St. Lucie County School District

Health Room Guidelines

Purpose: The school health room is an area designated in each school in the district to be utilized to assess the health needs of students and staff, perform prescribed treatments, administer first aid, administer medications, house student health records, perform mandated health screenings, and is to be used as an isolation area for suspected communicable conditions.

The Following health room equipment and supplies are recommended based on the Florida Administrative code chapter 64F-6.004.

Health Room

Each district school board must make adequate physical facilities available for health services per s. 381.0056(7), F.S. Existing school buildings are expected to comply with the minimum requirements as identified in the Department of Education's guidelines, *State Requirements for Educational Facilities.* These guidelines have specifications for school clinics. New school buildings must comply with clinic requirements specified in the Florida Building Code. School health coordinators should participate in the planning process for new school construction to ensure facilities meet or exceed health room requirements for the student population.

The school health room should:

- Be located away from noisy, congested areas and preferably near the administrative office.
- Be of sufficient size and layout to permit use for first aid, physical examinations, health screenings, and for student isolation or observations.
- Have direct line-of-sight from the health room staff desk to the cot area.
- Be equipped with minimum facilities such as: sink for hand washing, locking medicine cabinet, supply storage, and examining equipment.
- Preferably have a toilet facility included in the health room or at the very least be located adjacent to a toilet facility.
- Be of sufficient size and equipped with privacy screening to permit examination of students and to perform ordered procedures.
- Be appropriately staffed by trained personnel during school hours to serve the needs of students.
- Be equipped with a telephone extension, computer hook up, and internet access.

- Be considered an essential facility. The health room is the focal point for operation of an effective school health program and provides direct services to students and staff. The lack of an adequate health room will seriously hamper the delivery of school health services.
- In observance with best practice, the school health room should be accountable to a higher level of cleanliness. It is expected that the preparation and consumption of food in the school health room should be limited to students with a medically necessary reason.
- School health room cots should be cleaned with an approved disinfectant cleaner after each child or disposable cot paper should be used and discarded/replaced after each use.
- School health room counter tops, sinks and chairs should be cleaned with approved disinfectant at a minimum of daily or as needed.

Health Room Equipment and Supplies

Chapter 64F-6.004, F.A.C. requires that the school principal or designated person shall be responsible to assure first aid supplies, emergency equipment and facilities are maintained. Minimal health room equipment is as follows:

- Bed or cot; the number of cots is based upon student population; 3/500 students, 4/500-1000 students, plus 1 additional cot for each 1000 students.
- A separate cot area for boys and girls is essential at the secondary level (curtains can be used to separate these areas).
- Desk, chair, and file cabinet.
- Computer with internet access for record keeping and accessing health information.
- Basic first aid supplies.
- First aid equipment such as AED, CPR face shield, and first aid kit etc. (AED's should be placed throughout the school campus as needed).
- Covered trash container, biohazard trash container, sharps disposal container.
- Accurate scale for measuring student weight, accurate measuring device for determining student height.
- Wheel chair for transporting ill or injured students.
- Vision and hearing screening equipment.

Recommended health room supplies

- Cot paper rolls to cover cot.
- Emesis basin, wash basin (a plastic bucket with a disposable liner is recommended).
- Antibacterial liquid hand soap, approved spray disinfectant, room deodorizer, paper towels.

- Portable first aid kit for use on other parts of campus. Additional kits may be kept in the gym or for use on field trips.
- First aid supplies including: various sizes non-latex band-aids, gauze squares, gauze roll, cotton balls, cotton tipped applicators, tape and Bactine.
- Non-latex gloves.
- Paper cups, medicine cups, and tissues.
- Basic protection attire for emergency use, such as gown, mask, goggles.

- Thermometers.
- Access to the student emergency file card.
- Appropriate reference materials such as current drug handbook and *Control of Communicable Diseases* book.
- The use of other clinic supplies is dependent upon local school district policies and should be determined with the assistance of the School Health Coordinator(s) and School RN's.

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Use of Health Room Facilities in Emergency/Disaster

When a school building becomes the site of an emergency evacuation shelter facility, the health room facilities, equipment, and supplies may need to be utilized.

It is vital for the school administrator or designee to be on-site during these events. An agreement must be in place between the school district and the agency responsible for managing the shelter for replacement of any supplies or equipment that are used, broken, or lost.

Training for School Health Personnel

Training for school health paraprofessionals will take place annually based upon student population and need.

School staff designated to provide clinic coverage will participate in training every two years which shall include;

1. Medication administration
   a) General medication administration
   b) Emergency medication administration
2. Basic first aid and emergency response
3. First Aid Kit/ AED
4. Child specific training for management of chronic health conditions as needed

Emergency Response

It is recommended that each school designates an emergency response team to develop and implement emergency response plans to include:

1. AED plan and drill
2. Emergency Evacuation plan and drill
3. Nuclear disaster plan

Emergency drills should be conducted annually.

First Aid Kit Contents

- 1 Bactine Spray bottle : Expiration date_____
- 1 Emergency Vest
- 1 roll hypoallergenic tape
- 6 medium non-latex gloves
- 1 scissors
- 1 hard card (to remove stingers)
- 1 tooth container
- 6 each non-adherent adhesive bandages (2”x3”& 3”x4”)
- 12-24 3/4”plastic bandages
- 2 sterile elastic gauze bandage 4”x4.5 yards
- 12 sterile gauze pads 4”x4”
- 4 absorbent pads 5”x9”
- 1 emergency blanket
- 1 digital thermometer with plastic covers
- 1 single use airway shield
- 3 instant cold packs
- 1 red hazardous bags
- 1 small bottle of water
- 1 pair of eye goggles
- 12 antiseptic towelettes
- 1 small flashlight
- 1 emesis bag (may use 1 gallon zip-loc bag)

CLINIC POLICIES

1. A clinic log (SKYWARD preferred, paper log if necessary) must be used to document the date, time, student name, room/teacher, problem or complaint, action taken and the time the student leaves the clinic. Always document any and all phone numbers that were used if you contacted, or attempted to contact, a parent or guardian. This log is an important record of clinic activity. The clinic log data can also help you to identify any trends or spikes in symptoms. If at any time you notice a sudden increase in the number of students with similar symptoms/complaints or if you notice clustering of symptoms (several children from one class, pod or hallway) report the information to an administrator and the district nurse, if appropriate.

2. Students should have a clinic pass when entering the clinic unless it is an emergency.

3. Parents should always be notified of any injury or sudden illness and the action taken. Also, always notify your principal or a designated administrator of any serious accident or illness.

4. Refer to the Emergency Information Cards and SKYWARD for phone numbers and alternative adults who can be called if a parent is unavailable.

5. As noted in the First Aid Section, it is advisable to check the temperature of students who complain of headache, fever, chills, sore throat, stomachache, earache or who generally don't feel well. If the student has a fever, the parent should be called to take the student home. If the temperature is not elevated, the student should be allowed to rest for about 30 minutes. If the student still does not well, the parent should be called to decide if the student should go back to class or home.

6. Students with minor complaints should be encouraged to remain in school unless it will endanger the health of the student or classmates.

7. No student is permitted to leave a school campus on their own. The parent may, at times, delegate another adult to take the student home. Always follow the school policy for signing students out. Ill or injured students who drive themselves to school may leave only with parent permission. Written parent permission may be required depending on the type and/or severity of the illness or injury. When in doubt, an administrator should be contacted. This does not apply in the case of an emergency which requires a 911 call and immediate transfer to the hospital.

8. Never probe or remove foreign objects including splinters and ticks.

There is no substitute for good hand washing! Frequent and thorough hand washing is probably the most effective practice in preventing the spread of disease.

Procedure for hand washing:

* Wet your hands and wrists with running water.
* Apply soap from a dispenser.
* Work up a generous lather by rubbing your hands together vigorously for 15 seconds. Pay special attention to the area under fingernails, around cuticles, to the thumbs, knuckles, and sides of the fingers and hands. If you don't remove rings, move them up and down your fingers to clean beneath them.
* Rinse hands and wrists thoroughly under running water with flow directed from wrist down to fingers.
* Pat hands and wrists dry with a paper towel.
* Turn off faucets with paper towel.

Perform careful hand washing:

* Before and after physical contact with each student.
* Before and after eating, feeding another person, or handling food.
* Before and after giving first aid.
* Before and after giving medications.
* After assisting others to use the restroom.
* Before or after performing any bodily functions, such as blowing your nose or using the restroom.
* After cleaning surfaces soiled with body fluids.
* Before and after taking off gloves.
* After leaving playground and other out of doors areas.
* After changing a diaper or coming in contact with body fluids.
* Before and after handling pets

Note: Wash hands thoroughly with soap and water when possible. Antiseptic towelettes or waterless hand wash may be used when personnel must care for students in areas that are not accessible to water (i.e. bus, field trips). Towelettes are not adequate if a blood accident occurs.

STUDENT HEALTH RECORD REVIEWS

Refer to the current Health Paraprofessional calendar for a schedule of student health record reviews.

All student health records should be placed in a green Cumulative School Health Records folder (ordered from our Publications Department) before they are placed in the individual Cumulative Educational Records folder.

Front of Green Folder:
Check top section (name, DOB, etc) for accuracy.

Inside:
Immunization Form 680- should be complete and up to date for current grade level. Check for signature and possible temporary medical exemption date. SKYWARD information should match.

Physical- an appropriate school physical examination form should be kept in the health folder and entered on the computer. If there is no physical or a questionable physical, inform your RN so that it can be further investigated.

*If the above items are not found, always check the Cumulative Education Records folder in case they were placed in there instead of inside the health folder. If the student is transferring from another Florida school, there may be a FASTER (Florida Automated System for Transfer of Educational Records) print out containing immunization and physical dates.

Other items that should be filed in the health folders:
Height/weight/BMI graphs or letters, screening letters/reports and follow up treatment notes, medication logs (if any).

After review of the health folder is complete and *everything is in compliance,* be sure to initial and date the records review line under the appropriate grade level.
Our goal for the health records is accuracy, consistency and completeness.

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No special technique is required when putting on non-sterile gloves. Removal of gloves must be done carefully to avoid contaminating hands with the outside of the soiled glove. Remove gloves after disposing of contaminated materials. Grasp the edge of one glove and unroll the glove over the hand. Discard the glove in a lined receptacle. With the bare hand, grasp the opposite glove cuff on its inside edge. Remove the glove by inverting it over the hand. Discard glove in a lined receptacle and WASH HANDS.

Disinfection/Disposal of Contaminated Material and Surfaces
Floors, carpet, tile contaminated with body fluids, vomit, etc.

1) Apply dry cleaner to are and leave it on for a few minutes to absorb the fluid
2) Sweep up and discard sweepings in a plastic lined waste receptacle- double bag if necessary.
3) After removal of soil, apply approved disinfectant solution to area
4) Wash broom, mop, dustpan, bucket, etc. in soap and water. Rinse in disinfectant solution.
5) Remove plastic waste can liners at least once daily.

Clothing, towels and other non-disposable items soaked with body fluids
Using disposable gloves, rinse items and place in plastic bag. Seal and send home for washing.

Countertops, Cots, Changing Tables and Sinks
If soiled with blood or body fluids, thoroughly clean with soap and water and disinfect with an approved disinfectant. Clinic counters and changing tables should be routinely cleaned at least once a day with approved disinfectant.

Bandages, Gauze pads, Cotton Balls, Kleenex or other disposable items used in first aid or personal care should be discarded in the regular lined trash receptacle unless they are soaked with blood. If they are soaked they should be disposed of in a biohazardous red bag lined receptacle with a lid and foot pedal.

Diapers in the school setting should be disposed of in a regular lined trash receptacle that is emptied at least once daily.

Recommendations for Restrooms
Education of children in proper hand washing is essential to maintaining good health and breaking the chain of infection. Restrooms must be well maintained in order for this to be possible.

1) Toilet tissue, paper towels and soap supplies should be checked at least daily in each restroom and also after heavy use, such as the lunch hour.
2) Bar soap should not be used. Dispensers should be kept in working order and soap solutions in the recommended concentration available at all times.
3) Toilet seats and other restroom surfaces must be sanitized at least daily and preferably after heavy use.

Requirements for Rooms Where Diapers are Changed

1) Rooms where diapers are changed should have a sink which is used only for personal care activities. Sinks should be located near the changing table.
2) The changing table should have a plastic cover or other impervious surface for easy cleaning.
3) The table should be covered with protective paper prior to changing soiled diapers.
4) Disposable wipes should be used when changing diapers.
5) Paper products, wipes and soiled diapers should be disposed of in a lined receptacle with a lid that should be emptied at least daily.
6) Paper should be changed and the table cleaned after each use and disinfected with an approved disinfectant at least once daily.

Needles/Sharps

All needles or sharps (broken glass, etc) should be considered contaminated and handled with extreme caution. All needles and sharps should be disposed of in a special sharps solid red container usually located in the school clinic. The container should be kept close by where needles are being used so they can be disposed of quickly in the proper container. Needles should never be recapped; recapping increases the risk of accidental puncture.

CPR Shields

When administering mouth to mouth resuscitation, as in CPR, a resuscitation mask or shield with a one way valve is recommended.

Student Accidental Exposures to Body Fluids

HIV (Human Immunodeficiency Virus), HBV (Hepatitis B Virus), and HCV (Hepatitis C Virus) are spread from one person to another by exposure to blood or OPIM (other potentially infectious materials). 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. These viruses can be transmitted when a person is stuck with a needle that contains infected blood, or by getting blood or OPIM in the eyes, nose, mouth, or in an open cut. Special procedures have been developed to manage exposures to body fluids that may contain these viruses. 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). The risk for transmission of HBV, HCV and HIV from feces, nasal secretions, saliva, sputum, sweat, tears, urine and vomit is extremely low.

Management of Exposures to Body Fluids for Students

"Exposure Incident" means a specific contact between blood or OPIM and the eye, mouth, or other mucous membranes, non-intact (broken, cut, or punctured) skin, vein, or muscle.

The following are considered potential exposure incidents:

- Human Bites (both the person bitten and the person who inflicted the bite)
- Punctures or cuts with sharp objects such as needles, razors, glass, ear piercing apparatus, lancets, knives, pencils, etc. that involve more than one student.
- Splashing or spraying of blood or OPIM into eyes, nose, mouth, or an open cut
- Using other shared object/tools for the purpose of inflicting self-injury e.g. sharing erasers to create skin abrasion aka “erasing”

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 come in contact with non-intact (broken, cut, or punctured) skin, mucous membranes, or eye exposures

- The student should be referred to the school clinic immediately.
- The Health Aide will wash the injury immediately and thoroughly for at least 10 seconds with soap and water and refer to established school guidelines for First Aid Procedures for the specific type of injury. If running water is not available, cleanse with bottled water or waterless cleanser until running water is available.
- Mucous membrane (mouth, nose) exposure or eye exposure - flush exposed area thoroughly with copious amounts of water. Irrigate eyes with clean water, saline, or sterile wash if available
- Remove contaminated clothing as soon as possible to eliminate prolonged contact with the skin.
- Notify Administration, Health Department Registered Nurse, and the School District Registered Nurse of the incident.
- The Registered Nurse will notify the parent/guardian by phone and recommend that they contact the student's primary care provider immediately.
- Administration or Registered Nurse will send home written notification as a follow up.
- An accident or incident report will be completed and documentation of treatment will be entered into Skyward.

Evaluation of Exposure Incidents

The Registered Nurse should refer the student to be evaluated by a qualified health care provider to determine the appropriate follow-up. There are situations where post exposure medication therapy may be considered for the exposed person. Consultation with the health care provider within a few hours of the incident allows decisions for treatment to be made without delay. Individual student cases may require further discussion with the School District Risk Management Department.

Accident/Injury Report Forms

The SKYWARD clinic office visit screen should be used to document each accident/injury that occurs during school hours and on school property. Risk Management will access the information through SKYWARD as necessary.

A Standard Student Accident Report Form should be completed by the teacher or other school personnel responsible for the supervising the student at the time the accident occurred. The information provided on this form will help you complete the clinic office visit screen on SKYWARD and should then be filed in a designated folder for future reference if needed.

It is important to document the time and location of the accident, who reported it, the treatment provided, who provided treatment as well as detailed information about the actual injury. You will need to utilize the "Note" section of the clinic office visit area to provide the additional necessary information. Notes typed in that section should be accurate and fact based, not opinion based, and should be a description based on observation, not speculation.

Risk Management can and will view the clinic office visit area as necessary using SKYWARD and may ask for a copy of the Standard Student Accident Report Form.

If a parent requests a copy of the information regarding the injury and treatment, an individual student's clinic office visit report can be run off of Skyward. If you need assistance running the report, contact the District Nurse.

Parents can, and should, be referred to Risk Management if they have any further questions about school related injuries.

Performance of Health Related Services in School

When properly trained, nonmedical School District personnel are allowed to perform certain health-related services. Upon completion of child-specific training by a registered nurse, a licensed practical nurse, a licensed physician, or a certified physician assistant, all District personnel are allowed to perform the following procedures:

1) Clean intermittent catheterization

2) Gastrostomy tube feeding

3) Monitoring blood glucose

4) Administering emergency injectable medication

5) Other medical services when a licensed registered nurse, licensed practical nurse, licensed physician, or certified physician assistant determines that the employee shall be allowed to perform such service.

Nonmedical personnel *are not allowed* to perform invasive medical services that require special medical knowledge, nursing judgement, and nursing assessment, including but not limited to the following procedures:

1) Sterile catheterization

2) Nasogastric tube feeding

3) Cleaning and maintaining a tracheostomy and deep suctioning of a tracheostomy

Reference: Florida Statute 1006.062

For more specific information regarding delegation of care, please refer to Technical Assistance Guidelines- The Role of the Professional School Nurse in the Delegation of Care in Florida Schools (August 2006)

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Storage and Disposal of Health Records

1) ALL physician's orders for medications or treatments should be placed in the individual student's health folder at the end of the school year or when the student's records are transferred to another school.

2) ALL medication administration and/or treatment logs should also be placed in the individual student's health folder at the end of the school year or when the student's records are transferred to another school.

3) Letters sent home regarding failed screenings and follow up letters from physicians regarding treatment should be placed in the individual student's health folder.

4) Emergency cards need only be kept until obsolete. The old one can be destroyed when you receive a new one or when the information is considered old and no longer of use.

5) Clinic logs should be batched, labeled and kept for 7 years. Clinic logs older than 7 years can be disposed of.

6) Accident reports should be batched, labeled and stored for 5 years. Accident reports older than 5 years can be disposed of.

Cumulative Folder Checklist

Only the following information is to be included in the student's cumulative education record in this order:

1) Temporary Intra-District Transmittal Record (light purple)
2) Pupil Identification Data Form (white copy) for the current academic year
3) Birth Certificate (copy) or copy of other acceptable record of birth
4) Social Security Card (copy)
5) Withdrawal Form(s) (white copy) with current year on top
6) Health Record (green folder)
7) Standardized Test Scores (most recent on top)
8) A.I.P.- Academic Improvement Plan (most recent on top)
9) 504 Plan (red folder)
10) Exceptional Education (ESE) Information (blue folder)
11) Student Support Team (SST) information (white folder)
12) Legal Documents (e.g. adoption, custody, official name change, In-Loco Parentis, etc.)
13) Alternative Education Records (yellow folder)
14) Dropout Prevention Information
15) Migrant and/or Title 1 Forms
16) ESOL Envelope including home language survey & LEP English Proficiency Test
17) Transcripts including FASTER records (most recent on top)
18) Current Transcripts for withdrawals from district and graduates
19) Suspension and/or Expulsion Letters (NO Discipline Referrals)
20) Final Orders of Expulsion
21) Grade Retention Letters
22) Internet Application

St. Lucie County School Health Services
Guidelines for Individualized Health Care Plans (IHCP)

As the practice of school nursing becomes more complex, the need to coordinate student health care with school personnel is imperative. In accordance with state guidelines and the School Health Plan, the following policy has been developed for completing and disseminating information on the Individualized Health Care Plan (IHCP) for students in St. Lucie County with health conditions that could potentially impact their safety or educational progress at school. These health care plans are developed to help appropriate school personnel understand and assist the student with chronic health problems or disabilities to participate to the fullest possible extent in school activities.

The Individualized Health Care Plan (IHCP), a variation of the standard nursing care plan, has been developed specifically to address children in the St. Lucie County school setting. The professional school nurse (RN), who has the expertise to make a complete assessment of the student and determine their needs, will initiate the IHCP. IHCP's can stand alone or be combined with an Emergency Action Plan or 504 Plan. The IHCP contains the following components- nursing assessment/diagnosis, goals, plans of action or interventions and evaluation of outcomes.

The Individualized Health Care Plan is a confidential medical record. Confidential information is personal, sensitive, medical information obtained on a specific student concerning physical, developmental, or mental health conditions. Statutorily protected health information is sensitive health information that is protected by state statutes and requires an additional signed release from the parent or guardian. Sexually transmitted diseases, HIV/AIDS, tuberculosis, drug and alcohol addiction and psychiatric conditions are all statutorily protected. Since all information on the IHCP is confidential it should only be disseminated on a "need to know" basis. Those who "need to know" would be anyone who must have access to specific health information to perform their routine job duties, which includes providing a safe environment for all students.

Every year the school nurse (RN) will review the Health Conditions List from SKYWARD and determine which students need further assessment. The assessment may include contact with the parent/guardian via the Student Health History Questionnaire or a personal interview and may also include contact with the physician, health care provider, CMS, teacher, or other school district staff directly involved with the student. The school nurse will determine if an IHCP is required and the priority category according to the seriousness of the condition, with category 1 being the first priority. Priority will also be given to SHCP's that include an Emergency Action Plan or 504 Plan. An Emergency Action Plan (EAP) is a clearly written, step by step set of instructions for what to do in an emergency health situation.

The health paraprofessional should make the school RN aware of any changes in the health status of a student with an IHCP or any student who is diagnosed with a condition that may require an IHCP. Depending on the seriousness of the diagnoses or change, the RN should be notified by phone or at the time of the next school visit.

Once an IHCP is complete a copy should be placed in the red Health Care Plan binder in the clinic and in the Medication Log Book if the student receives medication at school. A copy should also be placed in the student's Cumulative Health Record. A copy of the IHCP will also be given to the parent/guardian for review. Proper documentation on Skyward is important- see below. The RN will keep the original of the IHCP in a secure manner. Due to the confidential nature of IHCP's, copies will be disseminated to other school personnel on a "need to know" basis as determined by the RN. For example, category 1 IHCP's will usually be distributed to a wider variety of school personnel. Teachers who receive an IHCP should include a copy in their substitute plans.

All IHCP's should be reviewed at least annually and updated or rewritten as needed. At the end of the school year, or anytime a student transfers out of the school, the copies of the IHCP that are in the School Clinic should be placed in the child's Cumulative Health Record.

Category 1 (CP1)

Severe Allergic Reaction (especially those prescribed Epi-Pen)
Severe Asthma
Diabetes (IDDM and those with Glucagon orders)
Seizure Disorder (recent active seizure activity)
Seizure Disorder (with emergency Diastat ordered)
Active Cardiac Conditions
Hemophilia (with emergency medication ordered)
Gastrointestinal Conditions (requiring g-tube feeding)
Kidney/Bladder Conditions (requiring catheterization)
Tracheostomy/Ventilator
Any Condition Requiring Oxygen at School
Any Condition Requiring Oral Suctioning
Any Condition Requiring Emergency Medication
Other Conditions as Identified by the Nurse

Category 2 (CP2)

Moderate Asthma
Diabetes (type II)
Seizure Disorder(seizures within last 2 years)
Juvenile Rheumatoid Arthritis
Sickle Cell Disease
Cystic Fibrosis
Cancer
Migraine (with medication at school)
Other Conditions as Identified by the Nurse

Individual Student Health Care Plan Documentation on SKYWARD

1) When a new IHCP has been written for a student, the RN should ensure that it is documented on SKYWARD on the student's Health Condition Screen as CP1 or CP2. A paper copy of **all** IHCP's (for regular and ESE students) should be kept in the school clinic.
2) Anytime (at least once a year) an existing IHCP is reviewed or updated it should be noted on SKYWARD. Go to the student's Health Condition Screen, highlight the CP1 or CP2 line and use the "edit" button. Type a note in the "Note" box that says the plan was reviewed or updated and include the date that it was reviewed or updated. Then hit "SAVE".
3) If an IHCP has been discontinued, document it on SKYWARD. Go to the student's Health Condition Screen, highlight the IHCP that has been discontinued and use the "edit" button. Change the Status from "active" to "inactive". Type a note in the "Note" box stating why the IHCP has been discontinued. Then hit "SAVE".

By doing the above, we can ensure that we are able to run an accurate SKYWARD Report of all active IHCP's by school. Using the report, we will be able to see which IHCP's have or have not been reviewed or updated as needed.

The School Nurse should also attach an electronic copy of the current IHCP/EAP on the Skyward IHP screen under Student Profile using the following steps.

Attaching Individual Health Plans (IHP) and Emergency Action Plans on Skyward (FOR RN's)

To post a newly written IHP on Skyward:

1) After typing the IHP, when you save it in your documents or on your flash drive, you must make it a "Read Only" document so that changes cannot be made once it is posted on Skyward. Do this by choosing "Mark As Final" when you save it.
2) On Skyward go to OFFICE > HEALTH RECORDS > STUDENT PROFILE. Then on the left choose IHP from the menu. On the right choose "ADD FILE". In the Form Description box type the condition that the IHP is addressing and then indicate whether it is a CP1 or a CP2.

Example: Diabetes-CP1 or Migraine Headaches-CP2.

3) Click on "Browse" and find the Care Plan and attach it.
4) In the comment box type "Written on ___/___/___". Then SAVE.

To update an IHP with new information:

1) Make the needed changes to the IHP in your documents or on your flashdrive. Fill in the "reviewed by" info at the bottom and save the changes. Be sure to choose "Mark As Final".
2) On Skyward go to OFFICE > HEALTH RECORDS > STUDENT PROFILE. Then on the left choose IHP from the menu. Click on the current IHP that you are updating. On the right choose "EDIT".
3) Click on "Browse" and find the updated Care Plan and attach it.
4) In the comment box type "Updated on ___/___/___". Then SAVE.
   The updated IHP will replace the original version of the IHP.

To review an IHP without making changes:

1) On the original IHP fill in the "reviewed by" information at the bottom. Save and be sure to choose "Mark As Final".
2) On Skyward go to OFFICE > HEALTH RECORDS > STUDENT PROFILE. Then on the left choose IHP from the menu. Click on the current IHP that you are reviewing. On the right choose "EDIT".
3) Click on "Browse" and find the reviewed Care Plan and attach it.
4) In the comment box type "Reviewed on ___/___/___. No changes made." Then SAVE.
   The reviewed IHP will replace the original version of the IHP.

***REMEMBER- Anytime you write, update or review the IHP you must choose "Mark As Final" when you save it so that people who pull it up on Skyward can view it and print it but not change the content.

Additional Information

*If the student has more than one IHP (for different health conditions), each IHP will have its own line on the IHP page on Skyward. When reviewing or updating an IHP be sure to choose the correct line to update.

*When an IHP is no longer active/needed use the VOID button on the right to void it and type a reason for the void in the comment box.

*When an IHP is entered for a student, there will be an asterisk(*) by IHP on the menu on the left.

Individual Student Health Care Plan Documentation on SKYWARD

1) When a new IHCP has been written for a student, the RN should ensure that it is documented on SKYWARD on the student's Health Condition Screen as CP1 or CP2. A paper copy of **all** IHCP's (for regular and ESE students) should be kept in the school clinic.
2) Anytime (at least once a year) an existing IHCP is reviewed or updated it should be noted on SKYWARD. Go to the student's Health Condition Screen, highlight the CP1 or CP2 line and use the "edit" button. Type a note in the "Note" box that says the plan was reviewed or updated and include the date that it was reviewed or updated. Then hit "SAVE".
3) If an IHCP has been discontinued, document it on SKYWARD. Go to the student's Health Condition Screen, highlight the IHCP that has been discontinued and use the "edit" button. Change the Status from "active" to "inactive". Type a note in the "Note" box stating why the IHCP has been discontinued. Then hit "SAVE".

By doing the above, we can ensure that we are able to run an accurate SKYWARD Report of all active IHCP's by school. Using the report, we will be able to see which IHCP's have or have not been reviewed or updated as needed.

The School Nurse should also attach an electronic copy of the current IHCP/EAP on the Skyward IHP screen under Student Profile using the following steps.

Attaching Individual Health Plans (IHP) and Emergency Action Plans on Skyward (FOR RN's)

To post a newly written IHP on Skyward:

1) After typing the IHP, when you save it in your documents or on your flash drive, you must make it a "Read Only" document so that changes cannot be made once it is posted on Skyward. Do this by choosing "Mark as Final" when you save it.
2) On Skyward go to OFFICE > HEALTH RECORDS > STUDENT PROFILE. Then on the left choose IHP from the menu. On the right choose "ADD FILE". In the Form Description box type the condition that the IHP is addressing and then indicate whether it is a CP1 or a CP2.
   Example: Diabetes-CP1 or Migraine Headaches-CP2.
3) Click on "Browse" and find the Care Plan and attach it.
4) In the comment box type "Written on ___/___/___". Then SAVE.

To update an IHP with new information:

1) Make the needed changes to the IHP in your documents or on your flash drive. Fill in the “reviewed by” info at the bottom and save the changes. Be sure to choose “Mark as Final”.
2) On Skyward go to OFFICE > HEALTH RECORDS > STUDENT PROFILE. Then on the left choose IHP from the menu. Click on the current IHP that you are updating. On the right choose “EDIT”.
3) Click on “Browse” and find the updated Care Plan and attach it.
4) In the comment box type “Updated on ___/___/___”. Then SAVE.
   The updated IHP will replace the original version of the IHP.

To <u>review</u> an IHP without making changes:

1) On the original IHP fill in the “reviewed by” information at the bottom. Save and be sure to choose “Mark as Final”.
2) On Skyward go to OFFICE > HEALTH RECORDS > STUDENT PROFILE. Then on the left choose IHP from the menu. Click on the current IHP that you are reviewing. On the right choose “EDIT”.
3) Click on “Browse” and find the reviewed Care Plan and attach it.
4) In the comment box type “Reviewed on ___/___/___. No changes made.” Then SAVE.
   The reviewed IHP will replace the original version of the IHP.

***REMEMBER- Anytime you write, update or review the IHP you <u>must choose</u> “Mark As Final” when you save it so that people who pull it up on Skyward can view it and print it but not change the content.

Additional Information

*If the student has more than one IHP (for different health conditions), each IHP will have its own line on the IHP page on Skyward. When reviewing or updating an IHP be sure to choose the correct line to update.

*When an IHP is no longer active/needed use the VOID button on the right to void it and type a reason for the void in the comment box.

*When an IHP is entered for a student, there will be an asterisk (*) by IHP on the menu on the left.

Nut Allergy Protocol

To establish a safe environment for students with severe nut allergies (with Epipen or Twinject ordered for anaphylaxis), the following guidelines should be followed in all schools with students in grades Pre-K through 8.

1) A child-specific Health Care Plan should be written by the school RN.
2) The Health Care Plan should be distributed and explained to all adults who will supervise the student throughout the day.
3) School Health Staff should notify the School Meals Program Manager of the allergy and provide a copy of the Health Care Plan.
4) Necessary staff should be trained on Epipen/Twinject administration, as well as signs and symptoms of anaphylaxis, by the school RN.
5) A classroom free of nut or nut products should be established. Parents should be notified not to send in nut product snacks or treats for the classroom. (See nut allergy classroom letter)
6) A table free of nut or nut products should be established in the cafeteria. Students with a severe nut allergy requiring emergency epinephrine administration will sit at the table free of nut or nut products. They should not sit alone. Allow the student to choose a friend or two to sit with them. The children chosen should have a school meal free of nut or nut products (not one brought from home). An adult must check to ensure lunches of each student sitting at the table free of nut or nut products are safe.
7) "No food sharing" should be enforced cafeteria-wide.
8) No food items containing nut products should be offered through the School Meals Program.
9) All students and staff should be encouraged to wash their hands after eating to reduce the transfer of peanut proteins.

Note: Special dietary accommodations require a signed prescription by a licensed physician or registered dietician prior to the School Meals Program making substitutions.

For additional guidelines please refer to the Technical Assistance Paper on Implementation of 2005 Legislation HB 279 also called the "Kelsey Ryan Act".

Nut Allergy Classroom Letter

Date

Dear Parent,

This letter is to inform you that a student in your child's classroom has a severe food allergy to peanuts/nuts. It is important that there is strict avoidance to this food in order to prevent a life-threatening allergic reaction. We are asking your help to provide the student with a safe school environment.

Any exposure to peanuts/nuts may cause a life-threatening allergic reaction that requires emergency medical treatment. To reduce the chance of this occurring, we are asking that you do not send any peanut or nut containing products to school with your child that will be eaten in the classroom. If your child has eaten peanuts/nuts before coming to school, please be sure your child's hands and face have been thoroughly washed before entering the school.

We appreciate your support of these procedures. Please complete and return this form so we are certain you have received this information. Please contact me if you have any questions.

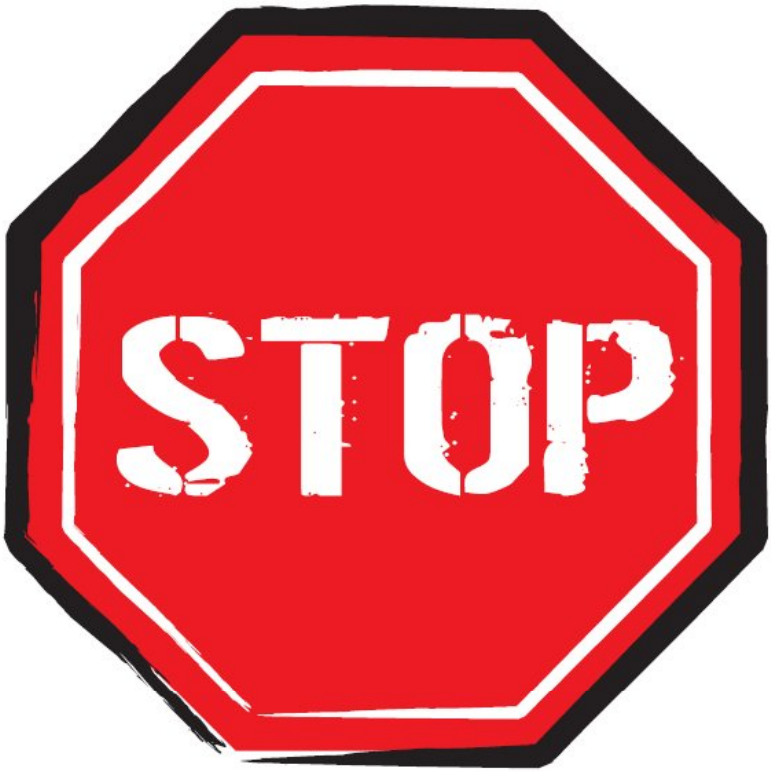
_____
(Teacher, Principal, School Nurse)

_____

I have read and understand the peanut/nut free classroom procedures. I agree to do my part in keeping the classroom peanut and nut free.

Child's Name _____
Parent's Signature _____
Date _____

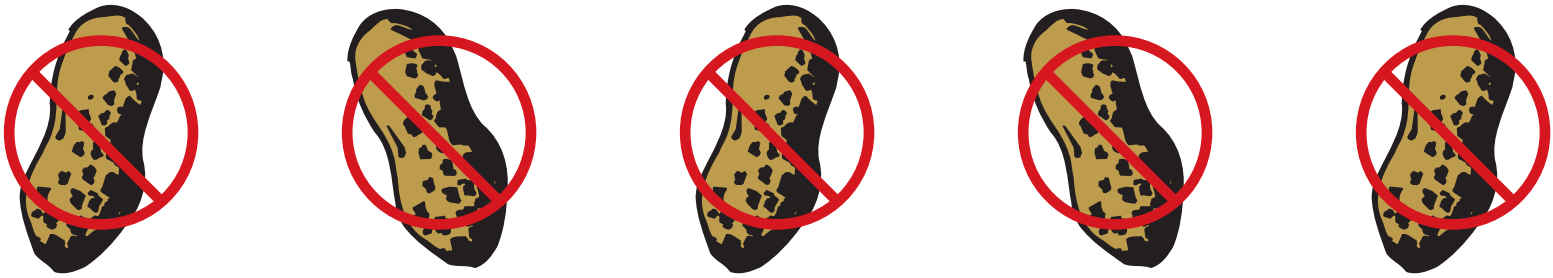
REDUCE THE RISK



THIS IS A PEANUT FREE ZONE!

Thank You
For Your
Cooperation

FOR THE SAFETY OF CHILDREN WHO HAVE LIFE-THREATENING PEANUT ALLERGIES, PLEASE DO NOT BRING PEANUTS OR NUT PRODUCTS INTO THIS AREA.
THANK YOU!



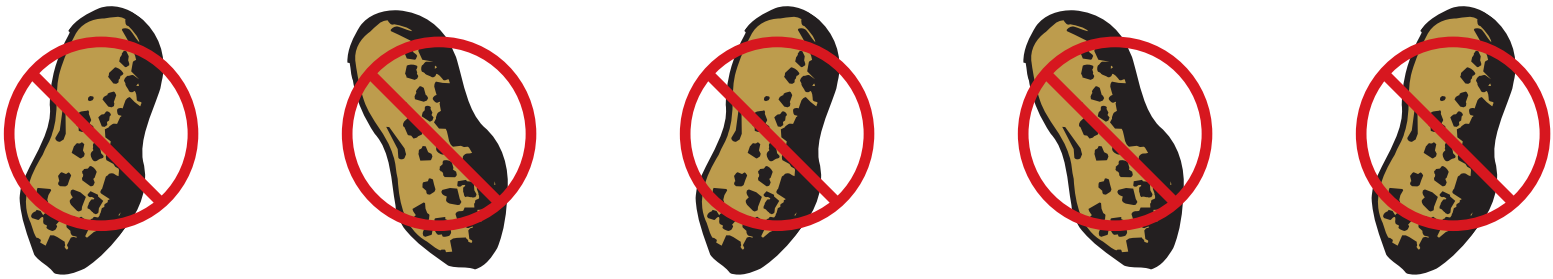
This is a

PEANUT

AND

TREE NUT FREE

Classroom



For more information, please contact the Food Allergy Initiative
Email: Info@FoodAllergyInitiative.org · www.FoodAllergyInitiative.org