parent permission form is on file. The only exception is emergency prn (as needed) medications. A written, locally approved authorization form is required for all medications. The determination of whether a medication is administered during a school-sponsored activity and by whom shall be determined by the designated school health professional in collaboration with the school administrator and parents. Options for administration of medications during field trips may include the following:

The parent/guardian may accompany student on the field trip and administer the medication. A single dose of the medication may be placed in a properly labeled envelope or container only by the licensed nurse, to be given on the field trip by school personnel. The Board of Pharmacy allows a parent to bring in a single dose of medication for the field trip in a properly labeled prescription or OTC container to be given on the school-sponsored trip by school personnel.

Upon completion of the field trip, the labeled container should be returned to the health suite. A notation shall be made on the student's medication record that the medication was administered. The person who administered the medication is responsible for documenting the administration of that

medication in accordance with local policy. If the parent accompanies the student on the field trip and administers medication not from the school supply, the parent should notify the school nurse of the time the medication was administered.

Errors in the Administration of Medication

If an error in medication administration occurs (such as missing a dose, giving the incorrect dose, giving a dose at the wrong time, giving incorrect medication to the student, or giving a student another student's medication even if the medication was the same drug and dose), follow the procedures listed below:

- Observe the student for untoward side effects;
- Take appropriate action based on nursing judgment and/or physician order;
- Notify the parent, school administrator, nursing supervisor and primary care provider of the child;
- Complete the appropriate reporting forms; and
- Document the specifics of the incident and the action taken. The local school health services program shall develop procedures to ensure accurate documentation.

Stolen or Lost Medication

If any medication is reported missing, the school administrator and the local school health services program administrator shall be notified and procedures for missing property on school grounds should be followed. Since the incident may involve controlled, dangerous substances, notification of the police may be appropriate. Parents shall also be told in order to replace the medication. Appropriate documentation shall be completed and the designated school health professional shall keep a copy of the documentation.

Education on the Use of Medication

It is strongly recommended that the school nurse assess and provide health education for students regarding their prescribed medications. This education should support/supplement the educational program implemented by the student's health care provider. Health education should include appropriate management of all aspects of a student's health maintenance including medication administration.

Since medication taken in school often assists the student to be available for instruction, the school nurse may work with the parent and school team to address issues surrounding the use of medication at school. This should include developing plans to assist students to remember to come to the health room for their medication.

It is also recommended that the policies, procedures, and forms regarding medication administration in schools be shared with local physicians, dentists, and health care providers.

Communication with Physicians Regarding Treatment of a Student

If the school nurse has concerns about the medical orders, or wants to share information that may be relevant to the treatment regimen with the physician, the school nurse and physician may communicate with each other regarding the medical orders and treatment regimen without written authorization of the parent. HIPAA allows health care professionals to share protected health information if it is for treatment purposes. Furthermore, regardless of the healthcare setting, state licensure statutes and professional standards of practice for nurses and physicians require nurses to question and clarify medical orders, when indicated, before carrying them out. They also require physicians to provide nurses with sufficient information for safe execution of the treatment plan. Therefore, such communication is based on state law and necessary.

Original date of issue: 1992; Revised 1997, 2000, 2006; Reference Update 2015



MARYLAND STATE SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM



This order is valid only for school year (current) _____ including the summer session.

School: _____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- * Prescription medication must be in a container labeled by the pharmacist or prescriber.
* Non-prescription medication must be in the original container with the label intact.
* An adult must bring the medication to the school.
* The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: None expected Specify: _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____

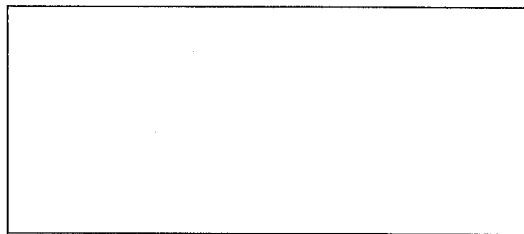
(Type or print)

Telephone: _____ FAX: _____

Address: _____

Prescriber's Signature: _____ Date: _____

(Original signature or signature stamp ONLY)



(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): _____ for the above medication on (Date): _____

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of emergency medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: _____

Signature Date

School RN approval for self carry/self administration of emergency medication: _____

Signature Date

Order reviewed by the school RN: _____

Signature Date

MEDICATION ADMINISTRATION RECORD FOR:
 (To Be Completed For Each Medication and Dosage Change)

Student Name _____ School Year _____

Date of Birth: _____ Gender: _____ Grade: _____ Teacher: _____ School: _____

Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

Medication: _____ Dosage: _____ Start Date: _____ Stop Date: _____

Route: _____ Frequency: _____ Time(s) Given During School: _____

Known Allergies: _____

Month/Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
September																															
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November																															
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January																															
February																															
March																															
April																															
May																															
June																															
July																															

Comments: _____

Initial: _____ Name: _____ Initial: _____ Name: _____

CODES FOR DAILY MEDICATIONS			
A	Absent	O	Out of Medication
D	Early Dismissal	R	Refused
F	Field Trip	W	Withheld Dosage
H	Holiday	X	No School

Section 13

Delegating Nurses and Medication Technicians

Delegating Nurses and Medication Technicians

Schools should follow the guidelines of the Maryland State Department of Education (MSDE) as they apply to private and parochial schools. School Nurses must be in compliance with the Maryland Board of Nursing (MBON) regulations, as well as MSDE guidelines. To be in compliance with MBON regulations, a school must have at least one nurse on staff that has completed the Delegating Nurse certification class, regardless of whether or not the nurse is actually delegating responsibilities to a certified medication technician. In addition, schools should have at least one staff member who is a certified medication technician.

The School's Administration and Delegating Nurse should jointly select candidates for medication technician training.

The MBON's case manager/delegating nurse training requirements for RNs in schools (which currently are set forth in COMAR 10.27.11) are as follows:

Maryland Board of Nursing Training Requirements for Registered Nurses in Schools:

Registered nurses (RNs) in Assisted Living, Developmental Disabilities Administration, Juvenile Services, and School Health (public and nonpublic) settings must complete a Case Manager/Delegating Nurse training program. The curriculum covers topics including, but not limited to: delegation requirements, principles of adult education, communication, and how to teach the updated medication technician training program. RNs who want to teach the medication technician training program must complete this curriculum. The Maryland Board of Nursing required parochial and private school RNs to complete the delegation course before the first day of school in August/September 2006.



DELEGATION OF NURSING FUNCTIONS TO UNLICENSED DIRECT CARE PROVIDERS IN A SCHOOL SETTING

MARYLAND STATE SCHOOL HEALTH SERVICES GUIDELINE

JANUARY 2006

Maryland State Department of Education
and
Student Services and Alternative Programs
Branch
200 West Baltimore Street
Baltimore, Maryland 21201
Phone: 410-767-0311
TTY/TDD: 410-333-6442

Maryland Department of Health
Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201
Phone: 1-877-463-3464
TTY/TDD: 1-800-735-2258



MARYLAND SCHOOL HEALTH SERVICES GUIDELINE

Foreword

There is a strong relationship between academic achievement and a child's physical, emotional and mental health. This link is the foundation for providing school health services as an important component of a school program. School health services provide primary prevention aimed at keeping students in schools through appropriate screenings, early identification of children at risk for physical, emotional and mental health concerns, and case management of students with chronic health concerns.

The Annotated Code of Maryland, Education Article, § 7-401 requires the Maryland State Department of Education (MSDE) and the Maryland Department of Health and Mental Hygiene (DHMH) to jointly develop public standards and guidelines for school health programs. The following guideline is developed in accordance with that requirement and is based on the expressed needs of the local school health services programs. These guidelines contain recommendations for minimum standards of care and current best practices for the health service topics addressed. It is intended that these guidelines will be used by the local school systems in developing local school health services policies and procedures as a means to assist local school health services programs in providing consistent and safe care to the students of Maryland. Specific laws and regulations that direct school nursing practice or other health services are identified in the guidelines.

This guideline, *Delegation of Nursing Functions to Unlicensed Direct Care Providers in a School Setting*, has been reviewed and approved by Maryland Board of Nursing.

The Maryland State School Health Council serves as an advisory council to both departments and as such, the council's School Health Services Subcommittee serves as the committee that develops and reviews these guidelines along with the specialists from MSDE and DHMH. School Health Services Program supervisors/coordinators also review and participate in the guideline development process. To those dedicated school health services professionals and administrators, our thanks.

DELEGATION OF NURSING FUNCTIONS TO UNLICENSED DIRECT CARE PROVIDERS IN A SCHOOL SETTING

Introduction

The school nurse (registered nurse currently licensed by the Maryland Board of Nursing) is the coordinator/facilitator of health care for all children in the school setting. The determination of nursing services required in school is made on a case-by-case basis with information obtained by the registered nurse, parents, physicians, and the school team. The registered nurse may delegate certain nursing tasks to unlicensed individuals. The Maryland State Board of Nursing delineates safe delegation of nursing tasks to unlicensed persons in the Nurse Practice Act (COMAR 10.27.11.01--06 and COMAR 10.27.09.03I). The Nurse Practice Act provides the legal parameters for nurses to follow when delegating tasks to unlicensed individuals. It charges the delegating registered nurse with the responsibilities of choosing, training, and supervising unlicensed persons to whom they delegate nursing tasks. "Nursing judgment shall be exercised within the context of the employing facility's model of nursing practice"(COMAR 10.27.11.03E).

The Individuals with Disabilities Education Act (IDEA) (20 U.S.C. §§1400 et seq, and 34 C.F.R. pt. 300) requires that eligible students with disabilities receive special education and related services that provide a free appropriate public education. "Related services" are determined by the Individualized Education Program (IEP) team to be necessary for the student to benefit from special education. "Medical services" are defined as services provided by a licensed physician to determine a child's medically related disability that results in the child's need for special education and related services.

In Cedar Rapids Community School District v. Garret F. 526 U.S. 66 (1999), the Supreme Court held that the continuous nursing services required by the quadriplegic, ventilator-dependent student in that case were "related services" that had to be provided by the school district during school hours under IDEA because the services were supportive services but did not constitute "medical services." Thus, related services must be provided to disabled students regardless of their nature or cost provided that they are (1) supportive services (i.e., necessary for the student to remain in school); and (2) non-medical (i.e., capable of being performed by someone other than a licensed physician) or are diagnostic and evaluative in nature.

Purpose

The purpose of this guideline is to provide protocol for delegation of nursing procedures, which assures safe practice for students, nurses, certified nursing assistants, and other unlicensed school staff.

School Nurse Responsibilities

- The school nurse is responsible for being familiar with the most recent requirements for delegation set forth in the Nurse Practice Act and adopted on May 10, 2004.
- In compliance with the Nurse Practice Act, the registered nurse shall determine the nursing tasks which will be delegated to the unlicensed person.
- In determining whether aspects of a student's health care may be delegated to an unlicensed person, the nurse must assess and document that:
 - The student's health care needs are **chronic, stable, uncomplicated, routine, and predictable;**
 - The student is unable to perform his/her own care;
 - The environment is conducive to delegation of nursing tasks; and
 - The unlicensed person is able to perform the delegated nursing in a safe and competent manner.
- The school nurse shall have input and agree with the selection of the unlicensed direct care provider to whom he/she will delegate nursing tasks.
- The school nurse is responsible for verifying the competency, orienting, instructing, supervising and evaluating the unlicensed person in the performance of delegated tasks.
- Any nursing function that requires nursing knowledge, judgment, and skill may not be delegated. These include, but are not limited to:
 - The initial nursing assessment or intervention;
 - Development of a nursing diagnosis;
 - Establishment of the nursing care goal;
 - Development of a nursing care plan; and
 - Evaluation of a student's progress or lack of progress toward goal achievement.
- Delegation depends on the complexity of the task and condition of the student. Therefore, continuation of delegation is entirely at the discretion of the delegating nurse, who may decide at any time that the student's medical safety requires a licensed professional to perform the task.

Delegatable Nursing Services

These are services, which may be delegated to and performed by an unlicensed direct care provider under the supervision of a registered nurse (RN). It is important to note that this list is not all inclusive and a specific task is only delegated for a **specific student**; therefore, a procedure that is delegatable for one student **may not necessarily** be delegatable for any other student. *It is imperative that the school nurse be knowledgeable of the current delegation regulations in the Nurse Practice Act.*

- Oral medication administration which does not require calculation of the dose
- Pharmacy or prescriber prepared hand held inhalant medication administration.
- Routine/non-complex/predictable gastrostomy-device feedings
- Clean, intermittent/non-complex bladder catheterization
- Monitoring of vital signs for reporting to the physician or RN
- Positioning
- Student specific emergency medications

- Oro-pharyngeal suctioning
- Assembly of supplies and supervision of student finger stick for blood sugar
- Tracheostomy suctioning for a student with a tracheostomy of long standing duration whose clinical status is stable and who does not have co-existing respiratory conditions or other conditions that have potential to cause unpredictable responses (Maryland Board of Nursing, Dec 2003-2)
- Medication by metered dose inhalant, nebulizer, and oxygen by nasal cannula or mask
- Medication by subcutaneous injection if the nurse has calculated the dose

Non-Delegatable Nursing Services as determined by the Nurse Practice Act

According to the Nurse Practice Act only an RN or Licensed Practical Nurse (LPN) may perform the following nursing functions:

- Complex tracheostomy suctioning (Maryland Board of Nursing, Dec 2003-2)
- Tracheostomy tube or inner cannula change or replacement
- Oxygen administration with titration
- Complex gastrostomy device feedings/replacements/venting
- Any medication that requires calculation of the dose or assessment before or after administration
- Certain medications given by injection
- Administration of medication by nebulization, unless medication is pre-packaged by pharmacy/prescriber and the decision to administer does not require a nursing assessment prior to or after administration
- Medication given in a gastrostomy device, which requires assessment or calculation of the dose
- Nasogastric tube feedings/placement
- Complex bladder catheterization
- Bladder irrigation (with assessment)
- Reinsertion of gastrostomy device
- Any other service needing nursing assessment and/or performed on an as needed basis.

Documentation

Accurate and complete recording of the delegated procedure is the responsibility of the unlicensed direct care provider, under the leadership and supervision of the registered nurse.

Supervision

COMAR 10.27.11.04B states the school nurse will be “readily available” (see COMAR 10.27.11.02B(14b) for definition) when delegating a nursing task to an unlicensed individual or certified nursing assistant.

GLOSSARY

Delegatable Nursing Services: Nursing functions, which may be delegated to and performed by an unlicensed direct care provider under the supervision of a registered nurse.

Delegation: “means the act of authorizing an unlicensed individual or certified nursing assistant (CNA) to perform acts of registered nursing or licensed practical nursing.” COMAR 10.27.11.02B(6)

Non-Delegatable Nursing Services: Nursing functions that require nursing knowledge, judgment, and skill and may not be delegated.

School Nurse: A registered nurse currently licensed by the Maryland Board of Nursing.

Unlicensed Individual: “means an individual who is not licensed or certified to provide nursing care under Health Occupations Article, Title 8, Annotated Code of Maryland.” COMAR 10.27.11.02B(21)

Section 14

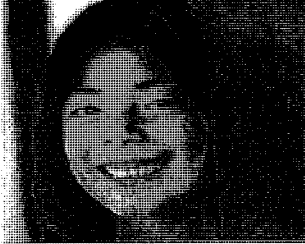
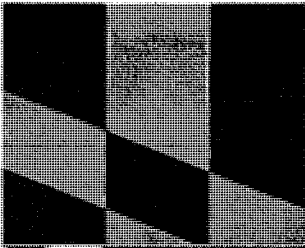
Management of Students with Asthma

Management of Students with Asthma

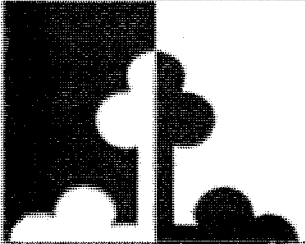
Contained in this section a copy of the document Management of Students with Asthma (February 2013).

It contains additional resources and definitions, as well as information pertaining to the laws governing asthma management in the school setting.

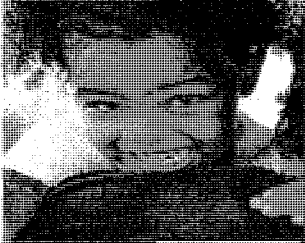
At the end of this section there are documents to assist in the administration of those students that are self-carry and self-administer.



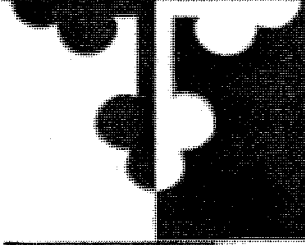
MANAGEMENT OF STUDENTS WITH ASTHMA



MARYLAND STATE SCHOOL HEALTH SERVICES GUIDELINE

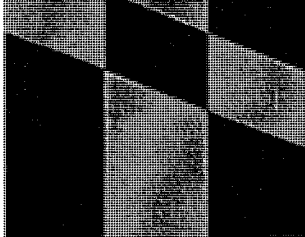


FEBRUARY 2013



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Maryland School Health Services Guideline-Management of Students with Asthma

Foreword

There is a strong relationship between academic achievement and a child's physical, emotional, and mental health. This link is the foundation for providing school health services as an important component of a school program. School health services provide primary prevention aimed at keeping students in schools through appropriate screenings: early identification of children at risk for physical, emotional, and mental health concerns; and case management of students with chronic health concerns.

The Annotated Code of Maryland, Education Article, §7-401 requires the Maryland State Department of Education (MSDE) and the Maryland Department of Health and Mental Hygiene (DHMH) to jointly develop public standards and guidelines for school health programs. The guidelines developed under §7-401 contain recommendations for minimum standards of care and current best practices for the health service topics addressed. The following guideline was developed in accordance with that requirement and is based on the expressed needs of the local school health services programs. It is intended that these guidelines will be used by the local school systems in developing local school health services policies and procedures as a means to assist local school health services programs in providing consistent and safe care to the students of Maryland. Specific laws and regulations that direct school nursing practice or other health services are identified in the guidelines.

To implement these guidelines, local school systems and local health departments should consult with the Maryland State Department of Education and the Department of Health and Mental Hygiene who will:

- Assist and provide technical assistance to local school health programs to support their efforts to plan for students with special health needs;
- Provide training to all appropriate school staff regarding issues related to students with special health needs including, but not limited to, planning, maintaining a safe environment, and medication administration issues; and
- Monitor the implementation of school health services programs including, but not limited to, programs and policies related to students and staff with special health needs.

Maryland School Health Services Guideline-Management of Students with Asthma

Introduction

In 2004, the 108th Congress passed legislation (H.R. 2023) that amended Section 399L of the Public Health Service Act (42 U.S.C. 280g) to allow the Secretary of the Department of Health and Human Services to give preference in asthma-related grants to states that require public elementary and secondary schools to allow students to self administer medication to treat asthma or anaphylaxis if certain stipulations are met. In 2005, the Maryland General Assembly passed legislation (House Bill 143-- *Public Schools - Use of Asthma Drugs and Related Medication*) creating a new statute, §7-421 of the Education Article, Annotated Code of Maryland. This statute requires public school systems to adopt policies authorizing students to possess and self-administer an asthma inhaler or other emergency medication for treatment of asthma or other airway constricting diseases. In 2007, the Maryland General Assembly passed HB 957--*Public Schools –Student Emergency Medical Care – Guidelines* creating another new statute, §7-426 of the Education Article, Annotated Code of Maryland. Under §7-426, the State Department of Education and the Department of Health and Mental Hygiene are required to establish guidelines for providing emergency medical care to students with special health needs, and to delineate the roles and responsibilities for planning and providing services to students with special health needs. Asthma is a common condition that is included in this requirement and the most common chronic condition managed in schools.

Planning is an essential part of the care for students with asthma. Communication, collaboration, coordination, and cooperation between the school, family, student and community health care provider is needed in order for the school nurse to effectively plan for the care of students while they are in school. Development of local school system policy is also an important part of the process of planning and implementing procedures to address student safety. Communication of guidelines, policies and procedures used for planning and implementing individualized health plans is important for fostering collaboration and cooperation with parents/guardians and health care providers.

Students with asthma require a thorough nursing assessment of their health needs to enable them to attend school regularly and to participate fully in the educational program. The school nurse must develop specific plans that consider student specific needs and any reasonable accommodations that may be required in school. These comprehensive guidelines will assist the school nurse in developing an individualized health plan, in conjunction with the family and the primary care provider, for students with asthma.

The management of students with asthma requires five key activities:

- 1) Asthma awareness;
- 2) Planning;
- 3) Allergen/asthma trigger avoidance measures;
- 4) Treatment strategies; and
- 5) Training.

School health services staff, other school staff, parents/guardians, and students all have responsibilities within each of these key areas. Managing asthma in school is a team effort

Maryland School Health Services Guideline-Management of Students with Asthma

among the health care provider, family, student, and school. When students with asthma enter school, the school nurse is the lead team member in assessing their health needs, performing a nursing appraisal and/or assessment, and developing an individualized health plan, if needed, that meets their health needs while they are in school. The school nurse is also responsible for making the appropriate school personnel aware of the special health needs of students with asthma. Additionally, the school nurse may provide health education to students with asthma, and guidance to school staff and school administrators regarding the student's need for accommodations (e.g., transportation, intermittent home teaching, and participation in educational activities). The guidelines that follow address the needs of students with asthma.

Purpose

1. To provide guidelines to school health staff for planning and addressing the needs of students with asthma;
2. To provide guidelines for the management and coordination of care of students with asthma;
3. To provide guidance on asthma trigger exposure reduction through education, training, and environmental assessments and controls; and
4. To define the roles and responsibilities of school health services staff, school administrators, school food service staff, and other school staff, parents/guardians and students in the planning and management of students with asthma.

Definition

Asthma is a controllable chronic lung disease characterized by inflammation of the airways, reversible airway constriction, and excess mucus secretion. Narrowing of the airway results in reduced airflow that may cause symptoms of wheezing, coughing, tightness of the chest, and difficulty breathing. Asthma triggers that may lead to an exacerbation or acute asthma symptoms include allergens, irritants, infections, exercise, strong expressions of feelings/emotions (laughing or crying), stress, and changes in weather or temperature.

Asthma treatment is determined by measures of asthma severity and asthma control as assessed by a health care provider. Each student with asthma should have orders specific to the daily management of asthma (if needed) and management of an asthma exacerbation. Signs and symptoms of an asthma exacerbation are included in Table 1.

Maryland School Health Services Guideline-Management of Students with Asthma

Table 1: SIGNS and SYMPTOMS OF AN ASTHMA EXACERBATION

Organ System	Sign(s)/Symptom(s)
<i>Mouth/Throat</i>	Hacking cough; tightening of throat; hoarseness; blue/gray color of lips; inability to speak or have a conversation
<i>Nose/Eyes/ears</i>	Nasal flaring; hay fever-like symptoms (when exacerbation is triggered by an allergen in an allergic person): runny, itchy nose; redness and/or swelling of eyes; throbbing in ears
<i>Skin</i>	Blue/gray discoloration
<i>GI</i>	Vomiting
<i>Lung</i>	Shortness of breath; wheezing; short, frequent, shallow cough; difficulty breathing; rapid breathing
<i>Heart</i>	Rapid pulse; palpitations; fainting; dizziness; pale, blue, or gray color of lips or nail beds
<i>Mental</i>	Uneasiness; agitation; unconsciousness
<i>Other</i>	Any other symptom specific to an individual's response to an asthma exacerbation

NOTE: Not all signs and symptoms need be present in an asthma exacerbation.

Emergency Management of an Asthma Exacerbation

1. Rapidly assess airway, breathing, and circulation (ABC's) and begin cardiopulmonary resuscitation (CPR) as necessary;
2. Follow emergency plan completed by the student's health care provider. This may include checking peak flow and administration of a metered dose inhaler (MDI), with or without a spacer, or medication by nebulizer. If the health care provider has not provided a plan or medication orders, or if the parent has not provided medication to be used in an emergency, respond to the emergency according to local policy (e.g. standard protocol.)
3. Directions for use of a metered dose inhaler: (Note-These instructions are for use of MDI's typically used for emergency use during an exacerbation and do not necessarily reflect directions for all types and formulations of MDI's in general manufacturer's guidelines for instructions).
 - a. **SHAKE THE INHALER WELL** immediately before each use. Then remove the cap from the mouthpiece. Make sure the canister is fully inserted into the actuator.
 - b. If the inhaler has not been used for more than 2 weeks or is a new canister, prime the inhaler by releasing four "test sprays" into the air, away from your face. **Note: some autohalers (breath activated) should be primed if used for 48 hours or more.** Shake the inhaler between each test spray.

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- c. **BREATHE OUT FULLY THROUGH THE MOUTH**, expelling as much air as possible. Place the mouthpiece into the spacer, if needed. Place the mouthpiece (or the mouthpiece of the spacer) fully into the mouth holding the inhaler in its upright position and closing the lips around it.
 - d. **WHILE BREATHING IN DEEPLY AND SLOWLY THROUGH THE MOUTH, FULLY PRESS THE TOP OF THE METAL CANISTER** with your index finger. Actuate the canister as close to the onset of inhalation as possible
 - e. **HOLD BREATH AS LONG AS POSSIBLE**, up to 10 seconds. Before breathing out, remove the inhaler from your mouth and release your finger from the canister.
 - f. If specified by the student's health care provider, additional puffs may be needed. Wait 1-3 minutes according to manufacturer's instructions, shake the inhaler again, and **repeat steps c through e**.
 - g. **If symptoms do not improve, an additional dose may be administered 15-20 minutes after the first dose in accordance with health care provider orders.**
4. **Call 911** if student shows signs of respiratory distress or if symptoms worsen. Call the student's parent/guardian if response to initial medication administration, or after second dose if ordered. Get vital signs if possible.
 5. Assist student into a comfortable position. Lay the student on their back as long as breathing is not uncomfortable or difficult in that position. **NOTE: *Children who are in respiratory distress may need to sit upright in order to maximize chest expansion.*** Light-headedness or loss of consciousness indicate low blood pressure which necessitate lying the student flat and elevating the legs.
 6. Loosen restrictive clothing. Give nothing by mouth. Reassure and assist to keep student calm;
 7. Stay with the student until 911 personnel arrive and accept care responsibilities; continue to assess ABC's;
 8. Notify parent/guardian or student's emergency contact;
 9. Follow local school system emergency policy regarding 911 calls;
 10. Complete documentation of the incident, including the time of MDI/nebulizer administration, the suspected precipitating cause, and 911 and parent notifications according to any local documentation guidelines;
 11. Send documentation of the event, including vital signs, interventions and student's identifying information to the hospital with EMS personnel according to local policy; and

Maryland School Health Services Guideline-Management of Students with Asthma

12. Maintain a copy of the above documentation for the health record according to local policy.

Health Appraisal and Nursing Assessment

Health Appraisal

The Code of Maryland Regulations (COMAR) 13A.05.05.07(C) (1)-(2) sets forth the process to be used by a designated school health professional to determine if a student has health problems that interfere with learning. COMAR 13A.05.05.06 defines the designated school health professional as “a health care provider, certified nurse practitioner, or registered nurse, or all of these, with experience or special training, or both, in working with children and families in community or school health programs and practices in accordance with the current medical and nursing standards of care.” In most Maryland public school health services programs, the designated health care professional is a nurse practitioner or a registered nurse. The health appraisal conducted by the nurse uses information obtained from, but not limited to:

- Health room visits and observations;
- Student interview;
- Parent/guardian report:
 - Emergency department visits;
 - Hospitalizations;
 - Medications;
 - Status of asthma (stable or change in control);
- Health care provider:
 - Medication orders;
 - Asthma status (severity and control);
 - Asthma action plan (AAP);
- School emergency information card;
- Physical exam form; and
- Information from previous school nurse.

After review of the data collected, based on nursing judgment regarding the level of asthma control and severity (e.g. poorly controlled vs. well controlled), a nursing assessment and an individualized health care plan may be needed. If a nursing assessment is not needed, use a individualized emergency plan, standard asthma action plan or standard respiratory distress emergency protocol. (See Appendix A for appraisal algorithm). The health appraisal of students with identified health problems (in this case, asthma) shall be repeated as frequently as deemed necessary by the designated school health services professional according to COMAR 13A.05.05.07(C)(2). The health appraisal is updated annually unless the condition is resolved as documented by the student’s health care provider, and there is no indication that the student is in need of nursing services during the school day (asthma is inactive). The health appraisal documentation can range from narrative notes to local program appraisal forms.

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NOTE-- For students with newly diagnosed asthma and those new to the school where no records from previous schools are available, this documentation should be from the student's health care provider and not only by parent report. For returning students who have previously provided health care provider documentation of a diagnosis of asthma, updated information may be obtained from the student's parent and further information may be obtained from the health care provider if necessary to complete a nursing assessment.

Nursing Assessment

Registered nurse standards of care in COMAR 10.27.09.02 list the components of the nursing process, which organizes delivery of care. The first step in the process is appraisal. Based on the appraisal, nursing judgment should determine whether an assessment is needed. The school nurse should assess the special health needs of students with asthma using local standard assessment procedures and the procedures outlined in the *Maryland State School Health Services Guidelines: Nursing Appraisal/Assessment of Students with Special Health Needs*, and the recommendations in Appendix A. The school nurse should use the information obtained in the health appraisal to develop a written assessment. The assessment includes subjective and objective data. Relevant information that may affect the student's care and safety should be sought from sources including, but not limited to:

- Student interview (as developmentally appropriate);
- Parent/guardian;
- Health care provider;
- Teaching staff; and
- Classroom observations.

Components of the nursing assessment include:

1) Identifying Information/Contact Information

- Name of parent/guardian, address, phone number, and annually updated (or more frequently as needed) list of emergency contacts;
- Student's date of birth (DOB) and grade;
- Primary care provider's name and phone number; and
- Name and phone number of asthma or allergy specialist (if under the care of one).

2) Student Information

- Birth history;
- Health and developmental history;
- Date of the initial asthma diagnosis, and progress of asthma;
- Family history of asthma;
- History of health emergencies/hospitalizations; and
- Other chronic health conditions.

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3) Current Asthma Status

- Current medication and treatment orders for asthma, including:
 - Asthma medications:
 - Quick relief medications, controller medications, or medications prior to exercise;
 - Delivery devices used (e.g. metered dose inhaler or nebulizer, type of spacer if provided);
 - Note side effects experienced;
 - Written copy of health care provider's trigger avoidance recommendations, if provided; and
 - Peak flow meter readings.
- Emergency plan, including emergency medications and the indication for their use;
- Asthma Action Plan from healthcare provider (see resource list for Maryland Asthma Control Program web site, which contains a sample asthma action plan):
 - Routine medications;
 - Trigger avoidance instructions; and
 - Emergency medications.
- Asthma severity level (see Appendix B for definition of asthma severity levels);
- Level of asthma control (see Appendix C and D for definition of asthma control and stepwise approach for management);
- Frequency/pattern of asthma signs and symptoms demonstrated by the student;
- Number of school days missed in the past year;
- Limitation of activities;
- Precipitating factors/asthma triggers (e.g. environment, food, weather, exercise, air quality, allergens, irritants, infection);
- Profile of typical exacerbation (i.e. description of past exacerbations, severity of past reactions); and
- Management and treatment for exacerbations, and typical response to interventions.

4) Current Status of Other Health Conditions

- Current diagnosed medical conditions other than asthma;
- Current medication and treatment orders for other diagnosed medical conditions; and
- Emergency plan for conditions other than asthma (if needed).

5) Self Care Skills

- Peak Flow Monitoring:
 - Purpose of testing;
 - Level of independence;

Maryland School Health Services Guideline-Management of Students with Asthma

- Frequency;
 - Required at school;
 - Performed in health suite or classroom;
 - Equipment used; and
 - Personal best peak flow measurement.
-
- Student's understanding of asthma and its management;
 - Student's understanding and demonstration of medication administration technique;
 - Level of independence with medication/treatment, including ability to possess and self-administer medication;
 - Asthma education program completed by student;
 - Interactions with peers and teachers in the past related to asthma and asthma management;
 - Interventions to be implemented in case of an asthma exacerbation.

6) Family Considerations

- Family's understanding of the condition;
- Ability of family and student to manage the student's asthma;
- Cultural considerations; and
- Resources needed.

NOTE: Tools such as an asthma control test (ACT) may be helpful in doing the nursing assessment. See Resources for on-line access to several ACTs.

The asthma assessment should contain educational considerations including determination of and recommendations regarding special accommodations needed due to:

- Student's class schedule;
- School-sponsored activities;
- Physical education/recess;
- Transportation; and
- Other circumstances.

The final nursing assessment should be placed in the student's health record. The record should also contain:

- Documentation of the nurse's recommendation as to whether health care provider recommended self-carrying of medication is appropriate;
- Current health care provider orders; and
- A current emergency care plan if not included in the individualized health care plan. If a standard emergency protocol is used, this should be stated in the student's record.

Individualized Health Care Plans and Emergency Plans/Protocols

Following completion of a nursing assessment, there will be other factors to consider along with the school nurse judgment to determine if an individualized health care plan (IHP) may need to be developed. However, each student with asthma should have an individualized asthma action plan developed by his/her health care provider as recommended by the National Heart, Lung, and Blood Institute Asthma Management Guidelines. The asthma action plan should include protocols for both routine and emergency administrations of medication. These plans may or may not consider the unique needs of students in the school setting and the school nurse may need to develop a plan that considers the school setting, i.e. an IHP.

School Environment Considerations

The school nurse should work with school administrators and other school staff to assess the school environment in order to identify possible asthma trigger exposures, barriers to emergency treatment, and address any identified barriers, with the goal to reduce or eliminate exposure to asthma triggers. Ongoing assessments and evaluation of environmental risks in the school setting should be performed to reduce environmental exposures to allergens. The Maryland State Department of Education School Facilities Branch has guidelines and technical bulletins on the topic of indoor air quality as resources for school system and schools. Asthma trigger reduction for various areas in the school may include the following:

- Classrooms: Work with teachers and school administrators to identify asthma triggers in the classroom such as craft materials with strong smells, classroom teaching materials, cleaning procedures, and policies on outside material brought into the classroom and pets in schools/classrooms.
- Cafeteria: Work with food service supervisors/directors and cafeteria managers to identify food ingredients in each menu items that should be avoided, plan for food substitutions if necessary, review sanitation procedures in cafeteria or other food service areas, food handling and distribution, and hand washing practices that may reduce exposure of students to food allergens or additives which may trigger an asthma exacerbation.

NOTE: Inhaled allergens and irritants are the most common triggers for persons with asthma (e.g. pollen, dust, mold, dander, chemicals, and fumes).

While food allergens are not a common precipitant of asthma symptoms, asthma is a risk factor for fatal anaphylactic reactions to food. Therefore, it is important to be aware of food allergy in students with asthma and refer to the school health services guideline entitled *Management of Students at Risk for Anaphylactic Reaction*. In addition, certain processed foods (e.g. potatoes, shrimp, or dried fruit) contain preservatives or other substances that may cause severe asthma exacerbations, particularly in patients who have severe persistent asthma.

Maryland School Health Services Guideline-Management of Students with Asthma

- School-sponsored activities: Work with athletic directors/supervisors, school affiliated parent groups, school administrators, and teachers to identify potential exposure to asthma triggers on field trips, recess, and other school sponsored activities and designate specific school staff to implement emergency plans and procedures.
- School bus: Work with bus drivers, assistants, and attendants to recognize an asthma exacerbation/episode, and to develop and implement bus emergency plans and procedures.

Accommodations

Based on the nursing assessment and health care provider recommendation, accommodations for individual students may be required. Accommodations should be developmentally appropriate and school specific. As the student advances through the school system, his/her needs may change, therefore, accommodations must change accordingly. Accommodations to reduce the risk of trigger exposure may include, but are not limited to:

- Removal/replacement of classroom teaching materials and other classroom items (e.g. air fresheners) that pose an exposure risk;
- Placement of student in an air conditioned building/classroom;
- Limits on outdoor activity when exposure to triggers are likely (e.g. pollen) and/or when air quality is poor (e.g. Ozone action days, pollution levels); and
- Modification of school/classroom policies on food brought in to the school by parents for celebrations or other events.

Some students with asthma may also have food allergies. Their asthma makes them more at risk for food related anaphylactic reactions. These students may require specific meal accommodations. Students who obtain school meals as part of any United States Department of Agriculture (USDA) school meal program (i.e. school breakfast program or school lunch program) are entitled to meal modifications because of their special health need. In order to plan for meal/food accommodations, the following additional information is required for both free and reduced priced meals as well as full price meals. USDA regulations, 7 CFR Part 15b, require substitutions or modifications in school meals for children whose disability restricts their diet. A child with a disability or special health need must be provided food substitutions when a statement signed by a licensed health care provider supports the need. The health care provider statement must identify or provide:

- The child's disability or special health need;
- An explanation of why the disability or health need restricts the child's diet;
- The major life activity affected by the disability or health need;
- The food or foods to be omitted from the child's diet; and
- The food or choice of foods that must be substituted.

If a student with asthma does not have an asthma action plan, and the school nurse cannot obtain one from the health care provider, then the school nurse should develop both an individualized health care plan and emergency plan. **NOTE: The emergency plan may be sufficient to serve**

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as the IHP, if indicated, based on the nursing assessment. Local school health services programs should develop procedures to communicate IHPs and emergency plans to appropriate school staff. The IHP and emergency plan should be developed in conjunction with the student (as appropriate), parent/guardian, and the health care provider(s).

NOTE: Each jurisdiction should develop a process to obtain an asthma action plan from health care providers. While action plans are recommended for each student, those with poorly controlled and/or those with severe asthma should be priority. The IHP developed by the school nurse serves as a plan of care for the school day and unlike an asthma action plan, may not contain all the medication and procedures for asthma management outside of the school setting.

Individualized Health Plan

The IHP provides a written record of a health care provision for a student. The IHP begins with the nursing assessment and lists the nursing diagnoses, student goals, interventions, and outcomes. The objectives of an IHP are to:

- Control asthma symptoms at school to ensure safety in the school environment;
- Control and minimize, to the extent possible, allergen and irritant exposure at school;
- Provide opportunity for optimal school performance;
- Assist the student to grow in self care skills;
- Allow full and normal participation by the student in school and school sponsored activities; and
- Promote the acceptance of the students with asthma.

The school nurse should consider the following information gathered from the assessment when developing individualized health plans for students with asthma:

- Level of asthma severity (see Appendix C for designation of asthma severity);
- Level of asthma control (see Appendix D for elements of asthma control);
- Student's ability to identify need for interventions;
- Specific asthma triggers and student's knowledge of those triggers;
- Medication administration, including self administration (See Appendix D for the stepwise approach to asthma medication management);
- Peak flow monitoring/frequency and personal best/green, yellow and red zones;
- Storage of medication and/or equipment (consider multiple locations);
- Whether the student carries medications/inhalers, spacers, and peak flow meters;
- Emergency care including provisions for a student in distress (i.e. adult escort to the office/health room, contacting the parent/guardian and health care provider, and determination of the appropriate personnel/staff responsible for monitoring the asthma nebulizer treatments);
- Plan to alert and train school staff regarding students with asthma and expected role in trigger avoidance and emergency plan implementation;
- Equipment (e.g. nebulizer use);

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- Emergency equipment (e.g. nebulizer, inhaler, spacer, medications, oxygen);
- Equipment labels and directions to follow in the event of an emergency;
- Identification and reduction or elimination of triggers (e.g. cleaning products, classroom materials, etc.);
- Schedule- PE, lunch, recess, field trips, other school-sponsored activities;
- Method of transportation to and from school;
- If the student wears medical alert identification (e.g. bracelet or necklace);
- Educational needs and accommodations (e.g. alternative arrangements in physical education, sports, and industrial arts classes);
- Knowledge of student's triggers by appropriate school staff, including substitutes, and accompanying staff training;
- Developmental considerations;
- Parental concerns and expectations;
- Student concerns;
- Social interactions;
- Staff training; and
- Coordination with other team members including health care provider, and other school services providers.

Emergency Care Plan (EP)

All students with asthma should have an emergency care plan. For some students, a standard protocol may be medically appropriate and sufficient to serve as an EP. Others will require an individualized emergency plan to be developed by the school nurse. This should be determined based on health care provider orders and the nursing assessment. The emergency care plan should communicate how and where emergency asthma medications should be securely placed and immediately accessible to all designated school personnel, and the emergency protocol to be followed in the event of an asthma exacerbation. The plan should include, but is not limited to:

- Health care provider's orders and nursing interventions;
- The health care provider's emergency orders/ specific emergency interventions needed;
- School system procedures and protocols;
- Emergency contact information that is updated as changes occur or documentation of where this information can be easily accessed;
- What should be done if a nurse is not available;

NOTE: The Maryland Nurse Practice Act (Annotated Code of Maryland, Health Occupations Article, Title 8 and COMAR 10.27.11) allows certain nursing functions to be delegated. The decision as to whether the student's health care needs may be delegated is based on the delegation criteria outlined in the Maryland Nurse Practice Act and the professional judgment of the school nurse. Persons who routinely perform delegated nursing tasks must be certified as a nursing assistant and/or medication technician.

- What the parent should provide (e.g. medications, medication order forms, medical alert bracelet/necklace);

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**Each jurisdiction should have written procedures that address what to do in the event that the student's parent has not provided orders for an inhaler and/or a rescue inhaler.*

- Signs and symptoms for which emergency care may be needed. This may vary from student to student;
- When to call 911; and
- How will asthma medications be stored to allow immediate availability to students and staff for students who are not able to possess and/or self-administer.

A copy of the emergency care plan should be shared in writing with the appropriate school staff (including bus drivers) and original placed in the student's health record. The school nurse should send a copy of the final plans to the parent/guardian and the health care provider for their records. School staff that has direct contact with the student should have immediate access to the emergency care plan at all times in a manner determined by the school nurse and the school staff. Health information should be shared in compliance with the Family Educational Rights and Privacy Act (20 U.S.C. § 1232g; 34 CFR Part 99) to protect the privacy of the student.

Communication

The school nurse should share the emergency plan with the parent/guardian and appropriate school management team/staff (including bus drivers), and place a copy in the student's health record. School staff who have direct contact with the student should have immediate access to the emergency care plan at all times in a manner determined by the school nurse and the school staff in order to allow immediate access while also protecting the student's confidentiality.

The school nurse should communicate to the school food service manager on site the necessary cafeteria accommodations needed by students with asthma and food allergies that place them at risk for anaphylaxis. The school nurse should determine needs in collaboration with the parent/guardian and health care provider.

It is important that parents and health care providers are aware of the school health services guidelines used to guide the development and implementation of care plans. Local school health programs should develop policies and procedures for making the guidelines available to parents and health care providers and on how to communicate the content of individualized health care plans to parents.

Self-Carry/Self-Administration of Medications

Students with asthma who are developmentally capable and have received appropriate and adequate instruction should be encouraged to possess and self-administer their asthma rescue inhalers. This requires the health care provider to complete a medication order form for the school and indicate that the student may possess and self-administer the medication. As stated in §7-421 of the Education Article, Annotated Code of Maryland, "The school nurse shall assess the student's ability to demonstrate the skill level necessary to ensure proper and effective use of

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the medication in school,” and “a student may be subject to disciplinary action if the student does not use the medication in a safe and proper manner.” The student’s ability to demonstrate proper and effective use of the inhaler includes the student’s safe use of the medication.

The school nurse should assess each student’s:

- Ability to communicate to school staff when a trigger exposure has occurred;
- Ability to use correct technique to self-administer a metered dose inhaler;
- Ability to recognize when to use the metered dose inhaler; and
- Ability to perform this task in a safe and responsible manner.

The school nurse should review annually with the student the correct procedures for storing and administering the asthma inhaler and discuss with their parent/guardian the need for a back up inhaler to be stored in the health room. The school nurse should inform the parent/guardian and the student’s health care provider if the student is not able to self-carry. The school nurse should assist the student to develop the necessary skills to become capable of self-management and self-carrying. Follow-up assessment by the school nurse should be done periodically for students who self-carry and those who do not.

For each student who self-carries and self-administers his or her asthma rescue inhaler, the school nurse should develop in conjunction with the student, a plan for communicating each instance of the rescue inhaler self-administration. The school nurse should develop a process for monitoring and tracking self-administration of asthma rescue inhalers for each student.

Case Management and Care Coordination

Some students with a diagnosis of asthma may need a designated school case manager to coordinate his/her care. The school nurse is often the case manager for students with asthma, however, another student services staff member, Individualized Education Program (IEP) member, or Section 504 Plan team member may be designated as the educational case manager. The school nurse serves as the liaison between the health care team, school staff, administration, pupil services staff, parents/guardians, food service managers, and the student regardless of who is the designated case manager. The school nurse can also refer the student and/or family for counseling, support groups, and access to medical care.

Effective case management requires coordination between all persons involved in the care of the student. Each person or team member has a specific set of responsibilities for the care of the student:

Parent Responsibilities

Parents are an integral part of the process of planning, care, and coordination of care for all students with asthma. It is important that school nurses and parents work collaboratively to provide for the health and safety of students with asthma. School nurses should involve the student’s parent/guardian to the fullest extent possible. In addition, Annotated Code of Maryland, Education Article Section 7-426 requires guidelines for providing emergency medical care to

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students with special health needs to describe certain parent/guardian responsibilities. The parent/guardian responsibilities include the following:

- Provide the school with emergency contact information that is accurate and updated as needed;
- Provide the school with complete and accurate medical information related to the student's asthma. This information includes but is not limited to:
 - Up-to-date and accurate history of asthma exacerbations and hospitalizations;
 - A written list of asthma triggers and respiratory or other allergens (e.g. foods, pollen); and
 - Written health care provider documentation of the student's asthma and allergies.
- Work with the school nurse to develop the plan of care for the student with asthma to the best of their ability;
- Annually supply and maintain at least one non-expired health care provider ordered medications (e.g. metered dose inhaler or nebulizer medications) , along with the appropriately completed written medication order in accordance with Education Article section 7-426 (b) (2) (ii);
- Work with the school nurse and health care provider to obtain additional metered dose inhalers based on need (e.g. work with health care/pharmacy insurer, identify and work to overcome barriers to obtaining medications);
- For students who self-carry, monitor the proper storage (i.e. away from light and high temperatures) and routinely check the expiration dates of metered dose inhalers;
- Provide the recommended and preferred medical identification bracelet/necklace indicating asthma and/or allergic conditions in accordance with Education Article Section 7-426 (b) (2) (ii); and
- Grant necessary permissions/consent to the school nurse to gather all needed information as part of the nursing assessment.

NOTE: Each jurisdiction should have a procedure or protocol that addresses what to do in the event that the parent has not provided a rescue inhaler.

Student Responsibilities

Coordinating and managing the care of students with asthma requires the school nurse to communicate to the student their role in the planning process. Student participation in planning

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must be developmentally appropriate. Student responsibilities must also be developmentally appropriate and may include, but are not limited to:

- Avoiding known allergens and asthma triggers;
- Informing school staff immediately in the event of symptoms after an exposure;
- Informing the school nurse or designated school health services personnel when the rescue inhaler is used according to the plan developed with the school nurse;
- Acting responsibly when possessing and self-administering medications, specifically, students must not misuse medication; and
- Participating in care planning.

School Responsibilities

Education Article Section 7-426, Annotated Code of Maryland, specifies certain school responsibilities for the care of students with asthma. School principals, or their designated administrator, should work closely with school nurses in planning for these students. The school principal/designated administrator, and school nurse should collaborate in gathering, maintaining, and reviewing school-wide information required to meet the needs of these students. School nurses should provide aggregate data to the school principal/designated administrator regarding the number of students with asthma and their needed accommodations.

The school principal or their designated administrator must be aware of students with asthma, and work with the school nurse to support the effective implementation of health care plans for these students. Implementation of the health care plans includes supporting reasonable accommodations that are based on the school nurse's assessment, healthcare provider orders, and the unique needs of each individual student.

The school principal/designated school administrator supports the school nurse's training, education and awareness activities, which includes, but are not limited to:

- Providing training for appropriate staff on the use of asthma inhalers;
- Planning for implementation of emergency plans on field trips and other school sponsored events;
- Providing outreach and education for parents, other caregivers, and the general school community;
- Providing school wide education and outreach conducted by the school nurse;
- Providing training of school volunteers as needed;
- Working collaboratively with the school nurse to make asthma inhalers as accessible as possible to avoid treatment delay; and
- Supporting the school nurse concerning the adherence of the parent/guardian responsibilities.

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School Staff Responsibilities

Other school team members may contribute to the management of students with asthma in ways that include but are not limited to:

Bus Drivers/other transportation staff	Respond to an emergency as instructed and trained; communicate problems or concerns with the transportation office, school nurse and school principal, or their designated administrator
Coaches/ advisors for School sponsored activities	Respond to an emergency during athletic or other activities as instructed and trained; communicate problems or concerns to the school nurse and school principal, or their designated administrator
Food Services Staff:	Make meal substitutions or modifications in school meals according to USDA requirements, assist with dietary accommodations as necessary; share food ingredient lists with school nurse
School Counselor	Assist with disability awareness, support groups/counseling
Pupil Personnel Worker/School Social Worker	Assist with transportation issues, home teaching and attendance issues
School Psychologist	Assist with any needed behavioral strategies
Teachers/paraeducator/personal assistants	Respond to an emergency as instructed and trained, communicate problems or concerns with school nurse and school principal, or their designated administrator

Outreach, Education and Asthma Awareness

School-wide asthma awareness and asthma trigger avoidance education is recommended in addition to specific staff training as stated below. School nurses should provide the parent/guardian of students with asthma information regarding resources (see resource list at the end of this guideline for a list of parent/guardian resources).

The school nurse should provide or arrange for all appropriate school staff to receive training on asthma. The school nurse should apprise all appropriate school staff who have responsibility for the student during the school day of the student's asthma and the specific interventions as needed. The school nurse may share student-specific information when necessary to protect the health of the student with asthma. Training may include, but is not limited to:

- Definition of asthma;

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- Classroom accommodations;
- Cafeteria accommodations;
- Transportation accommodations;
- Accommodations for school-sponsored activities;
- Asthma trigger avoidance and allergen exposure risk reduction;
- Symptoms to report to the school nurse (i.e. signs and symptoms of asthma exacerbation);
- Confidentiality protections;
- Review of the contents of and implementation of the individual emergency plan/protocol;
- Maintenance of emergency plans/protocols with information provided to staffing substitutes, e.g., classroom, school health, transportation, and food services staff;
- Inclusion of emergency plans in substitute plan for classroom, school health, transportation, and food services staff;
- Medication information related to storage, access, locations, and administration technique; and
- Education for school visitors or volunteers with student contact, as needed per local policy.

The school nurse should document the provision and the receipt of training for each staff member who attended.

Education Planning

A nursing assessment is a recommended part of the process for determining reasonable accommodations for students with asthma (e.g. change in school placement, concurrent or intermittent home teaching, or adaptations to physical education class). For more specific information regarding education planning, please refer to Maryland School Health Services Guideline: *Role of the School Nurse in Implementing 504 and Individualized Education Programs*.

School-Sponsored Activities

If a school-sponsored activity is planned, the assigned personnel should give sufficient notice to the school nurse so that preparation can be made and a plan can be developed for ensuring the safety of students with asthma. Prior to the school-sponsored activity, the school nurse should ensure the teacher/staff member in charge has copies of the emergency care plan for the student.

The school nurse should determine whether asthma medication needs to be administered during a school-sponsored activity/trip, when to administer the medication, and who should administer the medication in accordance with the student's individualized care plan. A designated person should administer asthma medication to students during school-sponsored trips/activities when necessary or as ordered. The school nurse may adjust the timing of scheduled medication doses if medically appropriate to accommodate the student's needs during the scheduled activity. Asthma medications must be administered in compliance with the State guidelines outlined in *Medication Administration in Schools*.

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The school nurse should work in collaboration with the school principal, or their designated administrator, and the student's parent/guardian and health care provider to develop the plan for medication administration during field trips/school sponsored activities.

Monitoring/Evaluation

The school nurse should evaluate and monitor asthma management. The school nurse should assess the student's response to and the effectiveness of the emergency plan and IHP to meet the student's health and educational needs on an ongoing basis and make appropriate adjustments. The school nurse evaluation should include the following:

- Assessment and documentation of student's response to the management plan;
- Effectiveness of the plan;
- Orders reviewed with family and health care provider at least annually and as necessary;
- Documentation of medications and treatments given;
- Documentation of number of health room visits and days missed from school due to asthma;
- Communications with the health care provider, family, and school staff; and
- Need for ongoing staff training.

The nurse's final IHP and EP should be placed in the student's health record and a copy should be shared with the parents/guardian and health care provider.

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GLOSSARY

ABC's: The acronym for "Airway, Breathing, and Circulation" used in the assessment of an ill individual by a health care provider or first responder.

Accommodations: Changes or adjustments in a work or school site, program, or job that makes it possible for an otherwise qualified employee or student with a disability to perform the duties or tasks required, as required under 7 CFR pt. 15B and 29 CFR pt. 1630.

Allergen: A substance that causes an allergic reaction. For persons with asthma due to allergies, an allergen can cause an asthma exacerbation.

Allergen/asthma trigger avoidance: Actions or activities documented in an individualized health care plan that specifically addresses the interventions needed to reduce the risk that an allergic person will come in contact with an allergen that puts them at risk for anaphylaxis or other allergic symptoms.

Asthma Action Plan: An individualized plan initiated by a health care provider, which includes routine and emergency medication and protocols.

Asthma Control: the degree to which the manifestations of asthma (symptoms, functional impairments, and risks of untoward events) are minimized and the goals of therapy are met.

Asthma Severity: the intrinsic intensity of the disease process. Severity is measured most easily and directly in a patient not receiving long-term-control therapy.

Asthma Trigger: A substance that may cause an asthma exacerbation.

Bronchodilator: Medication that relaxes smooth muscles around the bronchioles and allows them to open more completely.

CPR: The acronym for "Cardiopulmonary Resuscitation". CPR is done in response to an airway, breathing, or circulatory emergency in an attempt to maintain oxygenation to the brain and vital organs until normal body functions are restored or rescue personnel arrives.

Delegation: The act of assigning certain nursing tasks (in accordance with the Maryland Nurse Practice Act) to a certified nursing assistant (CNA), a certified medication assistant, or an unlicensed individual by a registered nurse or licensed practical nurse.

Emergency Plan: a document that specifies the actions needed to manage a student's specific, medical condition in the event of a medical emergency. For some students, a standardized asthma emergency protocol may suffice for an emergency care plan.

Health Appraisal: The process by which a designated school health services professional identifies health problems that may interfere with learning. These may include health

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observations, interviews, and conferences with parents/guardians, students, educators,, and other health professionals.

Individualized Health Plan: A type of nursing care plan that is developed by the school nurse utilizing the data from a nursing appraisal/assessment that is specific for a student with a chronic health condition and is designed to meet the student's unique health care needs. The individualized health plan should include an emergency care plan when needed. In some cases it may be appropriate for the individualized health plan to only contain care to be provided in an emergency.

Metered Dose Inhaler: A hand-held device that delivers a specified dosage of medication as a spray or a powder to be inhaled.

Nebulizer: A pressurized by air device that converts a liquid medication into a fine mist that can be inhaled.

Nurse Practice Act: A statute enacted by the legislature of any state or by the appropriate officers of the district. The act delineates the legal scope of the practice of nursing within the geographical boundaries of the jurisdiction. In Maryland, the Nurse Practice Act is codified under the Annotated Code of Maryland, Health Occupations Article, Title 8.

Nursing Assessment: The act of gathering and identifying data that assists the nurse, the client, and the client's family to identify the client's health concerns and needs. (Nurse Practice Act, Annotated Code of Maryland, Health Occupations Article, Title 8, COMAR Title 10, Subtitle 27.)

Peak Flow Meter: A device which measures flow rate of air breathed out during forced expiration.

School Health Services Coordinator: The designated person in each Maryland jurisdiction who is responsible for implementing State and local health policies in the public schools; ensuring that public schools adhere to local health services guidelines; and communicating State and local health policies to the parent/guardian of public school students. (Education Article §7-401, Annotated Code of Maryland).

School Nurse: A registered nurse currently licensed by the Maryland Board of Nursing who works in a school setting.

Self-Administration: The application or consumption of medication by an individual in a manner directed by the health practitioner without additional assistance or direction (Education Article §7-421, Annotated Code of Maryland).

Self-Carry: The possession of a medication on an individual's person to allow quick access to and administration of the medication and to allow self-administration when specified.

Spacer: A plastic device to assist with effective inhalation of the bronchodilator administered

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via metered dose inhaler.

RESOURCES

American Academy of Allergy, Asthma, & Immunology: <http://www.aaaai.org/>

American College of Asthma, Allergy & Immunology: <http://allergy.mcg.edu/home.html>
The American College of Asthma, Allergy & Immunology is an information and news service for patients and parents of patients.

Asthma & Allergy Foundation of America: <http://www.aafa.org>
The Asthma and Allergy Foundation of America is a patient organization dedicated to improving the quality of life for people with asthma and allergies through education, advocacy, and research. This site contains resources and continuing education programs for health care professionals.

American Academy of Allergy, Asthma, & Immunology: <http://www.aaaai.org>
This site contains a health care professional resource center and the Pediatric Asthma Clinical Guidelines.

American Association of Asthma Educators: <http://www.asthmaeducators.org>
The primary purpose of the Association of Asthma Educators is to promote asthma education as an integral component of a comprehensive asthma program, to raise the competence of health care professionals who educate individuals and families affected by asthma, and to raise the standard of care and quality of asthma education delivered to those with asthma. To that end, the Association recognizes that asthma education should reflect the recommendations contained in the national guidelines and meet the needs of the target population. The express purpose of asthma education is to improve health outcomes for individuals and families affected by asthma.

American College of Asthma, Allergy & Immunology: <http://allergy.mcg.edu/home.html>
The American College of Asthma, Allergy & Immunology is an information and news service for patients and families of persons with asthma.

American Lung Association: <http://www.lungusa.org>
The American Lung Association (ALA) is the oldest voluntary health organization in the United States. ALA fights all forms of lung disease with special emphasis on asthma, tobacco control, and environmental health. The site contains asthma education programs for children, advocacy, communications, and multicultural programs as well as data and statistics.

Asthma Control Test: Available at the following websites:
<http://www.asthma.com/resources/asthma-control-test.html>
<http://www.mayoclinic.com/health/asthma-control-test/AS00031>
<http://www.permanente.net/homepage/kaiser/pdf/56688.pdf>

Asthma & Allergy Foundation of America: <http://www.aafa.org>

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The Asthma and Allergy Foundation of America is a patient organization dedicated to improving the quality of life for people with asthma and allergies through education, advocacy, and research. This site contains resources and continuing education programs for health care professionals.

Centers for Disease Control and Prevention:

<http://www.cdc.gov/HealthyYouth/asthma/index.htm>.

Healthy Youth: Asthma in Schools provides information from the National Center for Chronic Disease Prevention and Health Promotion including fact sheets, data and statistics, science-based strategies, and links to other resources.

Children's Hospital National Medical Center (CHNMC) training for School Nurses:

<http://www03.activate.net/vspan/cnma/001211/index.asp> CHNMC provides an online tutorial for on asthma for nurses.

Environment Protection Agency's Indoor Air Quality Tools for Schools Program

http://www.epa.gov/iaq/schools/pdfs/kit/district_wide_factsheet.pdf

Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report 2007, National Asthma Education and Prevention Program

<http://www.nhlbi.nih.gov/guidelines/asthma/>

Maryland Asthma Control Program: <http://fha.maryland.gov/mch/asthma.cfm>.

The Maryland Asthma Control Program seeks to prevent asthma and maximize the health and well-being of children, adolescents, and adults living with asthma.

National Asthma Education and Prevention Program (NAEEP) Asthma Coalition

Exchange: <http://www.nhlbisupport.com/asthma/coalitioncorner/index.htm>

The National Asthma Education and Prevention Program is administered and coordinated by the National Heart, Lung, and Blood Institute and works with intermediaries including major medical associations, voluntary health organizations, and community programs to educate patients, health professionals, and the public. The ultimate goal of the NAEPP is to enhance the quality of life for patients with asthma and decrease asthma-related morbidity and mortality.

National Heart, Lung, & Blood Institute (NHLBI): <http://www.nhlbi.nih.gov/>

A division of the National Institutes of Health. The National Heart, Lung, and Blood Institute provide leadership for a national program in diseases of the heart, blood vessels, lung, blood, and blood disorders.

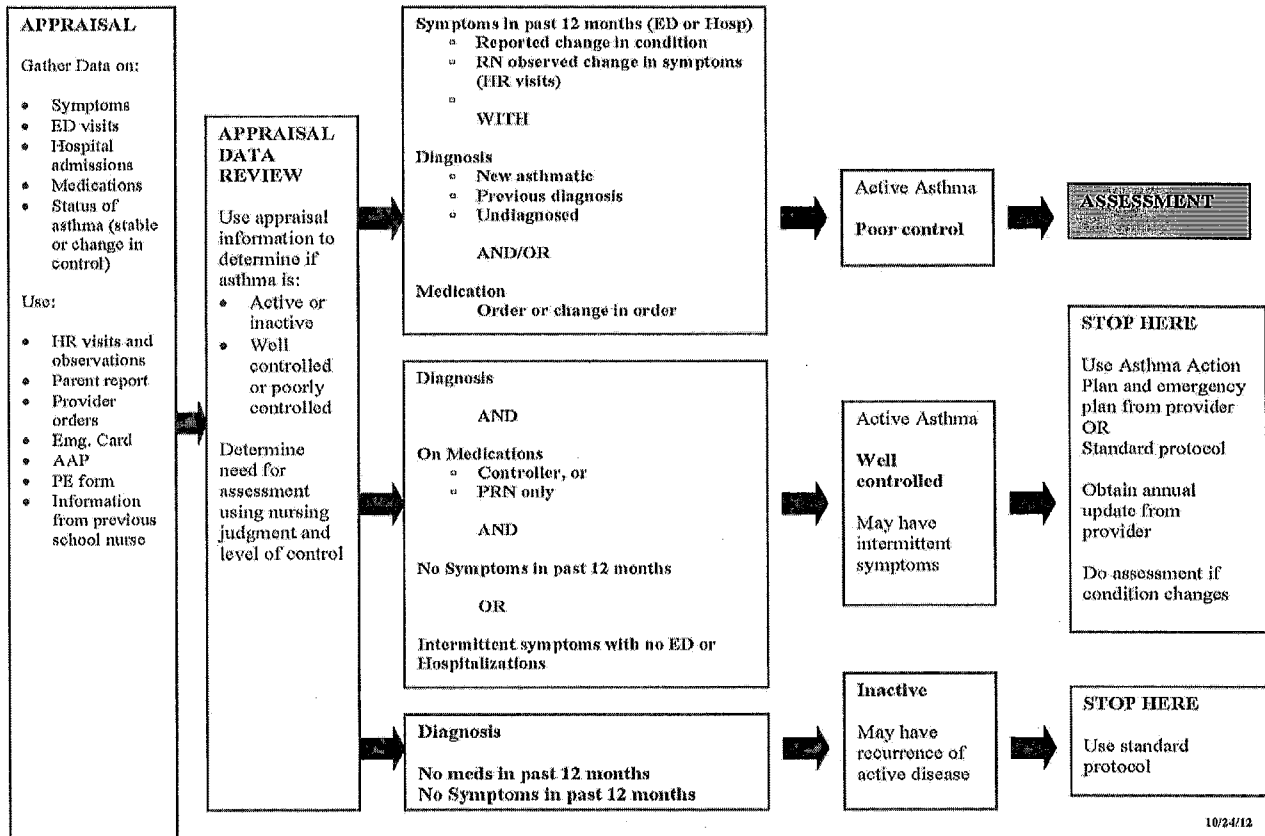
Winning with Asthma: Coaches Clipboard Program: <http://winningwithasthma.org>.

The program was developed through a collaborative effort between the Minnesota Department of Health Asthma Program and the Utah Department of Health Asthma Program. The website was created for coaches to have the opportunity to learn about asthma, how it affects an athlete's ability to compete, and how the coach can help athletes manage their symptoms while playing their very best.

APPENDIX A: ASTHMA APPRAISAL AND ASSESSMENT ALGORITHM

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Asthma Appraisal and Assessment Algorithm



10/24/12

**APPENDIX B: CLASSIFYING ASTHMA SEVERITY AND
INITIATING TREATMENT IN CHILDREN AND YOUTHS**

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CHILDREN 0-4 YEARS OF AGE

Components of Severity		Classification of Asthma Severity (0-4 years of age)			
		Intermittent	Mild	Persistent	
				Moderate	Severe
Impairment	Symptoms	≤2 days/week	≤2 days/week but not daily	Daily	throughout the day
	Nighttime awakenings	0	1-2x/month	3-4x/month	>1x/week
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	≤2 days/week but not daily	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
Risk	Exacerbations requiring oral systemic corticosteroids	0-1/year	≥2 exacerbations in 6 months requiring oral systemic corticosteroids, or ≥4 wheezing episodes/1 year lasting >1 day AND risk factors for persistent asthma		
		Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time.			
Recommended Step for Initiating Therapy		Step 1	Step 2	Step 3 and consider short course of oral systemic corticosteroids	
In 2-6 weeks, depending on severity, evaluate level of asthma control that is achieved. If no clear benefit is observed in 4-6 weeks, consider adjusting therapy or alternative diagnoses.					

Key: EIB, exercise-induced bronchospasm

- Level of severity is determined by both impairment and risk. Assess impairment domain by caregiver's recall of previous 2-4 weeks. Assign severity to the most severe category in which any feature occurs.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. For treatment purposes, patients who had ≥2 exacerbations requiring oral corticosteroids in the past 6 months, or ≥4 wheezing episodes in the past year, and who have risk factors for persistent asthma may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report 2007

CHILDREN 5–11 YEARS OF AGE

Components of Severity		Classification of Asthma Severity (5–11 years of age)			
		Intermittent	Mild	Persistent	
				Moderate	Severe
Impairment	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	≤2/month	3–4/month	≥1/week but not nightly	Often ≥2/week
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	<ul style="list-style-type: none"> • Normal FEV₁ between exacerbations • FEV₁ >80% predicted • FEV₁/FVC >80% 	<ul style="list-style-type: none"> • FEV₁ >80% predicted • FEV₁/FVC >80% 	<ul style="list-style-type: none"> • FEV₁ = 60–80% predicted • FEV₁/FVC = 75–80% 	<ul style="list-style-type: none"> • FEV₁ <60% predicted • FEV₁/FVC <70%
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year (see note)	≥2/year (see note)		
		<p>Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time for patients in any severity category.</p> <p>Relative annual risk of exacerbations may be related to FEV₁.</p>			
Recommended Step for Initiating Therapy		Step 1	Step 2	Step 3, medium-dose ICS option	Step 4, medium-dose ICS option, or step 4 and consider short course of oral systemic corticosteroids
In 2–6 weeks, evaluate level of asthma control that is achieved, and adjust therapy accordingly.					

Key: EIB, exercise-induced bronchospasm; FEV₁, forced expiratory volume in 1 second; FVC, forced vital capacity; ICS, inhaled corticosteroids

- Level of severity is determined by both impairment and risk. Assess impairment domain by patient’s/caregiver’s recall of the previous 2–4 weeks and spirometry. Assign severity to the most severe category in which any feature occurs.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report 2007

YOUTHS ≥ 12 YEARS OF AGE AND ADULTS

Components of Severity		Classification of Asthma Severity (Youths ≥12 years of age and adults)			
		Intermittent	Persistent		
Impairment	Symptoms	≤2 days/week	≤2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	≤2/month	3-4/month	> 1x/week but not nightly	Often 7x/week
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not >10/day	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	• Normal FEV ₁ between exacerbations • FEV ₁ ≥80% predicted • FEV ₁ /FVC normal	• FEV ₁ ≥80% predicted • FEV ₁ /FVC normal	• FEV ₁ >50% but <80% predicted • FEV ₁ /FVC reduced 5%	• FEV ₁ <50% predicted • FEV ₁ /FVC reduced ≥5%
Risk	Exacerbations requiring oral systemic corticosteroids	0-1/year (see note)	≥2/year (see note) →		
		← Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time for patients in any severity category. →			
		Relative annual risk of exacerbations may be related to FEV ₁			

- Level of severity is determined by assessment of both impairment and risk. Assess impairment domain by patient's/caregiver's recall of previous 2-4 weeks and spirometry. Assign severity to the most severe category in which any feature occurs.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report 2007

**APPENDIX C: ASSESSING ASTHMA CONTROL AND
ADJUSTING THERAPY IN CHILDREN AND YOUTHS**

Maryland School Health Services Guideline-Management of Students with Asthma

CHILDREN 0 – 4 YEARS OF AGE

Components of Control		Classification of Asthma Control (0-4 years of age)		
		Well Controlled	Not Well Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week	>2 days/week	Throughout the day
	Nighttime awakenings	≤1x/month	>1x/month	>1x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
Risk	Exacerbations requiring oral systemic corticosteroids	0-1/year	2-3/year	>3/year
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
Recommended Action for Treatment		<ul style="list-style-type: none"> Maintain current treatment. Regular follow-up every 1-6 months. Consider step down if well controlled for at least 3 months. 	<ul style="list-style-type: none"> Step up (1 step) and Reevaluate in 2-6 weeks. If no clear benefit in 4-6 weeks, consider alternative diagnosis or adjusting therapy. For side effects, consider alternative treatment options. 	<ul style="list-style-type: none"> Consider short course of oral systemic corticosteroids. Step up (1-2 steps), and Reevaluate in 2 weeks. If no clear benefit in 4-6 weeks, consider alternative diagnosis or adjusting therapy. For side effects, consider alternative treatment options.

Key: EIB, exercise-induced bronchospasm

Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report 2007

Maryland School Health Services Guideline-Management of Students with Asthma

CHILDREN 5-11 YEARS OF AGE

Components of Control		Classification of Asthma Control (5-11 years of age)		
		Well Controlled	Not Well Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week but no more than once on each day	>2 days/week or multiple times on ≤2 days/week	Throughout the day
	Nighttime awakenings	≤1x/month	>1x/month	≥3x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
	Lung function			
	• FEV ₁ or peak flow	>80% predicted/personal best	50-80% predicted/personal best	<50% predicted/personal best
	• FEV ₁ /FVC	≥80%	75-80%	<75%
Risk	Exacerbations requiring oral systemic corticosteroids	0-1/year	≥2/year (see note)	
		Consider severity and interval since last exacerbation		
	Reduction in lung growth	Evaluation requires long-term follow-up		
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome, and even some. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
Recommended Action for Treatment		<ul style="list-style-type: none"> • Maintain current step. • Regular follow-up every 1-6 months. • Consider step down if well controlled for at least 3 months. 	<ul style="list-style-type: none"> • Step up at least 1 step and • Reevaluate in 2-6 weeks. • For side effects, consider alternative treatment options. 	<ul style="list-style-type: none"> • Consider short course of oral systemic corticosteroids. • Step up 1-2 steps, and • Reevaluate in 2 weeks. • For side effects, consider alternative treatment options.

Key: EIB, exercise-induced bronchospasm; FEV₁, forced expiratory volume in 1 second; FVC, forced vital capacity

Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report 2007

Maryland School Health Services Guideline-Management of Students with Asthma

YOUTHS ≥ 12 YEARS OF AGE AND ADULTS

Components of Control		Classification of Asthma Control (Youths ≥12 years of age and adults)		
		Well-Controlled	Not Well-Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week	>2 days/week	Throughout the day
	Nighttime awakening	≤2x/month	1-5x/week	>4x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
	FEV ₁ or peak flow	>80% predicted/ personal best	60-80% predicted/ personal best	<60% predicted/ personal best
	Validated Questionnaires			
	ATAQ	0	1-7	8-14
	ACT	20-25*	23-25	N/A
	ACT	≥20	16-19	≤15
Risk	Exacerbations	0-1/year	≥2/year (see note)	
		Consider severity and interval since last exacerbation		
	Progressive loss of lung function	Evaluation requires long-term follow-up care		
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. This level of intensity does not translate to specific levels of control but should be considered in the overall assessment of risk.		

*ACQ values of 0.76-1.4 are indeterminate regarding well-controlled asthma.

Key: EIB, exercise-induced bronchospasm; FEV1, forced expiratory volume in 1 second. See figure 3-8 for full name and source of ATAQ, ACQ, ACT.

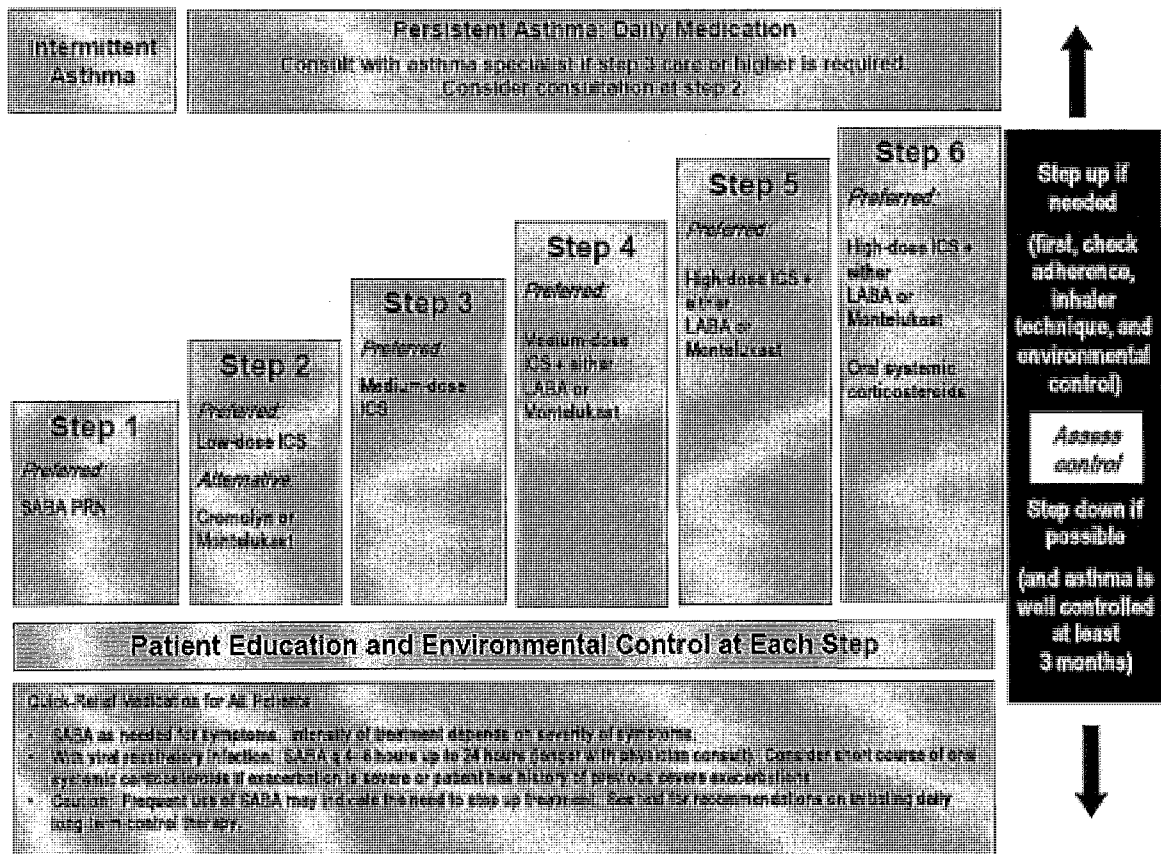
Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report 2007

**APPENDIX D: STEPWISE APPROACH FOR MANAGING ASTHMA
IN CHILDREN**

GENERAL STEPWISE APPROACH

Classification of Asthma Severity				
Lowest level of treatment required to maintain control	Intermittent	Mild	Moderate	Severe
		Step 1	Step 2	Step 3 or 4

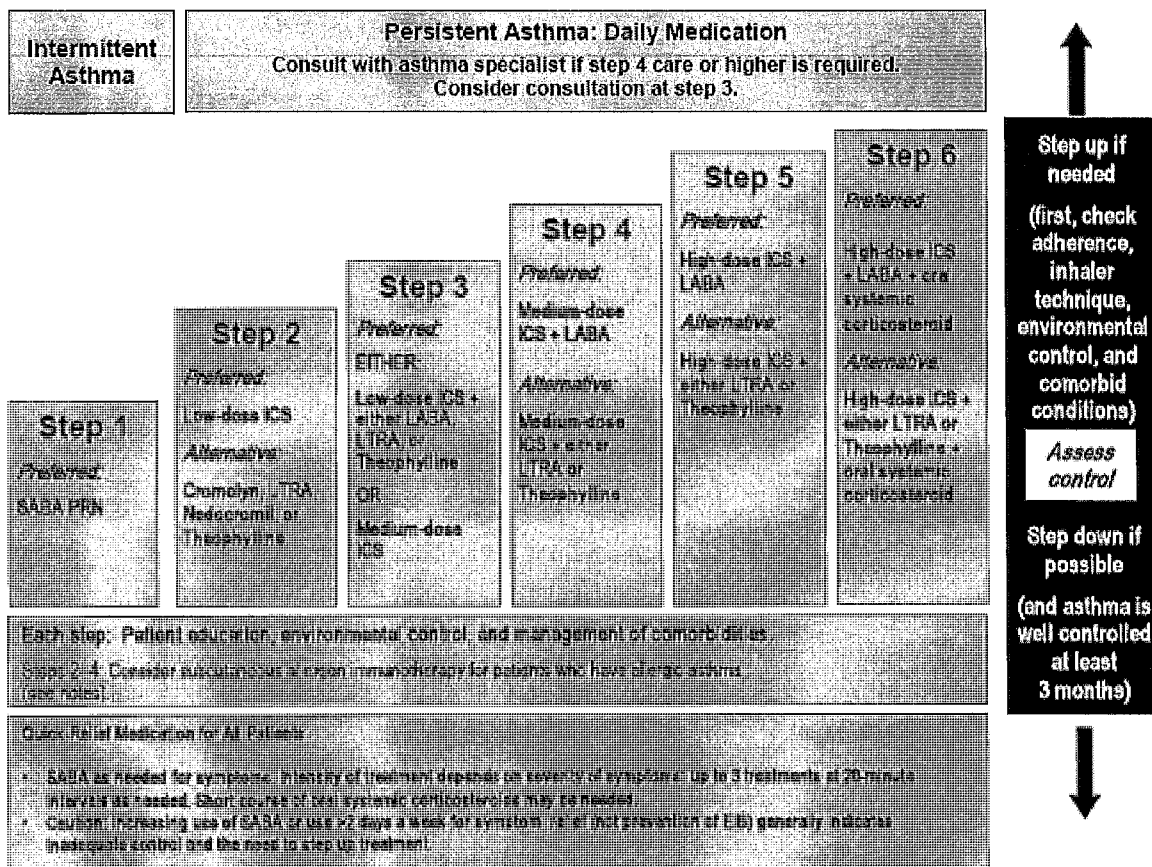
CHILDREN 0-4 YEARS OF AGE



Key: Alphabetical order is used when more than one treatment option is listed within either preferred or alternative therapy. ICS, inhaled corticosteroid; LABA, inhaled long-acting beta2-agonist; SABA, inhaled short acting beta2-agonist

Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report 2007

CHILDREN 5-11 YEARS OF AGE



Key: Alphabetical order is used when more than one treatment option is listed within either preferred or alternative therapy. ICS, inhaled corticosteroid; LABA, inhaled long-acting beta2-agonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting beta2-agonist

Source: National Heart, Lung, and Blood Institute National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma Full Report 2007

Maryland State School Asthma Medication Administration Authorization Form



ASTHMA ACTION PLAN _____ / _____ / _____ to _____ / _____ / _____ (not to exceed 12 months)

TRIGGER (LIST)

Child's Name: _____ DOB: _____ PEAK FLOW PERSONAL BEST: _____

Parent/Guardian's Name: _____ Home: _____ Work: _____ Cell: _____

ASTHMA SEVERITY: Exercise Induced Intermittent Mild Persistent Moderate Persistent Severe Persistent

GREEN ZONE		CONTROLLER MEDICATION - DAILY AT HOME UNLESS OTHERWISE INDICATED			
<input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can work, exercise, play <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow greater than _____ (80% personal best)	Medication	Dose	Route	Frequency/Time	<input type="checkbox"/> School
					<input type="checkbox"/> School
					<input type="checkbox"/> School
					<input type="checkbox"/> School
EXERCISE ZONE		RESCUE MEDICATIONS - TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS			
<input type="checkbox"/> Prior to exercise/sports/physical education (PE)	Medication (Rescue Medication)	Dose	Route	Frequency/Time	
If using more than twice per week for exercise/sports/PE notify the health care provider and parent/guardian.					
YELLOW ZONE		RESCUE MEDICATIONS - TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS			
<input type="checkbox"/> Cough or cold symptoms <input type="checkbox"/> Wheezing <input type="checkbox"/> Tight chest or shortness of breath <input type="checkbox"/> Cough at night <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow between _____ and _____ (50%-79% personal best)	Medication	Dose	Route	Frequency/Time	
If symptoms do not improve in _____ minutes, notify the health care provider and parent/guardian.					
If using more than twice per week, notify the health care provider and parent/guardian.					
RED ZONE		EMERGENCY MEDICATIONS - TAKE THESE MEDICATIONS AND CALL 911			
<input type="checkbox"/> Medication is not helping within 15-20 mins <input type="checkbox"/> Breathing is hard and fast <input type="checkbox"/> Nasal flaring or intercostal retraction <input type="checkbox"/> Lips or fingernails blue <input type="checkbox"/> Trouble walking or talking <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow less than _____ (50% personal best)	Medication	Dose	Route	Frequency/Time	
CONTACT THE PARENT/GUARDIAN AFTER CALLING 911.					

HEALTH CARE PROVIDER AUTHORIZATION
 I authorize the administration of the medications as ordered above.
 Student may self-carry medications Yes No
 Health Care Provider Name: _____
 Signature: _____
 Date: _____

PARENT/GUARDIAN AUTHORIZATION
 I authorize the administration of the medications as ordered above.
 I acknowledge that my child is is not authorized to self-carry his/her medication(s);
 Signature: _____
 Date: _____

REVIEWED BY SCHOOL NURSE
 Name: _____
 Signature: _____
 Date: _____
 Authorized to self-carry medications: Yes No

Self-carry and Self-Administration of Asthma Inhaler Evaluation

Student _____ Date of Birth _____

Grade _____ Homeroom/Teacher _____

Name of Medication _____

Current medication form on file with parent signature and health care provider signature authorizing self-carry and self-administration of the medication ____ Yes ____ No

Interview Date _____ Health Room Staff _____

Reviewed with teacher _____ Date _____

1. Student is capable of identifying individual medication ____ Yes ____ No
2. Student is knowledgeable of purpose of medication ____ Yes ____ No
3. Student is able to identify specific symptoms/triggers that indicate need for medication ____ Yes ____ No
4. Student is knowledgeable about medication dosage/frequency ____ Yes ____ No
5. Student demonstrates proper administration of medication ____ Yes ____ No
6. Student has plan for access to medication at all times ____ Yes ____ No (where it is to be kept during class, recess, gym)
7. Student is knowledgeable about how to access assistance for self if needed in an emergency. ____ Yes ____ No
8. Spare inhaler to be kept in health room ____ Yes ____ No
9. Student is aware that any inappropriate use or sharing with others may result in parental notification and limiting the right to carry medication. ____ Yes ____ No
10. The student and nurse have a plan for communicating each instance of rescue inhaler self-administration ____ Yes ____ No.

The student has completed the self-carry and self-administration evaluation and has demonstrated appropriate self-administration and level of responsibility to self-carry their medication.

_____ Health Room Signature

_____ Student Signature

_____ Date

Copy of form in student health file.

Self-Carry and Self-Administration of Asthma Inhaler Evaluation

Student _____ Date of Birth _____

Grade _____ Homeroom/Teacher _____

Name of Medication _____

Current medication form on file with parent signature and health care provider signature authorizing self-carry and self-administration of the medication ____ Yes ____ No

Interview Date _____ Health Room Staff _____

Reviewed with teacher _____ Date _____

1. Student is capable of identifying individual medication ____ Yes ____ No
2. Student is knowledgeable of purpose of medication ____ Yes ____ No
3. Student is able to identify specific symptoms/triggers that indicate need for medication ____ Yes ____ No
4. Student is knowledgeable about medication dosage/frequency ____ Yes ____ No
5. Student demonstrates proper administration of medication ____ Yes ____ No
6. Student has plan for access to medication at all times ____ Yes ____ No (where it is to be kept during class, recess, gym)
7. Student is knowledgeable about how to access assistance for self if needed in an emergency. ____ Yes ____ No
8. Spare inhaler to be kept in health room ____ Yes ____ No
9. Student is aware that any inappropriate use or sharing with others may result in parental notification and limiting the right to carry medication. ____ Yes ____ No
10. The student and nurse have a plan for communicating each instance of rescue inhaler self-administration ____ Yes ____ No.

The student has completed the self-carry and self-administration evaluation and has demonstrated appropriate self-administration and level of responsibility to self-carry their medication.

_____ Health Room Signature

_____ Student Signature

_____ Date

Copy of form in student health file.

Section 15

Management of Diabetes in School

Management of Students with Diabetes

Contained in this section is an annotated copy of the document Management of Students with Diabetes in Schools (May 2017). The full version of this document can be found at:

<http://marylandpublicschools.org/about/Pages/DSFSS/SSSP/SHS/SHSGuidelines.aspx>

The full version contains additional resources and definitions, as well as information pertaining to the laws governing diabetes management in the school setting.

The appendix of the document contains the most recent Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form.

This section of the Manual also contains handouts for staff education regarding the signs and symptoms of hyperglycemia and hypoglycemia.





MARYLAND STATE SCHOOL HEALTH SERVICES GUIDELINE




MANAGEMENT OF DIABETES IN SCHOOLS



MAY 2017



Maryland State Department of Education
Student Services and Strategic Planning Branch
200 West Baltimore Street
Baltimore, Maryland 21201
Phone: 410-767-0311
TTY/TDD: 410-333-6442



Maryland Department of Health and Mental Hygiene
Office of School Health
201 West Preston Street
Baltimore, Maryland 21201
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TTY/TDD: 1-800-735-2258



MARYLAND
Department of Health

SECTION II: MANAGEMENT OF DIABETES

DEFINITIONS OF DIABETES

Diabetes is a chronic disorder of carbohydrate, fat, and protein metabolism characterized by hyperglycemia and glycosuria resulting from inadequate production or utilization of insulin. Symptoms of diabetes include excessive thirst, excessive urination, excessive hunger, weight loss and fatigue. The long-term consequences of chronic hyperglycemia include damage to eyes, kidneys, nerves, heart and blood vessels.

There are three types of diabetes. These include:

- ❑ **Type 1 Diabetes:** Type 1 diabetes is an autoimmune disease. The autoimmune process results in the destruction of the beta cells of the pancreas causing an inability of the pancreas to produce insulin. A person with Type 1 diabetes needs daily administration of insulin to live;
- ❑ **Type 2 Diabetes:** Type 2 diabetes results from the body's inability to use insulin adequately due to insulin resistance. Type 2 diabetes is managed with diet, exercise, and medications. Sometimes insulin is required to treat type 2 diabetes; and
- ❑ **Gestational Diabetes:** Gestational diabetes is a temporary hormonally mediated state of insulin resistance that occurs during pregnancy and is managed primarily with diet. Physical activity and insulin may also be required. Gestational diabetes usually resolves after childbirth, but increases the mother and the child's risk of developing diabetes later in life.

Optimal diabetes management requires a balance between food intake (which increases blood glucose), exercise (which reduces blood glucose) and insulin/medications. When there is an imbalance, hypoglycemia (low blood glucose) or hyperglycemia (high blood glucose) may result.

ROUTINE DIABETES MANAGEMENT

Routine diabetes management requires coordination of blood glucose monitoring, meal planning, physical activity, and administration of insulin and other medication(s). For students with diabetes, these routine tasks must be performed in the context of the student's academic and other learning activities. School diabetes management should seek to provide diabetes care that minimizes disruption to the student's academic experience. Providing services through a collaborative team approach as well as student self-management of diabetes are effective strategies to achieve this goal.

BLOOD GLUCOSE MONITORING

Blood glucose monitoring may be ordered by the student's health care provider before lunch, before physical activity/exercise, before snacks, for symptoms of hypoglycemia or hyperglycemia, and/or other times (e.g., during an illness or recovery from an illness). Blood glucose monitoring in the classroom (or other locations in the school) is allowed, and should be supported as appropriate based on individual student needs. School system policy should not

prohibit blood glucose monitoring in the classroom. Determination of the student's ability to perform blood glucose monitoring in the classroom should be made based on several factors including DMMP/health care provider orders, nursing assessment, specific aspects of the school setting and the student's developmental capability. When assessing the student's ability to perform blood glucose monitoring in the classroom the school nurse should consider, as indicated, whether:

- The health care provider has indicated on the student's DMMP/health care provider orders the student is independent in doing blood glucose monitoring;
- The student desires to perform blood glucose monitoring in the classroom;
- The student can perform the procedure safely for him/herself and the protection of others;
- The student is aware of blood spill clean-up procedures/standard precautions;
- The equipment is safely stored and easily accessible to the student;
- The student is able to implement the plan for disposal of used lancets and blood glucose monitoring materials;
- The student feels comfortable performing the procedure outside of the health suite or there is a private space available;
- The classroom teacher is aware of the student's diabetes and needed care in the classroom; and
- The student is capable of consistently correctly responding to the blood glucose result.

CONTINUOUS GLUCOSE MONITORING (CGM)

Some students may utilize a continuous glucose monitor (CGM). The CGM works through a sensor inserted under the skin and measures interstitial fluid glucose levels at regular intervals and sends the current recorded level to a monitor. The monitor may be part of the insulin pump or a separate device, which may include a smartphone that is carried or worn by the student in a pocket, backpack, or purse. The CGM is a useful tool for identifying blood glucose trends and can enhance the ability of the student's personal diabetes health care team to make needed adjustments to the student's diabetes care plan.⁵

The CGM sets off an alarm when glucose levels are outside a set range or when they are increasing or decreasing at a rapid rate. Appropriate action should be taken in accordance with the student's DMMP/health care provider orders. **It is important to note that at this time, it is not routinely recommended that treatment decisions and diabetes care plan adjustments be based solely on CGM results.** School nurses should discuss this indication for CGM use on a case-by-case basis with the student's health care provider. The sensor's glucose levels should be confirmed with a blood glucose meter whenever the reading suggests a need for treatment.⁵ The school nurse or trained school staff should implement the student's DMMP or emergency plan for low alarms which may include verifying the blood glucose in the classroom or other designated location. If

the student is not able to perform the finger stick independently, a trained school staff may perform the finger stick. If necessary, the student should be escorted to the health room for a finger stick when not symptomatic.

Some CGMs transmit data remotely to multiple devices at the same time allowing the school nurse, the student's health care providers, as well as the parent/guardian access to the CGM data and alarms in real time at locations remote from the student. School nurses are not responsible for the continuous receipt of CGM results throughout the school day. Parents may communicate to the school nurse when notified of a high or low blood glucose result from a CGM. The school nurse should address the use of cell phone technology with the family and the provider on a case-by-case basis. Due to confidentiality concerns, school nurses should not maintain communication with a CGM through their personal cell phones.

Some pumps have the data from continuous blood glucose monitoring displayed on the pump screen. Communication between the pump and the CGM has led to a "threshold suspend pump" feature. This feature allows for the automatic cessation of insulin delivery from the pump when a pre-set low blood glucose threshold is detected by the CGM. When this occurs, the pump alarms and stops insulin delivery for two hours, unless the user manually restarts insulin delivery.

The following actions should be considered and implemented for students utilizing a CGM⁵:

- Confirm CGM results with blood glucose meter check before taking action on the sensor reading according to the student's DMMP/health care provider orders;
- Check finger stick blood glucose level regardless of CGM if student has signs or symptoms of hypoglycemia;
- Give insulin injections at least three inches away from the CGM insertion site;
- Develop a plan in collaboration with the student, parent/guardian and provider regarding CGM use for sports participation;
- Develop a plan in collaboration with the student, parent/guardian and provider regarding response to CGM alarms;
- Reinforce sensor placement with approved medical tape if the adhesive is peeling;
- Return sensor and device to the parent/guardian if the CGM becomes dislodged. Do not throw any part away; and
- Refer to the manufacturer's instructions on how to use the student's device.

KETONE MONITORING

Ketones develop because of insufficient insulin or lack of adequate carbohydrate intake and rarely due to elevated blood glucose. Unlike syringe injected insulin where a basal insulin can be present for several hours, when using an insulin pump, students can very quickly (1-2 hours) develop

ketones as a result of sudden cessation of insulin delivery (e.g., pump failure, site dislodging, insufficient bolusing). Ketone monitoring may be done via blood or urine testing and should be performed based on a student's DMMP/health care provider orders. Urine ketone levels lag behind blood levels. While blood testing provides more "real-time" results, cost may prohibit some students from using blood ketone monitoring.

CLINICAL LABORATORIES IMPROVEMENT ACT REQUIREMENTS

Each school with a student with diabetes in attendance must comply with the Federal and State requirements of the Clinical Laboratories Improvement Act (CLIA) to perform or assist students to perform or interpret finger stick blood glucose or urine or blood ketones testing.⁶ CLIA requires manufacturer's instructions for laboratory testing devices/equipment to be available on site for all devices used in the building. This may be done by having parents/guardians provide the necessary user manuals or by accessing them from manufacturer's websites and storing them electronically or in a binder in the health suite.

INSULIN ADMINISTRATION

Some students with type 1 or type 2 diabetes may need assistance administering their insulin while others may administer on their own. Those needing assistance may be supported by a school nurse or an appropriately trained school staff. Insulin should be administered according to the student's DMMP/health care provider orders. Every effort should be made to administer insulin in a manner that minimizes disruption to the student's schedule; however, It may be necessary to require insulin be administered in the health suite.

In order for children to receive medication or have medical procedures performed (e.g., blood glucose monitoring) in school, an order from an authorized prescriber must be in place. The school can only authorize medication administration and/or procedures based on the orders from a health care provider. However, the student's health care provider may authorize the student's parent/guardian to make changes to the orders (e.g., carbohydrate ratios, insulin dosage) within the parameters identified for each student and specified on the diabetes order form. This authorization may be necessary to maintain appropriate diabetes control and should be carried out in collaboration with the health care provider and the student's parent/guardian. This process requires ongoing communication between the school, school nurse, parent/guardian, and health care provider.

INSULIN PUMP MANAGEMENT

Students using pumps for insulin administration should have details of their insulin regimen on the DMMP/health care provider orders specifying the pump settings, including basal rates, carbohydrate ratios, correction factor and blood glucose target. The pump will calculate the insulin dose based on the blood glucose and carbohydrates to be eaten at a specific meal/snack. The pump calculation of the insulin dose is based on a defined algorithm that takes into account "insulin on board" (IOB); that is, it adjusts the needed insulin based on the amount of insulin remaining in the body (on board) from the previous insulin bolus by subtracting the IOB from the amount needed for the next bolus. The pump will indicate how the bolus amount was calculated based on the pump settings. The specific algorithm for IOB varies between pumps and type of insulin (e.g., action

time and time since last dose). **There is no need for the school nurse to verify/recalculate the pump derived insulin dose. The sophisticated nature of this calculation to determine the needed insulin bolus dose cannot be replicated by hand by the school nurse. However, the school nurse should verify the pump settings (based on the student’s diabetes medical management plan (DMMP)/health care provider orders or any updates provided by the parent/guardian) and that the correct blood glucose and carbohydrate amount eaten is entered in the pump. Once settings, carbohydrate intake and blood glucose entry is verified, the insulin dose calculated by the pump may then be administered.**

Parents/guardians and/or students who self-manage are required to communicate any changes with pump settings to the school nurse. The school nurse should document these changes in the student’s health record. Changes in pump settings should be consistent with the DMMP/health care provider orders. Changes outside the parameters of the DMMP/health care provider orders should be communicated to the school nurse by the health care provider. A collaborative approach should be used to determine the best mechanism for communication of changes in pump settings.

SELF-MANAGEMENT

Based on nursing assessment and provider orders, students who are developmentally capable and have received appropriate and adequate instruction should be supported to self-manage their diabetes including administration of insulin. The school nurse should assess each student individually. Information and input from the student’s parents/guardian, school staff, health care provider, and the student should be used to assess the student’s ability to self-manage including ability to self-administer insulin. Based on nursing judgment and considering the student’s developmental abilities and school schedule, the nurse will develop a plan for the student to self-manage their diabetes. Students who self-manage may also need assistance to perform diabetes care tasks from time to time.

For students to self-manage their diabetes, the health care provider and parent/guardian must indicate on the school diabetes medication order form which diabetes management tasks the student can perform independently and those for which they need supervision or assistance. It is important to understand the needs and the self-management skills of students with diabetes change over time and in different settings. This may require new orders from their health care provider and should be reflected on the student’s IHPs. It may also trigger a change to a Section 504 plan or IEP. (See Section IX for additional discussion of this topic). Communication between the school nurse, student, parent/guardian, and health care provider is important when supporting students to self-manage their diabetes. Students who self-manage their diabetes should be permitted to perform diabetes care tasks in the classroom, other locations at the school and at all school-sponsored events.

SECTION III: RECOGNITION AND MANAGEMENT OF HYPOGLYCEMIA AND HYPERGLYCEMIA

MANAGEMENT OF HYPOGLYCEMIA

Hypoglycemia occurs when the blood glucose level is abnormally low, usually below 70 mg/dl.⁷ Severe hypoglycemia, if left untreated, can cause seizures, coma or death. Hypoglycemia has many causes. Certain situations may place a student at risk of hypoglycemia. Causes include but are not limited to those contained in Table 1.

Table 1

CAUSES OF HYPOGLYCEMIA ⁷
Excess insulin
Delayed or skipped meals or snacks
Insufficient carbohydrate intake
Increased, intense or unplanned exercise or physical activity
Illness, especially gastrointestinal illness

Common signs and symptoms of hypoglycemia are contained in Table 2. The list in Table 2 is not all-inclusive. Symptoms may vary between/be unique to individuals. It is important for mild hypoglycemia to be treated quickly to prevent severe hypoglycemia. Severe hypoglycemia is a medical emergency; therefore, it is important for school staff to know the signs of hypoglycemia and how to respond according to the student’s DMMP/health care provider orders and emergency plan.

Table 2

SIGNS AND SYMPTOMS OF HYPOGLYCEMIA ^{5,7,8}		
Organ System	Mild/Moderate Sign(s)/Symptom(s)	Severe
<i>Mouth/Throat</i>		Inability to swallow
<i>Nose/Eyes/Ears</i>	Blurred vision	
<i>Skin</i>	Sweating; pallor	
<i>Heart</i>	Dizziness; palpitation; lightheadedness	
<i>Mental</i>	Drowsiness; anxiety/nervousness; restlessness; depressed mood; irritability; confusion/disorientation; unsteady/uncoordinated movement; inability to concentrate; abnormal behavior/changed personality	
<i>Neurologic</i>	Dizziness; tremor/shakiness; slurred speech; tingling in the hands, feet, lips, or tongue; headache; blurred vision; weakness; lethargy	Seizures; Unconsciousness; Unresponsive
<i>Other</i>	Hunger	Increased symptoms despite treatment for mild/moderate symptoms; Death

Prevention of hypoglycemia is an important aspect of diabetes management. Hypoglycemia can develop and evolve quickly (in minutes), so actions and plans to prevent hypoglycemia and quickly respond to hypoglycemia should be included in each student’s individualized health plan and/or emergency plan as specified in the student’s DMMP/health care provider orders. Treatment for hypoglycemia is guided by a student’s DMMP/health care provider orders. Delegation to a CMT and/or CNA or training and instruction to a designated unlicensed school staff may be required to ensure a rapid response to hypoglycemia. See the National Diabetes Education Program resource at the end of the Guideline for information regarding the principles of hypoglycemia management and emergency planning.

MILD OR MODERATE HYPOGLYCEMIA

Mild or moderate hypoglycemia should be treated quickly by the school nurse or other designated and trained school staff to prevent progression to severe hypoglycemia and eliminate or reduce the need for emergency intervention. Symptoms of low blood glucose should be treated quickly with a fast-acting sugar according to the student’s DMMP/health care provider orders and individualized health plan (IHP). When a student is having symptoms or reports hypoglycemia, immediately administer fast-acting sugar. See examples of fast-acting sugar in Table 3. **Specific products for individual students are dictated by the student’s DMMP/health care provider orders and parent preference.**

Table 3

Examples of Fast-Acting Sugar (for approximately 15 grams of sugar)	
100% fruit juice	4 ounces
Regular (not diet) soda	4-6 ounces
Easily chewable candy	<ul style="list-style-type: none"> • 2-3 rolls of Smarties® • 10 Sweet Tarts® • 15 Skittles® • 15 regular jelly beans • 7-8 gummy Life Savers®
Cake decorating gel (fat free)	3 teaspoons (1 Tablespoon)
Table sugar	<ul style="list-style-type: none"> • 1 Tablespoon • 4 packets
Glucose Tabs	3-4 tabs
Insta-Glucose® or similar product	Based on instructions

After treating hypoglycemia, it is important to continue monitoring blood glucose according to the student’s DMMP/health care provider orders. Follow the student’s DMMP regarding consumption of a meal or snack following treatment for hypoglycemia. If symptoms increase or blood glucose continues to decrease, follow the student’s DMMP/health care provider orders regarding glucagon administration and **call 911**.

SEVERE HYPOGLYCEMIA

Severe hypoglycemia is a medical emergency; therefore, it is important to have quick access to Glucagon. Glucagon is a hormone that is produced by the pancreas that raises blood glucose by

causing the release of glycogen (a form of stored carbohydrate) from the liver. When used as a medication, it raises blood glucose in instances of hypoglycemia. The school nurse may delegate glucagon administration to another member of the school health services team.^{9, 10} In addition, since glucagon is an emergency medication, glucagon may be administered by trained unlicensed school staff designated to do so.^{10,11}

Dosing and formulations of some glucagon products are contained in Table 4 as a reference. This does not constitute an exclusive list of formulations. **Each instance of glucagon administration should be administered in the dosage and route prescribed by the student’s DMMP/health care provider orders. If glucagon is administered, a call to 911 is required.**

Table 4

FORMULATION AND MANUFACTURERS’ DOSING OF GLUCAGON^{8, 12}			
Dosing Category	Weight	Glucagon Dosage and Administration	Device Formulation/ Products
Older Child (>6 years of age) and Adult	Greater than 44 lbs. (20 kg)	1.0 mg (1.0 unit) subcutaneous, intramuscular May repeat in 15 minutes if necessary	<ul style="list-style-type: none"> • Glucagon Kit[®] • GlucaGen HypoKit[®]
Younger Child (<6 years of age)	Less than 44 lbs. (20 kg)	0.5 mg (0.5 unit) subcutaneous, intramuscular Equal to: ½ adult dose of Glucagon May repeat in 15 minutes if necessary	<ul style="list-style-type: none"> • Glucagon Kit[®] • GlucaGen HypoKit[®]

Glucagon works only when the liver has sufficient glycogen stores. It is important to give sips of sugared drinks (e.g., juice or regular soda) as soon as the student is able to take fluids by mouth. Alternatively, other fast-acting sugar products may be used orally or intrabuccally according to the student’s DMMP/health care provider orders.

When a person is having, or is suspected of having a **hypoglycemic emergency**, the following emergency actions should be taken:

1. Rapidly assess Circulation, Airway, and Breathing, (CAB’s) and begin CPR as necessary;
2. Administer glucagon according to student’s DMMP/health care provider orders/emergency plan. Manufacturer’s instructions for the use of the Glucagon Kit[®] may be found at the manufacturer’s web site (<http://www.lillyglucagon.com/#how-to-use>). See Appendix A for alternate instructions for administering glucagon;
3. If there is no DMMP/Health Care Provider Order Form or glucagon available, follow protocol as outlined in the “*Guidelines for Emergency Care in Maryland Schools*” for diabetes emergencies;

4. Call 911 or direct someone to call 911. Notify the dispatcher that you are calling regarding a child (<18 y.o.) or an adult (>18 y.o.) with a diabetes hypoglycemia emergency and that glucagon was given for severe hypoglycemia with unconsciousness.¹³ Follow EMS instructions;

SPECIAL NOTE-- Emergency medical care is required for persons treated with glucagon for severe hypoglycemia. Therefore, 911 should always be called if glucagon is administered.

5. Discard sharps in accordance with the local blood borne pathogens procedures;
6. Continue to monitor vital signs (if trained to do so) and respond as indicated;
7. Place student in recovery position (**Note--after receiving glucagon a student may vomit. Observe and monitor to avoid choking if student vomits**);
8. Loosen restrictive clothing. Give nothing by mouth except as ordered by an authorized prescriber as part of an emergency plan to treat hypoglycemia;
9. When the student responds, give supplemental carbohydrate (snack or meal) according to student's emergency plan;
10. Stay with the student until 911 personnel arrive and accept care responsibilities;
11. Continue to monitor blood glucose level according to the student's DMMP/health care provider orders;
12. Notify parent/guardian or student's emergency contact;
13. Follow local school system emergency policy regarding 911 calls;
14. Complete documentation of the incident, including the time of glucagon administration, and 911 and parent notifications according to any local documentation guidelines;
15. Send documentation of the event, including vital signs, interventions and student's identifying information to the hospital with EMS personnel according to local policy; and
16. Maintain a copy of the above documentation for the health record according to local policy.

When a student experiences hypoglycemia it is important for the school nurse to communicate with the student and the student's parent/guardian regarding the precipitating factors and work with the student and the family to implement prevention interventions as appropriate. This should be done in collaboration with the student's health care provider and appropriate school personnel when needed.

MANAGEMENT OF HYPERGLYCEMIA

Hyperglycemia is when the blood glucose is above the target range for an individual. In general, hyperglycemia is due to a mismatch between carbohydrate intake, insulin, and physical activity. Severe hyperglycemia can develop over a period of hours to weeks and can cause a hyperglycemic emergency needing prompt intervention in the school setting. Diabetic ketoacidosis (DKA) is characterized by hyperglycemia (>250 mg/dl), ketosis, acidosis and dehydration.^{14, 15, 16, 17} In rare cases, DKA may occur with a blood glucose level <200-250 mg/dl.¹⁸ Another more rare hyperglycemic emergency is hyperglycemic hyperosmolar state (HHS) which is characterized by extreme hyperglycemia (>600 mg/dl) and hyperosmolarity often with little acidosis or ketosis.^{15, 16, 17} Some of the most common causes of hyperglycemia and precipitating factors for DKA and HHS are contained in Table 5. Insufficient insulin and infection are the most common causes. Management of hyperglycemia requires fluids, treatment of the underlying cause, and may require insulin administration.

Table 5

CAUSES OF HYPERGLYCEMIA ^{15, 16, 17}
Insufficient insulin (e.g., under treatment, non-compliance)
Illness
Inadequate glucose lowering medication
Decreased physical activity
Medications (e.g., corticosteroids)
Infection
Injury
Severe emotional or physical stress
Insulin pump malfunction
Drugs (e.g., cocaine) or alcohol

Signs and symptoms of hyperglycemia are contained in Table 6.

Table 6

SIGNS AND SYMPTOMS OF HYPERGLYCEMIA ^{5, 16, 17}		
Organ System	Mild/Moderate Sign(s)/Symptom(s)	Severe/Emergency
<i>Mouth/Throat</i>	Dry mouth; increased thirst	Extreme thirst; dehydration; fruity smelling breath
<i>Nose/Eyes/Ears</i>	Blurred vision	
<i>GI</i>	Change in appetite; nausea	Vomiting; severe abdominal pain
<i>Lung</i>		Heavy breathing; shortness of breath; rapid breathing
<i>Heart</i>		Chest pain
<i>Mental</i>		Sleepiness; lethargy; depressed consciousness
<i>Kidney</i>	Frequent or increased urination	
<i>Other</i>	Fatigue	

In the school setting, hyperglycemia should be treated according to the student's DMMP/health care provider orders and emergency plan. When treating hyperglycemia, it is important to consider the possibility of the presence of ketones and risk to progress to a hyperglycemic emergency (i.e., DKA). When treating ketones, additional insulin may be needed to account for ketone induced insulin resistance. Any additional insulin for correction of hyperglycemia with ketones should be done in accordance with the student's DMMP/ health care provider orders.

The school nurse or other designated school staff should follow the student's DMMP/health care provider orders for the management of hyperglycemia. In general, hyperglycemia should be managed as outlined below. See the National Diabetes Education Program resource at the end of the Guideline information on the principles of hyperglycemia management and emergency planning.

If the student has severe symptoms of ketosis such as altered mental status or is vomiting and unable to keep down fluids, the student requires immediate medical care. Call 911 or direct someone to call 911 and follow the student's DMMP/health care provider orders and Emergency Plan.

When a student experiences severe hyperglycemia it is important for the school nurse to communicate with the student and the student's parent/guardian regarding the precipitating factors and work with the family and the health care provider to determine if there is a pattern to the student experiencing hyperglycemia. The school nurse should work with the student and the family and the health care provider to implement prevention interventions as appropriate based on any identified cause (e.g., noncompliance in students who self-manage their diabetes).

SECTION IV: THE NURSING PROCESS RELATED TO STUDENTS WITH DIABETES

THE NURSING APPRAISAL

School management of students with diabetes is individualized and begins with a nursing appraisal. Based on the results of the appraisal and nursing judgment, a nursing assessment and development of an individualized health plan may be needed.

INFORMATION SOURCES TO GUIDE THE NURSING APPRAISAL

The school nurse should be informed of the medical, educational, and social issues regarding students with diabetes to the greatest extent possible. The school nurse should collect this information from a review of medical and educational records (i.e., the school health record, the Student Record Card, emergency health card, and the student cumulative education record).

It is necessary for the school nurse to obtain information related to the student's health condition(s) from the parent/guardian and the student's diabetes care provider and other health care providers including any certified diabetes educator working with the student and their family. This should include:

- Up-to-date history of diabetes status from parent/guardian and diabetes care provider(s);
- Up-to-date and accurate history of other medical conditions/diagnosis from parent/guardian and health care provider(s);
- Other relevant health information and assessments from the student's health care provider(s);
- The student's DMMP/health care provider orders; and
- Additional information from the following sources if needed:
 - Student (as developmentally appropriate)
 - Teaching staff
 - Coaches or other leaders of school sponsored after-school activities
 - Classroom observation(s).

THE NURSING ASSESSMENT

After review of the information obtained from the appraisal, the school nurse should assess the health needs of students with diabetes. The school nurse should use local standard assessment procedures and the procedures outlined in the *"Maryland State School Health Services Guidelines: Nursing Appraisal/Assessment of Students with Special Health Needs"* to conduct the nursing assessment. The school nurse should know and follow the Family Educational Rights and Privacy Act (FERPA), local policies regarding release of records, information sharing, and confidentiality

when performing the nursing appraisal, assessment and health care planning. Information gleaned from the nursing assessment may require additional follow-up to determine if a student qualifies for a Section 504 plan or IEP (addressed in Section XI). The school nurse should follow local school system protocol in communicating this information to the appropriate school officials.

IDENTIFYING INFORMATION/CONTACT INFORMATION

Identifying information, information specific to the student's diabetes, and treatment needs should include, but not be limited to the following:

- Name of parent/guardian, address, phone number, and emergency contacts;
- Student's date of birth (DOB) and grade;
- Primary care provider's name and phone number; and
- Diabetes care provider's name and phone number.

MEDICAL HISTORY

An important part of the medical history is a thorough assessment of the current diabetes status and treatment. Much of this information is included on the DMMP/health care provider orders. The diabetes specific information along with other relevant medical history may include the following:

- Other medical conditions;
- Current medication and treatment orders for diabetes and other identified conditions, and the indications for their use;
- Emergency medications and the indication for their use;
- History of side effects or adverse reactions to current and/or past medications;
- Family history of diabetes;
- Development of disease, progress of disease, and initial diabetes diagnosis date/age, honeymoon phase;
- History of diabetes emergencies and emergency department visits for hypoglycemia and hyperglycemia/DKA;
- Signs and symptoms of hypoglycemia unique to the student;
- Previous glucagon use;
- Most recent hemoglobin A1C;

- Patterns of blood glucose levels/level of diabetes control;
- Number of days of school missed in the past year;
- Routine and emergency care/medication orders and instructions;
- Written copy of health care provider's meal/diet recommendations;
- Student awareness of symptoms of hypoglycemia/hyperglycemia;
- Blood glucose monitoring:
 - Frequency; times
 - Equipment used for blood glucose monitoring
 - Target range of blood glucose levels
 - Level of independence and goals for independence with blood glucose monitoring
- Use of a continuous glucose monitor (CGM) for monitoring trends:
 - Glucose trend information
 - Who receives the trend information
 - Necessary equipment for the CGM
 - Level of independence with use of the CGM goals for independence
- Ketone testing:
 - Urine vs. blood
 - Frequency; times and reasons for
 - Type of ketone test strips used
 - Level of independence and goals for independence
- Insulin administration:
 - Method of insulin administration (pump vs. syringe vs. pen)
 - For students using insulin pumps, the following should be assessed:
 - Type of insulin pump
 - Length of time on pump therapy
 - Verify pump settings
 - Document parent/guardian and/or student communication regarding changes in pump settings
 - Level of independence and goals for independence
 - Self-administration

SELF-MANAGEMENT ASSESSMENT

Only those tasks that a student can perform based on the nursing assessment and DMMP/health care provider orders should be allowed to be performed independently. Not all skills need be at the same level of independence (e.g., a student who self-manages may not be able to prepare and insert infusion set but may still be allowed to self-manage.) The self-management assessment results should be documented, and parents/guardians, and the student, should acknowledge the plan regarding self-management. This acknowledgment does not constitute a contract and is subject to change based on student needs.

The school nurse should assess the student's ability to perform diabetes management tasks and level of independence with medication/treatment. See Appendix B for an example of a self-management skills checklist. Self-management skills to be assessed may include the student's ability to:

- Understand the goals/plans for self-management;
- Follow provider management plan with minimal supervision, or assistance;
- Count carbohydrates, calculate insulin dose;
- Measure insulin and self-inject correctly;
- Use their blood glucose meter and maintain needed supplies;
- Communicate to school staff and respond to symptoms of hypoglycemia or hyperglycemia;
- Treat/respond to hypoglycemia according to their IHP; and
- Store (i.e., away from direct light, extreme heat and freezing temperatures) and discard (i.e., within the number of days of opening specified in the manufacturer's instructions) insulin vials correctly.

The school nurse should assess whether student demonstrates the following self-management and/or pump management skills when the student's DMMP/health care provider orders indicates the student may self-manage:

- Setting a basal rate/temporary basal rate
- Disconnecting pump
- Reconnecting pump at infusion set
- Preparing infusion set
- Inserting infusion set

- Troubleshooting alarms and malfunctions
- Counting carbohydrates
- Bolusing insulin
- Calculating an insulin dose
- Resetting basal rate profiles
- Setting a temporary basal rate
- Administering an insulin injection if needed for dislodging of cannula
- Changing batteries
- Ability and willingness to meet student self-management responsibilities

EDUCATIONAL HISTORY/INFORMATION

- School performance
- Grade level
- Information needed for revision of existing/development of Section 504 plan
- Participation in special programs, (e.g., vocational program, work-study program, dropout prevention program, alternative education program, infant and toddler program, early childhood intervention, etc.)
- Participation in school sponsored after-school activities
- Transportation type and needs (e.g., length of bus ride, length of walk, does the student carry emergency supplies)

PSYCHOSOCIAL CONSIDERATIONS

- Family status and available supports
- Family stressors
- Ability of student and family to cope with disease
- Student and family understanding of the condition
- Parent/guardian ability to meet their responsibilities as outlined in Section VIII below

- History of diabetes education
- Developmental considerations (e.g., adolescent specific concerns)
- Involvement in disease related support groups
- Any issues related to access to health care and diabetes supplies;
- Health insurance needs and other additional resources
- Cultural considerations
- Level of independence and plans/goals for independence

The school nurse should maintain an up-to-date student health record for students with diabetes. The health record should contain:

- Current DMMP/health care provider orders;
- An initial and annually reviewed and updated health appraisal and nursing assessment;
- A current emergency plan; and
- Current emergency contact information and numbers, updated at least annually.

INDIVIDUALIZED HEALTH PLANS

The school nurse should develop a written individualized health plan (IHP) to provide appropriate diabetes management in school. The IHP should be based on the information obtained in the nursing appraisal and assessment and the student's DMMP/health care provider orders. The plan should be developed in collaboration with the student's parent/guardian and the student's health care provider(s). The plan should outline the student's needs and the specific interventions appropriate to meet those needs. The IHP is not meant to be a substitute for a Section 504 plan or IEP. Many of the issues addressed in an IHP should be considered when determining eligibility for and content of a Section 504 plan or IEP (see section XI for addition discussion on this topic).

The student's health care provider should submit the DMMP/health care provider order form to communicate the needed diabetes care in the school setting. See [Appendix C](#) for the Maryland Diabetes Medical Management Plan/Health Care Provider Order Form. The IHP should include the student's routine and emergency medication as ordered by the student's health care provider as well as address the unique aspects of the individual student's school experience/activities. The IHP includes the nursing diagnoses and desired student outcomes. Desired outcomes to monitor and evaluate the IHP should include student safety, independence in managing their diabetes, and equal access to school-sponsored activities. The school nurse interventions and evaluation of student outcomes should be documented. The plan should include processes for diabetes care during field trips and school-sponsored events and during times when a school nurse and/or other school health services staff is not available. The plan should also

identify unlicensed school staff trained to provide specified diabetes care tasks as prescribed in the student's DMMP/health care provider orders. The decision to train unlicensed school staff and the specific staff member (s) trained is based on the school nurse's judgment.

The school nurse should review the IHP at least annually and update as needed. The following information gathered from the nursing assessment should be considered when developing IHPs for students with diabetes:

- Compliance with expected behavioral aspects of management plan;
- Challenges to participation in care during school;
- Developmental factors that facilitate or impede management;
- Existing or potential barriers to best practice management (e.g., compliance, developmental, or behavioral issues);
- Parent/guardian concerns and expectations;
- Student concerns;
- Classroom, bus, and cafeteria accommodations (See section on education planning);
- The plan to alert and train school staff regarding student's diabetes and expected role in implementation of emergency plan (as appropriate if trained) when the school nurse/school health services staff is not available;
- The student's schedule and activities (e.g., physical education, lunch, recess, transportation to/from school, school-sponsored activities and events (including field trips and after school activities) to ensure student needs are met if school personnel need to be available to administer insulin during the school day and during other school-sponsored events and activities;
- Knowledge of student's diabetes by appropriate school staff, including substitutes;
- Recommended accommodations to communicate to the Section 504 plan team based on nursing assessment and the student's DMMP/health care provider orders;
- Medication administration, including:
 - Student's ability to self-manage;
 - Need to delegate medication administration to a CMT;
 - Need to train designated unlicensed school staff (based on nursing judgment and in accordance with the Maryland Nurse Practice Act) to administer medication according to student's DMMP/health care provider orders;

- Student's ability to recognize and communicate to designated school staff when experiencing symptoms of hyperglycemia/hypoglycemia;
- Storage of the medication and/or equipment including light and temperature exposure prevention precautions;
- Storage and plan for access to snacks and fast-acting glucose;
- Needs for immediate access to emergency medication (e.g., emergency plan); and
- Student's understanding and demonstration of medication administration technique.

A copy of the nurse's final IHP should be placed in the student's health record, shared with the parents/guardian, and may be shared with the student's health care provider with parent/guardian consent.

EMERGENCY PLANS/PROTOCOLS

Based on the nursing assessment and the DMMP/health care provider orders, the school nurse should develop an emergency plan for students with diabetes. The plan should communicate how to recognize and treat hypoglycemia/hyperglycemia. The plan should ensure glucagon and/or fast-acting sugar is immediately accessible to all designated school personnel and the emergency protocol to be followed in the event of severe hypoglycemia (e.g., fast-acting sugar and/or glucagon administration). In addition, a plan should be developed to address hyperglycemia and pump/equipment failure issues. The emergency plan should include, but not be limited to:

- Health care provider's emergency orders/specific emergency interventions needed;
- Emergency contact information that is updated as changes occur;
- The plan to address hypoglycemia in the classroom;
- Signs and symptoms for which emergency care may be needed;
- Procedures for classroom teachers and other school staff to contact the school nurse or other school health services staff in an emergency;
- Who and when to call 911 according to medical orders and local school system policy;
- How glucagon and fast acting sugar will be stored to allow immediate availability to students and staff for those students who do not possess and/or self-administer their medication;
- A plan for an adult to accompany a student to the health suite as appropriate when necessary;
- The protocol for how school staff should contact the school nurse in an emergency; and

- A list of school staff designated and trained to administer glucagon.

To facilitate immediate access to fast-acting glucose and glucagon to treat hypoglycemia and the need to respond quickly to hyperglycemia, the school nurse should consider the following when developing an emergency plan:

- Size and layout of the school building;
- Health services staffing model;
- Plan for having snacks, fast acting sugar located at multiple sites within the building;
- Plan for having beverages located at multiple sites within the building for hypoglycemia (sugared) or hyperglycemia (water or low calorie);
- Plan for immediate access to glucagon;
- Plan for students who self-manage to securely self-carry emergency supplies for immediate access (e.g., a fanny pack);
- Procedures for notifying the nurse of symptoms; and
- Availability of trained designated unlicensed school staff to administer fast-acting glucose and/or glucagon when a nurse is not available.

Emergency plans should also include plans for disaster preparedness in the event of situations such as lockdown, sheltering in-place and evacuation.¹⁹ Refer to the Maryland State School Health Services Guideline "*Guideline for Emergency Planning for School Nurses*." The plan should make provision for diabetes management medications and supplies needed during a disaster or emergency.

The school nurse should provide a copy of the emergency plan to the parent/guardian and appropriate school staff who have direct contact with the student (including bus drivers), and place a copy in the student's health record. Providing a copy of the plan to school staff should be in a manner determined by the school nurse to allow immediate access while also protecting the student's confidentiality.

DELEGATION OF NURSING TASKS RELATED TO DIABETES MANAGEMENT

The registered nurse is always the leader of the school health services team. See the guideline entitled "*Role of the School Health Services Staff in Schools*." The Maryland Nurse Practice Act (Annotated Code of Maryland, Health Occupations Article, Title 8) and regulations (COMAR, Title 10, Subtitle 27) allows certain nursing functions to be delegated. Delegation is "the act of authorizing an unlicensed individual, a certified nursing assistant, or a medication technician to perform acts of registered nursing or licensed practical nursing."²⁰ For the purposes of this Guideline, the term "delegation" is used to describe authorizing nursing tasks to be performed by

a CMT and/or CNA as a routine part of their job, and the term “trained” is used to describe the provision of instruction and direction to authorize tasks to be performed by an unlicensed school staff who does not routinely perform the task(s). The decision as to whether the student's health care needs may be met by delegation to other school health services staff (e.g., CMT, CNA) or by training an unlicensed individual (e.g., teacher, coach, other school staff) is made using the criteria for delegation outlined in the Maryland Nurse Practice Act, all applicable regulations, and the **registered nurse's professional judgment**.

When a school nurse is not available to provide the care needed by students with diabetes or other special health care needs (either during the day, on field trips or during after-school or other school sponsored activities), COMAR 13A.05.05.08 and this Guideline, as required under Annotated Code of Maryland, Education Article § 7-426.4, require the principal and the school health services staff person to identify school staff to receive training to provide needed services to students with special health needs (including diabetes).²¹ Trained unlicensed school staff may include, but are not limited to: teachers, school administrators, coaches and athletic trainers. The decision to include trained school staff to perform certain diabetes care tasks is based on the nursing assessment of student needs/care required as specified in the student's DMMP/health care provider orders, and nursing judgment as to whether the care may be provided in a safe manner by trained school staff. Diabetes care provided by trained school staff should be provided according to the student's DMMP/health care provider orders, IHP and local school system policy.

The school nurse (who must be an RN) will determine the appropriate person (e.g., a delegate such as a CMT and/or CNA or trained unlicensed school staff) to whom responsibility for performing and supervising blood glucose monitoring, insulin administration, administration of glucagon in an emergency, and any other treatments/medications may be delegated. The school nurse will also evaluate and determine whether a student is able to self-administer medication or do blood glucose monitoring in the classroom. This determination is made based on the nursing assessment of each student, and with input from the authorized prescriber and the parent/guardian.

Unlicensed school staff may be trained to administer insulin or support self-management of other diabetes care tasks (e.g., blood glucose monitoring, insulin administration). These staff are not required to become a CMT if they are not administering medications as a routine part of their job duties. The school nurse determines if it is appropriate to train unlicensed school staff to provide diabetes care. This decision is based on nursing judgment on a case-by-case basis with the student's health and safety as the primary concern. The acts of delegation to a CMT and/or CNA or training a school staff to administer insulin is not prohibited in the Maryland Nurse Practice Act,²² but both delegation and training must be done in accordance with the Maryland Nurse Practice Act,²³ all applicable regulations, best practices and principles of delegation, and local school system policy. The registered nurse in a school setting (or any other setting) is not required to delegate or train an unlicensed person to perform a nursing task.²⁴ **However, in the absence of a delegation or training decision and plan, the school system is still accountable to ensure the student's needs are met to comply with both state and federal laws.** The school nurse should communicate the student's needs to the school health services coordinator or manager, and school administrator and work with the school administrator so appropriate plans may be made. It is the school's responsibility to be sure a school nurse, other school health services staff, or trained school staff is available to provide (or support the student's self-management) needed care as indicated in the DMMP/health care provider orders during the school day and during all school-sponsored

activities. Training school staff to provide diabetes care in an emergency (e.g., provision of fast-acting glucose or administration of glucagon) is also a task that may be delegated. The Maryland Nurse Practice Act allows nurses to instruct and provide direction to unlicensed persons who are not a CMT or CNA to administer emergency medications.¹¹ Specific training provided to each school staff is determined by the school nurse based on a case-by-case basis based on student need, nursing judgment and school staff member capability.

SECTION V: MEALS AND SNACKS

Meal and snacks for students with diabetes are based on individual student needs. The school nurse should communicate with the on-site school food service manager to determine any necessary cafeteria procedures and mechanism to obtain carbohydrate content of school meals. The specific insulin regimen and carbohydrate counting are the most common method for balancing insulin needs with exercise and food intake. In general, there are no forbidden foods for students with diabetes. All students should be encouraged to eat healthily. The health care provider in conjunction with the student and family will develop an effective meal plan considering the scheduled school meal times and the student's overall needs. The plan for snacks should include any recommendations for snacks and appropriate placement of snacks based on student needs (e.g., the health suite, classrooms, with students, and in other areas of the school). Classroom teachers and other school staff should be aware of the importance of meal schedules and the need for snacks. Students should always be provided their meals and snacks according to their individualized meal plan and given adequate time to consume their meals or snacks. To avoid hypoglycemia, it is important that meals and snacks not be delayed.

When planning meals and snacks for students with diabetes, the school nurse should know whether the student will bring lunch or purchase at school and assess the student's level of understanding and independence with meal choices. Students who obtain school meals as part of any United States Department of Agriculture (USDA) school meal program (i.e., school breakfast program or school lunch program) are entitled to meal modifications because of their special health need. In order to plan for meal/food accommodations, the following information is required for both free and reduced priced meals as well as full price meals. USDA regulations 7 C.F.R. Part 15b requires substitutions or modifications in school meals for children whose disability restricts their diet. A child with a disability or special health need must be provided food substitutions when a statement signed by a licensed health care provider supports the need. The health care provider must provide a statement of the following information on a form provided by the local school system:

- The child's disability or special health need;
- An explanation of why the disability or health need restricts the child's diet;
- The major life activity affected by the disability or health need;
- The food or foods to be omitted from the child's diet; and
- The food or choice of foods that must be substituted.

SECTION VI: PHYSICAL EDUCATION, EXERCISE, AND PHYSICAL ACTIVITY

Exercise and physical activity are important elements of diabetes management. Schools must offer students with diabetes equal access to physical education classes and team sports. Accommodations may be needed and should be specified in the student's Section 504 plan or IEP and/or emergency plan and be based on the student's DMMP/health care provider orders. Planning to respond to an emergency during physical education class or other physical activity should include a plan to provide immediate and easy access to fast acting glucose and for timely glucagon administration according to a student's emergency plan. Physical education teachers, coaches, and athletic trainers should be aware of the student's diabetes care needs, understand their role in implementing any needed accommodations, and understand their role in responding to an emergency according to the student's emergency plan. This may include supporting the student to carry and maintain their supplies and snacks on athletic fields or other physical activity locations (e.g., gymnasium) as necessary.

SECTION VII: SCHOOL-SPONSORED ACTIVITIES AND FIELD TRIPS

According to Federal law, all students have the right to equal access to educational activities. No student may be denied participation in a field-trip or other school sponsored activities because of the need for medication/treatment or requirement of additional assistance.^{1,2} This requirement applies to student attendance as a participant (e.g., member of a club or athletic team) and does not pertain to activities where the student is participating as an observer/spectator (e.g., attending an athletic event or theatrical performance). The school has the responsibility to provide appropriate staff to provide or support the needed diabetes care during school sponsored activities and events (including field trips and after school activities) based on the student's DMMP/health care provider orders and nursing assessment. The school nurse, a substitute nurse (e.g., another nurse who is not the usual school nurse), or trained school staff should be available during all school-sponsored activities to provide needed diabetes care based on the student's needs or support the care of students who self-manage their diabetes. When appropriate, based on the activity, parents should be given the opportunity to participate if they choose. However, **parents cannot be required to participate in/attend a school-sponsored activity, event, or field trip as a condition of the student's participation.**

The staff person in charge of a planned school-sponsored activity or event should give sufficient notice of the activity (as stated in local school system policy for field trip notification) to the school nurse so preparations can be made and a plan developed to ensure the needs of the student are met. It is the school's responsibility to arrange for an appropriate person to attend the activity, event or trip to meet the routine and emergency needs of students with diabetes. This may be a nurse, CMT/CNA or unlicensed school staff. The school nurse determines, in collaboration with the parent/guardian, diabetes care provider and school administrator, the most appropriate person to attend the school sponsored event to provide or support diabetes care based on a nursing assessment, the student's needs and nursing judgment. The school nurse is not required to train unlicensed school staff to provide diabetes care during school sponsored events when in the nurse's

judgment it is not safe to do so.²⁴ Unlicensed school staff cannot be required to be trained to provide diabetes care during school sponsored activities. In that case, the school nurse must work with the school administrator to make sure the student has safe and equal opportunity to participate in the activity.^{1,2}

The school nurse is responsible to communicate the needs of students with diabetes to the school staff in charge of the activity. The school nurse will provide a copy of the emergency plan for students with diabetes (including for those students who self-manage their diabetes) to school staff in charge of the school-sponsored activity prior to the activity. The school nurse should work with the family to be sure all the student's supplies, equipment, medications, and food are packed and taken on the field trip or easily and immediately available during other school sponsored activities. The school nurse should also be sure the school staff understands the emergency plan, how to implement the plan (including administration of emergency medications as ordered and trained to do so), and is aware of the most likely emergency needs of the specific student. Communication should be documented, be done in a manner to ensure the student's safety and should include both verbal and written communication.

Medications needed for diabetes should be administered to students during school-sponsored trips/activities as ordered in the student's DMMP/health care provider orders. Medications must be administered in compliance with the Maryland State School Health Services Guideline: "*Administration of Medication in Schools*" and according to the student's DMMP/health care provider orders. The school nurse, in collaboration with the school administrator, parent/guardian, and health care provider may recommend to the Section 504 plan team any accommodations needed during a field trip/school-sponsored activity.

SECTION VIII: CARE COORDINATION

CARE COORDINATION ROLES AND RESPONSIBILITIES

Care coordination and collaboration between schools and health care providers and providing a safe learning environment is shown to improve A1C levels and the quality of life for students with diabetes.²⁵ The school nurse is always the leader of the school health services team (e.g., the leader in implementing and coordinating diabetes care in the school setting) regardless of the school health services program service delivery model. Diabetes care is provided according to the DMMP/health care provider orders and provided through a collaborative team based approach within each school. The school nurse makes decisions regarding how to implement the DMMP/health care provider orders and the members of the diabetes care team (e.g., who provides the care to students with diabetes) in the school setting.

Some students with diabetes may have a designated school case manager to coordinate his/her Section 504 plan or IEP. The Section 504 plan team or IEP team will designate the case manager who could be the school nurse. For students without a Section 504 plan or IEP, the school nurse serves as the case manager. The school nurse also serves as the liaison between the health care team, school staff, administration, pupil services staff, parents/guardians, food service staff, district dietician, and the student regardless of who is the designated case manager. The school nurse may

APPENDIX A
Glucagon Administration Instructions



Kennedy Krieger Institute

MARYLAND STATE DEPARTMENT OF
EDUCATION

PREPARING WORLD CLASS STUDENTS

Procedure for Glucagon Administration

SHNIC
Specialized Health Needs
Interagency Collaboration

To prepare glucagon for injection:



1. Locate emergency kit.
2. Remove the flip-off top from the powdered glucagon vial.



3. Remove needle cover from the syringe filled with diluting fluid. Insert needle into the powdered glucagon vial. Push the needle plunger to inject the entire liquid solution into the powdered vial.



4. Without removing the needle from the vial, gently swirl or roll to mix the powder. The powder should completely dissolve and the solution should be clear and colorless.



5. Hold vial upside down and draw up prescribed amount of medication into the syringe.



Note: If the dose given is to a child over 44 pounds, the entire solution (1mg) would usually be given. For a smaller child less than 44 pounds, $\frac{1}{2}$ the solution would usually be used (0.5mg). Check orders to verify dose.

6. Withdraw needle from vial and hold syringe upright. Gently push up plunger to remove any excess air from syringe.

7. Cleanse injection site if alcohol swab available. Expose injection site. Insert needle and inject medication.

- ⇒ For subcutaneous injection only: Pinch skin/tissue and insert needle.
- ⇒ For intramuscular injection: Insert needle straight into tissue at a 90 degree angle.



8. Withdraw needle and apply light pressure at the injection site.
9. Dispose of sharps in container.
10. Turn child on their side.

APPENDIX B

Sample Maryland Diabetes Self-Management Skills Assessment Checklist

Maryland Diabetes Self-Management Skills Assessment Checklist

Valid from ___/___/___ to ___/___/___ (not to exceed 12 months) or School Year _____

Knowledge of DMMP/Health Care Provider Order Form	Needs Assistance	Needs Supervision	Independent
Student verbalizes signs, symptoms, and treatment of HYPOGLYCEMIA: Low Blood Sugar: <input type="checkbox"/> Hungry <input type="checkbox"/> Weak/Shaky <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Confusion Very Low Blood Sugar: <input type="checkbox"/> Nausea <input type="checkbox"/> Slurred speech <input type="checkbox"/> Clamminess <input type="checkbox"/> Blurred vision <input type="checkbox"/> Loss of concentration Student's Usual Signs/Symptoms of Low Blood Sugar: _____			
Student verbalizes signs, symptoms, and treatment of HYPERGLYCEMIA: High Blood Sugar: <input type="checkbox"/> Increased thirst <input type="checkbox"/> Increased urination <input type="checkbox"/> Tired/drowsy <input type="checkbox"/> Blurred vision <input type="checkbox"/> Warm, dry or flushed skin <input type="checkbox"/> Weakness/muscle aches Very High Blood Sugar: <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Extreme thirst <input type="checkbox"/> Fruity breath odor Student's Usual Signs/Symptoms of Low Blood Sugar: _____			
Student identifies when and who to seek for assistance with diabetes management.			
Student identifies diabetes supplies needed at school and where they are stored.			
Skills: Blood Glucose Monitoring	Needs Assistance	Needs Supervision	Independent
Student demonstrates correct technique and understanding of blood glucose monitoring: <input type="checkbox"/> Washes hands <input type="checkbox"/> Verifies code of meter and matches test strip <input type="checkbox"/> Operates lancing device <input type="checkbox"/> Inserts test strip <input type="checkbox"/> Obtains blood sample <input type="checkbox"/> Records and communicates results <input type="checkbox"/> Interprets results			
Insulin administration: Method of Insulin Delivery: <input type="checkbox"/> Syringe <input type="checkbox"/> Pen <input type="checkbox"/> Pump <input type="checkbox"/> Carbohydrate Insulin Dose: One unit of insulin per _____ grams of carbohydrate <input type="checkbox"/> Calculates insulin to carbohydrate ratio per DMMP/Health Care Provider Order Form <input type="checkbox"/> Administers insulin at appropriate times <input type="checkbox"/> Can calculate the correction dose			

Skills: Insulin Administration	Needs Assistance	Needs Supervision	Independent
Insulin administration by SYRINGE: <input type="checkbox"/> Selects appropriate injection site <input type="checkbox"/> Draws up correct dose in syringe <input type="checkbox"/> Verifies insulin dose <input type="checkbox"/> Injects insulin <input type="checkbox"/> Disposes of sharps safely <input type="checkbox"/> Records administration			
Insulin administration by PEN: <input type="checkbox"/> Selects appropriate injection site <input type="checkbox"/> Primes pen with insulin, if necessary <input type="checkbox"/> Dials correct insulin dose <input type="checkbox"/> Verifies insulin dose <input type="checkbox"/> Injects insulin <input type="checkbox"/> Disposes of sharps safely <input type="checkbox"/> Records administration			
Insulin administration by PUMP: <input type="checkbox"/> Demonstrates basic pump function and troubleshooting (how to give a bolus, suspend pump, check pump status, verify dose delivered, change batteries, check insulin reservoir, and identify and respond to alarms) <input type="checkbox"/> Reports pump malfunctions to appropriate staff <input type="checkbox"/> Ensures pump safety during physical activity <input type="checkbox"/> Locates backup pump supplies, insulin, and syringe or pen in event of pump malfunction <input type="checkbox"/> Demonstrates ability to use insulin syringe or pen in event of pump malfunction <input type="checkbox"/> Records administration			
Skills: Management of Hypoglycemia	Needs Assistance	Needs Supervision	Independent
Management of Low Blood Glucose (below _____ mg/dl) Treatment Plan: <input type="checkbox"/> Take 15 grams of fast-acting carbohydrates <input type="checkbox"/> Retest blood glucose 10 – 15 minutes after treatment <input type="checkbox"/> Repeat steps 1 and 2 until blood glucose is above _____ mg/dl <input type="checkbox"/> Follow treatment with _____ grams of carbohydrate if more than one hour until next meal/snack or if going to physical activity <input type="checkbox"/> Delay exercise if blood glucose is below _____ mg/dl			

Skills: Management of Hyperglycemia	Needs Assistance	Needs Supervision	Independent
Management of High Blood Glucose (above _____ mg/dl) Treatment Plan: <input type="checkbox"/> Administer insulin correction dose determined by HCP's order for sliding scale <input type="checkbox"/> Retest blood glucose in _____ hours if above _____ 206 _____ mg/dl <input type="checkbox"/> Conduct ketone urine test if supplied by parent/guardian and ordered by HCP <input type="checkbox"/> Conduct ketone blood test if supplied by parent/guardian and ordered by HCP			
Skills: Ketone Testing	Needs Assistance	Needs Supervision	Independent
Student demonstrates technique for ketone testing and reporting of results: <input type="checkbox"/> Collects specimen (blood or urine) <input type="checkbox"/> Uses test strip appropriately <input type="checkbox"/> Records and communicates results <input type="checkbox"/> Understands treatment/action according to DMMP/Health Care Provider Order Form			
Skills: Nutrition and Activity	Needs Assistance	Needs Supervision	Independent
Student verbalizes healthy meal planning.			
Student identifies carbohydrate content of foods.			
Student adjusts foods based on blood glucose results and activity.			
Student verbalizes effects of exercise on insulin dose calculation.			
Student carries snack when engaged in physical activity.			
Student recognizes signs and symptoms of hypoglycemia and takes corrective action.			
Student recognizes signs and symptoms of hyperglycemia and takes corrective action.			
Skills: Safety	Needs Assistance	Needs Supervision	Independent
Student carries fast acting carbohydrate source for signs and symptoms of hypoglycemia.			
Student understands and practices universal precautions.			
Student able to carry diabetes supplies.			
Student does not share diabetes equipment.			
Student has access to emergency contacts.			
Student understands they are subject to periodic checks with nurse to ensure competency in self-management of diabetes care.			

APPENDIX C
Maryland Diabetes Medical Management Plan/
Health Care Provider Order Form and Form Guidance

Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form

Valid from: Start ___/___/___ to End ___/___/___ or for School Year _____

Student Name: _____	DOB: _____	Grade: _____
Blood Glucose Monitoring*		*Self-management skills to be verified by school nurse
Blood Glucose (BG) Monitoring:		
<input type="checkbox"/> Before meals <input type="checkbox"/> Before PE/Activity <input type="checkbox"/> After PE/Activity <input type="checkbox"/> Prior to dismissal <input type="checkbox"/> Additional monitoring per parent request <input type="checkbox"/> For symptoms of hypo/hyperglycemia & anytime the student does not feel well <input type="checkbox"/> Student may independently check BG*		
Continuous Glucose Monitoring		
<input type="checkbox"/> Uses CGM Make/Model: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ Alarms set for: Low _____ mg/dl High _____ mg/dl <input type="checkbox"/> If sensor falls out at school, notify parent		
Hypoglycemia Management*		*Self-management skills to be verified by school nurse
Mild or Moderate Hypoglycemia (BG _____ mg/dl to _____ mg/dl):		
<input type="checkbox"/> Provide quick-acting glucose product equal to 15 grams of carbohydrate (or glucose gel), if conscious & able to swallow. If glucose gel is given, place student in recovery position. <input type="checkbox"/> Suspend pump for BG < _____ mg/dl and restart pump when BG > _____ mg/dl <input type="checkbox"/> Student should consume a meal or snack within _____ minutes after treating hypoglycemia <input type="checkbox"/> Other: _____ Always treat hypoglycemia before the administration of meal/snack insulin Repeat BG check 15 minutes after use of quick-acting glucose <ul style="list-style-type: none"> • If BG still low, re-treat with 15 gram quick-acting CHO as stated above • If BG in acceptable range and it is lunch or snack time, have student eat and cover meal CHO per orders • If CGM in use and BG 70 and arrow going up, no need to recheck Student may self-manage mild or moderate hypoglycemia and notify the school nurse*: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Severe Hypoglycemia (BG < _____ mg/dl):		
If symptoms worsen despite treatment/retreatment _____ times, student is unconscious, semi-conscious, unable to control his/her airway, unable to swallow or seizing give: <input type="checkbox"/> GLUCAGON injection: <input type="checkbox"/> 1 mg <input type="checkbox"/> 0.5 mg IM or SQ <ul style="list-style-type: none"> • Place student in the recovery position • Suspend pump, if applicable, and restart pump at BG > _____ mg/dl • Call 911 and state glucagon was given for hypoglycemia; notify parent/guardian <input type="checkbox"/> Use glucose gel inside cheek, even if unconscious, seizing if glucagon not available or there is no response to glucagon administration. If glucose gel is given, place student in recovery position.		
Hyperglycemia Management*		*Self-management skills to be verified by school nurse
If BG greater than _____ mg/dl, or when child complains of nausea, vomiting, and/or abdominal pain, check urine/blood for ketones.		
<ul style="list-style-type: none"> • If urine ketones are trace to small or blood ketones _____ mmol/L: <ul style="list-style-type: none"> • Give _____ ounces of sugar-free fluid or water per hour • Give insulin as listed in Insulin Orders • If urine ketones are moderate to large or blood ketones greater than _____ mmol/L <ul style="list-style-type: none"> • Give _____ ounces of sugar-free fluid or water • Give insulin as listed in Insulin Orders • If large ketones, vomiting or other signs of ketoacidosis, call 911. Notify parent/guardian • Recheck BG and ketones _____ hours after administering insulin • Contact Parent/Guardian for: <input type="checkbox"/> BG > _____ mg/dl <input type="checkbox"/> Ketones _____ mmol/L Student may self-manage hyperglycemia with trace/small ketones and notify the school nurse: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Snacks		
Snacks needed: <input type="checkbox"/> Before physical education/physical activity/sports longer than _____ mins <input type="checkbox"/> Per parent/guardian <input type="checkbox"/> Per student <input type="checkbox"/> Limit snack to _____ grams of CHO <input type="checkbox"/> Delay snack if BG > _____ mg/dl <input type="checkbox"/> No snack coverage <input type="checkbox"/> Other: _____		
Provider Name: _____	Signature: _____	Date: _____
Acknowledged and received by: _____	School Nurse: _____	Date: _____

Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form

Valid from: Start ___/___/___ to End ___/___/___ or for School Year _____

Student Name:	DOB:	Grade:
Physical Education, Physical Activity, and Sports		
<input type="checkbox"/> Avoid physical education, physical activity, and sports if: <input type="checkbox"/> BG < ___ mg/dl <input type="checkbox"/> BG > ___ mg/dl <input type="checkbox"/> Ketones present <input type="checkbox"/> If BG is 80-100 mg/dl, give 15 grams of CHO and return to physical education, physical activity, or sports <input type="checkbox"/> May disconnect pump for sports activities <input type="checkbox"/> Student may set temporary basal rate <input type="checkbox"/> Other:		
Transportation		
<input type="checkbox"/> BG must be > ___ mg/dl for bus ride/walk home <input type="checkbox"/> Only check BG if symptomatic prior to bus ride/walk home <input type="checkbox"/> Allow student to carry quick-acting glucose for consumption on bus, as needed for hypoglycemia <input type="checkbox"/> Student must be transported home with parent/guardian if (specify): _____ <input type="checkbox"/> Other:		
Disaster Plan (if needed for lockdown, 72 hr shelter in place)		
<input type="checkbox"/> Continue to follow orders contained in this medical management plan <input type="checkbox"/> Additional insulin orders as follows: <input type="checkbox"/> Other:		
Pump Management		
Type of Pump:	Pump start date:	Child Lock: <input type="checkbox"/> On <input type="checkbox"/> Off
Basal rates: ___ unit(s)/hour ___ AM/PM	___ unit(s)/hour ___ AM/PM	___ unit(s)/hour ___ AM/PM
___ unit(s)/hour ___ AM/PM	___ unit(s)/hour ___ AM/PM	___ unit(s)/hour ___ AM/PM
___ unit(s)/hour ___ AM/PM	___ unit(s)/hour ___ AM/PM	___ unit(s)/hour ___ AM/PM
Additional Hyperglycemia Management:		
<input type="checkbox"/> If BG > _____ mg/dl and has not decreased over _____ hours after bolus, consider infusion site change. Notify parent/guardian <input type="checkbox"/> For infusion site failure: <input type="checkbox"/> Give insulin via syringe or pen <input type="checkbox"/> Change infusion site <input type="checkbox"/> For suspected pump failure, suspend or remove pump and give insulin via syringe or pen <input type="checkbox"/> If BG > ___ mg/dl and <u>moderate to large</u> ketones, student should change infusion site and give correction dose by pen or syringe <input type="checkbox"/> Comments:		
Independent Pump Management Skills and Supervision needs*		
*Skills to be verified by school nurse. Supervision will be provided if not fully independent when appropriate		
Student is independent in the pump skills indicated below:		
<input type="checkbox"/> Carbohydrate counting <input type="checkbox"/> Bolus an insulin dose <input type="checkbox"/> Set a basal rate/temporary basal rate <input type="checkbox"/> Reconnect pump at infusion set <input type="checkbox"/> Prepare and insert infusion set <input type="checkbox"/> Troubleshoot alarms and malfunctions <input type="checkbox"/> Give self-injection if needed <input type="checkbox"/> Disconnect pump <input type="checkbox"/> Other:		
Additional Orders		
<hr/> <hr/>		
Parent/Guardian Consent for Self-Management		
<input type="checkbox"/> I acknowledge that my child <input type="checkbox"/> is <input type="checkbox"/> is not authorized to self-manage as indicated by my child's health care provider. <input type="checkbox"/> I understand the school nurse will work with my child to learn self-management skills he/she is not currently capable of or authorized to perform independently.		
My child has my permission to independently perform the diabetes tasks listed below as indicated by my child's health care provider:		
<input type="checkbox"/> Blood glucose monitoring <input type="checkbox"/> Insulin administration <input type="checkbox"/> Pump management <input type="checkbox"/> Carbohydrate counting <input type="checkbox"/> Insulin dose calculation <input type="checkbox"/> Other:		
Parent/Guardian Name:	Signature:	Date:
Provider Name:	Signature:	Date:
Acknowledged and received by:	School Nurse:	Date:

Maryland Diabetes Medical Management Plan/Health Care Provider Order Form

Guidance Document

Form Section	Guidance
<p>Insulin Dosing</p> <p>Carbohydrate coverage</p> <p>Correction dose</p> <p>Fixed dose</p> <p>Fixed dose with sliding scale</p>	<p>Calculated to cover carbohydrate intake at meals or snacks. $\frac{\text{Grams of carbohydrate in meal}}{\text{Insulin to Carb Ratio}} = \text{units of insulin}$</p> <p>Calculated to correct a high blood glucose level to a desired goal. Sample formula: $\frac{\text{Blood glucose} - \text{Target blood glucose}}{\text{Sensitivity factor}} = \text{units for correction}$</p> <p>Set insulin dose at meals.</p> <p>Set insulin dose which is adjusted based on blood glucose levels.</p>
<p>Insulin Delivery Insulin Pumps</p>	<p>It is always helpful to have quick access to the instruction manual or the quick reference guide for each pump. All pump manufacturers have websites with instruction manuals and online trainings.</p>
<p>Insulin Dose Administration Principles</p>	<p>Insulin dose calculation: round up or down to the nearest half or whole unit. May use clinical discretion: if physical activity follows, round down.</p>
<p>Insulin Dose Administration Principles</p>	<p>Insulin should be given before a meal. If the CHO intake cannot be determined before the meal, consult with the parents and provider to develop a plan that would work best for the student.</p>
<p>Target Blood Glucose Range</p>	<p>Suggested ranges per the American Diabetes Association for all pediatric patients with Type 1.</p> <ul style="list-style-type: none"> • Before meals: 90-130 mg/dl • Bedtime/overnight: 90-150 mg/dl
<p>Continuous Glucose Monitoring</p>	<p>Monitors glucose level from the interstitial tissue. Provides valuable information on trends in glucose levels, pre- and post-meal glucose levels and glucose changes during exercise. System involves a sensor, transmitter and a receiver. Interstitial reading lags behind blood glucose readings by 5 minutes. Medtronic and Dexcom are the primary CGM manufacturers and each has helpful websites.</p>
<p>Hypoglycemia</p>	<p>Examples of quick acting glucose sources (equal to approximately 15 grams CHO) include:</p> <ul style="list-style-type: none"> - 4 ounces of fruit juice - 4-6 ounces of regular soda - 3-4 glucose tablets - 2-3 rolls of smarties

	<ul style="list-style-type: none"> - 10 sweet tarts - 15 regular jelly beans - 3 teaspoons of cake decorating gel (fat free) - 1 Tablespoon of table sugar - 4-5 packets of table sugar <p>Some students, especially younger students on insulin pumps, may need less amounts of quick acting glucose to correct a low BG. Parent may provide a chart with quick acting glucose amounts for BG less than target, per provider permission.</p>
Hypoglycemia Glucagon	Emergency injectable hormone that raises blood glucose levels within 5-15 minutes; dosing based on weight.
Hyperglycemia	Refer to the Hyperglycemia algorithm in the MSDE/DHMH Management of Diabetes in Schools. Encourage sugar free fluids per DMMP. Ketone monitoring is imperative in managing hyperglycemia. Ketones are released with a lack of insulin; untreated hyperglycemia can lead to elevated blood and urine ketone levels.
Physical Education, Physical Activity, Sports	Students on insulin pumps may have options in preparing for physical activity. For example; suspending the pump, modifying the basal rate, and disconnecting the pump.

References:

American Diabetes Association. Children and adolescents, Sec 11. In Standards of Medical Care in Diabetes – 2016. Diabetes Care 2016; 39(Suppl. 1): S86-93.

Maryland State School Health Services Guideline, Management of Diabetes in Schools, 2016.

Helping Administer to the Needs of Students with Diabetes in School, Training Program for School Nurses, 2014.

APPENDIX D

Section 504 Plan and IEP Parent and Educator Brochure

Classwork and Testing

- Student may take breaks to use the water fountain or bathroom, check blood glucose, or treat hypoglycemia/hyperglycemia during a test or other activity. The student will be given extra time to finish the test or other activity, without penalty.
- Student shall be given instruction to help him/her make up any classroom assignment missed due to diabetes care, without penalty.
- Student shall not be penalized for absences required for medical appointments and/or illness related to diabetes.
- Teacher will repeat directions and check for understanding when student was out of the room for medical purposes.
- Teacher will give extra time to complete tasks if necessary.
- Student must be allowed time to monitor blood glucose before standardized testing.

Social/Emotional Support

- School personnel should be aware of the student's feelings about having diabetes and identify ways to ensure the student is treated the same as other students.
- Student should be given the opportunity to discuss diabetes management with peers, if desired.
- Privacy should be provided when student performs diabetes care including blood glucose testing, insulin administration, etc.

Extracurricular and School Sponsored Activities

- Student shall have unrestricted access to participate in all extracurricular activities (e.g., sports, clubs, and enrichment programs) and school sponsored activities including field trips. Advanced planning may be required.
- All accommodations and modifications will be met, including necessary supervision by identified school personnel as determined by the School Nurse (RN). The student's parent/guardian will not be required to accompany the student on field trips or any other school sponsored activity in which the student attends as a participant.
- The School Nurse (RN) will create and communicate a plan to ensure student's diabetes care is safely managed at any school sponsored activity or field trip.



Section 504 Plan and Individualized Education Program (IEP) Considerations for a Student with Diabetes

FOR PARENTS AND EDUCATORS



Parents and educators working **TOGETHER** can **BEST** support a student's success!

Students with diabetes should be individually assessed for eligibility for services under Section 504 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. If a student is eligible, an appropriate Section 504 Plan or Individualized Education Program (IEP) should be developed by the school team, with input from the parent or guardian and school nurse.

This brochure contains lists of sample accommodations to be considered by the school team. Individual students with diabetes have different needs, but their education plans are likely to address these common elements. The accommodations are not necessarily appropriate for all students; accommodations for each student will vary because plans must be individualized. Considerations in this brochure are applicable to both Section 504 Plans and IEPs. Students with a pre-existing IEP would have accommodations added to their IEP as they are not eligible for both a Section 504 Plan and an IEP.

*A **Section 504 plan** is meant to protect eligible students with a disability from discrimination by providing accommodations and modifications that will allow them equal opportunity to participate in school programs and activities.*

Blood Glucose Monitoring

- Student's blood glucose will be monitored at the times designated in the student's health care provider's orders.
- A student deemed independent may self-manage anywhere (e.g., in the classroom), anytime, and keep their diabetes supplies with them as determined by school nurse assessment in conjunction with their parent/guardian, and healthcare provider.
- Student may monitor blood glucose in the classroom or any school setting as appropriate.
- A plan should be discussed for a student who is not independent in their care concerning where blood glucose monitoring will occur. This should be identified in the emergency action plan.
- A student experiencing hypoglycemia should be treated on the spot if possible. School health services staff should be notified.
- A student who is symptomatic should be accompanied by an adult staff member to the health suite when leaving their current location is safe and appropriate.
- Teachers will send student to the health suite at specified times (e.g. before lunch, dismissal) as indicated in the student's health care provider's orders.
- Student shall be provided with privacy for blood glucose monitoring if desired.

Health and Safety

- All school staff, including teachers, coaches and bus drivers who interact regularly with the student must know how to recognize high and low blood glucose levels and respond appropriately.
- Student should be permitted to leave the classroom to see the nurse for diabetes related issues without restriction and should be escorted if symptomatic.
- All teachers and substitute teachers will be provided with an emergency action plan and/or classroom plan created by the school nurse (RN).
- Trained school staff must be available during school and all school sponsored activities, which the student attends as a participant, to administer glucagon according to the health care provider orders and emergency action plan.
- Student access to a cell phone should be evaluated for health and safety.



Insulin Administration

- A student deemed to be independent in their care may self-administer insulin based on the student's health care provider's orders.
- Student shall be provided privacy for insulin administration if desired.
- A method of communication will be established for the independent student to report to the school nurse/school health services staff concerning insulin dose and administration.

Nutrition

- Student is permitted to eat whenever and wherever necessary including on school buses.
- Student should have appropriate and sufficient time to eat lunch.
- Food Services staff should provide carbohydrate counts and nutrition information for any food served at school.
- Student shall be permitted to have immediate access to water at all times.
- Student shall be permitted to have access to the bathroom without restriction.
- Student must have access to parent/guardian provided snacks, as needed.
- Student must have immediate access to fast-acting glucose.

Activity and Exercise

- Physical education instructors and coaches must have a copy of the emergency action plan and be able to recognize signs and symptoms of hypoglycemia and hyperglycemia.
- Student may monitor blood glucose before, during, and after activity/exercise based on student's health care provider's orders.
- Student should have access to fast-acting carbohydrates during physical education, physical activities, sports and recess.

*An **IEP** is a written document required under the Individuals with Disabilities Education Act for students with disabilities that outlines their need for special education and related services.*

Hypoglycemia

Hypoglycemia or low blood sugar is when your blood sugar is less than 70 mg/dl.

If you have these symptoms:



Shaking



Anxious



Sweating



Dizzy



Hunger



Fast
Heartbeat



Blurred
Vision



Weakness/
Fatigue



Headache



Irritable

Check your blood sugar. If it is less than 70 mg/dl:

- 1** Eat or drink a simple sugar such as honey, sugar, fruit juice or 1/2 cup of regular soda.
- 2** Wait 15 minutes and then check your blood sugar again.
- 3** If your blood sugar is still less than 70 mg/dl have another serving of simple sugar and
- 4** Then eat a snack of complex carbohydrate such as cheese and crackers, or half of a sandwich.



If your family or friends find you "sleeping" and cannot wake you, make sure they know to call 9-1-1.

How to Prevent Hypoglycemia

- Eat at regular times every day.
- Do not skip meals.
- Check your blood sugar every day.
- Take your medicine as directed.

If you continue to have low blood sugar, see your doctor as soon as possible.

Hyperglycemia

Hyperglycemia or high blood sugar is when your blood sugar is over 200 mg/dl.

If you have these symptoms:



Very thirsty



Hunger



Weakness/Fatigue



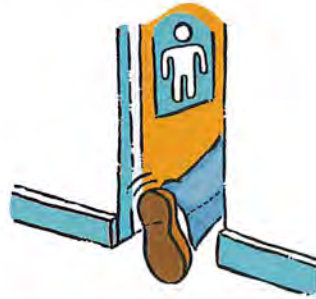
Blurred vision



Dry skin



Sore is not healing



Urinating often



Nausea

Check your blood sugar. If it is over 200 mg/dl:

- 1** Did you eat too much food? *If yes, drink 1 cup of water or a sugar-free drink every hour.*
- 2** Did you forget to take your medicine? *If yes, take your medicine.*
- 3** Do you have an infection? Flu? Stress?

If you have high blood sugars > 200 mg/dl for more than three days call your doctor.

How to Prevent Hyperglycemia

- Watch how much you eat.
- Exercise or move every day.
- Take your medicine as directed.
- Check your blood sugars every day.

Section 16

Bloodborne pathogens

Control

Bloodborne Pathogens Control

Contained in this section is a copy of the document BLOODBORNE PATHOGENS CONTROL AND HANDLING BODY FLUIDS IN THE SCHOOL SETTING (December 2007).



BLOODBORNE PATHOGENS CONTROL AND HANDLING BODY FLUIDS IN THE SCHOOL SETTING

MARYLAND STATE SCHOOL HEALTH GUIDELINE

DECEMBER 2007

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Student Services and Alternative Programs
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200 West Baltimore Street
Baltimore, Maryland 21201
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Maryland Department of Health
and Mental Hygiene Center for
Maternal & Child Health
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MARYLAND SCHOOL HEALTH SERVICES GUIDELINE

Foreword

There is a strong relationship between academic achievement and a child's physical, emotional and mental health. This link is the foundation for providing school health services as an important component of a school program. School health services provide primary prevention aimed at keeping students in schools through appropriate screenings, early identification of children at risk for physical, emotional and mental health concerns, and case management of students with chronic health concerns.

The Annotated Code of Maryland, Education Article, §7-401 requires the Maryland State Department of Education (MSDE) and the Maryland Department of Health and Mental Hygiene (DHMH) to jointly develop public standards and guidelines for school health programs. The following guideline is developed in accordance with that requirement and is based on the expressed needs of the local school health services programs. These guidelines contain recommendations for minimum standards of care and current best practices for the health service topics addressed. It is intended that these guidelines will be used by the local school systems in developing local school health services policies and procedures as a means to assist local school health services programs in providing consistent and safe care to the students of Maryland. Specific laws and regulations that direct school nursing practice or other health services are identified in the guidelines.

BLOODBORNE PATHOGENS CONTROL and HANDLING BODY FLUIDS IN THE SCHOOL SETTING

Introduction

The Maryland State Department of Education (MSDE) and the Department of Health and Mental Hygiene (DHMH) recognize that prevention of communicable diseases is an important area of concern for school staff. To assist local school systems (LSSs) in dealing with health-related issues, MSDE and DHMH have worked collaboratively to address these concerns. This resource manual was specifically developed to address prevention of the transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), and other bloodborne pathogens.

The Centers for Disease Control and Prevention (CDC) emphasizes the need to consider all blood and other potentially infectious materials (OPIM) from all individuals as potentially infectious for bloodborne pathogens. Many people who are infected with HIV, HBV, or HCV have no symptoms. Transmission of these diseases to other persons can occur through exposure to body fluids. Based on this fact, school staff should consider the body fluids from all persons as potentially infectious and should use universal precautions. Universal precautions are a method of infection control that considers blood and OPIM from all sources as potentially infectious for bloodborne pathogens.

In 1992, the Federal Occupational Safety and Health Administration (OSHA) promulgated the Bloodborne Pathogen Standard (BBPS), which was incorporated into the Maryland Occupational Safety and Health Regulation (MOSH) under Code of Maryland Regulations (COMAR) 09.12.31, J-1. Part 1910 of Title 29 of the Code of Federal Regulations (29 CFR 1910.1030) supplies the details of the BBPS. It requires that employers (including schools) who have employees at risk of being exposed to body fluids do the following:

- determine which employees have potential for occupational exposure;
- write and annually update an Exposure Control Plan;
- provide appropriate personal protective equipment (e.g., gloves);
- provide initial and annual training to all staff with the potential of occupational exposure;
- offer hepatitis B vaccine to employees who are identified at risk for occupational exposure;
- provide post exposure management of employees who have "exposure incidents";
- maintain records of training and exposure incidents, including all needlesticks; and
- provide appropriate engineering controls, such as safe needle systems, to reduce risk of needlesticks, with employee input in choosing safer devices.

Local school systems must provide initial and annual general information about bloodborne pathogens and universal precautions.

Purpose

To provide guidelines for policy and safe practices to prevent the transmission of HIV, HBV and HCV. In addition, this guideline may be used to supplement in-service training for school personnel.

Overview and Definitions

HIV, HBV, and HCV are spread from one person to another by exposure to blood or OPIM. All of these viruses cause serious illnesses, which can result in death. There are no cures for the diseases caused by these viruses; however, certain treatments may help improve the quality and length of life. The most common methods of spreading these viruses are unprotected anal, oral, or vaginal sexual intercourse with an infected person, injection of infected body fluids (such as occurs from sharing drug injection equipment), and from an infected mother to her baby during pregnancy, childbirth, or breast-feeding. These viruses can also be transmitted when a person is stuck with a needle that contains infected blood, or by getting blood or OPIM in the eyes, mouth, or in an open cut. Special procedures have been developed to manage exposures to body fluids that may contain these viruses. Management of exposures to body fluids is covered in this manual. Body fluids known to transmit these viruses are blood, semen, and vaginal secretions. These viruses are NOT spread by casual contact with an infected person, (e.g., hugging, sharing eating utensils, touching, sitting next to someone, shaking hands, sharing food or drink, or closed mouth kissing). Unless visible blood is present in saliva, tears, and sweat transmission of HIV, HBV, and HCV is generally not transmitted (Centers for Disease Control and Prevention, <http://www.cdc.gov/az/h.html>).

The spread of these viruses from one person to another can be prevented by abstaining from anal, oral, or vaginal sexual intercourse. **Risk of transmission can be significantly reduced by** using barriers (e.g., latex condoms) during intercourse, not sharing needles, and protecting oneself from blood and OPIM (e.g., using gloves). It is also recommended that individuals not share personal items such as razors, nail clippers, body-piercing implements, and toothbrushes, as blood may be present on these items.

Human Immunodeficiency Virus

HIV infection causes Acquired Immunodeficiency Syndrome (AIDS). HIV infection causes a person's immune system to weaken over time, making the person more vulnerable to otherwise harmless infections as well as malignancies. Current treatments for HIV infection have extended life expectancy for people with HIV/AIDS and have reduced the number and severity of infections.

People who have occupational exposure to HIV may benefit from postexposure prophylaxis (PEP), which means receiving medications that may prevent a person from acquiring HIV infection.

Hepatitis B Virus

HBV causes infection of the liver and may lead to liver failure and liver cancer. Some individuals who are infected with HBV will carry the virus for the rest of their lives. Hepatitis B carriers, or persons with chronic HBV infection, are often symptom-free. They may be unaware that they are infected with the virus, but they are capable of passing the virus on to others. The risk of hepatitis B infection following an exposure to blood far exceeds that for HIV infection. Unlike HIV, there is an effective vaccine to prevent HBV infection in adults and children. People who have occupational exposure to HBV may benefit from postexposure prophylaxis (PEP), which means receiving medications that may prevent a person from acquiring HBV infection.

Hepatitis C Virus

HCV also causes infection of the liver and may lead to liver failure and liver cancer. Certain people are at increased risk of getting hepatitis C, including people who received blood transfusions before screening of blood began in 1992 and drug users who share needles. Like HBV, some people can carry HCV after they have been infected and can transmit the disease even if they do not have symptoms. There is no vaccine to prevent hepatitis C. However, there are medications available to manage the disease process.

Approaches to Disease Prevention in the School Setting

Transmission of HIV, HBV, or HCV can result from contact with infected body fluids from an infected person. To help prevent the spread of bloodborne pathogens, the use of gloves is essential when contact with blood or other potential infected materials (OPIM) is anticipated, in addition to **thorough handwashing** (See Appendices B and C, Correct Procedure for Handwashing and Removing Gloves). Proper disposal of waste, clean up of body fluid spills, and proper cleaning of equipment are also essential techniques of infection control.

Gloves and Other Barriers (See Appendix B)

- ❑ All school staff shall routinely use gloves to prevent skin exposure when contact with blood or other potentially infectious body fluids is anticipated.
- ❑ Types of gloves: Disposable gloves are used as effective barriers. Keep in mind some people are sensitive to latex materials. It is recommended that custodial staff use washable, reusable gloves of a heavy material, such as industrial-type gloves designed for custodial work.
- ❑ Size of gloves: Fit is essential for protection of the individual wearing gloves. Gloves should be available in small, medium, and large sizes for use by school personnel.
- ❑ Accessibility: Disposable gloves should be available in every classroom, office area, custodial closet, cafeteria, and laundry area. These gloves should be maintained in locations accessible to all staff, substitutes, and volunteers. Gloves should also be available

during playground periods, physical education classes, athletic events, field trips, etc. All first aid kits should be stocked with gloves and replenished as necessary.

- Torn or punctured gloves should not be used.
- Disposal: Used gloves should be removed using the recommended procedure illustrated in Appendix B, Correct Procedure for Removing Gloves. Dispose of used gloves by placing them in a trash can lined with a plastic bag. Wash hands after removing gloves. Do not reuse latex, vinyl, or non-latex gloves.
- Staff instruction: Appropriate use of gloves and procedures for putting on, removing, and disposing of gloves should be included in staff education programs.
- Other barriers: When gloves are not immediately available, other barriers (e.g., a wad of tissues, paper, cloth towels, or clothing) should be used to prevent body fluids from getting on the hands. Other personal protective equipment (e.g., face shields) should be worn whenever splashes, spray, spatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated.

Handwashing (See Appendix C)

- Hands should always be washed before and after eating, and after toileting, sneezing, or coughing into the hands.
- Alcohol-based hand rubs are an efficacious agent for reducing the number of bacteria on the hands and have been recommended for routine decontamination of hands for all clinical indications (except when hands are visibly soiled).¹ When hands are visibly soiled or contaminated with blood or other body fluids, wash them with soap and water.
- Effective handwashing is accomplished by using soap and running water while rubbing hands together for at least 15 seconds.²
- Hands should be dried with disposable paper towels. Before discarding, these paper towels should be used to turn off faucets to prevent recontamination of hands.
- Any type of soap is effective. Antimicrobial soap is not necessary.³
- Hands should always be washed before and after providing first aid or similar treatment; after assisting with toileting, after cleaning up body fluid spills; and after handling potentially infectious materials. Always wash hands after removing gloves.

Disposal of Soiled Materials

- Liquid waste and body fluids may be discarded in the toilet or utility sink.

¹ *Guideline for Hand Hygiene in Health-Care Settings*. MMWR, October 25, 2002, Vol. 51, No. RR-16, p. 27.

² *Guideline for Hand Hygiene in Health-Care Settings*. MMWR, October 25, 2002, Vol. 51, No. RR-16, p. 32.

³ *Guideline for Hand Hygiene in Health-Care Settings*. MMWR, October 25, 2002, Vol. 51, No. RR-16, p. 32.

- ❑ Special medical waste may be defined as:

- (a) Liquid or semiliquid blood or another potentially infectious material;
- (b) A contaminated article that releases liquid or semiliquid blood or another potentially infectious material if compressed;
- (c) An article that contains dried blood or another potentially infectious material and is capable of releasing the blood or material during handling;
- (d) Pathological and microbiological waste containing blood or another potentially infectious material; and
- (e) Contaminated sharps.⁴

Special medical waste (waste that releases blood or another potentially infectious material) must be stored in closable, leak proof containers built to hold all contents during handling, storing, and transporting. Each school health suite should have a biohazard labeled trash can for disposal of regulated waste. The trash can should be lined with a plastic bag and have a lid. Daily, the contents of this trash can must be decontaminated by saturating it with a hospital grade disinfectant or with 1:10 to 1:100 bleach solution made daily or other recognized EPA tuberculocidal (See COMAR 10.06.06.04). This trash can then be double bagged and discarded with other school trash. In general, bandaids and menstrual products are not considered special medical waste.

- ❑ Disposable Sharps (i.e., needles, syringes, capillary tubes, and lancets) should be left intact and placed in puncture-resistant, leak-proof containers and labeled Biohazard. Never attempt to recap, bend, or purposely break needles. Do not overfill the container, as this can lead to needle-stick injuries. Schools are required to outline the disposal procedures for these containers in their Exposure Control Plan. These containers must be removed by special medical waste transporters under Maryland regulation, and may not be placed with the regular trash.

Clean up of Blood and OPIM

- ❑ Wear protective gloves.
- ❑ Use a hospital grade disinfectant to clean surfaces contaminated with blood and OPIM. The disinfectant should be registered by the U.S. Environmental Protection Agency (EPA) for use as a disinfectant in hospitals that are tuberculocidal (see Appendix E - Understanding the Labels of Germicides). A 1:10 solution of household bleach may be an adequate disinfectant only if mixed fresh every 24 hours.

Cleaning of Equipment/Clothing/Athletic Mats Soiled with Blood and other Body Fluids

- ❑ Handle soiled clothing as little as possible. Place soiled clothing in a leak- proof bag, seal, and send home to be laundered as soon as possible.

⁴ Code of Maryland Regulations 10.06.06.02.

- ❑ Wear protective gloves when handling soiled clothing.
- ❑ Clean sponges, mops, or other non disposable equipment which are contaminated with body fluids with soap and water and soak in a hospital grade disinfectant. (See Appendix E- Understanding the Labels of Germicides.)
- ❑ Wash toys and nonsoakable equipment soiled with body fluids with soap and water after each child's use.⁵ Clean them with a hospital grade disinfectant, rinse, and dry.
- ❑ Prohibit the sharing of athletic mouthpieces.
- ❑ Clean musical instrument mouthpieces by soaking them in a hospital grade disinfectant for 2-3 minutes. Rinse very well with water to remove all disinfectant.
- ❑ Develop a procedure to ensure the safety of students participating in life skills and community based programs that may expose them to bloodborne pathogens and OPIM, e.g., custodial tasks, laundering, etc.
- ❑ Clean/disinfect all equipment such as athletic equipment routinely (e.g. wrestling and gymnastic mats). If an incident occurs where blood or OPIM have contaminated a surface, cleaning and disinfecting should take place prior to allowing the activity to continue. The surface should be cleaned of visible contamination and then disinfected with an agent, such as a hospital grade disinfectant referenced above. It is recommended that an ample supply of disposable towels and tissues be available at athletic events for initial clean up.

Cleaning Carpets and Rugs

- ❑ Refer to Cleaning of Equipment/Clothing (above), for directions on how to clean any materials or equipment used to clean the carpet or rug.

Engineering Controls

- ❑ OSHA bloodborne pathogen standard requires use of the safest systems available to reduce the risks of needlesticks. Frontline staff must have input in considering and choosing safer needle devices as part of re-evaluation of appropriate engineering controls during annual review of exposure control plans.

Education and Training for School Staff

- ❑ Each LSS must develop a bloodborne pathogens Exposure Control Plan. (See Appendix A.) The LSS must ensure that all staff with potential for occupational exposure receives general information about bloodborne pathogens and occupational exposure risk factors associated with the transmission of HIV, HBV, and HCV. MOSH requires employers to maintain confidential medical records for each employee with an occupational exposure and training records that include dates and participants in the annual training sessions.

⁵ *Healthy Young Children, A Manual for Programs*, NAEYC, 2002.

Refer to Bloodborne Pathogens Regulations 29 CFR 1910.1030 through the following link:

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10052

MOSH provides consultation service for work sites. Contact the consultants by telephone at 410-537-4500 or 866-225-0478.

- LSSs must provide initial and annual general information about bloodborne pathogens and universal precautions.
- COMAR 13A.04.18.04 requires annual training about HIV/AIDS for the staff designated to teach HIV/AIDS prevention curricular topics.

Management of Exposures to Body Fluids

"Exposure Incident" means a specific contact between blood and OPIM and the eye, mouth, or other mucous membrane, non intact (i.e., broken or cut) skin, vein, or muscle. The following are NOT considered exposure incidents:

- Being in the same room as a person with HIV, HBV, or HCV infection;
- Touching a person infected with HIV, HBV, or HCV;
- Getting blood and OPIM on clothing or equipment;
- Getting blood and OPIM on intact (i.e., without cracks or cuts) skin;
- Sharing bathroom facilities; and
- Being bitten by mosquitoes or other insects.

Management of situations where body fluids get on non intact (i.e., broken or cut) skin or clothing

- Wash skin immediately and thoroughly with soap and running water. If running water is not available, cleanse with bottled water or waterless cleanser until running water is available.
- Remove contaminated clothing as soon as possible to eliminate prolonged contact with the skin.

Management of an Exposure Incident

- Perform emergency medical care and wound management following established school guidelines for First Aid Procedures. Use tepid or cool water for the following exposures:
 - Puncture exposure: As soon as possible, wash area with running water and soap or germicidal handwashing solution;
 - Mucous membrane exposure: Flush exposed area thoroughly with water or sterile saline;
 - Eye exposure: Flush eyes with copious amounts of clean running water; and

- Non intact skin exposure: Wash area with soap and water for at least 10 seconds. Rinse with water and dry.

Evaluation of Exposure Incidents

Each exposure incident should be evaluated by a qualified health care provider to determine the appropriate follow-up. The exposure incident, evaluation, follow-up recommendations, and actions should be documented according to MOSH regulations. All needlesticks must be documented on a log specifically used for that purpose. Each employee should immediately report an exposure incident to his or her supervisor or to the designated individual in the school. For exposure incidents occurring to those who are not employees, direct the person (or parent/guardian if the person is a minor) to immediately consult with his or her health care provider about the incident. There are situations where post exposure medication therapy may be considered for the exposed person.⁶ Consultation with the health care provider within a few hours of the incident allows decisions for treatment to be made without delay.⁷

Follow-up Procedure

Each school system's Exposure Control Plan should detail how exposure incidents will be managed. The source, if known, may be asked to be tested for HBV, HCV, and HIV infection following legally mandated procedures. The exposed employee will be referred to a licensed health care professional to manage the exposure incident. Non-employees will follow the advice of their health care provider.

Note: School health services programs should consult their local attorneys for any confidentiality issues arising from exposure.

Guideline Administrative History: Original date of Issue, 1992. Revised 2000 and 2007.

⁶“Postexposure Prophylaxis After Nonoccupational HIV Exposure”, Journal of the American Medical Association (11/25/98) Vol. 280, No.20, P. 1769; Lurie, Peter; Miller, Suellen; Hecht, Frederick; et. al.

⁷Centers for Disease Control and Prevention. “Management of Possible Sexual, Injecting-Drug-Use, or Other Nonoccupational Exposure to HIV, Including Considerations Related to Antiretroviral Therapy.” Public Health Service Statement. MMWR 1998; 47 (No. RR-17): 1-14.

References

Centers for Disease Control and Prevention. Guideline for Hand Hygiene in Health Care Settings. Morbidity and Mortality Weekly Report. Vol. 51, No. RR-16, October 25, 2002.

Infectious Disease Control Guide for School Staff. State of Washington Office of Superintendent of Public Instruction, Department of Health, April 2004.

Maryland Department of Health and Mental Hygiene. Code of Maryland Regulations, 10.06.06. Communicable Disease Prevention, December 20, 1993.

Maryland Occupational Safety and Health Bloodborne Pathogens Resources:
<http://www.dllr.state.md.us/labor/bbp/bbpappendixc.doc>.

Postexposure Prophylaxis after Nonoccupational HIV Exposure”Journal of the American Medical Association. November 25, 1998. Vol. 280, No. 20, p. 1769; Lurie, Peter; Miller, Suellen; Hecht, Frederick; et al.

Appendix A

SAMPLE BLOODBORNE PATHOGENS EXPOSURE CONTROL PLAN

MOSH provides guidelines and instructions for completing a bloodborne pathogens exposure control plan. The table of contents for the web based guideline is below. The following guideline can be obtained at <http://www.dllr.state.md.us/labor/bbp/bbpbrochure.doc>.

Guidelines and Instructions for Developing a Bloodborne Pathogen Exposure Control Plan

A. Exposure Determination

B. Implementation Schedule

- Engineering Controls
- Work Practice Controls
- Personal Protective Equipment
- Housekeeping
- Hepatitis B Vaccination
- Post-Exposure Evaluation and Follow-Up
- Information and Training
- Recordkeeping

C. Exposure Plan Review

Compliance Worksheet

Appendices

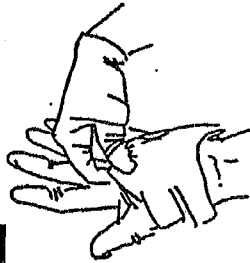
Appendix A — **29 CFR 1910.1030**

Appendix B — **Model Exposure Control Plan**

Appendix C — **Bloodborne Pathogens Information Resources**

The MOSH program is funded in part with up to 50% federal funds.
This **free publication** is not authorized to be copied and sold for commercial purposes.

Correct Procedure for Removing Gloves



1

Grasp glove at heel of hand without touching skin



2

Pull glove toward fingers



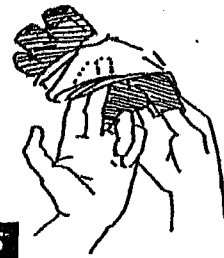
3

Remove glove from hand



4

While holding soiled glove, insert index finger and middle of free hand under glove at cuff



5

Pull glove toward fingers



6

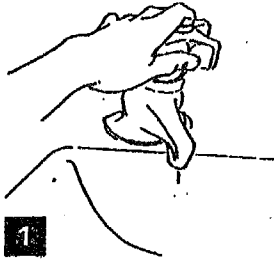
As glove is removed it is turned inside out, over the glove that has already been removed



7

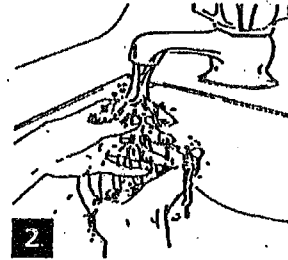
Discard contaminated gloves in appropriate waste container and wash hands

Handwashing Procedure



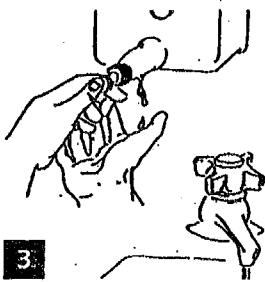
1

Open faucet



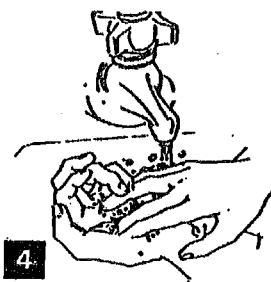
2

Wet hands thoroughly



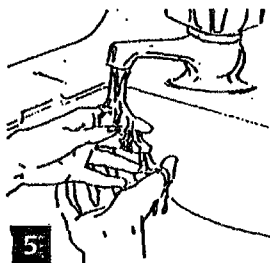
3

Apply soap



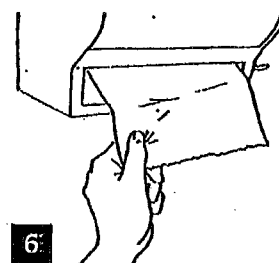
4

Rub vigorously
10 seconds or more



5

Rinse thoroughly



6

Dry hands with
disposable towel



7

Use towel to turn off faucet

UNDERSTANDING THE LABELS OF GERMICIDES

Under the Federal Insecticide, Fungicide and Rodenticide Act (FIFRA), the Environmental Protection Agency (EPA) is responsible for the registration and regulation of germicides. In exercising this responsibility, the EPA requires that label claims be truthful, meaningful and practical for safe and effective use of the product.

When a germicide is being considered for purchase, the label should be checked for:

1. The EPA registration number;
2. An ingredient statement;
3. Directions for use;
4. Adequate safety and precautionary information;
5. The name and address of the manufacturer or distributor.

The use of a disinfectant that is tuberculocidal is required by MOSH for proper clean up of blood/body fluid spills. The label of the product will state that it is tuberculocidal, if the product has been registered by the EPA as tuberculocidal.

Additionally, examine the label for the tabulation of benefits. The claims that appear on the label are established by testing the product against a uniform set of official standards of the Association of Official Analytical Chemists, which are used by the EPA. Under these standards a "hospital disinfectant" must be effective against the test organisms *Staphylococcus aureus*, *Salmonella choleraesuis* and *Pseudomonas aeruginosa*. A "tuberculocidal" label means the chemical has been tested against *Mycobacterium tuberculosis* var. *bovis*. Labels may also include fungicidal, virucidal, and sporocidal claims.

The label on a germicide is a legal document and is a guarantee that the product will perform as stated on the label. An informed examination of the label will result in the purchase of a germicide that will perform the desired functions effectively.

Section 17

Emergency Plans

Emergency Plans

All schools should have adequate emergency plans in place (for single person emergencies and multiple person or school-wide emergencies). The school principal is in charge of developing and updating the school's emergency plan.

The School Nurse and all health room staff should know their school's emergency plans. A copy of the school's emergency plans should be kept in the school's health room. The School Nurse also should participate in the school's crisis management committee.

The School Nurse should also have a plan in place to transport emergency student medication in the event of evacuation or emergency relocation. Student emergency information should be on file in the health room and be given to emergency medical services in the case of a student accident or health emergency.

Included in this section are:

- The Maryland State School Health Services model emergency plan for school nurses.
- HE 6.0 from the *Policy Manual for Elementary Schools for the Archdiocese of Baltimore*: Principals notify their local health department in cases of student absences due to a reportable communicable disease.
- COMAR 13A.05.05.09 School Health Services Standards- Emergency Services.
- A sample emergency form that can be kept on file in a school's health room for emergency personnel.

MODEL POLICY - EMERGENCY PLAN FOR SCHOOL NURSES

MARYLAND STATE SCHOOL HEALTH SERVICES GUIDELINE

JANUARY 2006

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& Child Health
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TTY/TTD: 1-800-735-2258



MARYLAND SCHOOL HEALTH SERVICES GUIDELINE

Foreword

There is a strong relationship between academic achievement and a child's physical, emotional and mental health. This link is the foundation for providing school health services as an important component of a school program. School health services provide primary prevention aimed at keeping students in schools through appropriate screenings, early identification of children at risk for physical, emotional and mental health concerns, and case management of students with chronic health concerns.

The Annotated Code of Maryland, Education Article, § 7-401 requires the Maryland State Department of Education (MSDE) and the Maryland Department of Health and Mental Hygiene (DHMH) to jointly develop public standards and guidelines for school health programs. The following guideline is developed in accordance with that requirement and is based on the expressed needs of the local school health services programs. These guidelines contain recommendations for minimum standards of care and current best practices for the health service topics addressed. It is intended that these guidelines will be used by the local school systems in developing local school health services policies and procedures as a means to assist local school health services programs in providing consistent and safe care to the students of Maryland. Specific laws and regulations that direct school nursing practice or other health services are identified in the guidelines.

The Maryland State School Health Council serves as an advisory council to both departments and as such, the council's School Health Services Subcommittee serves as the committee that develops and reviews these guidelines along with the specialists from MSDE and DHMH. School Health Services Program supervisors/coordinators also review and participate in the guideline development process. To those dedicated school health services professionals and administrators, our thanks.

EMERGENCY PLANNING FOR SCHOOL NURSES

Introduction

Emergency preparedness takes on heightened significance as Maryland communities have responded to and recovered from weather-related emergencies, sniper attacks, and other emergency situations in recent years. As local school systems (LSSs) and schools in Maryland continue to review and revise their emergency plans, the absolute need to involve the larger community does not waiver. The Maryland State Department of Education published the *Emergency Planning Guideline for Local School Systems and Schools* (MSDE 2003) to assist LSSs and schools in their efforts to plan for and respond to emergencies. The guideline is divided into three sections: emergency management, plan development, and testing the plan. Please refer to this document to become familiar with the complete emergency management process.

School nurses are key members of the emergency management team at the LSS and school levels. There are many aspects of emergency preparedness that affect the school health services program. School nurses enhance the school's emergency preparedness by participating in all phases (i.e., mitigation, planning, response, and recovery) related to the tasks and functions specific to school health services.

Purpose

This guideline provides school nurses with information specifically related to the school health services program that will assist in preparing for emergencies in and around the school. This document identifies and emphasizes the particular knowledge and skills school nurses must have about the health and safety needs of students and staff.

Definition

Emergency preparedness is a continuous process. The emergency planning done by school nurses is one facet of the whole school emergency preparedness process. "Emergency management is an organized process by which communities prepare for hazards that cannot fully be mitigated, respond to emergencies that occur, recover from emergencies to restore the community to its pre-emergency condition, and mitigate risks" (Federal Emergency Management Agency (FEMA), 2002). These guidelines present ways in which school nurses may plan for these four components of emergency management.

Role of the School Nurse

The unique perspective of school nurses influences every phase of emergency management, from the mitigation of potential risks to the planning, response, and recovery of actual events (New York State Department of Education, 2002 and Doyle, J. & Loyacono, T., 2002). School nurses participate in the schoolwide practice and testing of emergency plans. They also assist with developing, evaluating, and revising emergency plans.

FEMA conducts training for schools and school districts titled *Multi-Hazard Emergency Planning for Schools*. The four phases of the emergency management process are mitigation, planning, response, and recovery. The school nurse has a specific role in each of these phases. The nurse assists with mitigating risks in the health room, as well as in other areas of the building. School nurses assist in preparing and planning for hazards that cannot be fully mitigated, responding to emergencies that do occur, and recovering from those emergencies.

Mitigation

Mitigation is “an action or plan to reduce the loss of life, damage to property from all hazards, or trauma to people; it is a type of prevention” (MSDE 2003). Mitigation involves assessing the school environment for hazards and limiting or minimizing the risks of those hazards (FEMA 2002). School nurses join the rest of the emergency management team in mitigation activities. The school nurse is familiar with potential hazards in the health room, which is crucial knowledge for hazard analysis and mitigation. The school nurse can also assist with hazard analyses in classrooms, on playgrounds, on sports fields, and other areas. During the mitigation phase of the emergency preparedness process, the school nurse should:

- ❑ Obtain and store first aid kits in classrooms and other strategic locations in the school including the health room. The school nurse should document the locations of the first aid kits in the emergency response plan and in the health room substitute folder (e.g., a large first aid kit is stored in the gym and cafeteria).
- ❑ Ensure emergency supplies are on hand for at least 24 hours in the event of a disaster that delays the response of emergency responders to the school. School nurses collaborate with other members of the school emergency preparedness team to determine water, food, and sanitation supplies that should be stored at the school (Doyle & Loyacono, 2002). It is essential that supplies for individual classrooms and the entire school are on hand before an emergency situation occurs.
- ❑ Identify staff who have first aid and cardio-pulmonary resuscitation (CPR) training (in accordance with the Code of Maryland Regulations (COMAR) 13A.05.05.09) to determine their availability to assist in an emergency. This information is especially necessary if the school nurse is not assigned fulltime to the school. If the school does not have staff other than the school nurse trained in first aid and CPR, mitigating risks would involve the school nurse collaborating with the school administrator and staff to identify potential trainees for first aid and CPR certification.
- ❑ Determine what medications must accompany students in the event of an emergency evacuation of the school building. A current list of students who require life-sustaining medications or medications/treatments that are crucial for management of chronic health conditions must be maintained. A safe and secure means of transporting required medications is maintained by the school nurse. Accompanying the first aid bag and crucial medications are the emergency care plans and medication/treatment orders of students who may need medication in the event of an emergency evacuation.

Planning

Emergency planning is “a proactive process to create a detailed scheme or program, including training and exercising, that enables schools to reduce the frequency and magnitude of an emergency” (MSDE 2003). The school nurse contributes to the planning component of emergency management in several ways. Planning for emergencies requires the school nurse to:

- ❑ Document the special health needs of students. This knowledge will assist the school nurse in planning for emergencies related to these students (National Association of School Nurses, 2001). School nurses have traditionally provided emergency plans, including evacuation plans for students with special health needs. It is imperative to know the location of all students with various physical disabilities and other health needs throughout the school day. This information along with specific emergency and evacuation plans is disseminated to appropriate school staff.
- ❑ Develop an evacuation plan & emergency procedure for students with disabilities.
- ❑ Provide training to school staff on the evacuation and emergency procedures for special needs students. Assistance from community first responders may be helpful as the school nurse determines the safest methods of evacuating students who may have physical challenges. They must also determine what students require life sustaining care or medications/treatments for a 24 -hour period. If a school is in lockdown or shelter-in-place mode, depending on the community circumstances, there will need to be contingency plans in the event the emergency assistance to the school is delayed.
- ❑ Maintain information on student and staff experiencing temporary health conditions that may require special care in the event of an emergency, e.g., temporary use of crutches or a wheelchair.
- ❑ Collaborate with the entire emergency planning team as one of the trainers of the plan. Conducting training sessions for school staff, parents/guardians, school volunteers, and students in the health related aspects of the emergency plan is an essential role for school nurses. These training sessions provide an opportunity to give the rationale for the emergency planning health focus. It can also give the school nurse an indication of other health concerns that may require attention during an emergency. Training sessions can also demystify the process involved in responding in an emergency, thereby contributing to smoother operations in an actual emergency. There may also be increased confidence in the measures taken to prepare for health aspects of school emergencies.
- ❑ Collaborate with the entire emergency planning team to test the plan. Testing the plan presents the school nurse with an opportunity to put into practice the plan for health related aspects of the schoolwide emergency plan. As the school nurse practices the various drills and other exercises (e.g., tabletop exercises) that test the emergency plan, there is the opportunity to determine ways in which to adjust the processes in place. As drills and practice exercises related to the plan occur, essential medications and first aid

supplies must exit with the school nurse. Along with those items are signed medication authorization forms and emergency plans, list of students with chronic health problems, and student phone numbers. Additionally, food items that are essential to some students (e.g., students with diabetes will need quick acting sugar sources, glucose tabs, or glucose gel) will need to be placed in evacuation bags and taken out of the building even in drills. The school nurse must also make provision to have the supplies he or she needs to carry out necessary treatments, procedures, and other tasks. Prepack the essential items so that there are fewer last minute items to gather in the event of an evacuation.

- ❑ Assist the schools in identifying what procedures to follow in the event that there is no school nurse on site when an emergency occurs. If the school has ancillary school health services staff or no health services staff in the absence of the school nurse, the procedures written in the plan for that staff cannot require the expertise of a licensed nurse.
- ❑ Remain informed of specific preparations required for bioterrorism. School nurses are aware of specific geographical situations in the school community and that knowledge informs the emergency planning process. For example, if the school is located near a military base, base procedures in the event of a suspected bioterrorism incident may affect the ability of students who live on the base to get home. Contingency plans must be made, especially for students with health conditions that require special care. The school nurse coordinates with the student, family, and school in order to develop a plan that will meet the needs of the student in that situation. If the school is near a nuclear facility, the school nurse must be aware of the protocols for the administration of potassium iodide. School nurses continually add to their knowledge of signs and symptoms of bioterrorism. If students and staff report to health rooms with similar unexplained symptoms, more investigation is warranted to determine what is occurring.

In Maryland, school nurses are primarily employees of school systems or health departments. As part of the planning process they need to know their agency responsibilities in the event of emergencies in the school and larger community. All Maryland public schools are required to plan for emergencies using a team approach. The school nurse is a critical member of that team.

Response

Response is “the act of determining who will make critical decisions, how to get necessary resources, how to handle a crime scene, and tasks to be completed immediately and by whom” (MSDE 2003). During the time of a disaster or emergency incident, the school nurse activates the part of the emergency plan assigned to him or her. School nurses function within the organizational structure chosen by the local school system. The MSDE *Emergency Planning for Local School Systems and Schools* (MSDE, 2003) presents the Incident Command System as a viable method for managing emergencies. During the response phase of the emergency preparedness process, the school nurse should:

- ❑ Direct the triage of health emergencies until the local emergency management services arrives. Maloney, Fitzgerald, Elam, & Doyle (2000) provide specific information on triage methods in emergency management. School nurses also provide emergency treatment for school staff and students until community emergency medical services arrive. First aid care is rendered by the nurse and other identified staff who are certified in first aid. Safety of those involved in rescue efforts during this response phase is of utmost importance. School nurses provide reminders to all team members to practice universal precautions.
- ❑ Document events and care rendered throughout the emergency incident. While the school nurse is familiar with documentation as a job responsibility, care must be given during emergency incidents to maintain communication through accurate documentation. The schoolwide emergency plan may utilize forms that are very different from those used in routine school health services. School nurses will use the forms specified in the emergency plan.

Recovery

Recovery is the process of returning the school to its normal operations as quickly and completely as possible (MSDE 2003). The entire school and greater community is involved with the recovery process after an emergency incident at school. Recovery includes people and the physical plant and surroundings. The school nurse during the recovery phase should:

- ❑ Assess potential health and safety hazards arising from the emergency that may affect school staff and students. Once the school is reopened after the incident, school nurses observe any lingering physical and psychological responses by students and staff to the emergency event. They can make referrals to the crisis response teams who will assist staff and students with psychological health concerns. School nurses support students by developing or updating health information as necessary. They are alert to potential alterations in functioning that may require accommodations for students to participate in their educational process. In collaboration with families, students, and appropriate school staff, school nurses develop individualized health plans for the students.
- ❑ Join the school emergency preparedness team to evaluate the emergency response. The school nurse will also evaluate the response from the health services perspective. Evaluation of all aspects of the plan, including supplies, triage, first aid, documentation, and general effectiveness is the role of the school nurse. The first aid portion of the emergency plan is then revised, ideally with input from community emergency medical services responders.

Summary

The school nurse is an integral part of the school system and individual school emergency planning team. The perspective from the school health professional adds to the completeness of the overall school emergency plan. School nurses must also make specific plans for mitigation, planning, response, and recovery in the areas that pertain to health considerations. Emergency planning in schools is a continual process. Funding for supplies is a topic to explore with central office and school health services administrative staff.

The skill of school nurses in application of the nursing process aids emergency planning. As they assess, develop nursing diagnoses, identify outcomes, plan, implement, and evaluate throughout the emergency planning process, school nurses contribute to preparedness in the school community. Collaboration and coordination with other members of the emergency planning team enhances the effectiveness of the emergency planning process.

GLOSSARY

Drills: Testing aspects of a response; practicing and perfecting a single emergency response.

Emergency Management: A proactive process to create a detailed scheme or program, including training and exercising, that enables schools to reduce the frequency and magnitude of an emergency.

Emergency Planning: A proactive process to create a detailed scheme or program, including training and exercising, that enables schools to reduce the frequency and magnitude of an emergency.

Emergency Preparedness: Process by which schools and community officials develop a plan that tells how they will respond to an emergency and what steps they will take to recover from the emergency.

Hazard: Natural, manmade, or technological disasters.

Hazard Analysis: The process of looking for hazards or potential hazards around the community, neighborhood, and school.

Mitigation: An action or plan to reduce the loss of life, damage to property from all hazards, or trauma to people; a type of prevention.

Recovery: The long-range actions to return the school to its normal operations; restore normal operations as quickly and completely as possible.

Response: The act of determining who will make critical decisions, how to get necessary resources, how to handle a crime scene, tasks to be completed immediately and by whom.

Tabletop Exercises: Exercises that enable staff members to walk through an emergency scenario and make decisions similar to those made in an actual emergency; lend themselves to low stress discussion of plans, policies, and procedures; provide an opportunity to resolve questions of coordination and responsibility.

REFERENCES

- Doyle, J. & Loyacono, T. (2002). *Disaster preparedness guideline for school nurses*. Castle Rock, Co: National Association of School Nurses.
- Federal Emergency Management Agency (2002). *Multi-hazard emergency planning for schools*, Course 362. Emmitsburg, MD: Author.
- Maloney, P., Fitzgerald, S., Elam, K., & Doyle, J. (2000). *Managing school emergencies III*. Scarborough, ME: National Association of School Nurses.
- Maryland State Department of Education, Division of Student and School Services (2003). *Emergency Planning Guideline for Local School Systems and Schools*: Author.
- National Association of School Nurses. (2001) *National Association of School Nurses position statement: School Nurses Role in Emergency Preparedness*. Scarborough, ME: Author.
- New York State Department of Education (2002). *School Health Professionals: Their role in emergency preparedness*: Author.

Original date of issue: 2006



HE 6.0

The principal must develop an adequate plan to ensure the health and safety of students, staff, and visitors.

Purpose:

- To ensure a safe environment

Commentary/Procedural Points:

- The plan must be communicated to the staff and parents.
- Principals are responsible for determining an appropriate response to any individual who appears to have an injury or an illness.
- Completion of an accident report is mandatory for all injuries.
- The school maintains a daily log documenting illnesses, injuries and administration of medication.
- Parents are notified of instances of injury or illness, as necessary.
- In case of a serious injury, the principal communicates with the Department of Catholic Schools and the Archdiocesan Office of Risk Management.
- This plan is communicated to parents upon request

References:

- AOB forms:
 - Head Injury Report to Parent
 - Minor Injury Report to Parent
 - Report to Parent of Health Room Visit

http://www.marylandpublicschools.org/MSDE/divisions/studentschoolsvcs/student_services_and_school_health_services/

October 10, 2013

.09 School Health Services Standards — Emergency Services.

A. Personnel Qualifications. At least one adult in each school, other than the designated school health services professional and the school health services aide, shall be currently certified both in the First Aid Program of the American National Red Cross or its equivalent, and in adult or pediatric cardiopulmonary resuscitation (CPR), or both. One certified person shall be available on site during the regular school day and at all school-sponsored athletic events.

B. Emergency Care Procedures.

(1) A guide for emergency care management shall be developed and distributed by the local health department and the local board of education to each school, and copies shall be placed in multiple locations.

(2) An emergency information card shall be maintained for each student, and shall be updated at least annually.

(3) Emergency evacuation plans shall be developed in consultation with the fire department, and shall include provisions for physically handicapped students and students with other special health needs.

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

- (1) Complete all items on this side of the form. Sign and date where indicated.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
Street/Apt. # City State Zip Code

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment:	C:	H:
		W:		
		Place of Employment:	C:	H:
		W:		

Name of Person Authorized to Pick up Child (daily) _____
Last First Relationship to Child

Address _____
Street/Apt. # City State Zip Code

Any Changes/Additional Information _____

ANNUAL UPDATES _____
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

Medications currently being taken by your child: _____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

COMMENTS: _____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

Name of Health Practitioner

Date

Signature of Health Practitioner

(_____)_____
Telephone Number

Section 18

Automatic External Defibrillator (AED)

Automated External Defibrillators (AEDs)

Every school should strongly consider acquiring (and properly registering and maintaining) an AED unit or units. When weighing the importance of having an operational unit available, schools should consider the following:

- Sudden Cardiac Arrest (SCA) is a leading cause of death in the US, killing an estimated 325,000 Americans each year.
- It is estimated that 95 percent of those who suffer cardiac arrest die before they reach a hospital or other source of emergency help.
- SCA kills on average 1,000 people every day. That's one person every two minutes.
- Without emergency medical help, SCA leads to death within minutes.

Victims of cardiac arrest may be saved if an AED is available to deliver an electric shock and restore the heart to its normal patterned rhythm.

If your school has an AED, is it in compliance with Maryland State law?

Under Maryland State law, COMAR 30.06.01-05, all locations having an AED unit must have a valid certificate for each AED unit prior to putting the unit into service. It is critical that all AED units are properly registered with the State. Failure to do so will result in the loss of critical civil immunities that are granted to those locations that comply by having properly registered units.

If you determine that your school has an AED unit which is not properly registered, you should go to <http://www.miemss.org/home/hospitals/aed-program> in order to complete the registration process for the unit(s).

If your school does not currently have an AED unit, but is interested in learning more about possibly acquiring a unit, these vendors can provide additional information:

<u>Medline Industries</u> 1-800-MEDLINE (1-800-633-5463) Fax: 1-800-351-1512 http://www.medline.com/ service@medline.com	<u>Chesapeake AED Services</u> 810 Back River Neck Road Essex, MD 21221 Phone: 410-238-2242 Toll Free: 866-597-4277 Fax: 410-238-7761 http://chesapeakeaedservices.com / info@chesapeakeaedservices.com	<u>Cintas</u> 10611 Iron Bridge Road Suite K Jessup, MD 20794 301-429-6144 http://www.cintas.com/firstaidsafety/automatic-external-defibrillator/reviveraed.aspx
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Should your school have interest in acquiring an AED unit but cost considerations have been a barrier, please consider the following as possible means by which to fund an AED unit:

- Does the school have a parent of a student or alumni who is a physician and would be willing to sponsor the unit?
- Does the school have the support of a Knights of Columbus Council? Would the Council be willing to assist with the cost of the unit?
- Would your parent association assist with the cost of the unit?

Here you will find some additional funding resources for starting an AED Program:

- Raskob Foundation for Catholic Activities, Inc.
 - <http://www.rfca.org/> - Contact: Frederick J. Perella, Jr., Exec. V.P.
- CPR Savers AED Grant Program
 - http://www.cpr-savers.com/AED-Grant-Programs_ep_51-1.html
- AEDGrant.com
 - <http://www.aedgrant.com/>

Section 19

Heath Room Supplies

Health Room Supplies

Suggested:

- Adult, large adult, and child blood pressure cuffs
- Bandage Scissors
- Benzethonium chloride
- Bottled Water
- Biohazard bags
- Contact lens solution
- Contact lens case
- Cotton balls
- Cotton tipped applicators
- Cups for water
- Dental wax
- Duffle bags to send field trip medications and supplies
- Elastic bandages:
 - 3", 4"
- Emergency
- Exam paper
- Extra batteries
- Eye wash
- Eye wash cups
- Eyeglass repair kit
- Face masks
- Fast acting glucose
- Feminine pads
- Flash light
- Flexible cohesive bandage wrap
- Freezer bags
- Gauze:
 - 4" x 4", 2" x 2", Roll
- Hand sanitizer
- Hemostatic Agent Dressings (ex. Quick Clot)
- Hypoallergenic lotion
- Ice packs

Latex-free bandages:

- ¾", 1", 2"x 4", butterfly, fingertip, 4-wing flexible fabric, junior, spot

Latex-free exam gloves

Latex-free medical tape

Large rolling suitcase for transporting emergency medications

Makeup remover

Mirror

N95 masks

Nail clippers

Nail polish remover

Nebulizer

New sponges

Otoscope and disposable tips

Paper towels

Pulse oximeter

Salt for gargling

Sandwich bags

Sanitizing wipes

Sharps container

Slings

- Adult and child

SAM/EverReady universal aluminum splints

Stethoscope

Tampons

Thermometer and appropriate cover/sheath

Tongue depressors

Tooth boxes

Transfer Sling

Tweezers

Various sized underwear (depending on student population)

Vaseline

Wheelchair

Wound wash

Emergency first aid bag containing:

Section 19

4" x 4" gauze

ABD pad (or other large absorbent pad or overnight diaper)

Ace wrap

Ammonia inhalants

Assorted band aids

CPR mask

Face mask

Fast acting glucose

Flashlight

Foil blanket

Goggles

Hand sanitizer

Hemostatic agent dressings (ex. Quick clot)

Instant ice pack

Large ziploc bag

Latex-free exam gloves

Pen & Paper

SAM/EverReady universal aluminum splints

Self-adherent wrap

Scissors

Sling

Tape (duct, and latex-free medical)

Thermometer and thermometer covers

Tourniquet

Watch with a second hand

Whistle

Last Updated April 2018

Section 20

Commonly Used Forms

Commonly Used Forms

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:

- (1) Complete all items on this side of the form. Sign and date where indicated.
- (2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name _____ Birth Date _____
Last First

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____
Street/Apt. # City State Zip Code

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: _____	C: _____	H: _____
		W: _____		
		Place of Employment: _____	C: _____	H: _____
		W: _____		

Name of Person Authorized to Pick up Child (daily) _____
Last First Relationship to Child

Address _____
Street/Apt. # City State Zip Code

Any Changes/Additional Information _____

ANNUAL UPDATES _____
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

2. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

3. Name _____ Telephone (H) _____ (W) _____
Last First

Address _____
Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care _____ Telephone _____

Address _____
Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

INSTRUCTIONS TO PARENT/GUARDIAN:

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

Medications currently being taken by your child: _____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

COMMENTS: _____

Note to Health Practitioner:

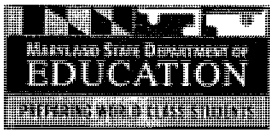
If you have reviewed the above information, please complete the following:

Name of Health Practitioner

Date

Signature of Health Practitioner

(_____) _____
Telephone Number



Maryland Schools Record of Physical Examination

To Parents or Guardians:

In order for your child to enter a Maryland Public school for the first time, the following are required:

- **A physical examination by a physician or certified nurse practitioner must be completed within nine months prior to entering the public school system or within six months after entering the system.** A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement. (<http://www.dsd.state.md.us/comar/comarhtml/13a/13a.05.05.07.htm>)
- **Evidence of complete primary immunizations against certain childhood communicable diseases is required for all students in preschool through the twelfth grade.** A Maryland Immunization Certification form for newly enrolling students may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend school. This form can be found at:
[https://phpa.health.maryland.gov/OIDEOR/IMMUN/Shared%20Documents/Maryland%20Immunization%20Certification%20Form%20\(DHMH%20896%20-%20February%202014\).pdf](https://phpa.health.maryland.gov/OIDEOR/IMMUN/Shared%20Documents/Maryland%20Immunization%20Certification%20Form%20(DHMH%20896%20-%20February%202014).pdf).
- **Evidence of blood testing is required for all students who reside in a designated at risk area when first entering Pre-kindergarten, Kindergarten, and 1st grade.** The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at:
https://phpa.health.maryland.gov/OEHFP/CHS/Shared%20Documents/Lead/MarylandDHMHBloodLeadTestingCertificateDHMH4620_revised3.24.2016c.pdf.

Exemptions from a physical examination and immunizations are permitted if they are contrary to a students' or family's religious beliefs. Students may also be exempted from immunization requirements if a physician/nurse practitioner or health department official certifies that there is a medical reason not to receive a vaccine. Exemptions from Blood-Lead testing is permitted if it is contrary to a family's religious beliefs and practices. The Blood-lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

The health information on this form will be available only to those health and education personnel who have a legitimate educational interest in your child.

Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.

If your child requires medication to be administered in school, you must have the physician complete a medication administration form for each medication. This form can be obtained at <http://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SHS/medforms/medicationform404.pdf>. If you do not have access to a physician or nurse practitioner or if your child requires a special individualized health procedure, please contact the principal and/or school nurse in your child's school.

Maryland State Department of Health and Mental Hygiene

Maryland State Department of Education

Records Retention - This form must be retained in the school record until the student is age 21.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade
Address (Number, Street, City, State, Zip)			Phone No.	
Parent/Guardian Names				
Where do you usually take your child for routine medical care?			Phone No.	
Name:		Address:		
When was the last time your child had a physical exam? Month			Year	
Where do you usually take your child for dental care?			Phone No.	
Name:		Address:		
ASSESSMENT OF STUDENT HEALTH				
To the best of your knowledge has your child any problem with the following? Please check				
	Yes	No	Comments	
Allergies (Food, Insects, Drugs, Latex)				
Allergies (Seasonal)				
Asthma or Breathing Problems				
Behavior or Emotional Problems				
Birth Defects				
Bleeding Problems				
Cerebral Palsy				
Dental				
Diabetes				
Ear Problems or Deafness				
Eye or Vision Problems				
Head Injury				
Heart Problems				
Hospitalization (When, Where)				
Lead Poisoning/Exposure				
Learning problems/disabilities				
Limits on Physical Activity				
Meningitis				
Prematurity				
Problem with Bladder				
Problem with Bowels				
Problem with Coughing				
Seizures				
Serious Allergic Reactions				
Sickle Cell Disease				
Speech Problems				
Surgery				
Other				
Does your child take any medication?				
No		Yes Name(s) of Medications: _____		
No		Yes Treatment _____, etc.)		
Does your child require any special procedures? (catheteriz				
No		Yes _____ ation, etc.)		
Parent/Guardian Signature _____				Date: _____

PART II - SCHOOL HEALTH ASSESSMENT
To be completed **ONLY** by Physician/Nurse Practitioner

Student's Name (Last, First, Middle)	Birthdate (Mo. Day Yr.)	Sex (M/F)	Name of School	Grade
--------------------------------------	----------------------------	--------------	----------------	-------

1. Does the child have a diagnosed medical condition?
No Yes _____

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".
No Yes _____

3. Are there any abnormal findings on evaluation for concern?

Evaluation Findings/CONCERNS

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculoskeletal/orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896 is required to be completed by a health care provider or a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis.
No Yes - _____
(A medication administration form must be completed for medication administration in school).

6. Should there be any restriction of physical activity in school? If yes, specify nature and duration of restriction.
No Yes _____

7. Screenings	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

PART II - SCHOOL HEALTH ASSESSMENT - continued
To be completed **ONLY** by Physician/Nurse Practitioner

(Child's Name) _____ has had a complete physical examination and has:

no evident problem that may affect learning or full school participation problems noted above

Additional Comments:

Physician/Nurse Practitioner (Type or Print)	Phone No.	Physician/Nurse Practitioner Signature	Date

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

If you are enrolling a child in **child care, pre-kindergarten, kindergarten or first grade**, you must complete and submit this form (COMAR 10.11.04.05, 13A.17.03.02.D). **PLEASE PRINT CLEARLY.**

CHILD'S NAME _____ / _____ / _____
 LAST FIRST MIDDLE
 CHILD'S ADDRESS _____ / _____ / _____
 ADDRESS CITY STATE ZIP
 SEX: MALE FEMALE BIRTHDATE _____ / _____ / _____

PARENT _____ / _____ / _____ OR
 GUARDIAN _____ / _____ / _____
 ADDRESS CITY STATE ZIP

CERTIFICATION INFORMATION

Complete Box A if the child has had blood lead testing, Box B if testing was not required (see conditions in Box B), OR Box C if testing declined on religious grounds.

BOX A

Check at least one:

- This child was born on or after January 1, 2015 AND lives in Maryland.
- This child was born before January 1, 2015 AND is enrolled in Medicaid EPSDT.
- This child was born before January 1, 2015 AND has lived in an "at risk" ZIP code (see list on reverse).
- This child was born before January 1, 2015 AND has at least one risk factor for lead exposure, as determined by the health care provider.

RECORD OF BLOOD LEAD TEST RESULTS

Test #1. _____ Date: _____
 Test # 2. _____ Date: _____
 Comments:

Person completing form: Health Care Provider/Designee OR
 School Health Professional/Designee

Printed Name: _____
 Signature: _____
 Date: _____
 Office Address _____

 Phone: _____

BOX B

BLOOD LEAD TESTING NOT REQUIRED

- This child does not and has never lived in an at-risk area (see ZIP codes on facing page) AND was born before January 1, 2015.

Parent or Guardian Name (Print) _____
 Signature _____
 Parent or Guardian
 Date: _____

BOX C

Complete the section below if the child is exempt from lead testing on religious grounds. A lead risk assessment questionnaire must be administered by a health care provider if the child is exempt from lead testing on religious grounds:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

To be completed by Parent or Guardian:
 Parent or Guardian Name (Print) _____
 Signature _____
 Parent or Guardian
 Date: _____

To be completed by a Health Care Provider:
 Lead risk poisoning risk assessment questionnaire done: YES NO

Printed Name: _____
 Signature: _____
 Date: _____

HOW TO USE THIS FORM

The documented tests should be the tests at 12 months and 24 months of age. Two test dates are required if the 1st test was done prior to 24 months of age. If the 1st test is done after 24 months of age, one test date is required. The child's **primary health care provider** may record the test dates directly on this form (check marks are not acceptable) and certify them by signing or stamping the signature section. A **school health professional or designee** may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record. A list of children (including home contact information) whose parent/guardian does not comply with the requirement to provide evidence of blood lead testing, must be forwarded to the Local Health Department in the jurisdiction where the child resides.

Maryland Childhood Lead Poisoning Targeting Plan At Risk Areas by ZIP Code (for children born BEFORE January 1, 2015)

<u>Allegany</u>	<u>Baltimore Co. (Cont.)</u>	<u>Frederick. (Cont)</u>	<u>Montgomery (Cont)</u>	<u>Queen Anne's</u>
ALL	21239	21757	20812	21607
	21244	21758	20815	21617
<u>Anne Arundel</u>	21250	21762	20816	21620
20711	21251	21769	20818	21623
20714	21282	21776	20838	21628
20764	21286	21778	20842	21640
20779	<u>Baltimore City</u>	21780	20868	21644
21060	ALL	21783	20877	21649
21061		21787	20901	21651
21225	<u>Calvert</u>	21791	20910	21657
21226	20615	21798	20912	21668
21402	20714		20913	21670
		<u>Garrett</u>		
<u>Baltimore Co.</u>	<u>Caroline</u>	ALL		<u>Somerset</u>
21027	ALL		<u>Prince George's</u>	ALL
21052		<u>Harford</u>	20703	
21071	<u>Carroll</u>	21001	20710	<u>St. Mary's</u>
21082	21155	21010	20712	20606
21085	21757	21034	20722	20626
21093	21776	21040	20731	20628
21111	21787	21078	20737	20674
21133	21791	21082	20738	20687
21155		21085	20740	
21161	<u>Cecil</u>	21130	20741	
21204	21913	21111	20742	<u>Talbot</u>
21206		21160	20743	21612
21207	<u>Charles</u>	21161	20746	21654
21208	20640		20748	21657
21209	20658	<u>Howard</u>	20752	21665
21210	20662	20763	20770	21671
21212			20781	21673
21215	<u>Dorchester</u>	<u>Kent</u>	20782	21676
21219	ALL	21610	20783	
21220		21620	20784	
21221	<u>Frederick</u>	21645	20785	
21222	20842	21650	20787	<u>Washington</u>
21224	21701	21651	20788	ALL
21227	21703	21661	20790	
21228	21704	21667	20791	<u>Wicomico</u>
21229	21716		20792	ALL
21234	21718	<u>Montgomery</u>	20799	
21236	21719	20783	20912	<u>Worcester</u>
21237	21727	20787	20913	ALL



**MARYLAND STATE
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM**



This order is valid only for school year (current) _____ including the summer session.

School: _____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- * Prescription medication must be in a container labeled by the pharmacist or prescriber.
- * Non-prescription medication must be in the original container with the label intact.
- * An adult must bring the medication to the school.
- * The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: None expected Specify: _____

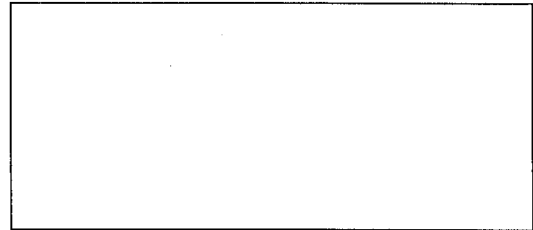
Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____

(Type or print)

Telephone: _____ FAX: _____

Address: _____



Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)

(Use for Prescriber's Address Stamp)

A verbal order was taken by the school RN (Name): _____ for the above medication on (Date): _____

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

Self carry/self administration of **emergency** medication may be authorized by the prescriber and must be approved by the school nurse according to the State medication policy.

Prescriber's authorization for self carry/self administration of emergency medication: _____
Signature Date

School RN approval for self carry/self administration of emergency medication: _____
Signature Date

Order reviewed by the school RN: _____
Signature Date

MEDICATION ADMINISTRATION RECORD FOR:

(To Be Completed For Each Medication and Dosage Change)

Student Name _____

School Year _____

Date of Birth: _____ Gender: _____ Grade: _____ Teacher: _____ School: _____

Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

Medication: _____ Dosage: _____ Start Date: _____ Stop Date: _____

Route: _____ Frequency: _____ Time(s) Given During School: _____

Known Allergies: _____

Month/Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
August																																
September																																
October																																
November																																
December																																
January																																
February																																
March																																
April																																
May																																
June																																
July																																

Comments: _____

Initial: _____ Name: _____ Initial: _____ Name: _____

CODES FOR DAILY MEDICATIONS			
A	Absent	O	Out of Medication
D	Early Dismissal	R	Refused
F	Field Trip	W	Withheld Dosage
H	Holiday	X	No School

ARCHDIOCESE OF BALTIMORE

Maryland State School Asthma Medication Administration Authorization Form

ASTHMA ACTION PLAN _____ / _____ / _____ to _____ / _____ / _____ (not to exceed 12 months)



TRIGGER (LIST)

Child's Name: _____ DOB: _____ PEAK FLOW PERSONAL BEST: _____
 Parent/Guardian's Name: _____ Home: _____ Work: _____ Cell: _____

ASTHMA SEVERITY: Exercise Induced Intermittent Mild Persistent Moderate Persistent Severe Persistent

GREEN ZONE		CONTROLLER MEDICATION - USE DAILY AT HOME UNLESS OTHERWISE INDICATED			
<input type="checkbox"/> Breathing is good <input type="checkbox"/> No cough or wheeze <input type="checkbox"/> Can work, exercise, play <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow greater than _____ (80% personal best)	Medication	Dose	Route	Frequency/Time	<input type="checkbox"/> School
					<input type="checkbox"/> School
					<input type="checkbox"/> School
					<input type="checkbox"/> School
ORANGE ZONE		RESCUE MEDICATIONS - TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS			
<input type="checkbox"/> Prior to exercise/sports/physical education (PE)	Medication (Rescue Medication)	Dose	Route	Frequency/Time	
If using more than twice per week to exercise/sports/PE, notify the health care provider and parent/guardian.					
YELLOW ZONE		RESCUE MEDICATIONS - TO BE ADDED TO GREEN ZONE MEDICATIONS FOR SYMPTOMS			
<input type="checkbox"/> Cough or cold symptoms <input type="checkbox"/> Wheezing <input type="checkbox"/> Tight chest or shortness of breath <input type="checkbox"/> Cough at night <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow between _____ and _____ (50%-79% personal best)	Medication	Dose	Route	Frequency/Time	
If symptoms do not improve in _____ minutes, notify the health care provider and parent/guardian. Using more than twice per week, notify the health care provider and parent/guardian.					
RED ZONE		EMERGENCY MEDICATIONS - TAKE THESE MEDICATIONS AND CALL 911			
<input type="checkbox"/> Medication is not helping within 15-20 mins <input type="checkbox"/> Breathing is hard and fast <input type="checkbox"/> Nasal flaring or intercostal retraction <input type="checkbox"/> Lips or fingernails blue <input type="checkbox"/> Trouble walking or talking <input type="checkbox"/> Other: _____ <input type="checkbox"/> Peak flow less than _____ (50% personal best)	Medication	Dose	Route	Frequency/Time	
CONTACT THE PARENT/GUARDIAN AFTER CALLING 911					

HEALTH CARE PROVIDER AUTHORIZATION
 I authorize the administration of the medications as ordered above.
 Student may self-carry medications Yes No
 Health Care Provider Name: _____
 Signature: _____
 Date: _____

PARENT/GUARDIAN AUTHORIZATION
 I authorize the administration of the medications as ordered above.
 I acknowledge that my child is is not authorized to self-carry his/her medication(s):
 Signature: _____
 Date: _____

REVIEWED BY SCHOOL NURSE
 Name: _____
 Signature: _____
 Date: _____
 Authorized to self-carry medications: Yes No



PLACE
PICTURE
HERE

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING: SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A
COMBINATION
of symptoms
from different
body areas.



- INJECT EPINEPHRINE IMMEDIATELY.**
- Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

- Antihistamines may be given, if ordered by a healthcare provider.
- Stay with the person; alert emergency contacts.
- Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

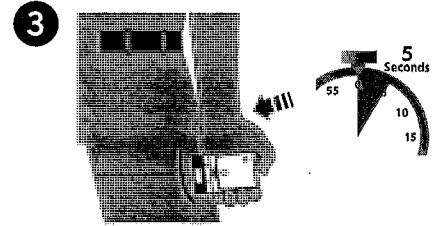
Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____



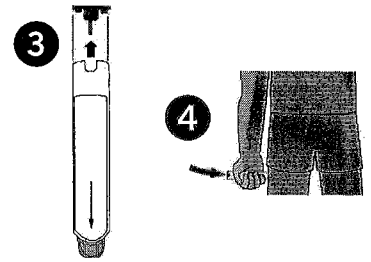
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



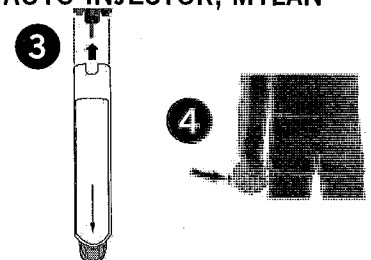
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



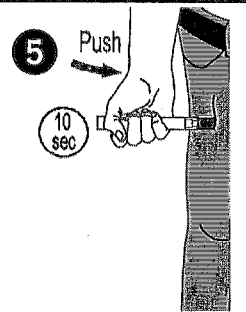
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENALCLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____



Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form
Valid from: Start ___/___/___ to End ___/___/___ or for School Year _____



Demographics

Student Name:	DOB:	Grade:	Diagnosis:
Parent/Guardian:	Home Phone:	Work Phone:	Cell Phone:

Insulin Orders

Insulin Dosing:

Carbohydrate coverage
 Correction dose only
 Correction dose plus CHO coverage
 Fixed dose
 Fixed insulin dose with dosing scale
 See attached dosing scale

Insulin(s):

Rapid Acting:
 Apidra
 Humalog
 Novolog
 Any of the **rapid acting** insulins may be substituted for the others
 Long Acting (if given at school): _____ Give _____ unit(s) at _____ (time)

Insulin Delivery:
 Pen
 Syringe
 Pump (make/model): _____

Carbohydrate (CHO) Coverage per meal:

_____ unit(s) of insulin SQ per _____ grams of CHO at breakfast
 _____ unit(s) of insulin SQ per _____ grams of CHO at lunch

Carbohydrate Dose Adjustment Prior To Strenuous Exercise:

Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at breakfast
 Use exercise/PE CHO ratio of _____ unit(s) of insulin per _____ grams of CHO at lunch

Correction Dose:

Give _____ unit(s) of insulin SQ for every _____ mg/dl greater than target BG of _____ mg/dl
 If pre-meal BG less than _____ mg/dl, subtract _____ unit(s) of insulin dose

Fixed Dose Insulin: _____ unit(s) of insulin SQ given before school meals
 Split Insulin Dose:
 Give _____ unit(s) or _____% of meal insulin dose SQ before meal and _____ unit(s) or _____% of meal insulin dose SQ after meal

Snack Insulin Coverage:

_____ unit(s) of insulin SQ per _____ grams of CHO in snack
 _____ unit(s) of insulin SQ for snack greater than _____ grams of CHO

Ketone Coverage

For ketones trace to small (urine)/< _____ mmol/L (blood)	For ketones moderate to large (urine)/> _____ mmol/L (blood)
<input type="checkbox"/> Correction dose plus _____ unit(s) of insulin	<input type="checkbox"/> Correction dose plus _____ unit(s) of insulin
<input type="checkbox"/> _____ unit(s) of insulin	<input type="checkbox"/> _____ unit(s) of insulin

Insulin Dose Administration Principles

Insulin should be given:

- Before meals Before snacks Other times (please specify): _____
- For hyperglycemia if BG > _____ mg/dl and _____ hours since last dose/bolus
- If CHO intake cannot be predetermined, insulin should be given no more than _____ minutes after start of meal/snack
- If parent requests, insulin should be given no more than _____ minutes after start of meal/snack
- Use pump or bolus device calculations per programmed settings, once settings have been verified
- Parent has permission to increase/decrease insulin correction dose by +/- _____ unit(s) or by ratio _____ unit(s) to _____ mg/dl
- Parent has permission to increase/decrease CHO coverage by +/- _____ unit(s) of insulin or by ratio of _____ unit(s) to _____ grams of CHO

Independent Insulin Administration Skills & Supervision Needs* *Skills to be verified by school nurse

<input type="checkbox"/> Insulin dose calculations	<input type="checkbox"/> Carbohydrate counting	<input type="checkbox"/> Measuring insulin	<input type="checkbox"/> Insulin administration
<input type="checkbox"/> Independent <input type="checkbox"/> With Supervision	<input type="checkbox"/> Independent <input type="checkbox"/> With Supervision	<input type="checkbox"/> Independent <input type="checkbox"/> With Supervision	<input type="checkbox"/> Independent <input type="checkbox"/> With Supervision

Other Diabetes Medication

Name of Medication	Time	Dosage	Route	Possible Side Effects

Authorizations

HEALTH CARE PROVIDER AUTHORIZATION		PARENT/GUARDIAN AUTHORIZATION	
I authorize the administration of the medications and student diabetes self-management as ordered above.		By signing below, I authorize:	
Provider Name (PRINT): _____		• The designated school personnel to administer the medication and treatment orders as prescribed above.	
Phone: _____ Fax: _____		By signing below, I agree to:	
Provider Signature: _____		• Provide the necessary diabetes management supplies and equipment; and	
Date: _____		• Notify the nurse of any changes in my child's care or condition.	
		Parent Signature: _____	Date: _____

Acknowledged and received by: _____	School Nurse: _____	Date: _____
--	----------------------------	--------------------

Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form

Valid from: Start ___/___/___ to End ___/___/___ or for School Year _____

Student Name:	DOB:	Grade:
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Blood Glucose Monitoring*		<small>*Self-management skills to be verified by school nurse</small>	
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Blood Glucose (BG) Monitoring:

Before meals
 Before PE/Activity
 After PE/Activity
 Prior to dismissal
 Additional monitoring per parent request
 For symptoms of hypo/hyperglycemia & anytime the student does not feel well
 Student may independently check BG*

Continuous Glucose Monitoring

Uses CGM Make/Model: _____
 Other: _____ Other: _____
Alarms set for: Low _____ mg/dl High _____ mg/dl If sensor falls out at school, notify parent

Hypoglycemia Management*		<small>*Self-management skills to be verified by school nurse</small>	
---------------------------------	--	---	--

Mild or Moderate Hypoglycemia (BG _____ mg/dl to _____ mg/dl):

Provide quick-acting glucose product equal to 15 grams of carbohydrate (or glucose gel), if conscious & able to swallow. If glucose gel is given, place student in recovery position.
 Suspend pump for BG < _____ mg/dl and restart pump when BG > _____ mg/dl
 Student should consume a meal or snack within _____ minutes after treating hypoglycemia
 Other: _____

Always treat hypoglycemia before the administration of meal/snack insulin

Repeat BG check 15 minutes after use of quick-acting glucose

- If BG still low, re-treat with 15 gram quick-acting CHO as stated above
- If BG in acceptable range and it is lunch or snack time, have student eat and cover meal CHO per orders
- If CGM in use and BG 70 and arrow going up, no need to recheck

Student may self-manage mild or moderate hypoglycemia and notify the school nurse*: Yes No

Severe Hypoglycemia (BG < _____ mg/dl):

If symptoms worsen despite treatment/retreatment _____ times, student is unconscious, semi-conscious, unable to control his/her airway, unable to swallow or seizing give:

GLUCAGON injection: 1 mg 0.5 mg IM or SQ

- Place student in the recovery position
- Suspend pump, if applicable, and restart pump at BG > _____ mg/dl
- Call 911 and state glucagon was given for hypoglycemia; notify parent/guardian

Use glucose gel inside cheek, even if unconscious, seizing if glucagon not available or there is no response to glucagon administration.
If glucose gel is given, place student in recovery position.

Hyperglycemia Management*		<small>*Self-management skills to be verified by school nurse</small>	
----------------------------------	--	---	--

If BG greater than _____ mg/dl, or when child complains of nausea, vomiting, and/or abdominal pain, check urine/blood for ketones.

- If urine ketones are **trace to small** or blood ketones _____ mmol/L:
 - Give _____ ounces of sugar-free fluid or water per hour
 - Give insulin as listed in Insulin Orders
- If urine ketones are **moderate to large** or blood ketones greater than _____ mmol/L
 - Give _____ ounces of sugar-free fluid or water
 - Give insulin as listed in Insulin Orders
- **If large ketones, vomiting or other signs of ketoacidosis, call 911.** Notify parent/guardian
- Recheck BG and ketones _____ hours after administering insulin
- Contact Parent/Guardian for: BG > _____ mg/dl Ketones _____ mmol/L

Student may self-manage hyperglycemia with trace/small ketones and notify the school nurse: Yes No

Snacks

Snacks needed:

Before physical education/physical activity/sports longer than _____ mins
 Per parent/guardian Per student
 Limit snack to _____ grams of CHO
 Delay snack if BG > _____ mg/dl
 No snack coverage Other: _____

Provider Name:	Signature:	Date:
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Acknowledged and received by:	School Nurse:	Date:
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Maryland Diabetes Medical Management Plan/ Health Care Provider Order Form

Valid from: Start ___/___/___ to End ___/___/___ or for School Year _____

Student Name:	DOB:	Grade:
Physical Education, Physical Activity, and Sports		
<input type="checkbox"/> Avoid physical education, physical activity, and sports if: <input type="checkbox"/> BG < ___ mg/dl <input type="checkbox"/> BG > ___ mg/dl <input type="checkbox"/> Ketones present <input type="checkbox"/> If BG is 80-100 mg/dl, give 15 grams of CHO and return to physical education, physical activity, or sports <input type="checkbox"/> May disconnect pump for sports activities <input type="checkbox"/> Student may set temporary basal rate <input type="checkbox"/> Other:		
Transportation		
<input type="checkbox"/> BG must be > ___ mg/dl for bus ride/walk home <input type="checkbox"/> Only check BG if symptomatic prior to bus ride/walk home <input type="checkbox"/> Allow student to carry quick-acting glucose for consumption on bus, as needed for hypoglycemia <input type="checkbox"/> Student must be transported home with parent/guardian if (specify): _____ <input type="checkbox"/> Other:		
Disaster Plan (if needed for lockdown, 72 hr shelter in place)		
<input type="checkbox"/> Continue to follow orders contained in this medical management plan <input type="checkbox"/> Additional insulin orders as follows: <input type="checkbox"/> Other:		
Pump Management		
Type of Pump:	Pump start date:	Child Lock: <input type="checkbox"/> On <input type="checkbox"/> Off
Basal rates: ___ unit(s)/hour ___ AM/PM	___ unit(s)/hour ___ AM/PM	___ unit(s)/hour ___ AM/PM
___ unit(s)/hour ___ AM/PM	___ unit(s)/hour ___ AM/PM	___ unit(s)/hour ___ AM/PM
___ unit(s)/hour ___ AM/PM	___ unit(s)/hour ___ AM/PM	___ unit(s)/hour ___ AM/PM
Additional Hyperglycemia Management:		
<input type="checkbox"/> If BG > _____ mg/dl and has not decreased over _____ hours after bolus, consider infusion site change. Notify parent/guardian <input type="checkbox"/> For infusion site failure: <input type="checkbox"/> Give insulin via syringe or pen <input type="checkbox"/> Change infusion site <input type="checkbox"/> For suspected pump failure, suspend or remove pump and give insulin via syringe or pen <input type="checkbox"/> If BG > ___ mg/dl and <u>moderate to large</u> ketones, student should change infusion site and give correction dose by pen or syringe <input type="checkbox"/> Comments:		
Independent Pump Management Skills and Supervision needs*		
<small>*Skills to be verified by school nurse. Supervision will be provided if not fully independent when appropriate</small>		
Student is independent in the pump skills indicated below:		
<input type="checkbox"/> Carbohydrate counting <input type="checkbox"/> Bolus an insulin dose <input type="checkbox"/> Set a basal rate/temporary basal rate <input type="checkbox"/> Reconnect pump at infusion set <input type="checkbox"/> Prepare and insert infusion set <input type="checkbox"/> Troubleshoot alarms and malfunctions <input type="checkbox"/> Give self-injection if needed <input type="checkbox"/> Disconnect pump <input type="checkbox"/> Other:		
Additional Orders		
_____ _____		
Parent/Guardian Consent for Self-Management		
■ I acknowledge that my child <input type="checkbox"/> is <input type="checkbox"/> is not authorized to self-manage as indicated by my child's health care provider. ■ I understand the school nurse will work with my child to learn self-management skills he/she is not currently capable of or authorized to perform independently. My child has my permission to independently perform the diabetes tasks listed below as indicated by my child's health care provider:		
<input type="checkbox"/> Blood glucose monitoring <input type="checkbox"/> Insulin administration <input type="checkbox"/> Pump management <input type="checkbox"/> Carbohydrate counting <input type="checkbox"/> Insulin dose calculation <input type="checkbox"/> Other:		
Parent/Guardian Name:	Signature:	Date:
Provider Name:	Signature:	Date:
Acknowledged and received by:	School Nurse:	Date:

Suspected Head Injury Assessment Form

Directions: This form is to be completed if a student is reported to have a potential head injury (whether sustained at school or outside of school) and no documentation is provided indicating he/she has been evaluated for potential immediate care needs (see the Protocol for Suspected Head Injuries).

Student Information:

Student's Name: Enter Student's Full Name.

Student's Grade: Choose Grade Level.

Date Injury Occurred: Click here to select a date.

Time Injury Occurred: Enter Time

Description of injury (Include information about any loss of consciousness and duration, memory loss, seizures following injury, prior concussions if any):

Enter full description of injury.

Head Injury Danger Signs Checklist:

Directions: Observe and interview the student, and place a check next to all symptoms that apply. The student should be seen immediately by emergency medical providers and the parent/guardian contacted if one or more of the following symptoms apply:

- One pupil (the black part in the middle of the eye) larger than the other
- Drowsiness or cannot be awakened
- A headache that gets worse and does not go away
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Difficulty recognizing people or places
- Increasing confusion, restlessness, or agitation
- Unusual behavior
- Loss of consciousness (even a brief loss of consciousness should be taken seriously)

If none of the above listed Danger Signs are present, complete the Concussion Signs and Symptoms Checklist

Resolution of Injury and Disposition of Student (Check all that apply):

- Student departure for emergency medical care: Time Enter time.
- Student returned to class: Time Enter time.
- Student sent home: Time Enter time.
- Student referred to health care professional with experience in evaluating for concussion.
- Parent/Guardian contacted: Time Enter time.
- Notified appropriate school personnel:
 - Building administrator: Enter name and title.
 - Coach, Trainer, or Athletic Director: Enter name and title.
 - Teacher(s): Enter name of all that apply.
 - Other: Enter name and title.
- Notes: Enter additional notes.

***Parent/Guardian, it is advisable to continue to monitor the student referencing the symptoms listed on the Concussion Signs and Symptoms Checklist and seek medical attention if signs or symptoms present.**

CONCUSSION SIGNS AND SYMPTOMS CHECKLIST

STUDENT NAME: Click here to enter text.

DATE: Click here to enter a date.

TIME: Click here to

Directions: If at any time during assessment the student develops one or more of the symptoms listed on the **Head Injury Danger Signs Checklist** refer the child immediately for emergency medical care.

To complete the **Concussion Signs and Symptoms Checklist** interview the student and assess for the symptoms of concussion listed in the "Observed Symptoms" column. Place a check mark for each symptom observed in the column marked "0 Minutes" next to the symptom observed. If one or more of the boxes are checked after the initial observation, contact the parent/guardian as the student should be referred to a health care professional with experience in evaluating for concussion. Continue to monitor the student using the checklist until the parent/guardian arrives. If the student shows no observed symptoms after the initial completion of the checklist at 0 minutes, continue to administer the checklist at 15 minutes after the initial observation and again 30 minutes after the initial observation. If during any of these subsequent observations one or more symptoms of concussion is observed, contact the parent/guardian as the student should be referred to a health care professional with experience in evaluating for concussion. If after thirty minutes the student shows no symptoms of concussion, the student may be returned to class.

Observed Symptoms	0 Minutes	15 Minutes	30 Minutes	45 Minutes
Appears dazed or stunned	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is confused about events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repeats questions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Answers questions slowly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't recall events <i>prior</i> to injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't recall events <i>after</i> injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of consciousness (even briefly)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shows behavior or personality changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forgets Class schedule or assignments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache or "pressure" in head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance problems or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue or feeling tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurry or double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does not "feel right"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty thinking clearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling more slowed down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling sluggish, hazy, foggy or groggy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More emotional than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of School Staff Member completing this form:

Title: _____

Date: _____

Parent Signature:

Date: _____



ARCHDIOCESE OF BALTIMORE
DEPARTMENT OF MANAGEMENT SERVICES
OFFICE OF RISK MANAGEMENT

REPORT OF STUDENT INJURY

NAME OF CHILD:	_____	GRADE:	_____	GENDER	_____
NAME OF PARENT GUARDIAN:	_____				
ADDRESS	_____				
CITY:	_____				
STATE:	_____				
ZIP:	_____				
TELEPHONE	_____				

DAY/DATE OF ACCIDENT	_____
CIRCUMSTANCES	_____

FOLLOW-UP CARE:	_____

NAME OF SCHOOL	_____
SUBMITTED BY:	_____
DATE:	_____
E-MAIL ADDRESS:	_____
PHONE NUMBER:	_____

Submit to:	Cathy O'Brien, Risk Management Associate
	Fax: 410-547-3153
	E-mail cathy.obrien@archbalt.org

1. Please refer to Student Injury Reporting and Submission Guidelines for information on completion of this form.

Notification of Injury: Abrasions, Cuts or Puncture Wounds

Student Name _____ Date/Time of Injury _____

Dear Parents/Guardians:

Your child was seen in the school health office for an injury that caused an opening in their skin, or wound. The wound type is a: Abrasion (scrape) Laceration (cut) Puncture (skin pierced by object) to

_____.
The wound was cleaned and covered with a dry bandage. Student is advised to keep wound clean and covered.

Openings in the skin such as abrasions (scrapes) or cuts need to be kept clean, dry, and covered until the skin is healed to keep the wound from becoming infected. Remind your child to wash their hands before or after touching the wound. The bandaid or gauze should be changed every day and more often if it becomes wet or dirty. It is normal for the wound to drain clear yellow or pink liquid in the beginning and to be sore when touched.

When changing the bandage, it is important to look at the wound **every day** for signs of infection such as:

- Increasing redness of the skin around the wound
- Swelling of the area
- Liquid coming from the wound that is making the bandage very wet, is thick, turns green, or dark yellow, and/or smells bad
- Pain at the wound or in the part of the body where the wound is located
- Skin is very warm around the wound

If you see any of the above signs, or your child has a fever, call your doctor or health care provider!

A wound infection may not always start right away, and some infections may be from germs (bacteria) that can cause very serious illness. It is **VERY** important to call your doctor or health care provider **right away** if you see any of the following in your child:

- Fever (temperature at or over 101° on the thermometer) and/or chills
- Pain, swelling, redness and warmth where the injury occurred which gets bad very quickly
- Liquid coming from the wound that is making the bandage very wet, is thick, turns green, or dark yellow, and/or smells bad.
- Complains of stomach pain, decreased appetite, nausea or vomiting
- Dizziness, light headed and/or headache
- Confusion and/or weakness, or sleeping a lot
- Rash anywhere on body

Completed by: _____

Please contact the School Nurse if you have any questions or concerns

Self-Carry and Self-Administration of Asthma Inhaler Evaluation

Student _____ Date of Birth _____

Grade _____ Homeroom/Teacher _____

Name of Medication _____

Current medication form on file with parent signature and health care provider signature authorizing self-carry and self-administration of the medication ____ Yes ____ No

Interview Date _____ Health Room Staff _____

Reviewed with teacher _____ Date _____

1. Student is capable of identifying individual medication ____ Yes ____ No
2. Student is knowledgeable of purpose of medication ____ Yes ____ No
3. Student is able to identify specific symptoms/triggers that indicate need for medication ____ Yes ____ No
4. Student is knowledgeable about medication dosage/frequency ____ Yes ____ No
5. Student demonstrates proper administration of medication ____ Yes ____ No
6. Student has plan for access to medication at all times ____ Yes ____ No (where it is to be kept during class, recess, gym)
7. Student is knowledgeable about how to access assistance for self if needed in an emergency. ____ Yes ____ No
8. Spare inhaler to be kept in health room ____ Yes ____ No
9. Student is aware that any inappropriate use or sharing with others may result in parental notification and limiting the right to carry medication. ____ Yes ____ No
10. The student and nurse have a plan for communicating each instance of rescue inhaler self-administration ____ Yes ____ No.

The student has completed the self-carry and self-administration evaluation and has demonstrated appropriate self-administration and level of responsibility to self-carry their medication.

_____ Health Room Signature

_____ Student Signature

_____ Date

Copy of form in student health file.

Self-Carry and Self-Administration of Auto-Injectable Epinephrine Evaluation

Student _____ Date of Birth _____
Grade _____ Homeroom/Teacher _____
Name of Medication _____
Current medication form on file with parent signature and health care provider signature
authorizing self-carry and self-administration of the medication ____ Yes ____ No
Interview Date _____ Health Room Staff _____
Reviewed with teacher _____ Date _____

1. Student is capable of identifying individual medication ____ Yes ____ No
2. Student is knowledgeable of purpose of medication ____ Yes ____ No
3. Student is able to identify specific symptoms/triggers that indicate need for medication
____ Yes ____ No
4. Student is knowledgeable about medication dosage/frequency ____ Yes ____ No
5. Student demonstrates proper administration of medication ____ Yes ____ No
6. Student has plan for access to medication at all times ____ Yes ____ No (where it is to be kept
during class, recess, gym)
7. Student is knowledgeable about how to access assistance for self if needed in an
emergency. ____ Yes ____ No
8. Spare auto-injectable epinephrine to be kept in health room ____ Yes ____ No
9. Student is aware that any inappropriate use or sharing with others may result in
parental notification and limiting the right to carry medication. ____ Yes ____ No
10. The student is aware that they have to notify nearby school staff and the health room
immediately if the medication is used, and that emergency services will be notified
____ Yes ____ No.

The student has completed the self-carry and self-administration evaluation and has demonstrated appropriate self-administration and level of responsibility to self-carry their medication.

_____ Health Room Signature
_____ Student Signature
_____ Date

Copy of form in student health file.

Section 21

Resources

Resources

Resources

Archdiocese of Baltimore Contacts

Department of Schools: (410) 547-5515

Director of Child and Youth Protection: (410) 547-5368

Director of Student Support Services: (410) 625-8495

Director of Risk Management: (410) 547-5424

<https://www.archbalt.org/office-of-risk-management/>

Online Resources

Active Shooter Civilian Response training: <https://www.alicetraining.com/>

American Academy of Pediatrics: <https://www.aap.org>

American Diabetes Association: www.diabetes.org

American Heart Association Information: www.heart.org

American Public Health Association (School based health):
www.Apha.org/schoolhealth

American School Health Association: www.Ashaweb.org

Epilepsy Foundation: www.epilepsy.com

FARE (Food Allergy Research and Education): <https://www.foodallergy.org/>

Glucagon Training: <https://www.lillyglucagon.com/>

International Students (general questions): www.ice.gov/

Maryland Asthma Control Program: www.asthmacommunitynetwork.org

Maryland Occupational Safety and Health Regulations:
<http://www.dllr.state.md.us/labor/mosh;>

Maryland School Health: www.mdschoolhealthservices.org;

Maryland State Board of Nursing: www.mbon.org

Maryland State Department of Education, Students Services Branch, 200 West Baltimore Street, Baltimore MD 21201, (410)767-0311:
www.marylandpublicschools.org

Maryland State Department of Health and Mental Hygiene, 201 West Preston Street, Baltimore, MD 21201, (877) 463-3464: <https://health.maryland.gov/>

National Association of School Nurses: www.nursesource.org

National Asthma Education and Prevention Program: <https://www.nhlbi.nih.gov>

National Catholic Educational Association: www.ncea.org

National Centers for Disease Control and Prevention, general information: (1-800-232-4636): www.cdc.gov

National Heart, Lung, and Blood Institute: <http://www.nhlbi.nih.gov/>

National Hemophilia Foundation: <http://www.hemophilia.org>

Poison Hotline- 800-222-1222: www.poison.org

School Based Asthma Management System:

<https://www.hipxchange.org/SAMPRO>

Specialized Health Needs Interagency Collaboration Project (SHNIC):

<https://www.kennedykrieger.org/community/community-programs/specialized-health-needs-interagency-collaboration>

US Department of Education FERPA for parents and students:

<https://studentprivacy.ed.gov/training/student-privacy-101>

State of Maryland

Local Department of Social Services

Allegheny County

1 Frederick Street, Cumberland, MD 21501

Phone: (301)784-7122; after hours (301) 759-0362

Anne Arundel County

7500 Ritchie Highway, Glen Burnie, MD 21401-1787

Phone: (410)421-8400

Baltimore City

1900 N. Howard Street, Baltimore, MD 21218

Phone: (410)361-2235 (24 hours)

Baltimore County

6401 York Road, Baltimore, MD 21212

Phone: (410) 853-3000 (24 hours) Option 1

Carroll County

1232 Tech Drive #1, Westminster, MD 21157

Phone: (410) 386-3434 (24 hours)

Cecil County

170 East Main Street

Elkton, MD 21922

Phone: (410) 996-0100 (Option 3)

Frederick County

100 East All Saints Street, Frederick MD 21701

Phone: (301) 600-2464; after hours-(301) 564-8230 (police department)

Harford County

2 South Bond Street, Bel Air, MD 21014

Phone: (410) 836-4713; after hours-(410) 683-4500 (Sheriff's Office)

Howard County

7121 Columbia Gateway Drive, Columbia MD 21046

Phone: (410) 872-4203; after hours-(410)313-2929 (police department)

Queen Anne's County

125 Comet Drive, Centreville, MD 21617

Phone: (410) 758-8000 (24 hours)

Washington County

122 North Potomac Street, Hagerstown, MD 21741-1419

Phone: (240) 420-2222 (24 hours)

Table 3

MARYLAND LOCAL HEALTH DEPARTMENTS

Addresses & Telephone Numbers for Infectious Disease Reporting

* Telephone (T) or Pager (P) Number for After Hours and Weekend Reporting

JURISDICTION	ADDRESS	JURISDICTION	ADDRESS
ALLEGANY Ph. 301-759-5112 Fax 301-777-5669 *T 301-759-5000	PO Box 1745 12501 Willowbrook Road SE Cumberland MD 21501-1745	HARFORD Ph. 410-612-1774 Fax 410-612-9185 *T 443-243-5726	1321 Woodbridge Station Way Edgewood MD 21040
ANNE ARUNDEL Ph. 410-222-7256 Fax 410-222-4004 *T 443-481-3140	Communicable Disease & Epi. 1 Harry S. Truman Parkway Room 231 Annapolis MD 21401	HOWARD Ph. 410-313-1412 Fax 410-313-6108 *T 410-313-2929	8930 Stanford Blvd Columbia MD 21045
BALTIMORE CITY Ph. 410-396-4436 Fax 410-625-0688 *T 410-396-3100	1001 E. Fayette Street Baltimore MD 21202	KENT Ph. 410-778-1350 Fax 410-778-7913 *T(410) 708-5611	125 S. Lynchburg Street Chestertown MD 21620
BALTIMORE CO. Ph. 410-887-6011 Fax 410-377-5397 *T 410-832-7182	Communicable Disease, 3rd Floor 6401 York Road Baltimore MD 21212	MONTGOMERY Ph. 240-777-1755 Fax 240-777-4680 *T 240-777-4000	2000 Dennis Avenue Suite 238 Silver Spring MD 20902
CALVERT Ph. 410-535-5400 Fax 410-414-2057 *P 443-532-5973	PO Box 980 975 Solomon's Island Road Prince Frederick MD 20678	PR. GEORGE'S Ph. 301-583-3750 Fax 301-583-3794 *T 240-508-5774	3003 Hospital Drive Suite 1066 Cheverly MD 20785-1194
CAROLINE Ph. 410-479-8000 Fax 410-479-4864 *T 443-786-1398	403 South 7th Street Denton MD 21629	QUEEN ANNE'S Ph. 410-758-0720 Fax 410-758-8151 *T 410-758-3476	206 N. Commerce Street Centreville MD 21617
CARROLL Ph. 410-876-4900 Fax 410-876-4959 *T 410-876-4900	290 S. Center Street Westminster MD 21158-0845	ST. MARY'S Ph. 301-475-4316 Fax 301-475-4308 *T 301-475-8016	PO Box 316 21580 Peabody Street Leonardtown MD 20650
CECIL Ph. 410-996-5100 Fax 410-996-1019 *T 410-392-2008	John M. Byers Health Center 401 Bow Street Elkton MD 21921	SOMERSET Ph. 443-523-1740 Fax 410-651-5699 *T 443-614-6708	Attn: Communicable Disease 7920 Crisfield Highway Westover MD 21871
CHARLES Ph. 301-609-6810 Fax 301-934-7048 *T 301-932-2222	PO Box 1050 White Plains MD 20695	TALBOT Ph. 410-819-5600 Fax 410-819-5693 *T 410-819-5600	100 S. Hanson Street Easton MD 21601
DORCHESTER Ph. 410-228-3223 Fax 410-901-8180 *P 410-221-3362	3 Cedar Street Cambridge MD 21613	WASHINGTON Ph. 240-313-3210 Fax 240-313-3334 *T 240-313-3290	1302 Pennsylvania Avenue Hagerstown MD 21742
FREDERICK Ph. 301-600-3342 Fax 301-600-1403 *T 301-600-1603	350 Montevue Lane Frederick MD 21702	WICOMICO Ph. 410-543-6943 Fax 410-548-5151 *T 410-543-6996	Attn: Communicable Disease 108 E. Main Street Salisbury MD 21801-4921
GARRETT Ph. 301-334-7777 Fax 301-334-7771 Fax 301-334-7717 *T 301-334-1930	Garrett Co. Community Health Ctr. 1025 Memorial Drive Oakland MD 21550-4343 (Fax for use during emergencies)	WORCESTER Ph. 410-632-1100 Fax 410-632-0906 *T 443-614-2258	PO Box 249 Snow Hill MD 21863

Table 4 MARYLAND STATE HEALTH DEPARTMENT (DHMH) OFFICES

Addresses & Telephone Numbers for Infectious Disease Reporting

* Telephone (T) or Pager (P) Number for After Hours and Weekend Reporting

OFFICE	ADDRESS
CENTER FOR HIV SURVEILLANCE, EPIDEMIOLOGY & EVALUATION Ph. 410-767-5939 Fax Do NOT Fax *P 410-716-8194 (For use when Local Health Department is unavailable.)	Maryland DHMH 500 North Calvert Street, 5 th Floor Baltimore, MD 21202 ATTN: CHSE
CENTER FOR SEXUALLY TRANSMITTED INFECTION PREVENTION Ph. 410-222-6690 Fax 410-528-6098 *P 410-716-8194 (For use when Local Health Department is unavailable.) sti@dhhm.state.md.us	Maryland DHMH 500 North Calvert Street, 5 th Floor Baltimore MD 21202 ATTN: CSTIP
CENTER FOR TUBERCULOSIS CONTROL AND PREVENTION Ph. 410-767-6698 Fax 410-383-1762 *P 410-716-8194 (For use when Local Health Department is unavailable.)	Maryland DHMH 500 North Calvert Street, 5 th Floor Baltimore MD 21202 ATTN: TB Control
INFECTIOUS DISEASE EPIDEMIOLOGY & OUTBREAK RESPONSE BUREAU Ph. 410-767-6700/6709 Fax 410-225-7615 *T 410-795-7365 (For use when Local Health Department is unavailable.)	Maryland DHMH 201 West Preston Street, 3 rd Floor Baltimore MD 21201 ATTN: PHPA/OIDEOR/Unit 26

MEDICAL TERMINOLOGY ABBREVIATIONS

The following list contains some of the most common abbreviations found in medical records. Please note that in medical terminology, the capitalization of letters bears significance as to the meaning of certain terms, and is often used to distinguish terms with similar acronyms.

@—at
A & P—anatomy and physiology
ab—abortion
abd—abdominal
ABG—arterial blood gas
a.c.—before meals
ac & cl—acetest and clinitest
ACLS—advanced cardiac life support
AD—right ear
ADL—activities of daily living
ad lib—as desired
adm—admission
afeb—afebrile, no fever
AFB—acid-fast bacillus
AKA—above the knee
alb—albumin
alt dieb—alternate days (every other day)
am—morning
AMA—against medical advice
amal—amalgam
amb—ambulate, walk
AMI—acute myocardial infarction
amt—amount
ANS—automatic nervous system
ant—anterior
AOx3—alert and oriented to person, time, and place
Ap—apical
AP—apical pulse
approx—approximately
aq—aqueous
ARDS—acute respiratory distress syndrome
AS—left ear
ASA—aspirin
asap (ASAP)—as soon as possible
as tol—as tolerated
ATD—admission, transfer, discharge
AU—both ears
Ax—axillary
BE—barium enema
bid—twice a day
bil, bilateral—both sides
BK—below knee
BKA—below the knee amputation
bl—blood
bl wk—blood work
BLS—basic life support
BM—bowel movement
BOW—bag of waters
B/P—blood pressure
bpm—beats per minute
BR—bed rest

BRP—bathroom privileges
BS—breath sounds
BSI—body substance isolation
BSO—bilateral salpingo-oophorectomy
BUN—blood, urea, nitrogen levels
BVM—bag-valve-mask
bx—biopsy
c—with
C & S—culture and sensitivity
c-spine—cervical spine
CA—cancer
CAD—coronary artery disease
cal—calorie
CAT—computerized axial tomography
cath—catheter
CBC—complete blood count
cc—cubic centimeters
CC—chief complaint
CCU—coronary care unit, critical care unit
CHD—coronary heart disease
CHF—congestive heart failure
CHO—carbohydrate
chol—cholesterol
circ—circumcision
cl liq—clear liquid
CNS—central nervous system
c/o—complains of
COPD—chronic obstructive pulmonary disease
CPK—creatine phosphokinase
CPR—cardiopulmonary resuscitation
CPT—chest physical therapy
CS—central supply
CSF—cerebrospinal fluid
CT—computer tomography
CVA—cerebrovascular accident (stroke)
CVU—cardiovascular unit
cx—cervix or complaint of
CXR—chest X ray
cysto—cystography
d/c—discontinue
D & C—dilation and curettage
DAT—diet as tolerated
DC—discontinue or discharge
del—delivery
Del. Rm.—delivery room
diff—differential
DNA—deoxyribonucleic acid
DNR—do not resuscitate
DOA—dead on arrival
DOB—date of birth
DPT—diphtheria, pertussis, tetanus
DRG—diagnosis-related grouping
D/S—dextrose in saline
DT's—delirium tremens
DW—distilled water
D5W 5%—dextrose in water
Dx—diagnosis

EBL—estimated blood loss
ECG—electrocardiogram
ED—emergency department
EEG—electroencephalogram
EENT—eyes, ears, nose, throat
EKG—electrocardiogram
EMG—electromyogram
EOA—esophageal obturator airway
ESR—erythrocyte sedimentation rate
est—estimated
ER—emergency room
ET—endotracheal
ETA—estimated time of arrival
etiolo—etiology
ETOH—ethyl alcohol, intoxicated
exam—examination
exp—exploratory
ext—external, extract, extraction
FBOA—foreign body obstructed airway
FBS—fasting blood sugar
FBW—fasting blood work
FF (F. Fl)—force fluids
FH—family history
FHS—fetal heart sounds
FHT—fetal heart tone
FIFO—first in, first out
FSH—follicle-stimulating hormone
ft—foot
FUO—fever of undetermined origin
Fx—fracture
GB—gallbladder
GI—gastrointestinal
GU—genitourinary
GTT—glucose tolerance test (pancreas test)
gtt(s)—drop(s)
gyn—gynecology
H & H—hemoglobin and hematocrit
HCG—human chorionic gonadotrophin
hct—hematocrit
HDL—high-density lipoprotein
hgb—hemoglobin
HOB—head of bed
hr (h)—hour
HIV—human immunodeficiency virus
H&P—history and physical
HR—heart rate
hs—hour of sleep, bedtime
ht—height
Hx—history
hypo—hypodermic injection
hyst—hysterectomy
IBS—irritable bowel syndrome
I & D—incision and drainage
I & O—intake and output

ICP—intracranial pressure
ICU—intensive care unit
IM—intramuscular
ing—inguinal
inj—injection
IPPB—intermittent positive pressure breathing
irrig—irrigation
IS—intercostal space
isol—isolation
IT—inhalation therapy
IUD—intrauterine device
IV—intravenous
IVF—in vitro fertilization
IVP—intravenous pyelogram
K+—potassium
KCl—potassium chloride
KUB—kidney, ureter, bladder
L—lumbar
L & D—labor and delivery
lac—laceration
lab—laboratory
lap—laparotomy
lat—lateral
LD—lethal dose
LDH—lactic dehydrogenase
LDL—low-density lipoprotein
liq—liquid
LLQ, LLL—left lower quadrant (abdomen), lobe (lung)
LMP—last menstrual period
LOC—level of consciousness
LP—lumbar puncture
lt—left
LUQ, LUL—left upper quadrant (abdomen), lobe (lung)
MA—mental age
MAST—medical antishock trousers
MCI—mass casualty incident
meds—medications
MI—myocardial infarction
MICU—mobile intensive care unit
min—minute
MN—midnight
MOM—milk of magnesia
MRI—magnetic resonance imagery
MS—morphine sulfate, multiple sclerosis
MVA—motor vehicle accident
NVD—nausea, vomiting, diarrhea
Na+—sodium
NaCl—sodium chloride
N/C—nasal cannula
no—complaints
neg—negative
neuro—neurology
NG—nasogastric
NGT—nasogastric tube
nitro—nitroglycerine
NKA—no known allergies
noc (t)—night
NPO—nothing by mouth

NS—normal saline
nsg—nursing
NSR—normal sinus rhythm
NVS—neurological vital signs
O—oxygen
OB—obstetrics
OD—right eye, overdose
oint—ointment
OOB—out of bed
OPD—outpatient department
OR—operating room
ord—orderly
ORTH—orthopedics
ortho—correct, right (bones)
os—mouth
OS—left eye
OT—occupational therapy
OU—both eyes
oz—ounce
p—after
P—pulse
P & A—percussion and auscultation
PAC—premature atrial contraction
palp—palpation
PAR—post-anesthesia room
PAT—paroxysmal atrial tachycardia
pc—after meals
pCO₂—partial pressure of carbon dioxide
PDR—physician's desk reference
PE—physical exam, pulmonary embolism
PEDS—pediatrics
per—by or through
PERL(A)—pupils equal and reactive to light (and accommodation)
PET—positron emission tomography
PH—past history
pH—hydrogen ion concentration
PID—pelvic inflammatory disease
PKU—phenylketonuria
pm—between noon and midnight
PNS—peripheral nervous system
po—by mouth
post (pos)—posterior
postop, PostOp—postoperative
pp (p.p.)—postprandial (after eating)
pO₂—partial pressure of oxygen
PPD—purified protein derivative (TB test)
preop, PreOp—before surgery
prn—as needed, whenever necessary
pro time—prothrombin time
pt—patient, pint
PT—physical therapy
PTT—partial prothromboplastin time
PVC—premature ventricular contraction
Px—physical exam, prognosis
q—every
qd—every day
qh—every hour
q2h, q3h, ...—every two hours, every three hours, ...

qhs—every night at bedtime
qid—four times a day
qns—quantity not sufficient
qod—every other day
qs—quantity sufficient
r (R)—rectal
R (resp)—respirations, rectal
RAIU—radioactive iodine uptake study
RBC—red blood cell/count
reg—regular
Rh—rhesus
RK—radial keratomy
RL—ringer's lactate
RLQ, RLL—right lower quadrant (abdomen), lobe (lung)
RML—right middle lobe (lung)
RO—reality orientation
R/O—rule out
ROM—range of motion
R.R.—recovery room
RUQ, RLL—right upper quadrant, lobe
rt—right
RV—residual volume
Rx—take (prescription)
s—without
S & S—signs and symptoms
ss—1/2
Sats—oxygen/blood saturation level
SA—sinoatrial
SB—small bowel
sc—subcutaneous
SGOT—serum glutamic oxaloacetic transaminase
SGPT—serum glutamic pyruvic transaminase
SIDS—sudden infant death syndrome
Sig.—label/write
SL—sublingual
SMAC—sequential multiple analysis computer
SOB—shortness of breath
spec—specimen
sp. gr.—specific gravity
SQ, sub q—subcutaneous
SSE—soap suds enema
stat—immediately
STD—sexually transmitted disease
STH—somatotropic hormone
SVD—spontaneous vaginal delivery
SVN—small volume nebulizer
SVT—supraventricular tachycardia
Sx—symptoms
T—temperature, thoracic
T & A—tonsillectomy and adenoidectomy
tab—tablet
tachy—tachycardic
TAH—total abdominal hysterectomy
TB—tuberculosis
TCDB—turn, cough, deep breath
temp (T)—temperature
TH—thyroid hormone
TIA—transient ischemic attack

tid—three times a day
TMJ—temporomandibular joint
tol—tolerated
TPN—total parenteral nutrition
TPR—temperature, pulse, respirations
tr—tincture
trach—tracheotomy, tracheostomy
TSH—thyroid-stimulating hormone
TT—tetanus toxiod
TUR—transurethral resection
TV—tidal volume
TVH—total vaginal hysterectomy
TX—traction
UA—urinalysis
umb—umbilicus
unc.—unconscious
ung—ointment
unk—unknown
ur—urine
URC—usual, reasonable, customary
URI—upper respiratory infection
US—ultrasonic
UTI—urinary tract infection
V fib—ventricular fibrillation
V tach—ventricular tachycardia
vag—vaginal
VC—vital capacity
VD—venereal disease
vit—vitamin
vo—verbal order
vol—volume
V/S—vital signs
WA—while awake
WBC—white blood cell/count
w/c—wheelchair
WNL—within normal limits
wt—weight
y/o—year(s) old

Section 22

References

References

Alabama State Department of Education, <https://www.alsde.edu/>

Archdiocese of Baltimore, Department of Schools, Policy Manual for Elementary Schools, 2017

Maryland School Health, www.mdschoolhealthservices.org

Maryland State Department of Education, www.marylandpublicschools.org

National School Association of School Nurses, www.nasn.org

Oklahoma State Department of Health, www.ok.gov

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