Parents' Guide to Florida School Immunization Requirements at a Glance

2009 - 2010 School Year

Grade	DTaP Series	Polio Series	MMR 1	MMR 2	Hep B Series	Varicella 1[2]	Varicella 2[3]	Pneumococcal Conjugate[4]	Hib	Td/Tdap Booster	Completed Certificate[5]
Pre-K[1]	X	X	X		X	X		X	X		B
K	X	X	X	X	X	X	X				A
1	X	X	X	X	X	X	X				A
2	X	X	X	X	X	X					A
3	X	X	X	X	X	X					A
4	X	X	X	X	X	X					A
5	X	X	X	X	X	X					A
6	X	X	X	X	X	X					A
7	X	X	X	X	X	X				Tdap	A
8	X	X	X	X	X	X				X	A
9	X	X	X	X	X					X	A
10	X	X	X	X	X					X	A
11	X	X	X	X	X					X	A
12	X	X	X	X	X					X	A

1. Children entering or attending public pre-school are required to have an **age-appropriate** number of DTaP, Polio, MMR, Hepatitis B, Varicella, and Hib immunizations. Public pre-school students aged 3 and 4 years do not typically have all immunizations required for Kindergarten entry, thus their Certificates of Immunization are most often signed in *Temporary Medical Exemption (Part B-Temporary).* The expiration dates on these Certificates of immunization are typically set at Kindergarten entry or the child's fifth birthday.
2. Effective 2001-2002 school year, children entering kindergarten will be required to receive one dose of varicella vaccine. Each subsequent year thereafter, the next highest grade will be included in the requirement.
3. Beginning 2008-2009 school year, children entering kindergarten will be required to receive two doses of varicella vaccine. Each subsequent year thereafter, the next highest grade will be included in the requirement. Varicella vaccine is not required if there is history of varicella disease documented by the health care provider.
4. Effective January 2008, children age 2 to 24 months, entering or attending child care or family day care facilities, will be required to have documentation of age-appropriate pneumococcal conjugate vaccination.
5. **Certificates of Immunization for students of any age/grade who are lacking immunizations required for their grade level should be signed in *Temporary Medical Exemption (Part B-Temporary)* with an appropriate expiration date to recall the student for the missing immunizations.**
6. **Effective with the 2009-2010 school year, in addition to all other compulsory school immunizations, children entering, attending, or transferring to the seventh grade in Florida schools are required to complete one dose of tetanus-diphtheria-pertussis vaccine (Tdap).**

Dear Parent/Guardian of: _____

Your child has been evaluated in the School Health Clinic by a School Health Nurse from the Santa Rosa County Health Department and has a suspicious skin infection. Some skin infections are caused by Methicillin-resistant Staphylococcus aureus (MRSA). You do not need to be alarmed about this, but the Health Department would like to provide you with information about this type of infection.

Staphylococcus aureus ("staph") is a type of bacteria found in the environment and on the skin or in the nose of 25% to 30% of healthy individuals. It is a common cause of bacterial skin lesions, such as impetigo, furuncles, carbuncles, abscesses and infected cuts and is most commonly spread through direct physical contact (skin-to-skin) with an infected person. In the past 25 years, more and more of these staph infections have become resistant to the antibiotics commonly prescribed to treat them – penicillin and methicillin. These MRSA infections therefore require more persistence to treat and more vigilance to prevent.

It is neither practical nor necessary to bar children with MRSA infections from attending school; however, precautions need to be taken to prevent the spread to other persons. MRSA infections are treatable, and early treatment can help keep the infection from getting worse. We ask that you consult with your health care provider as soon as possible. Depending on the severity of the infection, he or she may send a sample for laboratory testing and may prescribe antibiotics. <u>The infected area must remain bandaged until the wound is dry, especially if your student is involved in contact sports.</u> Remember, even if the infection appears to be healing, the treatment instructions should continue to be followed to prevent the infection from coming back or becoming worse.

The following are the best ways to prevent MRSA infections:

- Wash hands frequently with soap and warm water, especially after changing your own bandages or the bandages of another person.
- Do not share personal items such as razors, towels, bed sheets, clothes, deodorant, sporting equipment.
- Wash all cuts, scratches and abrasions with soap and water. Keep them covered with a clean, dry bandage until healed.
- Avoid contact with open wounds and cuts.
- Wash soiled towels, bed sheets, and clothes in hot water with soap and bleach. Dry clothes in a hot dryer, heat helps kill the bacteria.
- Never touch, squeeze or pop any boils. This can spread the bacteria to other parts of your body or to other people. The pus is full of bacteria.
- Keep all common areas, like bathrooms and kitchens clean. A 1:10 bleach solution or chemical germicide will kill the bacteria.

If you have any questions, please contact your physician, or your School Health Nurse at 983-5200.

FLORIDA DEPARTMENT OF HEALTH
SANTA ROSA COUNTY HEALTH DEPARTMENT
COMMUNICABLE DISEASE

COMMUNICABLE DISEASE SCHOOL MANUAL

Updated 3/2010

5527 STEWART STREET
MILTON, FLORIDA 32570

(850) 983-5200
Fax (850) 983-4504

Emergency Health Care Plan Procedure

Purpose: This procedure establishes guidelines for School Health Registered Nurses (RNs) in collaboration with School Health Clinic Staff and school personnel to develop or revise students Emergency Health Care Plans.

Definitions: ***Emergency Health Care Plan*** – a written plan of action developed for students with emergency health conditions that require an action or a response of school personnel to protect and preserve the health and safety of that student during the school day
Emergency Health Condition - any physical or mental health issue that would require emergency responses to protect and preserve the health and safety of the student
Accommodations - modification of actions to meet the needs of the student

Procedure:

I. Identification of students with emergency health conditions

A. Review previous year Emergency Health Care Plans to create a list of current students
B. Review School Health Clinic medications and/or Medication Log
C. Review student Emergency Health Card
D. Request teachers submit list of students with emergency health conditions
E. Request data entry list of students with health conditions
F. Utilize kindergarten registration log to identify students
G. Direct observation of student(s)

II. Contact parent/guardian

A. Obtain contact information on student from:
   1. Student Emergency Health Card
   2. Santa Rosa County School District registration form
   3. Consult school district data entry for student demographics
B. Initiate parent/guardian contact
   1. Schedule parent/guardian conference
      a. Hold a face to face parent/guardian conference with or without teacher and school staff.
      b. Conduct a telephone interview.
      c. Conduct a home visit.
   2. Send Health Problem letter home to parent/guardian
      a. Initiate Emergency Health Care Plan procedure as indicated on parent/guardian response.
      b. File letter in student Cumulative School Health Record.
      c. Document in student Cumulative School Health Record attempts to contact parent/guardian.

III. For Emergency Health Care Plans that require emergency medications, health staff will make three (3) attempts to contact parent/guardian to collect the medication(s). If medication is not collected, the Emergency Health Care Plan can be revised to note "Contact EMS/911 as appropriate."

IV. Emergency Health Care Plan completion note, this document is to be written by the School Health Registered Nurse (RN).

A. Student demographics
   1. Obtain from student Emergency Health Card
   2. Obtain demographic printout from data clerk
   3. Obtain from student registration form
   4. Obtain from parent/guardian interview

B. Health condition/length of time
   1. List chronic health condition(s)
   2. Utilize Emergency Health Care Plan template for:
      a. Asthma
      b. Allergy
      c. Diabetes
      d. General - Blank
      e. Insect allergy
      f. Migraines
      g. Nut allergy
      h. Peanut allergy
      i. Seizures
   3. Note time of onset or length of time existed
      a. Obtain from interview with parent/guardian
      b. Obtain from student Emergency Health Card

C. Allergies – check appropriate category and list allergy within that category
   1. None
   2. Food
   3. Medication(s)
   4. Other (environmental, animal, insects, etc.)

D. Medication
   1. Medication at home – list medications taken at home
   2. Medication at school – list medications to be taken at school and the medication storage location
      a. School Health Clinic
      b. Classroom
      c. Student backpack
      d. Other

E. Potential Emergency and Emergency Response
   1. Use Emergency Health Care Plan template (for asthma, allergy, diabetes, general - blank, insect allergy, migraines, nut allergy, peanut allergy, seizures).
   2. List the potential emergency situation.
   3. Note the symptoms that would be seen.
   4. Record the actions to be taken for each emergency situation or symptom listed.
   5. Verify dose with Medication Authorization Form.

F. Special needs and limitations
    1. Diet
        a. Describe any foods or items restricted from diet.
        b. List foods that may be allowed.
        c. Note if the student eats from school cafeteria or eats lunch from home.
    2. Activity level/physical restrictions
        a. Note any restriction in physical activity at recess or PE.
        b. Note activities that may not be allowed.
        c. Note any activities allowed to participate.
        d. Note any actions to be taken during physical activity such as water breaks, rest periods, etc.
    3. Accommodations needed in classroom
        a. Define teacher responsibilities for student during class.
        b. Define classroom accommodations for class parties, field trips, or class activities, etc.
        c. Define accommodations specific to child's health condition.

G. Other considerations
    1. Define plan for field trips.
    2. Note anything that was not addressed above.
    3. Utilize Medical Procedures Addendum Form where applicable.

H. Send copies of the Emergency Health Care Plan to appropriate staff (see staff checked to receive copies of Emergency Health Care Plan)

I. Signature section
    1. Obtain parent/guardian signature if possible.
    2. Obtain signatures of school personnel attending health care plan meeting or involved in health care plan.

J. Updates
    1. Two annual updates allowed: check if done by person-to-person interview or by telephone interview
    2. Obtain signatures of those involved in health care plan update.

K. Emergency Health Care Plan disposition
    1. File original form in student Cumulative School Health Record.
    2. Allow for individual communication with school personnel who need to be informed of Emergency Health Care Plan.
    3. Maintain copies of Emergency Health Care Plans, stored alphabetically in a binder in the School Health Clinic.
    4. It is recommended that the School Health Registered Nurse (RN) maintain a copy.

MEDICAL PROCEDURE ADDENDUM TO
EMERGENCY HEALTH CARE PLAN

Student: _____

Description of Procedure:

_____
_____
_____.

Time/Frequency of Procedure:

_____
_____.

Equipment Needed:

_____
_____
_____.

Person(s) Trained and Designated by School to Carry Out Procedure:

_____.

Adverse Signs/Symptoms or Potential Emergency Treatment:

_____
_____
_____.

Additional Instructions/Other:

_____
_____
_____.

_____ _____
Signature of Person Completing Form ***Date***

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

_____ _____
Physician Signature ***Date***

□ **See attached Physician Order**

Santa Rosa County Public Schools
Individual Emergency Health Care Plan
School_____

Grade ____Teacher _____Year _____
Grade ___ Teacher _____Year _____
Grade ___ Teacher _____Year _____

Student Name: _____DOB_____
Parent: _____ Phone#1_____Phone#2_____
2nd Parent: _____ Phone#1_____Phone#2_____
Emergency Contact: _____Phone:_____
2nd Emergency Contact: _____Phone:_____
Physician Name: _____Phone:_____
Specialist Name: _____Phone:_____

1. Health condition/ Length of time condition has existed: _____
_____

2. Allergies:

- ☐ **None**
- ☐ **Food**_____
- ☐ **Medication** _____
- ☐ **Other**_____

3. Medications at home	**Medications at school**	**Medication Storage Location**
		☐ Classroom ☐ Clinic ☐ Student Backpack ☐ Other:_____

4. Potential Emergency Situation	**Emergency Response**

5. Special Needs/Limitations
Diet: _____
_____
_____

Activity Level/Physical Restrictions: _____
_____
_____

Accommodations needed in classroom: _____
_____
_____

6. Other Considerations: _____
_____
_____

Send Copies To: __Teacher __Clinic __Guidance __PE __Art __Music __Cafeteria __Teacher Asst. __Bus Driver
__School Nurse __Media Center Specialist __Athletic Director __Other_____

Student Name _____

*By my signature on this form, I acknowledge receipt of the Notice of the Privacy Practices Act, and authorize designated Santa Rosa County School District personnel, Santa Rosa County Health Department School Health personnel, and any other contracted health care agencies to provide emergency care for my child and/or to exchange medical information as necessary to support the continuity of care of my child.

Parent Signature_____**Date** _____

☐ **Obtained via telephone interview with parent** **School Year**_____

Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**School Health Technician**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 2 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 3 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

***Note: 1. Significant changes to plan of care require a new Individual Health Care Plan be completed.**
2. At the beginning of the 4th school year based on the inception date of this plan a new plan will be written.

Santa Rosa County Public Schools
Individual Emergency Health Care Plan
School_____

Grade ____Teacher _____Year _____
Grade ___ Teacher _____Year _____
Grade ___ Teacher _____Year _____

Student Name: _____DOB_____
Parent: _____ Phone#1_____Phone#2_____
2nd Parent: _____ Phone#1_____Phone#2_____
Emergency Contact: _____Phone:_____
2nd Emergency Contact: _____Phone:_____
Physician Name: _____Phone:_____
Specialist Name: _____Phone:_____

1. Health condition/ Length of time condition has existed: Allergy
Reaction occurs if student has following type of contact: ☐ Ingestion ☐ Skin contact ☐ Inhalation ☐ Other: _____

2. Allergies:

☐ **Food**_____
☐ **Medication** _____
☐ **Other** _____

3. Medications at home	**Medications at school**	**Medication Storage Location**
_____	_____	☐ Classroom ☐ Clinic ☐ Student Backpack ☐ Other:_____

4. Potential Emergency Situation	**Emergency Response**
• Swelling of the lips, tongue, or eyes • Swelling or tightness in throat • Difficulty talking/hoarse voice • Difficulty breathing or noisy breathing • Wheezing or persistent cough • Vomiting, stomach cramps, diarrhea • Rash, Hives or Welts • Loss of Consciousness and/or collapse • Blue Discoloration of lips or fingernails • Student becomes pale or floppy • Other: _____	• Stay calm • Stay with student and escort student to the clinic • Give medications as ordered by doctor/parent Give **Benadryl** immediately for mild reactions Administer as directed Give **Epinephrine** immediately for severe reactions such as difficulty breathing etc. Route :__IM_____ Amount: ___1 Pen_____ • Other_____ **Call 9-1-1 immediately if**: Epinephrine given, lips or fingernails turn blue or gray, breathing worsens, continuous spasmodic coughing, continued swelling of lips, throat, or tongue, loss of consciousness/collapse, start **CPR immediately if student stops breathing and has no pulse.**

5. Special Needs/Limitations
Diet: _____
_____
_____
Activity Level/Physical Restrictions: _____
_____
_____
Accommodations needed in classroom: _____
_____
_____

6. Other Considerations: Take emergency medication on all off campus activities _____
_____
_____

Send Copies To: __Teacher __Clinic __Guidance __PE __Art __Music __Cafeteria __Teacher Asst. __Bus Driver
__School Nurse __Media Center Specialist __Athletic Director __Other_____

Student Name _____

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Parent Signature_____**Date** _____

☐ **Obtained via telephone interview with parent** **School Year**_____

Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**School Health Technician**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 2 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 3 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

***Note: 1. Significant changes to plan of care require a new Individual Health Care Plan be completed.**
2. At the beginning of the 4th school year based on the inception date of this plan a new plan will be written.

Santa Rosa County Public Schools
Individual Emergency Health Care Plan
School_____

Grade ____Teacher _____Year _____
Grade ___ Teacher _____Year _____
Grade ___ Teacher _____Year _____

Student Name: _____DOB_____
Parent: _____ Phone#1_____Phone#2_____
2nd Parent: _____ Phone#1_____Phone#2_____
Emergency Contact: _____Phone:_____
2nd Emergency Contact: _____Phone:_____
Physician Name: _____Phone:_____
Specialist Name: _____Phone:_____

1. Health condition/ Length of time condition has existed: **Asthma**

2. Allergies:

- ☐ **Food**_____
- ☐ **Medication** _____
- ☐ **Other** _____

3. Medications at home	Medications at school	Medication Storage Location
_____	_____	☐ Classroom
_____	_____	☐ Clinic
_____	_____	☐ Student Backpack
_____	_____	☐ Other:_____
_____	_____	_____

4. Potential Emergency Situation

- Noisy breathing or wheezing
- Excessive coughing
- Shortness of breath
- Complaining of tight feeling in chest or chest pressure
- Difficulty breathing
- Other:_____
  _____

Triggers that may cause an asthma attack: cold weather, cigarette smoke, dust mites, exercise, respiratory infections, strong odors or fumes, pollen, mold foods, and
Other:_____

Emergency Response

- Allow student to use inhaler if carried with student
- Stay with student and escort student to the clinic
- Keep student upright and encourage SLOW, deep breaths in through nose and out through puckered lips
- Give Nebulizer Treatment in Clinic if ordered
- Notify Parent immediately

Call 9-1-1 immediately if: lips or fingernails turn blue or gray, breathing worsens, continuous spasmodic coughing, increased anxiety or confusion, struggling or gasping for air, cannot walk or talk, skin pulling around collar bones and ribs with breathing, and start **CPR immediately if student stops breathing and has no pulse.**

5. Special Needs/Limitations
Diet: _____
_____
_____
Activity Level/Physical Restrictions: _____
_____
_____
Accommodations needed in classroom: _____
_____
_____
6. Other Considerations: **Take emergency medication on all off campus activities** _____
_____
_____

Send Copies To: __Teacher __Clinic __Guidance __PE __Art __Music __Cafeteria __Teacher Asst. __Bus Driver
__School Nurse __Media Center Specialist __Athletic Director __Other_____

Student Name _____

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Parent Signature_____**Date** _____

☐ **Obtained via telephone interview with parent** **School Year**_____

Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**School Health Technician**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 2 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 3 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

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Revised: June, 2012

Santa Rosa County Public Schools
Individual Emergency Health Care Plan
School_____

Grade ____Teacher _____Year _____
Grade ___ Teacher _____Year _____
Grade ___ Teacher _____Year _____

Student Name: _____DOB_____
Parent: _____ Phone#1_____Phone#2_____
2nd Parent: _____ Phone#1_____Phone#2_____
Emergency Contact: _____Phone:_____
2nd Emergency Contact: _____Phone:_____
Physician Name: _____Phone:_____
Specialist Name: _____Phone:_____

1. Health condition/ Length of time condition has existed: Diabetes

2. Allergies:
☐ **Food**_____
☐ **Medication** _____
☐ **Other** _____

3. Medications at home	**Medications at school**	**Medication Storage Location**
		☐ Classroom ☐ Clinic ☐ Student Backpack ☐ Other:

4. Potential Emergency Situation

Hypoglycemia (low blood sugar level) symptoms:

Headache	Nervousness	Drowsiness
Tremors	Pale Skin	Weakness
Cold sweats	Confusion	Fatigue
Hunger	Uncooperativeness	Dizziness
Irritability	Unconsciousness	Poor coordination
Slurred speech	Combativeness	Convulsions
Unconscious		

Hyperglycemia(high blood sugar level) symptoms:

Increased urination	Increased hunger	Sleepiness
Increased thirst	Fruity breath	Weakness
Blurred vision	Vomiting	Stomach pains
Difficulty breathing	Unconscious	

Other:_____

Emergency Response

- Stay calm and remain with student
- Escort student to the clinic or call for help
- Give medication or food according to symptoms or blood sugar if available and follow student's Diabetes action plan /doctor's orders
- Give **Glucagon** immediately if: **student is unconscious**
  Route: SQ____ Amount: _____
  *****Call 9-1-1 immediately**
- Notify parents
- Other_____

Call 9-1-1 immediately if: Glucagon is given, student is unconscious, has breathing difficulties, has a seizure, or **if student stops breathing or has no pulse start CPR immediately!**

5. Special Needs/Limitations
Diet: _____

Activity Level/Physical Restrictions: _____

Accommodations needed in classroom: _____

6. Other Considerations: Take emergency medication on all off campus activities _____

Send Copies To: __Teacher __Clinic __Guidance __PE __Art __Music __Cafeteria __Teacher Asst. __Bus Driver
__School Nurse __Media Center Specialist __Athletic Director __Other_____

Student Name _____

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Parent Signature_____**Date** _____

☐ **Obtained via telephone interview with parent** **School Year**_____

Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**School Health Technician**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 2 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 3 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

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2. At the beginning of the 4th school year based on the inception date of this plan a new plan will be written.

Santa Rosa County Public Schools
Individual Emergency Health Care Plan
School_____

Grade ___Teacher _____Year _____
Grade ___ Teacher _____Year _____
Grade ___ Teacher _____Year _____

Student Name: _____DOB_____
Parent: _____ Phone#1_____Phone#2_____
2nd Parent: _____ Phone#1_____Phone#2_____
Emergency Contact: _____Phone:_____
2nd Emergency Contact: _____Phone:_____
Physician Name: _____Phone:_____
Specialist Name: _____Phone:_____

1. Health condition/ Length of time condition has existed: **Insect Allergy**

2. Allergies:
☐ **Food**_____
☐ **Medication** _____
☐ **Other** _____

3. Medications at home	Medications at school	Medication Storage Location
_____	_____	☐ Classroom
_____	_____	☐ Clinic
_____	_____	☐ Student Backpack
_____	_____	☐ Other:_____
_____	_____	_____

4. Potential Emergency Situation	Emergency Response
• Swelling of the lips, tongue, or eyes • Swelling or tightness in throat • Difficulty talking/hoarse voice • Difficulty breathing or noisy breathing • Wheezing or persistent cough • Vomiting, stomach cramps, diarrhea • Rash, Hives or Welts • Loss of Consciousness and/or collapse • Blue Discoloration of lips or fingernails • Student becomes pale or floppy • Other:_____-	• Stay calm • Stay with student and escort student to the clinic • Give **Benadryl** immediately for mild to moderate symptoms – Administer as directed • Give **Epinephrine** immediately for severe symptoms such as difficulty breathing etc. Route: IM Amount: 1 pen • Notify parents • Other_____ **Call 9-1-1 immediately if:** lips or fingernails turn blue or gray, breathing worsens, continuous spasmodic coughing, continued swelling of lips, throat, or tongue, loss of consciousness/collapse, start **CPR immediately if student stops breathing and has no pulse.**

5. Special Needs/Limitations
Diet: _____

Activity Level/Physical Restrictions: _____

Accommodations needed in classroom: _____

6. Other Considerations: **Take emergency medication on all off campus activities** _____

Send Copies To: __Teacher __Clinic __Guidance __PE __Art __Music __Cafeteria __Teacher Asst. __Bus Driver
__School Nurse __Media Center Specialist __Athletic Director __Other_____

Student Name _____

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Parent Signature_____**Date** _____

☐ **Obtained via telephone interview with parent** **School Year**_____

Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**School Health Technician**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 2 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 3 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

***Note: 1. Significant changes to plan of care require a new Individual Health Care Plan be completed.**
2. At the beginning of the 4th school year based on the inception date of this plan a new plan will be written.

Santa Rosa County Public Schools
Individual Emergency Health Care Plan
School_____

Grade ___Teacher _____Year _____
Grade ___ Teacher _____Year _____
Grade ___ Teacher _____Year _____

Student Name: _____DOB_____
Parent: _____ Phone#1_____Phone#2_____
2nd Parent: _____ Phone#1_____Phone#2_____
Emergency Contact: _____Phone:_____
2nd Emergency Contact: _____Phone:_____
Physician Name: _____Phone:_____
Specialist Name: _____Phone:_____

1. Health condition/ Length of time condition has existed: **Migraines**

2. Allergies:
☐ **Food**_____
☐ **Medication** _____
☐ **Other** _____

3. Medications at home	Medications at school	Medication Storage Location
_____	_____	☐ Classroom
_____	_____	☐ Clinic
_____	_____	☐ Student Backpack
_____	_____	☐ Other:_____
_____	_____	_____

4. Potential Emergency Situation

- Symptoms of an aura:
  Flashing lights Visual disturbances
  Speech difficulties Tingling
  Limb weakness Abdominal pain
- Light sensitivity
- Sound sensitivity
- Nausea, vomiting, diarrhea
- Increased urination
- Dizziness
- Increased thirst
- Odor sensitivity
- Other: _____
  _____
  _____

Emergency Response

- Allow student to rest in dark, quiet environment
- Give medications per doctor's orders and if available
- Call parents if pain persists
- Other_____
  _____
  _____
  _____

5. Special Needs/Limitations
Diet: _____
_____
_____
Activity Level/Physical Restrictions: _____
_____
_____
Accommodations needed in classroom: _____
_____
_____
6. Other Considerations: **Take emergency medication on all off campus activities** _____
_____
_____

Send Copies To: __Teacher __Clinic __Guidance __PE __Art __Music __Cafeteria __Teacher Asst. __Bus Driver
__School Nurse __Media Center Specialist __Athletic Director __Other_____

Student Name _____

*By my signature on this form, I acknowledge receipt of the Notice of the Privacy Practices Act, and authorize designated Santa Rosa County School District personnel, Santa Rosa County Health Department School Health personnel, and any other contracted health care agencies to provide emergency care for my child and/or to exchange medical information as necessary to support the continuity of care of my child.

Parent Signature_____**Date** _____

☐ **Obtained via telephone interview with parent** **School Year**_____

Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**School Health Technician**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 2 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 3 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

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Santa Rosa County Public Schools
Individual Emergency Health Care Plan
School_____

Grade ____Teacher _____Year _____
Grade ___ Teacher _____Year _____
Grade ___ Teacher _____Year _____

Student Name: _____DOB_____
Parent: _____ Phone#1_____Phone#2_____
2nd Parent: _____ Phone#1_____Phone#2_____
Emergency Contact: _____Phone:_____
2nd Emergency Contact: _____Phone:_____
Physician Name: _____Phone:_____
Specialist Name: _____Phone:_____

1. Health condition/ Length of time condition has existed: Nut Allergy
Reaction to peanuts occurs if student has following type of contact: ☐ Ingestion ☐ Skin contact ☐ Inhalation ☐ Other:_____

2. Allergies:
☐ **Food**_____
☐ **Medication** _____
☐ **Other** _____

3. Medications at home	Medications at school	Medication Storage Location
_____	_____	☐ Classroom
_____	_____	☐ Clinic
_____	_____	☐ Student Backpack
_____	_____	☐ Other:_____
_____	_____	

4. Potential Emergency Situation

- Swelling of the lips, tongue, or eyes
- Swelling or tightness in throat
- Difficulty talking/hoarse voice
- Difficulty breathing or noisy breathing
- Wheezing or persistent cough
- Vomiting, stomach cramps, diarrhea
- Rash
- Loss of Consciousness and/or collapse
- Blue Discoloration of lips or fingernails
- Student becomes pale or floppy
- Other: _____

Emergency Response

- Stay calm
- Stay with student and escort student to the clinic
- Give **Benadryl** immediately for mild to moderate symptoms – Administer as directed
- Give **Epinephrine** immediately for severe symptoms such as difficulty breathing etc.
  Route: IM Amount: 1 pen
- Notify parents
- Other_____

Call 9-1-1 immediately if: lips or fingernails turn blue or gray, breathing worsens, continuous spasmodic coughing, continued swelling of lips, throat, or tongue, loss of consciousness/collapse, start **CPR immediately if student stops breathing and has no pulse.**

5. Special Needs/Limitations
Diet: Avoid any of the following nuts in diet: _____

Activity Level/Physical Restrictions: _____

Accommodations needed in classroom: Assist student to avoid ingestion or skin contact with nut products. Notify parent volunteers assisting with class of student's allergy _____

6. Other Considerations: Take emergency medication on all off campus activities _____

Send Copies To: __Teacher __Clinic __Guidance __PE __Art __Music __Cafeteria __Teacher Asst. __Bus Driver
__School Nurse __Media Center Specialist __Athletic Director __Other_____

Student Name _____

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Parent Signature_____**Date** _____

☐ **Obtained via telephone interview with parent** **School Year**_____

Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**School Health Technician**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 2 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 3 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

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Santa Rosa County Public Schools
Individual Emergency Health Care Plan
School_____

Grade ____Teacher _____Year _____
Grade ___ Teacher _____Year _____
Grade ___ Teacher _____Year _____

Student Name: _____DOB_____
Parent: _____ Phone#1_____Phone#2_____
2nd Parent: _____ Phone#1_____Phone#2_____
Emergency Contact: _____Phone:_____
2nd Emergency Contact: _____Phone:_____
Physician Name: _____Phone:_____
Specialist Name: _____Phone:_____

1. Health condition/ Length of time condition has existed: Peanut Allergy
Reaction to peanuts occurs if student has following type of contact: ☐ Ingestion ☐ Skin contact ☐ Inhalation ☐ Other:_____

2. Allergies:
☐ **Food**_____
☐ **Medication** _____
☐ **Other** _____

3. Medications at home	Medications at school	Medication Storage Location
_____	_____	☐ Classroom
_____	_____	☐ Clinic
_____	_____	☐ Student Backpack
_____	_____	☐ Other:_____
_____	_____	

4. Potential Emergency Situation

- Swelling of the lips, tongue, or eyes
- Swelling or tightness in throat
- Difficulty talking/hoarse voice
- Difficulty breathing or noisy breathing
- Wheezing or persistent cough
- Vomiting, stomach cramps, diarrhea
- Rash
- Loss of Consciousness and/or collapse
- Blue Discoloration of lips or fingernails
- Student becomes pale or floppy
- Other: _____

Emergency Response

- Stay calm
- Stay with student and escort student to the clinic
- Give **Benadryl** immediately for mild to moderate symptoms – Administer as directed
- Give **Epinephrine** immediately for severe symptoms such as difficulty breathing etc.
  Route: IM Amount: 1 pen
- Notify parents
- Other_____

Call 9-1-1 immediately if: lips or fingernails turn blue or gray, breathing worsens, continuous spasmodic coughing, continued swelling of lips, throat, or tongue, loss of consciousness/collapse, start **CPR immediately if student stops breathing and has no pulse.**

5. Special Needs/Limitations
Diet: Avoid peanuts and peanut products in diet: _____

Activity Level/Physical Restrictions: _____

Accommodations needed in classroom: Assist student to avoid ingestion or skin contact with peanuts or peanut products. Notify parent volunteers assisting with class of student's allergy._____

6. Other Considerations: **Take emergency medication on all off campus activities** _____

Send Copies To: **__Teacher __Clinic __Guidance __PE __Art __Music __Cafeteria __Teacher Asst. __Bus Driver __School Nurse __Media Center Specialist __Athletic Director __Other_____**

Student Name _____

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Parent Signature_____**Date** _____

☐ **Obtained via telephone interview with parent** **School Year**_____

Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**School Health Technician**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 2 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 3 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

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Santa Rosa County Public Schools
Individual Emergency Health Care Plan
School_____

Grade ____Teacher _____Year _____
Grade ___ Teacher _____Year _____
Grade ___ Teacher _____Year _____

Student Name: _____DOB_____
Parent: _____ Phone#1_____Phone#2_____
2nd Parent: _____ Phone#1_____Phone#2_____
Emergency Contact: _____Phone:_____
2nd Emergency Contact: _____Phone:_____
Physician Name: _____Phone:_____
Specialist Name: _____Phone:_____

1. Health condition/ Length of time condition has existed: Seizures_____
2. Allergies: ☐ **None**_____
☐ **Food**_____
☐ **Medication** _____
☐ **Other**_____

3. Medications at home	**Medications at school**	**Medication Storage Location**
_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	☐ Classroom ☐ Clinic ☐ Student Backpack ☐ Other:_____ _____

4. Potential Emergency Situation

Tonic Clonic /Generalized	**Partial Complex**	**Absence/Petit Mal**
*Convulsing *Shaking *Jerking *Stiffness *Loss of consciousness *Loss of bowel or bladder function *Falls or collapses	*Muscle twitching or jerking on one side of body *may see, hear or smell things that are not there *confused or dazed *unable to talk *picks at things or clothing	*Stares *Appears dazed *repetitive blinking or chewing *Unresponsive *Blank stare

*Student's usual signs/symptoms of seizure:_____
_____
Triggers that may cause seizures:
_____
_____

Emergency Response

- Stay calm and remain with student
- Help the student to the floor and place on left side
- Clear objects out of the way and remove other students from the area
- Place something soft and flat under the students head
- Loosen any constricting cloths around neck
- Monitor breathing
- Do NOT try to stop the seizure
- Look at the clock and time the length of seizure
- Comfort student and allow to rest after the seizure
- Reorient student after seizure
- Give Diastat as ordered by physician if seizure last greater than 5 minutes and the student has doctor's orders
- Notify parents
- Other_____

Call 9-1-1 immediately if: the student is pregnant, is a diabetic, is injured, has no history of seizures, Diastat is given, remains unconscious after seizure, the seizure last more than 5 minutes, has two or more seizure consecutively, continues to have bluish/pale skin or lips, noisy breathing after seizure, **if student stops breathing or has no pulse start CPR immediately!**

5. Special Needs/Limitations
Diet: _____
Activity Level/Physical Restrictions:_____
_____
Accommodations needed in classroom: _____
_____

6. Other Considerations: Take emergency medications on all off campus activities_____
_____

Send Copies To: __Teacher __Clinic __Guidance __PE __Art __Music __Cafeteria __Teacher Asst. __Bus Driver
__School Nurse __Media Center Specialist __Athletic Director __Other_____

Student Name _____

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Parent Signature_____**Date** _____

☐ **Obtained via telephone interview with parent** **School Year**_____

Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**School Health Technician**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 2 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

☐ **person-to-person interview** **_____ No changes to current plan**

☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

Year 3 review*: Update to Individual Emergency Health Care Plan School Year _____

Status determined by:

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☐ **telephone interview**

☐ **update letter**

Parent Signature	**Date**		
Administrator Signature	**Date**	**Guidance Signature**	**Date**
Teacher Signature	**Date**	**Nurse Signature**	**Date**

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SCHOOL HEALTH CARE PLAN LOG SHEET

School:_____ School Nurse:_____

School Year:_____

Student Name	Grade	Teacher	Health Concern	Date Written	Distributed

Procedure for Providing and Conducting Health Screenings in the School Setting (Vision, Hearing, Height, Weight, Body Mass Index {BMI}, Scoliosis)

Purpose: This procedure establishes guidelines for providing health screenings in the school environment as mandated by the Florida Administrative Code, Chapter 64F-6.003. The screenings will allow the School Health Nurse to identify students with suspected abnormalities who will subsequently be referred for appropriate follow-up care.

Definitions: **Body Mass Index** - (BMI) is a number calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problem.

CDC - Centers for Disease Control and Prevention

Myopia - a vision abnormality commonly known as "near-sightedness"; the student will readily see things that are near, but may have trouble seeing objects at a distance (i.e. the board, road signs, etc.)

Hyperopia - a vision abnormality commonly known as "far-sightedness"; the student will be able to see things at a distance, but will have difficulty clearly seeing objects that are near (i.e. words in a book, on a computer screen, etc.)

Strabismus - the deviation of an eye from its axis so the eyes are not focused together on the same object; this is due to an eye muscle imbalance

Scoliosis - a disorder in which there is a sideways curve of the spine, or back bone; curves are often S-shaped or C-shaped

Procedure: **(Procedures for specific screening will follow on subsequent pages)**

I. Parent/Guardian should be notified of general population screenings via letter, student handbook, newsletter, school website, student Emergency Health Card, etc.

II. Parents/Guardians and students have the right to refuse screenings and may "opt" out of screenings by notifying the school; documentation of the refusal should be kept in the student Cumulative School Health Record.

III. Screenings are provided to students in response to the Florida Mandate as well as by referral for a suspected abnormality or as a routine part of evaluating students for special services.

IV. Students may be referred for screening by:
   A. Guidance Counselor or other school administration or designee
   B. Teacher
   C. School Health Clinic Staff
   D. Parent/Guardian
   E. Self-referred

V. The School Health Registered Nurse (RN) may also decide that screening is appropriate based on the assessment of the student.

Growth and Development Screening: Height, Weight, and BMI

Procedure: I. Students to be screened:

A. All first, third, and sixth grade students
B. Any student referred by the guidance counselor or teachers for screening
C. A student may be self-referred or referred by parent/guardian for a screening

II. Screening set-up:

A. Screenings should be performed on a flat, level, and hard surface.
B. If possible, screenings should take place in an area/room that allows for privacy.
C. Utilize a standard floor scale for weight and a stadiometer or wall-mounted measuring tape for height.
    1. Locate the electronic scale near an electrical outlet as needed for power or ensure that batteries are charged.
    2. Equipment should be calibrated and maintained as recommended by the manufacturer or as determined by the Department of Health.
D. When screening large numbers of students, volunteers may be needed to help perform the screenings. Ensure that volunteers are appropriately trained in the use of the equipment.
E. The student's gender and date of birth will be needed for Body Mass Index (BMI) calculation. Obtain this information from student records or utilize screening forms with labels printed with appropriate demographic information.
    1. Student labels for grade level screenings may typically be obtained from the Santa Rosa County School Districts' Data Processing Department located in the County Complex on Canal Street.

III. Performing the height and weight screenings

A. Prepare students for the screenings by explaining the procedures.
B. Have the students remove bulky jackets or sweaters. Students should be weighed in minimal indoor clothing.
C. If practical, have the student remove shoes. Otherwise, adjust the height recording if needed to reflect an accurate measurement.
D. Student may need to remove hair accessories for measurement.
E. Measuring the student
    1. Instruct the student to stand with back as straight as possible, with feet slightly apart, and arms relaxed. The heels, buttocks and shoulder blades should touch the wall or measuring surface being used.
    2. Lower the measuring bar or paddle to the crown of the head.
    3. Record the height on the screening form.
F. Weighing the student
    1. Instruct the student to stand in the middle of the scale or as indicated for the equipment being used.

2. Student should remain still until the measurement is recorded.
3. Record the weight on the screening form.

IV. Determining BMI

A. The CDC's Body Mass Index (BMI) calculator may be used to obtain the BMI. This can be found at: http://apps.nccd.cdc.gov/dnpabmi/calculator.aspx
   1. The date of measurement, date of birth, gender, height and weight data should be entered into the calculator.
   2. Record the BMI on the screening form.
   3. Record the BMI-for-age percentile on the screening form.

B. Other acceptable WEB calculators or programs may be used (with approval from the School Health Nurse) to determine BMI.
   1. Record calculated BMI and BMI-for-age percentile on the screening form.

C. BMI may be determined by manual calculation.
   1. Use the formula: weight (in pounds) divided by height (in inches) times height (in inches), and then multiply by 703.

$$\frac{\text{weight (lb)}}{\text{height (in) x height (in)}} \times 703$$

   2. The result of the calculation is the student's BMI.
   3. Next, plot the BMI on the growth chart/graph to determine the BMI-for-age percentile.
   4. Record the BMI and the BMI-for-age percentile on the screening form.

V. Interpreting BMI results and appropriate follow-up

A. The following are the CDC's categories for BMI-for-age percentiles:
   1. Underweight: less than the 5th percentile
   2. Healthy weight: 5th percentile up to the 85th percentile
   3. Overweight: 85th percentile to less than the 95th percentile
   4. Obese: equal to or greater than the 95th percentile

B. School Health Nurse discretion: according to the Florida School Health Administrative Guidelines, in special situations, "consideration should be made for environmental and genetic influences in determining the average size of children in various populations".

C. Based on the percentile categories and nursing discretion, a referral letter recommending a medical assessment will be sent to the parent/guardian of any student in the underweight or obese categories.

D. If no parental response is received, additional follow-up phone calls or letters may be sent to the parent/guardian.

E. A BMI referral with no parental response or medical assessment is considered an incomplete referral.

F. All information concerning the referral, follow-up, and outcome is recorded on and/or attached to the screening form. Screening forms are filed in the student's Cumulative School Health Record when the process is complete.

Dear Parent or Guardian,

Nurses from the Santa Rosa County Health Department will be at _____
To conduct a sixth grade health screening on _____ . The State of Florida's Department of Health mandates these screenings on students at various grade levels.

The health screenings will consist of:

- **Hearing and Vision Screenings**
- **Height and Weight checks** (With Body Mass Index [done with respect to privacy])
- **Spine check for Scoliosis** (Curvature of the spine)

The School Health Nurse will notify you if a problem is suspected as a result of any of the screenings. Initial failed hearing and vision screenings will receive a re-check by the School Health Nurse. **Please make sure that your child brings or wears any corrective lenses on the day of the health screenings.**

Scoliosis checks are extremely important in early adolescence, as this is the time when children are growing rapidly. A chiropractor, nurse practitioner, volunteer physician or experienced school nurse performs these exams. Every effort is made to insure your child's modesty and privacy during these screenings; therefore, **boys and girls are screened separately and in different locations**. To insure a proper exam, the back area must be exposed. **Therefore, we recommend that female students wear an undergarment, halter, or bathing suit top under their shirt, which can be kept on during the check**.

Please send a note to school by _____ if you **do not** want your child to participate in all or any portion of these health screenings.

As always, if you have questions or concerns please feel free to contact your School Health Nurse, _____ at _____

Sincerely, _____

_____ _____

Principal School Nurse

Frequently Asked Questions about BMI for Children

What is BMI?

- BMI stands for Body Mass Index. It is a number that shows body weight adjusted for height. BMI for children, also referred to as BMI-for-age, is gender and age specific. BMI-for-age is graphed on a boy or girl growth chart and given a percentile ranking. BMI can be figured with this equation:

$$BMI = \left(\frac{\text{Weight in Pounds}}{(\text{Height in inches}) \times (\text{Height in inches})} \right) \times 703$$

How is BMI used?

- Body mass index is used to see how a child is growing. BMI is NOT a diagnostic tool. If your child's BMI is below the 5th percentile or above the 85th percentile, it is recommended that he/she be seen by a doctor.
- BMI is an indirect measure of body fatness. Studies have shown that a high BMI indicates a high percentage of body fat in most, but not all, cases.
- BMI relates to health risks including high cholesterol, high blood sugar, and high blood pressure. Children with high BMI's are at risk for conditions that can lead to heart disease and diabetes.
- BMI can be used to track body size throughout the life cycle. This is important because BMI-for-age in childhood predicts adulthood BMI.

What do the BMI percentiles mean?

- Health care professionals use the following established percentile cutoffs for children age 2 to 20:
    - Underweight: BMI less than the 5th percentile
    - Normal: BMI 5th percentile to the 85th percentile
    - At risk for overweight: BMI 85^{tth} percentile to the 95th percentile
    - Overweight: BMI greater than or equal to the 95th percentile

For more information about BMI for children, visit the Center for Disease Control's website at http://www.cdc.gov/nccdphp/dnpa/bmi.

Student Name:_____ **Grade**_____
Date:_____

The Santa Rosa County Health Department wants to work with your family, community health care providers, and our school district to help our students become healthier. Our School District is working hard to provide healthier classrooms and healthier meal choices such as:

- **Salad bars and/or chef salad. A variety of fruits and dark green/orange vegetables**
- **Lean meats that include turkey, turkey ham, chicken breast, and reduced fat hamburger**
- **Whole grain pastas, bread, and dessert choices**
- **Only 1% or less low fat flavored and unflavored milk and 100% juice**

BMI (Body Mass Index) is a measurement tool used to help identify students who are at risk for weight-related health problems such as osteoporosis, type I diabetes, or possibly an eating disorder.

Your child was weighed and measured along with all students in their grade.*

_____ **Height** _____ **Weight**
_____ **BMI** _____ **BMI Percentile**

Based on your child's height, weight, and gender, his/her BMI was found to be lower than recommended for his/her age (less than the 5th percentile).

- underweight, less than the 5th percentile
- healthy weight, 5th up to the 85th percentile
- overweight, 85th to less than the 95th percentile
- obese, equal to or greater than the 95th percentile

Please share this result with your health care provider. If you do not have a health care provider you can seek additional insurance information at: www.FloridaKidCare.org

Consider this…

+ + = 450 calories

Juice

+ + = 0 calories

Water

This amount of juice is 1/3 of the calories that most kids should have in a day.
Food is the most important part of a balanced diet.

5	Servings of fruits and vegetables every day	**2**	Less than 2 hours of screen time every day	**1**	One hour of physical activity every day	**0**	Zero soda or sugar sweetened beverages every day

PARENT/GUARDIAN REPLY

Please complete the following and return this entire form to the school nurse.

Health Care Provider comments:_____
_____
Parent comments:_____
_____

Parent/Guardian Signature: _____ ***Date:*** _____

***required by the Florida Administrative Code, Chapter 64F-6.003.**

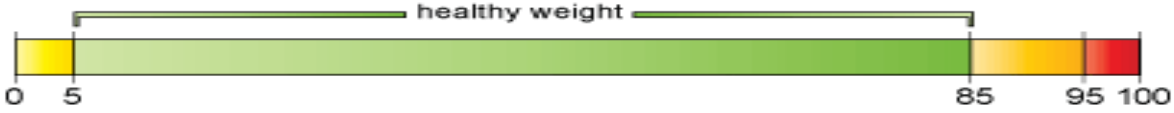
Student Name:_____ **Grade**_____
Date:_____

The Santa Rosa County Health Department wants to work with your family, community health care providers, and our school district to help our students become healthier. Our School District is working hard to provide healthier classrooms and healthier meal choices such as:

- **Salad bars and/or chef salad. A variety of fruits and dark green/orange vegetables**
- **Lean meats that include turkey, turkey ham, chicken breast, and reduced fat hamburger**
- **Whole grain pastas, bread, and dessert choices**
- **Only 1% or less low fat flavored and unflavored milk and 100% juice**

BMI (Body Mass Index) is a measurement tool used to help identify students who are at risk for many weight-related health problems including high blood pressure, high cholesterol, type 2 diabetes, fatty liver, and heart disease. Each year, Santa Rosa County students are becoming more overweight and obese.

Your child was weighed and measured along with all students in their grade.*



_____ **Height** _____ **Weight**
_____ **BMI** _____ **BMI Percentile**

Based on your child's height, weight, and gender, his/her BMI was found to be higher than recommended for his/her age (equal to or greater than the 95th percentile**).**

- underweight, less than the 5th percentile
- healthy weight, 5th up to the 85th percentile
- overweight, 85th to less than the 95th percentile
- obese, equal to or greater than the 95th percentile

Please share this result with your health care provider. If you do not have a health care provider you can seek additional insurance information at: www.FloridaKidCare.org

Consider this…


Juice **= 450 calories**


Water **= 0 calories**

This amount of juice is almost 1/3 of the calories that most kids should have in a day.
Food is the most important part of a balanced diet.

5 Servings of fruits and vegetables every day

2 Less than 2 hours of screen time every day

1 One hour of physical activity every day

0 Zero soda or sugar sweetened beverages every day

PARENT/GUARDIAN REPLY

Please complete the following and return this entire form to the school nurse.

Health Care Provider comments:_____
_____
Parent comments:_____
_____

Parent/Guardian Signature: _____ ***Date:*** _____

***required by the Florida Administrative Code, Chapter 64F-6.003.**

BMI Coding Summary Sheet

School: School Nurse: Date Screened:

	Male E1	Female E1	Male E3	Female E3	Male E6	Female E6
O521 Normal 5%-85%						
O522 Underweight <5%						
O523 Overweight 85%-94%						
O524 Obese >95%						
Total by Category						
Total by Grade						

Vision Screening

Procedure: I. Students to be screened:

A. All sixth grade students
B. Any student referred by the guidance counselor or teachers for screening
C. A student may be self-referred or referred by parent/guardian for a screening.

II. Screening set-up:

A. Screening should take place in a well lit area with minimal glare.
B. Depending on available space and age of student, a wall chart, lighted chart, or Titmus machine may be utilized to perform the screening.

Using a Wall chart and light box

1. Place the eye chart or light box at eye level for the student. The chart should be attached to an uncluttered wall.
2. Measure a 10 to 20 foot distance (depending on chart), and mark the area with a line of tape to indicate where the student will need to stand to perform the screening.
3. The distance between the line and the chart should be free of objects, and the electrical cord from the light box should not pose a safety hazard.

Using a Titmus machine

1. If utilizing a Titmus machine, position the machine on a table or counter at a comfortable viewing height for student.
2. Clean lenses as needed so that they are clear and free of smudges.
3. Plug in the power cord for the machine, assuring that the cord will not be a safety hazard for the student. Turn on the machine.
4. Assure that there is space for the School Health Nurse to remain near the student and to adjust the machine controls as needed.

C. For screening a large number of students, volunteers may be needed to help administer the screenings. Ensure that volunteers are appropriately trained in the use of the Titmus or wall chart/light box.
D. During any screening procedure, the School Health Nurse should take note of any eye abnormality (i.e. eye deviation, “lazy eye”, etc.).
E. Notify school to have student wear or bring corrective lens as appropriate.

III. Administering the vision screening (using an eye chart)

A. Position the student at the measured and marked distance from the chart.
B. If the student wears glasses, ask student to put on his/her glasses before performing the screening.

C. Have the student occlude one eye using their hand (or other occluding device) and have the student read the appropriate line of the chart (20/40, 20/30, etc.).
D. Have the student occlude the other eye and repeat the process.
E. To pass the screening, students age six (6) and over must correctly read one more than half of the letters or pictures on the 20/30 line, for students five (5) and under, they must correctly read one more than half of the letters or pictures on the 20/40 line.
F. Record visual acuity for each eye (i.e. the smallest line correctly read) on the screening form.
G. Rescreen student at a later date if necessary (i.e. if student forgot glasses, had an eye infection/problem on the day of screening, if the School Health Nurse feels rescreening is appropriate, etc.).
H. Alert teacher/appropriate school personnel as needed to provide preferential seating for those students who fail the screening, until results of a professional evaluation are received.
I. A referral letter recommending follow-up with a professional provider is sent to the parent/guardian of those students with screening failures.
J. If no parental response is received, a phone call or a second letter should be sent to the parent/guardian.
K. A third attempt is made to follow-up on the referral as needed.
L. A vision failure with no parental response or professional evaluation is considered an incomplete referral.
M. All information concerning the referral, follow-up and outcome is recorded on and/or attached to the screening form. Screening forms are filed in the student's Cumulative School Health Record when the process is complete.

IV. Administering the vision screening (using the Titmus machine)

A. Position the student in front of the Titmus machine at a comfortable viewing height for the student.
B. If the student wears glasses, ask student to put on his/her glasses before performing the screening.
C. Instruct the student to look into the machine, keeping both eyes open throughout the test.
D. Ask the student to read the letters on the 20/30 line. If the student is unable to read the 20/30 line, instruct him/her to move up to the 20/40, 20/50, etc.
E. The right column indicates the visual acuity for the right eye. The left column indicates the visual acuity for the left eye. The center column is a test of visual acuity in both eyes.
F. The student may miss one letter in each column and pass for that acuity level. Record visual acuity for each eye (i.e. the smallest line correctly read) on the screening form. 20/30 acuity in each eye is needed to pass the screening.
G. Rescreen student at a later date if necessary (i.e. if student forgot glasses, had an eye infection/problem on the day of screening, if the School Health Nurse feels rescreening is appropriate, etc.).

H. Alert teacher/appropriate school personnel as needed to provide preferential seating for those students who fail the screening, until results of a professional evaluation are received.
I. A referral letter recommending follow-up with a professional provider is sent to the parent/guardian of those students with screening failures.
J. If no parental response is received, a phone call or a second letter should be sent to the parent/guardian.
K. A third attempt is made to follow-up on the referral as needed.
L. A vision failure with no parental response or professional evaluation is considered an incomplete referral.
M. All information concerning the referral, follow-up and outcome is recorded on and/or attached to the screening form. Screening forms are filed in the student's Cumulative School Health Record when the process is complete.

Date: _____ _____
Month Year

Dear Parent/Guardian of _____ attending

_____ Grade _____.
Name of School

Your child's Vision Screen results _____ done on _____ indicate a need for an additional medical evaluation. Since a screening test is not diagnostic, it is suggested that your child be given a further vision examination by a family physician, eye doctor, or other specialist.

Your child is qualified to participate in the Jeppesen Vision Quest (JVQ) vision program, which provides free eye exams and glasses to eligible children. A referral will be faxed to the JVQ program with your child's information and vision results upon notification by you of your desire to participate in the program. *Please call your School Health Nurse to inform them of your decision*.

Upon agreement to participate in the JVQ program you will be receiving notification from JVQ on the program and the doctor assigned to your child's care.

Upon receipt of the doctor's name and phone number, please make an appointment for your child. Tell the doctor's staff that you are with Jeppesen Vision Quest program. If glasses are required, JVQ will manufacture quality new glasses and send them to the doctor for dispensing.

If you have further questions or concerns please feel free to contact your School Health Nurse.

_____ _____
School Health Nurse Phone Number

Sincerely,

Santa Rosa County School Health Nurse

Santa Rosa County School Health - Vision Follow-up

Name: _____ Grade: _____ Date: _____
School: _____ Teacher: _____

Dear Parent / Guardian:

Your child did not pass the vision screening administered on _____by the school health nurse. Please let us know if your child has been seen by a doctor or if an appointment has been made to follow-up on this screening.

If finances are a problem, community resources may be available. Please contact your school health nurse.

Return this slip with parent's and/or doctor's comments to the school health clinic, or feel free to call the school nurse listed below to discuss this screening.

Thanks for your assistance.

School Health Nurse
Santa Rosa County Health Department

Parent's Comments:

_____

_____

_____

Parent's Signature: _____ **Date:** _____

Doctor's Comments

Diagnosis: _____

Comments: _____

_____

_____

Doctor's Signature: _____ **Date:** _____

Hearing Screening

Procedure: I. Students to be screened:

A. All kindergarten, first, and sixth grade students
B. Any student referred by the guidance counselor or teachers for screening
C. A student may be self-referred or referred by parent/guardian for a screening

II. Screening set-up:

A. Audiometers should be calibrated and maintained as recommended by the manufacturer or as determined by the Department of Health.
B. Screening should take place in a quiet area or room, taking care to control the level of surrounding noise as much as possible.
C. Audiometers may operate with batteries or the screening area should be located near an electrical outlet for its power source. Ensure that power cords will not be a safety hazard.
D. For screening a large numbers of students, volunteers may be needed to help perform the screenings. Ensure that the volunteers are appropriately trained in the use of the audiometer.

III. Administering the hearing screening

A. Explain to the student how the audiometer will be used to screen hearing.
    1. Instruct the student to raise and lower the appropriate hand when the tone is heard in the right or the left ear.
    2. Remind the student that the headphones fit snugly.
B. If the student wears hearing aids, perform the screening with the devices on if indicated.
C. Have the student put the earphones on or place the earphones on the student (depending on the student's age, abilities, and nurse preference).
    1. The red ear piece is placed on the right ear, and the blue ear piece is placed on the left ear.
    2. Be sure that the earphones are snug over the ears and that nothing interferes with the placement (i.e. earrings, glasses, barrettes, etc.).
D. Have the student face away from the audiometer or ensure that the student is unable to see the audiometer during the screening.
E. The hearing threshold should be set at 25db, and the hearing should be tested at frequencies of 4000Hz, 2000Hz, and 1000Hz in both ears.
F. If necessary, vary the tones from right to left to prevent an established pattern that the student may recognize.
G. To pass the screening, the student must correctly respond to tones at 25dB and at levels of 4000/2000/1000Hz in both the right and the left ear.

H. Record the results on the screening form.
I. Rescreen students at a later date as needed for possible failures due to ambient noise in the screening area, the presence of nasal congestion, etc.
J. Alert teacher/appropriate school personnel to provide preferential seating near the source of sound for those students who fail the hearing screening.
K. After any necessary rescreening is accomplished, a referral letter recommending follow-up with a professional provider is sent to the parent/guardian of those students with screening failures.
L. If no parental response is received, a phone call or a second letter should be sent to the parent/guardian.
M. A third attempt is made to follow-up on the referral as needed.
N. A hearing failure with no parental response or professional evaluation is considered an incomplete referral.
O. All information concerning the referral, follow-up and outcome is recorded on and/or attached to the screening form. Screening forms are filed in the student's Cumulative School Health Folder when the process is complete.

Santa Rosa County School Health - Hearing Follow-up

Name: _____ Grade: _____ Date: _____
School: _____ Teacher: _____

Dear Parent / Guardian:

Your child did not pass the hearing screening administered on _____by the school health nurse. Please let us know if your child has been seen by a doctor or if an appointment has been made to follow-up on this screening.

If finances are a problem, community resources may be available. Please contact your school health nurse.

Return this slip with parent's and/or doctor's comments to the school health clinic, or feel free to call the school nurse listed below to discuss this screening.

Thanks for your assistance.

School Health Nurse
Santa Rosa County Health Department

Parent's Comments:

_____

_____

_____

Parent's Signature: _____ **Date:** _____

Doctor's Comments

Diagnosis: _____

Comments: _____

_____

_____

Doctor's Signature: _____ **Date:** _____

Scoliosis Screening

Procedure: I. Students to be screened:

A. All sixth grade students
B. Any student referred by the guidance counselor or teachers for screening
C. A student may be self-referred or referred by parent/guardian for a screening

II. Screening set-up:

A. This screening is best done by a School Health Registered Nurse (RN) or other medical professional.
B. Screening should take place in an area/room that allows for privacy.
C. Boys and girls must be screened separately.
D. Ideally, two adults should be present during screenings.

III. Performing the scoliosis screening

A. Prepare the student for the screening by explaining the procedure.
B. Have the student remove his/her shirt as appropriate to best visualize the back area. Girls should wear a bathing suit top, bra, or other appropriate clothing. Screening may be performed with light weight clothing on if necessary, taking care to identify the curvature and landmarks of the back as much as possible.
C. First, have the student stand erect, with feet slightly apart, and arms hanging loosely at their sides. (A mark can be placed on the floor to indicate where the student should stand). The examiner should be several feet behind the student to best visualize the appearance of the back. Make note of any of the following abnormalities:
    1. One shoulder is higher than the other.
    2. One shoulder blade is higher or more prominent than the other.
    3. The spine has an S-shaped or C-shaped curve.
    4. One hip is higher than the other.
    5. The space between the area and the body is greater on one side than the other side.
    6. The head does not appear centered directly over the pelvis.
D. Next view the student in a forward-bending position. The student should bend forward at the waist 90 degrees. Palms of the hands are held together or can be facing each other as the arms hand down. The head should be down. Make note of any of the following possible abnormalities:
    1. One side of the rib cage is not symmetrical with the other.
    2. One side of the lower back is not symmetrical with the other.
    3. A curve in the alignment of the spinous processes
E. Record observations and results on the screening form. Additionally, make note of any student complaint of back pain or history of scoliosis.
F. Rescreen students at a later date if needed.

G. A student found to have a possible abnormal spinal curve should be referred to a physician for further evaluation. A referral letter recommending this follow-up is sent to the parent/guardian of those students identified.
H. If no parental response is received, a phone call or a second letter should be sent to the parent/guardian.
I. A third attempt is made to follow-up on the referral as needed.
J. A scoliosis referral with no parental response or professional evaluation is considered an incomplete referral.
K. All information concerning the referral, follow-up and outcome is recorded on and/or attached to the screening form. Screening forms are filed in the student's Cumulative School Health Record when the process is complete.

Santa Rosa County School Health - Scoliosis Follow-up

Name: _____ Grade: _____ Date: _____
School: _____ Teacher: _____

Dear Parent / Guardian:

Your child was screened for scoliosis during the 6th grade health screening day at school on _____ . Please let us know if your child has been seen by a doctor or if an appointment has been made to follow-up on this screening.

If finances are a problem, community resources may be available. Please contact your school health nurse.

Return this slip with parent's and/or doctor's comments to the school health clinic, or feel free to call the school health nurse listed below to discuss this screening.

Thanks for your assistance.

School Health Nurse
Santa Rosa County Health Department

Parent's Comments:

_____

_____

_____

Parent's Signature: _____ **Date:** _____

Doctor's Comments

Diagnosis: _____

Comments: _____

_____

_____

Doctor's Signature: _____ **Date:** _____

Santa Rosa County Health Department
School Health Nursing

Student: _____ Date: _____Grade_____

Teacher: _____ School: _____

Vision

Wears glasses: Yes___ No___ **Tested with glasses: Yes___ No ___**

Note: 20/40 = Pass

Initial test Date: _____ **Retest: Date: _____**

Pass: ____ Fail: ____ **Pass: ____ Fail: ____**

R eye: 20/_____ L eye: 20/_____ **R eye 20/_____ L eye: 20/_____**

Time In: _____ Nurse Signature: _____ Time out: _____

Hearing

Test @ 25 dB

Initial Test Date_____ **Retest: Date: _____**

Pass: ____ Fail: ____ **Pass: ____ Fail: _____**

	R	L		R	L
1000 Hz	_____	_____	1000 Hz	_____	_____
2000 Hz	_____	_____	2000 Hz	_____	_____
4000 Hz	_____	_____	4000 Hz	_____	_____

Time In: _____ Nurse Signature: _____ Time out: _____

Follow-up: No: ___ Yes: ___

Comments:_____

_____

_____

_____

Santa Rosa County Health Department
School Health Nursing

Student: _____ Date: _____Grade_____

Teacher: _____ School: _____

Vision

Wears glasses: Yes___ No___ **Tested with glasses: Yes___ No ___**

Note: 20/30 = Pass

Initial test Date: _____ **Retest: Date: _____**

Pass: ____ Fail: ____ **Pass: ____ Fail: ____**

R eye: 20/_____ L eye: 20/_____ **R eye 20/_____ L eye: 20/_____**

Time In: _____ Nurse Signature: _____ Time out: _____

Hearing

Test @ 25 dB

Initial Test Date_____ **Retest: Date: _____**

Pass: ____ Fail: ____ **Pass: ____ Fail: _____**

	R	L		R	L
1000 Hz	_____	_____	1000 Hz	_____	_____
2000 Hz	_____	_____	2000 Hz	_____	_____
4000 Hz	_____	_____	4000 Hz	_____	_____

Time In: _____ Nurse Signature: _____ Time out: _____

Height: _____ Weight:_____ BMI:_____ Percentile:_____

<5% Underweight **5% - <85% Normal**

85% - <95% Overweight **≥95% Obese**

Time In: _____ Nurse Signature: _____ Time out: _____

Follow-up: No: ___ Yes: ___
Comments:_____
_____
_____
_____

Santa Rosa County Health Department
School Health Nursing

Student: _____ Date: _____Grade_____

Teacher: _____ School: _____

Vision

Wears glasses: Yes___ No___ **Tested with glasses: Yes___ No ___**

Note: 20/30 = Pass

Initial test Date: _____ **Retest: Date: _____**

Pass: ____ Fail: ____ **Pass: ____ Fail: ____**

R eye: 20/_____ L eye: 20/_____ **R eye 20/_____ L eye: 20/_____**

Time In: _____ Nurse Signature: _____ Time out: _____

Height: _____ Weight:_____ BMI:_____ Percentile:_____

<5% Underweight **5% - <85% Normal**

85% - <95% Overweight **≥95% Obese**

Time In: _____ Nurse Signature: _____ Time out: _____

Follow-up: No: ___ Yes: ___
Comments:_____
_____
_____
_____

Santa Rosa County Health Department
School Health Nursing

Student: _____ Date: _____Grade_____

Teacher: _____ School: _____

Vision

Wears glasses: Yes___ No___ **Tested with glasses: Yes___ No ___**

Note: 20/30 = Pass

Initial test Date: _____ **Retest: Date: _____**

Pass: ____ Fail: ____ **Pass: ____ Fail: ____**

R eye: 20/_____ L eye: 20/_____ **R eye 20/_____ L eye: 20/_____**

Time In: _____ Nurse Signature: _____ Time out: _____

Hearing
Test @ 25 dB

Initial Test Date_____ **Retest: Date: _____**

Pass: ____ Fail: ____ **Pass: ____ Fail: _____**

	R	L		R	L
1000 Hz	_____	_____	1000 Hz	_____	_____
2000 Hz	_____	_____	2000 Hz	_____	_____
4000 Hz	_____	_____	4000 Hz	_____	_____

Time In: _____ Nurse Signature: _____ Time out: _____

Height: _____ Weight:_____ BMI:_____ Percentile:_____

<5% Underweight **5% - <85% Normal**

85% - <95% Overweight **≥95% Obese**

Time In: _____ Nurse Signature: _____ Time out: _____

Follow-up: No: ___ Yes: ___
Comments:_____
_____
_____
_____

Santa Rosa County School Health Referral Form

(From School to Parent/Guardian)

The 1974 Florida School Health services Act mandated that height/weight measurements, vision, hearing and scoliosis screenings be proved cooperatively by school personnel and County Health Department personnel. This service will be provided at designated grade levels and upon request by teachers, guidance counselors, parent/guardians or students, if a problem is suspected.

A _____ screening was done on _____
(Type Screening) (Student Name)

A student at _____ on _____
(School) Dates(s)

Your child was in one of the targeted screening grades for this year (Yes ___) or was referred for screening (Yes ___) by _____ . The result of the screening is as follows:

_____

_____

_____

_____

_____

It is suggested that your child be given further examination by a family physician, eye doctor or other specialist. If such an examination or follow-up will be a financial burden, please contact your School Health Nurse _____ at _____ as there are community resources available to assist eligible students.
Please call if you have additional questions or concerns.

PLEASE HAVE THIS PORTION COMPLETED BY THE PHYSICIAN, EYE DOCTOR, ETC. RETURN TO THE SCHOOL HEALTH CLINIC.

TO BE PLACED IN YOUR CHILD'S SCHOOL HEALTH FOLDER

Doctor's finding and/or treatment(s):

_____

_____

_____ _____

Doctor Signature **Date**

STUDENT HEALTH SCREENING LOG SHEET

School:_____ School Nurse:_____

School Year:_____

Date	Student Name	Grade	Teacher	Screening & Result	Comments	Coded

Screening Referral Follow- Up Sheet

SCHOOL: NURSE: YEAR:

Student Name	Teacher/ Grade	Referral date	contact #1	contact #2	contact #3	Comments	Outcome	coded on EARS

Contact Codes:

LS - Letter Sent

LM - Letter mailed

PC - Phone Call (NA-no answer or MSG-message left)

TC - Teacher contact

Outcome Codes

MET - Medical eval./Tx

MEN - Medical eval. No TX

AP - Appointment pending

WD - Withdrawn

NC - Non-Compliant

Rev May 2013

Santa Rosa County School Health Policy and Procedure Manual

Forms For:

Pediatric Services of America

May 2013

SANTA ROSA DISTRICT SCHOOLS DAILY HEALTH ROOM ACTIVITY LOG

School: _____ **Date:**_____

TIME IN	STUDENT NAME	GR	M/F	H/C	COMPLAINTS OF & REFFERED BY	ACTION TAKEN	INIT	DIS-POSITION	TIME OUT

H/C – HEALTH CODES:

1 _____ RX Meds Administered
2 _____ Non-RX Meds Administered
_____ **Total Meds Administered (#1-2)**

3 _____ Minor Injuries
4 _____ Major Injuries
_____ **Total First Aid Administered (#3-4)**

5 _____ Physical Complaints
6 _____ Intentional Injuries
7 _____ Chronic Conditions
8 _____ Head lice/Scabies *(Screening)*
9 _____ Head lice/Scabies *(Positive)*
10 _____ Other
11 _____ Medication Intake *(to the clinic)*

DISPOSITION:

RC _____ Return to Class
SH _____ Sent Home
MI _____ Medication Intake *(to the clinic)*
ER _____ Emergency Response (911)
_____ **Total Disposition**

**Refer to addendum for approved abbreviations*

_____ **Total Paraprofessional Visits (Totals of #1 thru-11)**

_____AED Check *(Weekly)*

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Initials	**Printed Name**	**Signature**	**Title**

Rev 05/15/2013