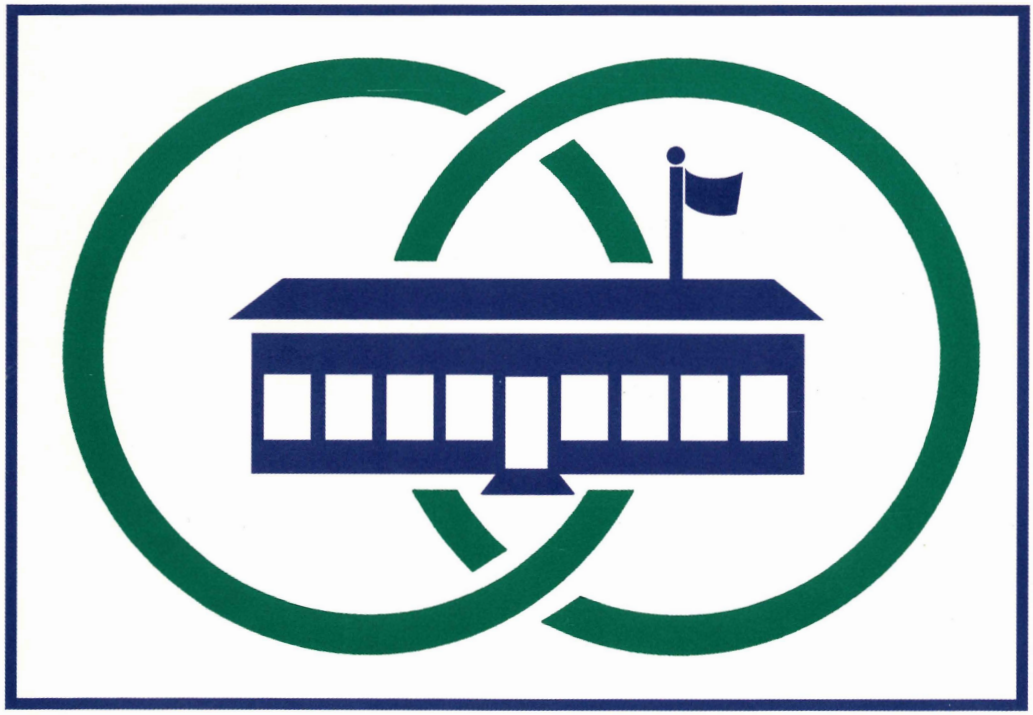
The Comprehensive SCHOOL HEALTH MANUAL

Revised 2007



Massachusetts Department of Public Health

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Chapter 2

DEVELOPING AN EFFECTIVE SCHOOL HEALTH PROGRAM

About The Information in This Manual

From time to time, the Massachusetts Department of Public Health may update some of the materials. Please check the School Health Manual online to see if there are any recent updates.

Please be certain to check for new laws and regulations that may be in effect after publication of this Manual. You may find the Massachusetts General Laws online at http://www.mass.gov/legis/laws/mgl/ and the Code of Massachusetts Regulations at http://www.lawlib.state.ma.us/cmr.html. These sites are periodically updated, but are not the official version of the Massachusetts General Laws (MGL) or Code of Massachusetts Regulations (CMR). You should always refer to an official edition of the MGL and CMR. Official editions may be found at the Statehouse Bookstore and many public and law libraries.

Chapter 2

DEVELOPING AN EFFECTIVE SCHOOL HEALTH PROGRAM

This chapter describes strategies for developing a coordinated school health and human services program, which encompasses the 9 components of school health described in Chapter 1. Although all components are mentioned in this chapter, the main focus is on health services. The other components are addressed in greater detail in later chapters.

A comprehensive, coordinated school health and human services program:

- focuses on health needs of students;
- employs multiple methods and approaches;
- considers a diversity of health issues in the community;
- engages those most affected by the program; and
- involves specially trained staff to deliver the program.

Establishing an effective school health service program maximizes students' educational experience, while providing a safe, caring, healthful environment for both students and staff. An effective health service program includes the following components:

- ***A qualified school nurse leader*** (DOE licensed with a baccalaureate or, preferably, a masters degree in nursing), who is relieved from direct services to students and is employed fulltime in the designated role. The nurse leader is a member of the administrative management team and has responsibility and authority for the entire district's school health service program.
- ***A health coordinator*****,** who is responsible for coordinating the implementation of the health education and prevention programs, collaborating with other members of the team, including the school nurse leader.
- ***A comprehensive school health advisory committee*****,** which includes broad internal and community representation, reviews the needs assessment, goals, and objectives; monitors program effectiveness; and provides recommendations for policy and program development and/or improvement.
- ***A school and community health needs assessment*****,** which evaluates the health status of the students and the broader community, promotes ongoing health condition surveillance, identifies and prioritizes health issues to be addressed, and follows the CDC model of comprehensive, coordinated school health.
- ***A planning and implementation process*****,** based on the results of the needs assessment, which identifies key steps, involves essential disciplines, and develops a plan.
- ***An action plan*****,** which addresses health needs and disparities and provides a vision (with goals and objectives) and appropriate strategies to improve student health and reduce disparities.
- ***Interdisciplinary collaboration*****,** which involves personnel from all areas of the school, as well as relevant community resources, and encourages them to work together to improve school health and human services.
- ***Safe and effective staffing patterns for school health personnel*** engaged in

comprehensive, coordinated health services, health education, and behavioral health services.

- ***Inter-agency agreements*****,** which clarify the working relationships between the school and community-based agencies providing school health or human services.
- ***A skills based health education program,*** grades pre-kindergarten to twelve, based on the Massachusetts Health Curriculum Frameworks.
- ***Models for delivery of services*****,** which describe possible ways to deliver school health and human services, such as through a basic essential model (school nurse working with a school physician), a school-based health center, or a family health center.
- ***Policies and protocols for decision making*** and implementation of program plans.
- ***Planned, written protocols for emergencies*** (individual or group emergencies, disasters, and bioterrorism events). These include preventive activities, post-event recordkeeping/documentation, and plans for implementing mock drills.
- ***School health facilities*** to address the diverse and complex health service needs of large populations of students and school personnel.
- ***School health records*****,** which provide an accurate, cumulative, specific, objective, and confidential record of each student's health status. (These records should be computerized.)
- ***Information for parents, students, and other consumers*** describing the mission and services offered by the health service program.
- ***Program evaluation protocols*** that document and evaluate the comprehensive, coordinated health program, while measuring success through both process and outcome indicators. This includes ongoing quality improvement to assess the results of interventions. Ongoing client satisfaction surveys are essential.
- ***Data collection and analyses*** to track important health indicators, identify potential outbreaks, interpret program activity to decision makers, identify the need for new programs or strategies, prepare budgets, and document health system changes. This includes population-based surveillance of conditions such as asthma and life-threatening allergies.

This chapter provides guidelines for implementation and explains why each of these components is critical to a comprehensive, coordinated school health and human services program. The order of the list above does not necessarily imply the order in which the components should be implemented. Some components, especially the needs assessment, should occur prior to addressing other components; others may take place concurrently. Typically, the following sequence is followed:

> Establish advisory committee → Assess health status of school and community → Identify health disparities and risk factors → Develop a strategic plan (action plan) → Implement program → Evaluate program → Reassess, modify, and implement revised plan.

COMPREHENSIVE SCHOOL HEALTH PROGRAM ADVISORY COMMITTEE

A district-wide school health advisory committee is an essential component of a successful, comprehensive, coordinated school health program. A committee's collective knowledge, expertise, influence, and advocacy can be a powerful force on behalf of the program. As a district-wide advisory body, the committee can identify health and social problems related to the community's youth, develop viable solutions, and identify key resources. Responsibilities may include the following:

- assisting in the development of a school and community needs assessment to identify student health needs;
- aligning the comprehensive health curriculum with Health Curriculum Frameworks;
- reviewing local, state, and federal requirements related to school health services;
- developing and/or reviewing program guidelines in such areas as environmental health, health appraisal, communicable disease control, physical education, emergency health care, bioterrorism planning, and a comprehensive health education curriculum, with a focus on prevention;
- developing and/or reviewing guidelines for the health service program goals and objectives, as well as policies and protocols for personnel, facilities, and supplies;
- making recommendations to the school committee, or designee, on school health issues;
- serving as an advocacy group for improved school and community health services;
- identifying and developing resources for the school health program; and
- participating in evaluating the outcomes and effectiveness of the program.

The committee needs a chairperson to organize the agenda and schedule the meetings. In many school districts, the health coordinator and nurse leader jointly assume this responsibility. Membership of the committee will include both internal and community representatives. Ideally, the following from the school community should be included:

- parents/guardians;
- students;
- school nurse leader;
- the health and human services coordinator;
- school nurses;
- school physician;
- school-based health center (SBHC) staff, if the school has an SBHC;
- members of the administrative, teaching, and counseling staffs;
- safe and drug-free school coordinator;
- food service director;
- health educators representing elementary, middle, and high school levels;
- physical educators;
- special educators;
- athletic director; and
- school committee representatives.

In addition to the above-mentioned participants, membership may be open to other community representatives interested in school health issues: board of health officials; local and regional health and human service providers; state agencies; primary care providers; members of business, faith-based, and service organizations; members of the police and fire departments; and other local officials. The practical size limit for a workable committee is approximately 20 people. Because the committee should promote and encourage links between the school and the community, it should strive for a diverse and sizable representation. This will enable new voices to be heard and new ideas to be shared.

The entire committee should meet as necessary, but at least quarterly. Meetings should be scheduled at times and locations that are most convenient for members, and agendas should be planned and distributed prior to the scheduled meeting date. It may be important to prepare some members in advance to make them feel comfortable and to encourage participation during meetings. For example, parents who have not had experience serving on committees or whose first language is not English may wish to be contacted and briefed by the school prior to attending their first advisory committee meeting.

The committee may wish to organize small work groups that are project specific or establish standing subcommittees in such areas as health policies, health curriculum, violence prevention, emergency preparedness, and/or nutrition/physical activity programs.

SCHOOL AND COMMUNITY HEALTH ASSESSMENT

In collaboration with the school health services staff, one of the major tasks of the school health advisory committee is to identify the need for school health services. The advisory committee also identifies the feasibility of obtaining resources for programs, projects, curricula, and/or materials, while helping the school committee or its designee set priorities. The health needs of the general student population in the school district — as well as specific populations (such as children with life-threatening allergies or those at risk for overweight or type II diabetes) — must be clearly documented and not simply presumed to exist. Specific programs and/or curricula are then implemented in response to the student population's health needs.

An advisory committee may recommend needs assessment protocols, with the actual assessment implemented by a subgroup of the advisory committee, an outside consultant, the nurse leader, health coordinator, or a school administrator. A needs assessment may be conducted through surveys of school staff and community members, face-to-face or phone interviews, and/or focus groups. Reviewing health statistics from state (e.g., MassCHIP, birth, death, emergency room visit data) and local sources, as well as relevant research results, is also important. Consultation may be obtained from experts on content and proposed methods.

A needs assessment aims to answer questions such as:

- What are the demographics (e.g., cultural, linguistic, economic, social) of the school population?
- What data on health status (e.g., teen pregnancy, school drop-out, asthma, overweight, communicable disease rates) are already available from local and statewide sources?
- Do health disparities exist in the student population?
- What health issues and problems (e.g., peer violence, depression, asthma, overweight, anorexia) are identified by students, parents, faculty, and administration?

Exhibit 2-1 contains a sample school and community needs assessment instrument. The DPH and DOE issue health status reports annually that will be helpful in assessing local health needs. The Centers for Disease Control and Prevention also have developed useful needs assessment instruments, such as the School Health Index (see Exhibit 2-2 for more information about this tool, which is available online at http://apps.nccd.cdc.gov/shi/).

PROGRAM PLANNING AND IMPLEMENTATION

After the school and community health assessment is completed, the advisory committee will discuss the findings and share them with appropriate school and community officials, such as school committee members, the superintendent, principals, the local board of health, health educators, pupil personnel services coordinator, special education director, local health providers, and human service agencies, as well as parents/guardians. Based on needs assessment results and community priorities, the committee will recommend action steps and assist the school department in the development and implementation of program plans.

Vision Statement and Logic Model

As the advisory committee and school department develop a plan for the school health program, it may be helpful to construct a vision statement, with goals that include desired changes or objectives. One example of a vision statement is: "Students and staff will improve their nutritional habits." An even more specific statement is, "Students and staff will reduce their lunchtime fat and sugar intake by 15% during year 1 of the program." Vision statements evolve from a focus on the most important health issues and specific health status disparities identified by the committee during the needs assessment process.

Once a vision statement has been developed, it may be helpful to construct a logic model. A logic model is a systematic and visual way to describe the sequence of activities that will bring about change and explain how a program is expected to work or achieve results. It illustrates the relationships between the various components of a program:

Inputs – the resources used to conduct a program
Activities – the specific actions a program carries out
Outputs – the products created by the activities of a program
Outcomes – the results or changes a program achieves

In some logic models, **influential factors** or **contextual enablers** and **barriers** are identified as variables that pertain to the environmental conditions in which a program operates. Although these variables are often not under the control of program staff, they can have a significant impact on the success of a program. Examples include political influences, social norms, history, and socioeconomic factors.

Although some logic models include all outcomes in one category, it is often helpful to distinguish between outcomes that are likely to occur early in the program and those that may take years to achieve. In doing so, it is easier to determine what initial outcomes are necessary to achieve final outcomes and, as those early outcomes are accomplished, to document progress in attaining the program's overall purpose. In general, outcomes can be divided into 3 categories:

- **Initial or short-term outcomes** – changes in awareness, knowledge, or attitude
- **Intermediate or mid-term outcomes** – changes in behavior, actions, or policy
- **Long-term outcomes or impact** – changes in systems and improvement in conditions

Logic models are developed in many different formats and vary considerably in their level of complexity, depending on the specific function of a program or project. An example of a logic model for a school-based asthma program is presented in Exhibit 2-3.

Some helpful online resources for developing goals and objectives, as well as logic models, are:

- http://www.gse.harvard.edu/hfrp/pubs/onlinepubs/rrb/learning.html
- http://www.wkkf.org/Programming/ResourceOverview.aspx?CID=281&ID=3669
- http://national.unitedway.org/outcomes/resources/
- http://www.healthypeople.gov/state/toolkit/
- http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html
- http://www.ces.ncsu.edu/depts/fcs/pub/2002su/betts.html

Action Plan

In addition to defining the vision and mapping the rationale and expected results, programs require action plans. An action plan is a project management tool that shows, often through a set of program objectives and a timeline or task outline, what *staff or others need to do* to implement a program. Exhibits 2-4 and 2-5 contain a sample action plan and a sample form that may be used for developing one.

Interdisciplinary Collaboration

Interdisciplinary collaboration (in the context of comprehensive, coordinated school health and human services) involves personnel from all areas of the school working cooperatively to deliver health education and services. In addition, it involves working with community partners that have a stake in the health of children, adolescents, and their families, such as the local board of health, public safety, primary care providers, insurers, civic associations, faith organizations, and business leaders. Interdisciplinary collaboration can provide many advantages and opportunities, including the following:

- Participants bring a range and depth of experience, skills, expertise, and creativity, which are helpful in supporting and guiding all aspects of a school health program, from obtaining appropriate services for an individual student to revamping the entire school health program.
- Collaboration reduces duplication of efforts and services.
- Collaboration increases the ability to track outcomes. For example, when an interdisciplinary team focuses on a particular at-risk student, he/she is more likely to be tracked for referral and support, rather than lost to follow-up.
- Involvement of parents/guardians, students, and other members of the community ensures that key resources and concerns from the community are brought to the school's attention.

There are both formal and informal mechanisms for interdisciplinary collaboration in a school and within a community.

Formal Collaboration

Formal collaboration typically occurs in 3 ways:

(1) *An organized team meets regularly to identify and address issues*. An example of this type of collaboration is a case management team that explores the needs of students who are identified as "at educational or health risk" and develops a plan to meet an individual student's needs through referral, onsite support services, or both. In some school districts, such a team meeting may also be known as a "pre-referral" team.

The identification and referral program, described in Exhibit 2-6, is an example of an organized team. Other examples include IEP Teams, which complete Individual Education Plans (IEPs) for special education students, and student assistance teams, which provide referral and support focusing on substance abuse and addiction.

Some members of the case management team may be permanent; others may have limited terms or be included with the understanding that participation is on an as-needed basis. For example, the school nurse should routinely be notified of all IEP meetings and other support meetings so that she/he may attend if there are any physical and/or behavioral health issues that may impact educational outcomes.

Usually one team member has primary responsibility for the student. Permanent members of this team may include the principal and/or director of discipline, guidance counselor, school psychologist, and school nurse. Temporary or ad hoc members may include educators, parents/guardians, and experts from the community, such as parole officers, staff from the Department of Youth Service (DYS), and law enforcement representatives. Parent attendance is considered essential for the IEP teams, whereas they are not part of the child study teams.

(2) *An "ad hoc" team is formed to address a specific health or behavioral problem and disbands when the issue is addressed or problem resolved*. For example, a team may be organized to deal

with increased numbers of injuries on an elementary-school playground. Such a team might include the principal, the school nurse, educators, playground monitors, custodian, and parents/guardians.

(3) *Two or three people in the school meet formally on a regular basis to share information and discuss common issues, concerns, and problems*. For example, the school nurse and athletic director may meet quarterly to review the status of sports physical examinations. Or, the school nurse may meet monthly with the director of special education services to review any health challenges that may influence adherence to a student's individualized educational plan (IEP), as well as to integrate the individual health care plan (IHCP) into the IEP.

Informal Collaboration

Informal collaboration occurs on a temporary, as-needed basis for information exchange, as when the school nurse informs (while adhering to protocols for confidentiality) the physical education teacher that a particular student may not participate in athletic activities because of a recent injury.

Examples of Collaboration

Collaboration may occur in the 9 key areas of a comprehensive, coordinated school health and human services program, as shown below (see also Chapter 1). Several examples of collaborative initiatives are included for each area, along with **starter lists** of suggested participants.

Note:

- Proactive administrative support is critical to the success of all initiatives such as those described below. This may include (a) providing staff with preparation time and resources, (b) participating in planning committees, and (c) garnering support from the school committee and community.
- An active school health advisory committee, often co-led by a health coordinator and school nurse leader, with school committee and community representation, should be involved in most initiatives relating to a comprehensive, coordinated school health and human services program.
- If there is a school-based health center (SBHC) in the school, the SBHC staff should be included in any health-related collaborations and committees.

(1) Health Education

- **Develop, review, and revise health education curriculum.**
  Suggested participants: Health educator, school nurse, behavioral health specialist/counselor, administrator in charge of curriculum, and other school health personnel, in consultation with the school health advisory committee.
- **Co-sponsor health fairs with external agencies.** Examples of external agencies include local chapters of the American Lung Association, American Heart Association, Youth and Family Services, and Melanoma Foundation of New England. The health fairs may target specific populations, such as students, educators, parents/guardians, and the community.
  Suggested participants: Health educator, school nurse, behavioral health specialist/counselor, athletics staff, food service, and other school health personnel, with consultation from the school health advisory committee.

(2) Physical Education

- **Ensure that all students have physical examinations prior to participation in competitive sports.** This is required by M.G.L. c.71, s.57, and 105 CMR 200.00, as well as the Massachusetts Interscholastic Athletic Association (MIAA).
  Suggested participants: Physical educator, athletic director, and school nurse.
- **Promote the benefits of wellness programs for students and staff.** Such programs may include healthy nutrition and exercise (e.g., walking programs).

Suggested participants: Physical educators and health educators can partner with the school nurse and food services personnel.

(3) Health Services

- **Document and present to the community, as well as to local health providers, the results of a health needs assessment of the student population; include recommended interventions in the presentation**.
  Suggested participants: School nurses, school physician, and behavioral health specialists/counselors, in collaboration with community health care providers.
- **Establish building-specific and district-wide emergency plans, including plans for multicasualties, terrorism events, and crisis issues within the school population.**
  Suggested participants: School nurse; school physician; behavioral health specialists/counselors; local, state, and federal emergency medical services; board of health; and police and fire departments.

(4) Nutrition Services

- **Offer students meals based on nutritional guidelines and recommended standards.**
  Suggested participants: Food service personnel, school nurse, school physician, budget officer, educators, principal or his/her designee, school administrators, and local food suppliers.
- **Ensure a safe environment for students with life-threatening food allergies.**
  Suggested participants: School nurse, school physician, food service personnel, educators, custodians, bus drivers, and so forth, in collaboration with parents/guardians and community primary care providers.

(5) Health Promotion for Staff

- **Coordinate community resources to provide school-site prevention programs, such as weight reduction classes.**
  Suggested participants: School nurse, health educator, physical educator, and community organizations (e.g., weight reduction organizations for youth, adults, and family groups).
- **Organize a support group for staff who are caring for their elder parents**.
  Suggested participants: School nurse, physical educator, behavioral specialists/ counselors, and community organizations (e.g., local elder and/or family services).

(6) Counseling and Psychological Services

- **Work with the school administration and faculty to promote respect within the school culture and implement interventions should bullying occur.**
  Suggested participants: School administrators**,** behavioral health specialists/counselors, school nurse, educators, student peer support groups, and external community program resources.
- **Support re-entry of students who have been excluded from school for any reason (e.g., substance abuse treatment, depression, acts of violence).**
  Suggested participants: Behavioral health specialists/counselors, school nurse, school administrators, special education director, student peer support groups, educators, and external community program resources.

(7) Healthy School Environment

- **Implement a program such as the Environmental Protection Agency's "Tools for Schools" to prevent and/or identify air quality problems.**

Suggested participants: Facilities managers, school administrator, bus companies, school nurse, school physician, and school budget officer.

- **Ensure that facilities are inspected regularly for safety and handicap accessibility.**
  Suggested participants: Facilities manager, school administrator, local fire and law enforcement, school nurse, school physician, physical educators, playground monitors, science/lab instructors, and so forth.

(8) Parent/Community Involvement

- **Develop communitywide initiatives to address overweight issues.**
  Suggested participants: Physical educator, health educator, athletic director, school nurse, behavioral health specialists/counselors, representatives from the mayor's office/town selectmen, parents/guardians, students, local health care providers (e.g., hospitals, clinics), and so forth.
- **Establish a communitywide effort to promote skin cancer prevention.**
  Suggested participants: Health educators, school nurses, physical educators, athletics director, coaches, after-school program advisors, facilities managers, parks and recreation director, board of health, local dermatologists, and representatives from organizations (e.g., the Melanoma Foundation of New England).

(9) Family and Consumer Science Education

- **Implement a curriculum assisting students to be knowledgeable and media-literate consumers.**
  Suggested participants: Health educators, family and consumer science educators, representatives from local businesses, school nurse, school physician, and representatives from the local media.
- **Promote student awareness of the decision-making process involved in legislation that affects consumers**.
  Suggested participants: Family and consumer science educator, school administrator, health and other educators, school nurse, and representatives from local and state government.

Staffing Patterns for School Health Personnel

A school district may employ a variety of staff that are licensed (certified) by the Massachusetts Department of Education as regular employees or as external contractors. (See Chapter 13 for laws requiring criminal background checks and CORI requirements.) Each school and/or school district must provide written position descriptions and an organizational chart that defines reporting relationships and supervisory authority of the comprehensive health and human services staff. In some school districts, staff may serve dual roles (e.g., as school nurse leader and health coordinator). Such staff members typically have either two position descriptions or one description that synthesizes the responsibilities of both roles.

School health education and human services program staff typically fall into at least 5 categories:

(1) **School Nurse Leader** has the responsibility and authority for managing the school health services program. The School Nurse Leader should have at least a baccalaureate in nursing (master's degree is preferred), a current license to practice nursing in the Commonwealth of Massachusetts, and a current license (or eligibility for licensure) as a "school nurse" from the Massachusetts Department of Education. An individual holding this position should be employed full time in her/his designated role, relieved from direct care. She/he should be a member of the school's administrative management team and have responsibility for the district-wide school health service program, staff, and budget. In those school districts with an Essential School Health Service grant, the Nurse Leader also manages the grant, collaborating with the school

building principals to implement the health service program and evaluate the school nurses.

(2) **Health Services Staff** may include the school nurses, school physician consultant, health aide, school nurse practitioner, and health education/human services coordinator. Each school system develops its own position descriptions for these roles. Exhibits 2-7 through 2-12 present sample descriptions for general school health services staff.

School nurses: The foundation of the health services program consists of the school nurse(s). They are required to be registered nurses with a Bachelor's or Master's of Science in nursing and be licensed (certified) by the Massachusetts Department of Education. (See http://www.doe.mass.edu/lawsregs/603cmr7.html for complete requirements.)

The school nurse is a public health nurse, responsible for the health of the population of children in the specific school building(s) to which she/he is assigned. In this role, the nurse serves as clinical expert, service provider, and health program manager in the educational setting. By necessity, the school nurse must maintain a wide range of skills including, but not limited to, clinical, public health, and managerial skills. Ideally, the number of school nurses (registered nurses meeting the licensure requirements of the Massachusetts Department of Education) responsible for the school health services program should be determined by a needs assessment of the health status of the student population/community. When data on the health needs of local students are not readily available, regional or statewide health status data may provide a useful starting point for planning the staffing patterns.

In the 1998 Report to the Massachusetts Legislature, *Options for Developing School Health Services in the Commonwealth of Massachusetts,* the Department of Public Health recommended the following:

- One fulltime equivalent (FTE) licensed school nurse for each building (both public and nonpublic) with 250 to 500 students;
- An additional 0.1 FTE for each additional 50 students in buildings with more than 500 students; and
- 0.1 FTE for each 25 students in buildings with fewer than 250 students.

When developing staffing plans, other factors to consider include the number of children with special health care needs, the number of buildings, and distance and/or travel time between buildings.

Licensed Practical Nurses: The Massachusetts Department of Education defines the requirements for school nurses. While Licensed Practical Nurses (LPNs) do not meet the DOE licensure requirements and therefore are not school nurses, they may perform other roles. In some school districts, an LPN may provide care to a child who needs a one-to-one nurse, based on the school nurse's assessment of the appropriate level of care.

Note: In such situations, the LPN, under her/his license, may administer prescription medications, but only under the supervision of the school nurse. This is a requirement of the Regulations Governing the Administration of Prescription Medications (105 CMR 210(I), which states:

> "For the purposes of 105 CMR 210.000, a Licensed Practical Nurse functions under the general supervision of the school nurse who has delegating authority."

School Physician/Medical Consultant: Under M.G.L. c.71, s.53, each public school district must also appoint a school physician who provides medical consultation and acts as a liaison to community primary care providers. The Department recommends that the school physician be board certified in a specialty appropriate to school-age population (e.g., pediatrics, family practice, adolescent medicine). (See Exhibit 2-9 for the Template for the Massachusetts School Physician/Consultant Role.)

Other: Additional staff may include health aides/health assistants and technology and clerical support. In some schools, a health aide performs support activities (such as recordkeeping and vision and hearing screening) under the supervision of the school nurse. As management information technology and data requirements expand, many school districts are also obtaining additional technical assistance for the program data and evaluation systems.

(3) **School Counseling and Psychological Services Staff** includes school guidance counselors, adjustment counselors, social workers, and psychologists. See Chapter 11 or the licensure section of DOE's website (http://www.doe.mass.edu/Educators/licensureregs.html) for licensure requirements.

(4) **Comprehensive Health Education/Physical Education Staff** bring the school health program into the classroom through standards-based instruction and a focus on teaching the skills to promote health literacy. Licensure (certification) to teach health education full time in schools is currently covered by an all-levels Health/Family and Consumer Sciences license. Educators holding older but active Health Education certificates for grades K-9 or 5-12 are also qualified. Elementary- (grades 1-6), middle- (5-8), and high-school educators (9-12) may teach health education for up to 20% of their time, but they should have knowledge of the field of health, skills-based instruction, curriculum content, and methods of teaching health before being assigned that responsibility.

Community-based health educators sometimes work with the schools, as well as in community settings. Although they are usually not licensed educators, they may hold national certification as a Certified Health Education Specialist (CHES).

Health Coordinators are responsible for the PreK-12 comprehensive school health and health education program, including training and ongoing support; not all school districts have a staff person officially designated as Health Coordinator (see Chapter 3).

(5) **External Contractors** may include mental health workers, substance abuse counselors, physical therapists, occupational therapists, nutrition counselors, and speech and language pathologists.

External Inter-Agency Agreements

Typically, a formal written agreement is required whenever school health or human services are provided by an agency other than the school department itself. This agreement, sometimes called a "memorandum of agreement" (MOA) or "memorandum of understanding"(MOU), clarifies the responsibilities of each party. Examples of such agreements are ones between (a) a school department and board of health, (b) a public school district and a nonpublic school, (c) a school department and a visiting nurse association or other community service agency, (d) a school department and a local hospital or health center, and (e) an education collaborative and the school district. Other agreements may be needed by transportation companies, external agencies sponsoring before- and after-school programs, or community organizations using the school facilities

before or after school hours. These agreements may state what health services will be provided, such as staff trained in first aid or the use of epinephrine for students with life-threatening allergic conditions. Such agreements provide effective mechanisms for collaboration between the various agencies. Agreements should be reviewed by the school legal counsel for compliance with federal, state, and local laws and regulations. Exhibit 2-13 shows a sample formal written agreement.

Models for Delivery of Services

There are several different models for the delivery of school health and human services, including the *basic essential school health service model* and the *school-based health center*s.

Basic Essential School Health Service Model

The most common model, the basic essential school health service model, consists of a school nurse leader, school nursing staff, a school physician consultant, and other clinical support staff such as behavioral health workers, occupational therapists, physical therapists, and health assistants. The staff are either employed by the school department or by the local health department. In some communities, where accessibility to primary care is an issue, school-based health centers may be established after the basic essential school health service program is implemented. These centers provide primary health care in the school setting.

The basic essential model should apply to all school districts within the Commonwealth and includes the school nurse leader as the manager of the program. The nurse leader ensures consistency of nursing standards, policy development, program implementation, and employment practices across the district. She/he is also responsible for collaborating with other disciplines to plan and establish a comprehensive school health program.

The implementation of the Essential School Health Service (ESHS) Programs was originally funded by the tobacco excise tax and tobacco settlement funds. The ESHS guidelines have been refined and implemented in more than 100 school districts throughout the Commonwealth and have become a template for all of the Commonwealth's school health service programs. ESHS Programs must satisfy specific requirements in 4 areas:

(1) strengthening the administrative infrastructure of the school health service program (nurse leader, staffing requirements, health assessments, policies, emergency care, individual health care plans, etc.);
(2) ensuring implementation of comprehensive health education, including tobacco prevention and cessation programs;
(3) linking school health service programs with community-based health providers, local youth-serving agencies, and public health insurance programs; and
(4) developing management information systems that will help to effectively describe and monitor the program.

Guidelines and detailed information about grant requirements are available online at http://www.mass.gov/dph/fch/schoolhealth/eshs.htm.

Because the ESHS programs are a community model, each school district receiving funding must provide, as a beginning step, basic health services (health screenings, immunization reviews, identification of primary care providers, individualized health care planning, etc.) to the nonpublic and charter schools located within their borders, if this collaboration is agreed upon by the parties. Nonpublic/charter schools must comply with minimum safety standards and must support the school nursing services. The future goal is that all children, whether enrolled in public or nonpublic schools, will have the same level of high-quality school health services.

School-based Health Centers (SBHCs)

In certain schools, after the basic essential school health service program is developed, the health

needs of the students may necessitate consideration of a school-based health center; school nurses should always be involved in these decisions. School-based health centers are primary care clinics located on the campus of an elementary, middle, or high school. In Massachusetts, they are licensed satellite clinics of community health centers or hospitals (parent organizations) and are required to meet certain standards. An SBHC provides comprehensive primary care, in a school setting, for those students who lack access to care. In addition to improving access to primary care, an SBHC promotes positive health behaviors and increases student health knowledge and decision-making skills. Education-related goals include improved involvement in the educational process, decreased absenteeism, and an increased student graduation rate.

The SBHC model of care first emerged in the early 1970s in California and Texas and developed in Massachusetts during the 1980s. The model was initially implemented to meet the health care needs of adolescents, a group that typically engages in high-risk behaviors, often has complex medical and social needs, and tends to use physician services less frequently than all other age groups. The SBHC is one strategy for decreasing barriers to care for this age group. These barriers may include discomfort in conventional health care settings and inability to access care during and after school hours. Although the SBHC model originally developed in high schools, it has also proved effective in providing accessible primary care to students in elementary and middle schools.

Although an SBHC may offer certain services similar to those of the basic essential school health services, such as health promotion, it differs in some important respects. The SBHC offers primary care, including diagnosis and treatment, counseling, referral, and follow-up. The SBHC provides primary care to those students enrolled in the SBHC program (i.e., those who have the necessary consent forms signed), whereas the basic essential school health services provide services to all students in the school. Usually the SBHC's target population is students who either lack or do not regularly visit a primary care provider.

Students enrolled in an SBHC receive their care from a multidisciplinary team of professionals, typically including nurse practitioners, physicians, physician assistants, social workers, and counselors. SBHCs focus on preventive health care and offer services that are comprehensive, accessible, and developmentally appropriate. The SBHC, with its parent organization, provides a mechanism to ensure continuity of care during periods when the SBHC is closed, such as evenings, weekends, and school vacations.

The Department of Public Health, in collaboration with MassHealth, has developed quality standards for SBHCs. The standards development project was part of a larger MassHealth project to improve access to comprehensive health care for children and adolescents in Medicaid managed care programs. Compliance with established standards will ensure provider ability to maximize third-party reimbursement for SBHC services.

If a school is planning an SBHC, it is essential, at the onset, to include the participation and support of the school administration, the nurse leader, the school nurse, school physician, students, parents/guardians, community providers, and other organizations that serve youth. SBHC programs should complement existing school and community health and social services. SBHC staff must work collaboratively with the school health services program and the community. Mechanisms for joint planning and daily communication regarding the health issues of students are vital to achieving success.

Policies and Protocols

General Guidelines

School departments require well-defined school health policies and protocols. A policy is a guide for

decision making within an organization — a rule for action. A protocol is a sequence of steps that should be followed in implementing policies or plans. Whereas policies are broad, allowing flexibility, protocols are specific and detailed. Both require signed and dated review and revision at least every 2 years, and more frequently as needed.

The process of developing and disseminating school health policies helps both staff and community to clarify the vision of school health. It also provides an opportunity to plan for health improvement. Well-defined school health policies are critical to a highly-functioning school health program.

Policies are not developed in a vacuum. They may be based on federal, state, and local laws or regulations; on standards established by state agencies, such as the Massachusetts Department of Education, Massachusetts Department of Public Health, or the Board of Registration in Nursing; or on standards set by professional organizations, such as the American Nurses Association (ANA), National Association of School Nurses, American Academy of Pediatrics, American School Health Association, and American Alliance for Health, Physical Education, Recreation, and Dance. Codes of ethical conduct for the various professions are also honored when developing policies (e.g., the ANA's Code for Nurses, included in Exhibit 6-1, at the end of Chapter 6). See Exhibit 5-1 in Chapter 5 for the Overview of Basic Required School Health Services.

In addition to following federal and state statutes and standards, school health policies are based on a school district's philosophy and the community's values and beliefs. This should be the case, even if a policy is developed only for a particular school. Some school policies may be long-standing, such as maintenance of health records, whereas others may be newly developed in response to emerging issues. Examples of areas where recent events have focused attention on the need for development of school policies are emergency preparedness for multicasualty incidents, sun safety, and promotion of a positive, respectful climate.

Approval and Communication on Policies and Protocols

Schools need to establish mechanisms for policy development. A policy-making body may be a subcommittee of the school health advisory committee. It should include the stakeholders affected by the policy. For example, a policy-making committee for removal of infectious disease waste from the schools might include the school administrator, school nurse, school physician, facility management services, faculty, students, parents/guardians, and the local board of health.

Generally, policies are reviewed by local legal counsel prior to the required approval by the school committee. In cities or towns where the board of health participates in the provision of school health services, the board is also involved in the approval process, including the signing and dating of policies. After development and/or revision and subsequent approval, health policies should be disseminated and/or communicated to all pertinent school staff, health staff, parents/guardians, and students. In addition, a copy of the health policy manual should be made available for review by any interested parent/guardian or student. Whenever possible, the local media — newspapers, radio and television stations, and cable television providers — should publicize important new policies.

Policy and Protocol Manual

Each school district typically has a policy and protocol manual for school health services, containing the relevant district- and school-specific information about the school health program. A loose-leaf format permits addition of new pages with new or revised policies, the removal of outdated content, and the inclusion of relevant forms in each section. Exhibit 2-14 includes a sample outline for a comprehensive policy and protocol manual. A school district just beginning to develop a manual will need time to include all these policies.

Note: Because the policies and protocols in this manual are not copyrighted, they may be adopted by school districts and placed on district letterhead.

EMERGENCY MANAGEMENT BASICS AND PLANNING

A health emergency may occur in any school, at any time. Sometimes the risk is predictable, but often it is not. As more children with special health care needs are integrated into community schools (see Chapter 7), there is increased likelihood that some of these children will need emergency care. However, students with no history of health problems can also become seriously ill or injure themselves in a number of settings, including playgrounds, classrooms, laboratories, or workshops. Students are also at an increased risk for violence-related injuries and/or emotional crises, including depression and suicide attempts. Furthermore, although the natural tendency is to think first of students when considering risk of illness or injury, adults (educators, administrators, support staff, etc.) may also be susceptible. Beyond individual health emergencies, there is also the possibility of disasters — ranging from extreme weather conditions to acts of terrorism — which may precipitate group emergency situations resulting in multiple casualties. In cases of illness, injury, or other emergency, efficient and effective school procedures are essential.

Responding to Emergency Situations

Categories of Emergency Injuries and Conditions

Emergencies may be classified into 3 major categories:

- **Life-threatening or potentially disabling**: Because these emergencies can cause death or disability within minutes, they require immediate intervention, medical care, and, usually, hospitalization.
- **Serious or potentially life-threatening or potentially disabling**: Because these may soon result in a life-threatening situation or may produce permanent damage, they must be treated as soon as possible.
- **Non-life-threatening**: These are defined as any injury or illness that may affect the general health of a person (e.g., fever, stomachache, headache, seizures, fractures, cuts). The student should be evaluated by a licensed provider as soon as the parents/guardians are notified, or certainly within a few hours.

Note: Anaphylaxis is one of the most serious and life-threatening emergency situations to which school personnel may have to respond. Please refer to Chapter 7 for a detailed discussion of life-threatening allergic conditions and to Chapter 6 for a discussion of regulations governing the administration of epinephrine by unlicensed personnel.

Emergency plans should be posted with clear instructions on how to activate the local emergency medical services (usually calling 911). In either a life-threatening or potentially disabling situation, it is important to:

- remain with the student and remain calm;
- avoid moving the ill/injured person, unless there is more danger if left in that location;
- assess the emergency at hand;
- activate the emergency plan (referring to the student's individual emergency plan and individual health care plan, if appropriate);
- notify the school nurse;
- notify the EMS;
- notify parent/guardian;
- notify school administration;

- notify student's primary care provider and/or specialist;
- manage crowd control;
- direct EMS to site;
- accompany student to emergency facility, with EMS if appropriate; and
- assist student's re-entry into school.

Note: Many of the above actions are performed concurrently. Also, although the list above refers to students, the same guidelines would apply to situations affecting staff or visitors.

When emergency services are required for life-threatening or potentially disabling situations:

- Direct a responsible person to call the Emergency Medical Services (EMS). The EMS phone number MUST be prominently displayed near all phones.
- Instruct the person placing the emergency call that he/she MUST stay on the phone until it is certain that EMS has all necessary information. The person placing the call should also:
  - briefly describe the emergency situation (what is wrong);
  - state his/her name as well as the name, exact address, and phone number of the school;
  - give simple, specific directions;
  - specify the exact location within the school of the ill/injured person;
  - tell EMS that he/she will meet them at a specific entrance of the school; and
  - call back for reassessment if necessary (e.g., person has stopped breathing).

Note: Because school phone lines are often busy, DPH recommends that schools install an "override" for an extra outside line for use during an emergency. **There should be no delay in calling 911 in a medical emergency.**

Unless the nature of the illness/injury is minor, it is prudent to activate the local EMS system. If the injury/illness is later determined by the school nurse or other trained personal to be relatively minor, the EMS response can be canceled or the EMS units can clear the scene after evaluating the situation.

In dealing with life-threatening or potentially disabling injuries/illnesses or serious injuries, school personnel should attempt to notify the parent or legal guardian that the ambulance is transporting or has transported the patient to the nearest hospital. The parents/guardians should be advised to have someone drive them to the hospital with reassurance that trained EMS personnel are caring for their child. Ideally, it is best to:

- have available the child's emergency response card with the phone numbers of parents/guardians;
- have another designated person call the parent/guardian while EMS is being activated; and
- give the emergency card to the EMT (Emergency Medical Technician). (It should have the signatures of parents/guardians, which may expedite treatment in the emergency room while awaiting their arrival.)

School personnel should not delay calling for an ambulance while awaiting the permission or arrival of a parent in cases of potentially life-threatening or disabling or other potentially serious situations.

The following tables and algorithms, from *Guidelines for the Nurse in the School Setting* (Illinois Emergency Medical Services for Children) show a list of injuries/conditions and the triage categories into which they fall, along with steps to follow for each category. This list is not all-inclusive. The full document contains detailed algorithms for an extensive list of specific injuries and conditions and may be accessed at: http://www.luhs.org/depts/emsc/Schl_Man.pdf. **Note:** While many situations require a judgment call, it is prudent to call EMS in any serious incident.

TRIAGE CATEGORIES (Figure 1)

The 3 commonly recognized triage categories are *emergent, urgent,* and *nonurgent.* The table below lists triage categories and examples of problems that fall within each category.

Category	Examples
Emergent Student requires immediate medical attention. Condition is acute and has the potential to threaten life, limb, or vision.	• Cardiopulmonary arrest • Shock (hypovolemic, cardiogenic, or distributive) • Severe respiratory distress or failure • Major burns • Cervical spine compromise • Severe medical problems, such as diabetic complications • Poisoning or overdose • Emergency childbirth • Acute seizure states • Prolonged loss of consciousness • Caustic chemical spills in the eyes
Urgent Student requires medical intervention within 2 hours. Condition is acute but not severe or life-threatening.	• Deformity suggesting fracture of a long bone without circulatory compromise • Lacerations in which sutures are required but bleeding is controlled and there is no significant blood loss • Moderate pain following abdominal trauma • Head injury with brief loss of consciousness • Minor burns • Persistent nausea, vomiting, or diarrhea
Nonurgent Student may require referral for routine medical care. Minor or nonacute conditions.	• Minor abrasions or bruises • Muscle sprains and strains • Mild pain

Source: Illinois Emergency Medical Services for Children, Maywood, IL, 2003. Adapted with permission.

INTERVENTIONS, EVALUATION, AND DISPOSITION (Figure 2)

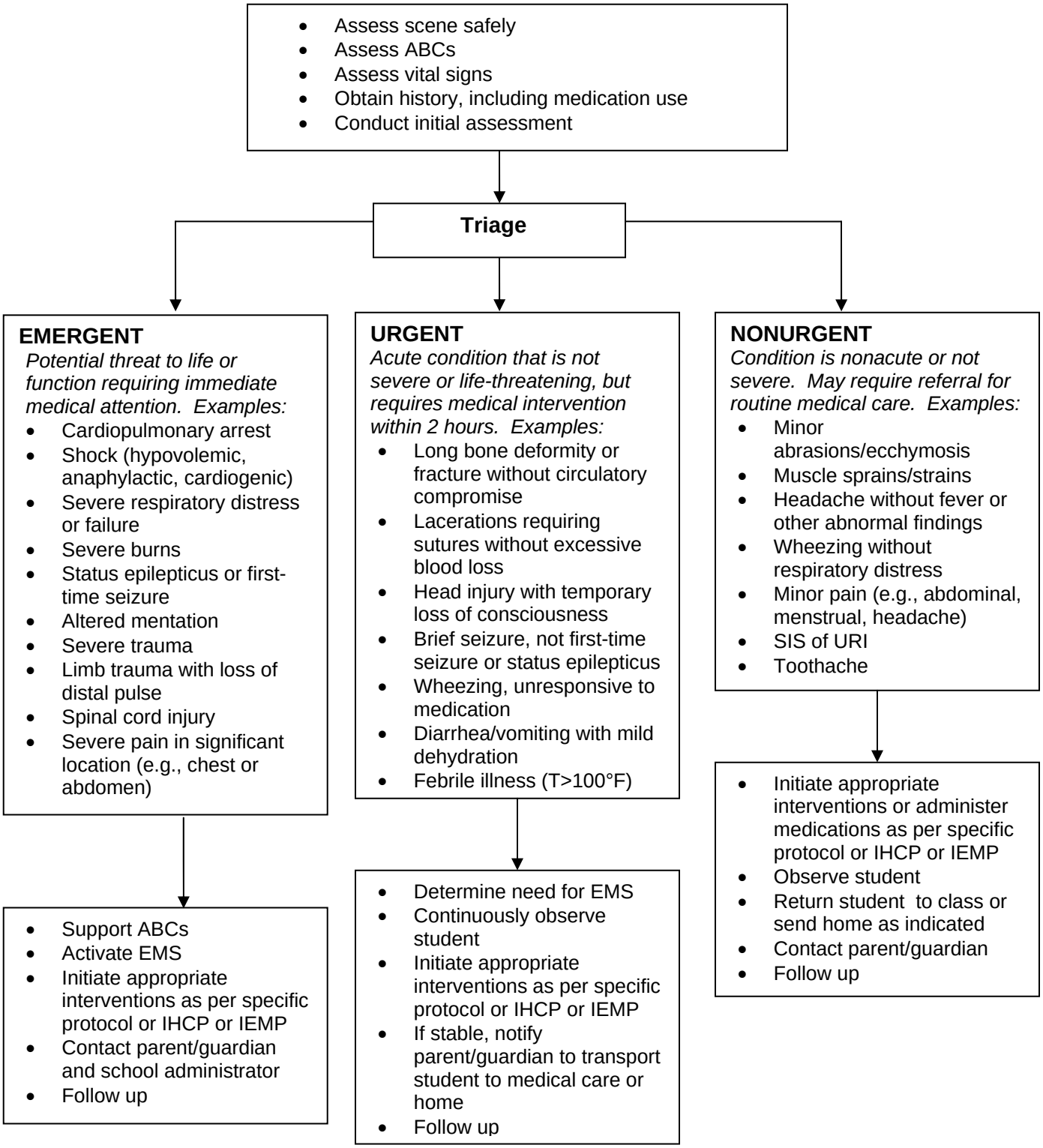
The triage decision is based on findings from the initial and detailed assessments, and allows one to formulate a nursing diagnosis, develop the plan of care, evaluate the student's response to interventions, and determine whether the student's health status has improved or worsened. The following table gives one a basis for disposition.

Evaluation	Disposition*
Emergent triage category	Monitor in health office and transport to emergency care facility via ground or air EMS
Urgent triage category	Monitor in health office and transport to emergency care facility via EMS, parent/guardian, or other adult as appropriate
Nonurgent episodic illness	Monitor in health office and transport to primary health care provider or home, as appropriate, via parent/guardian or other adult
Insect bite or sting with no evidence of anaphylaxis	Monitor in health office and transport to home via parent/guardian or other adult
Minor head injury with no loss of consciousness	Return to class while you notify parent/guardian; reevaluate subsequently
Essentially well with minor illness	Return to class

***Monitoring should be performed by school nurse.**

Source: Illinois Emergency Medical Services for Children, Maywood, IL, 2003. Adapted with permission.

INITIAL ASSESSMENT AND TRIAGE (Figure 3)



The School Nurse Task Force of the Illinois Emergency Medical Services for Children has exercised extreme caution that all information presented is accurate and in accordance with professional standards in effect at the time of publication. The information does not serve as a substitute for the professional advice of a physician; does not dictate an exclusive course of treatment; and should not be construed as excluding other acceptable methods of treatment. It is recommended that care must be based on the child's clinical presentation and on authorized policies.

Source: Illinois Emergency Medical Services for Children, Maywood, IL, 2003. Adapted with permission.

Importance of a Formal Emergency Plan

Schools should develop a detailed written plan to respond to individual and group emergencies in the school community, whether the emergencies are life-threatening or potentially life-threatening illnesses, injuries, and/or emotional and behavioral crises. The comprehensive emergency plan should:

- include building-specific plans as well as school district-wide plans;
- address before- and after-school emergencies; and
- be linked to local, state, and federal Emergency Management Systems (EMS).

All school staff and adjunct personnel should become familiar with the plan, which should be presented as part of both annual staff in-service training and new staff orientation. At a minimum, this training and the plan itself should spell out how school staff will:

- recognize that an emergency is occurring;
- implement the emergency plan;
- provide immediate first-aid care;
- remain with the injured person while summoning assistance;
- activate the local EMS system; and
- notify the parent/guardian or person identified as an emergency contact.

An emergency plan includes an algorithm designating individuals who will respond to an emergency, including the presence or absence of a school nurse.

Developing a Formal Emergency Plan

Legal/Regulatory Issues

This section provides a brief overview of *some* general laws relevant to prevention of intentional injuries and violence in Massachusetts public schools. For more detailed information on each law, please check the DOE website at http://www.doe.mass.edu, as well as other websites listed here.

What the Law Says

Requirements for formulation of a multi-hazard evacuation plan for school districts are codified in Section 363 of Chapter 159 of the Acts of 2000. It begins with the following:

> "Notwithstanding any general or special law to the contrary, the superintendent of each school district shall, prior to the beginning of the school year, meet with the fire chief and police chief of the city, town or district to formulate a school specific "multi-hazard evacuation plan" for each school under the superintendent's supervision. Said multi-hazard evacuation plan shall encompass, but not be limited to, evacuations for fires, hurricanes and other hazardous storms or disasters in which serious bodily injury might occur, shootings and other terrorist activities, and bomb threats. Said plan shall be designed for each school building after a review of each building. Said plan shall include, but not be limited to:
> (1) establishment of a crisis response team;
> (2) a designation as to who is in charge of said team and designated substitutes;
> (3) a communication plan;
> (4) crisis procedures for safe entrance to and exit from the school by students, parents and employees; and
> (5) policies for enforcing school discipline and maintaining a safe and orderly environment during the crisis.

Each district, with the assistance of the local police and fire departments, shall annually review and update as appropriate said plan. At the beginning of each school year, students at each school shall be instructed as to the plan that is developed."

Here are some links to additional resources for school safety and security:
http://www.state.ma.us/eops/publications/preplan.htm.
http://www.state.ma.us/eops/download/council_report.pdf.
http://www.ed.gov/offices/OSERS/OSEP/Products/earlywrn.html.

The first step in developing a basic written emergency plan is to convene an Emergency Planning Committee for the school. (This may be the same as or a subcommittee of the School Health Advisory Committee.)

The purpose of the Committee is threefold:

- bring together all of the individuals and agencies involved in providing emergency care;
- develop policies & protocols for individual and group emergencies; and
- develop policies & protocols to prevent emergencies from occurring or minimize their effect.

Participants should, at a minimum, include a school administrator, school health personnel (school nurse, school physician, school-based health center personnel (when applicable), etc.), guidance, intervention and adjustment counselors, educators, special program staff (e.g., industrial arts, consumer science, music and creative arts, laboratories), physical education staff (e.g., coaches, athletic directors), support staff (e.g., administrative assistants), activities advisors, food service staff, custodians, students, parents/guardians, and representatives of the local police, fire and health departments, ambulance service, and community hospital emergency department.

Once the Emergency Planning Committee is in place, its first priority should be to perform an emergency preparedness needs assessment in the school. This entails surveying both staff and community resources and assessing the infrastructure of the school.

It should also include identifying the potential for multicasualty and/or terrorism emergencies, based on the school's location (see also Chapter 13). School staff and community services personnel who are prepared to handle an emergency should be identified, and an inventory of these resources, their services, and response times should be compiled and documented. For example, this group should identify how many individuals on staff and within the community have completed the American Heart Association’s Heartsaver Automatic External Defibrillator (AED) Course and Heartsaver AED with Pediatric CPR Course**.** These courses teach the basic techniques of CPR, use of an AED, first aid for choking, and recognition of 4 major emergencies: heart attack, stroke, cardiac arrest, and choking.

Ideally, everyone on the school staff should be able to administer basic first aid. The Massachusetts Department of Public Health (DPH) recommends that, as a *minimum standard,* at least 5 persons trained in first aid/CPR be available in each school at all times when students are on the school grounds, including before and after school. The actual *suggested ratio* is 1 trained staff member for every 50 students (1:50). In high-risk populations, it is recommended that there be one first aid trained person for every medically or emotionally fragile person (1:1).

The Department also recommends that all coaches and athletic trainers, as a prerequisite for employment, should be trained in CPR and other first aid techniques, including Automatic External Defibrillator (AED) implementation*.* ***The school's emergency planning should include a system of assurance that CPR, first aid-trained individuals will be available*** *to respond to an emergent event at all times when the school facilities are open and in use.*

Information should be collaboratively exchanged between the school community and the surrounding community. Responding to emergencies requires a coordinated effort between the school district and local service providers (e.g., EMS, Fire, Police, ER). Representatives from each of these organizations should tour the school at the beginning of each school year, prior to the occurrence of any emergency, to familiarize themselves with all entrances and exits. As renovations occur, additional walkthroughs may be necessary to maintain current knowledge of the building layout. EMS providers should be made aware of the scope of special health needs (urgent and chronic) within the student population, without identifying individuals. (Written parental permission is required if individual health information is shared.) EMS providers should also be informed of any language, cultural, and/or religious diversities existing in the school that might affect their ability to provide basic or advanced life support, ensure scene safety, or transport patients to an appropriate health care facility.

Community EMS providers will be able to provide an assessment of the acceptability of the existing school and classroom layout in terms of emergency response requirements. In addition, it is essential to ensure that sufficient numbers of telephone lines are available to allow school personnel to place an outside call to the EMS system (including fire, police, and poison control centers). ***Procedures for accessing an outside telephone line should be defined and posted.***

When all of the critical information has been collected, the next step is the development of policies and protocols to be followed in case of an emergency. These policies should factor in any suggestions made by the community service providers and include the chain of command for decision making, as well as responsibilities for implementation of the emergency plan. Once the chain of command has been established and responsibilities have been defined, actual names must be attached to those itemized responsibilities. It is essential to identify school personnel who will assume responsibility for administering first aid, calling an ambulance (activating EMS), and notifying a parent/guardian or other emergency contact.

Clinically trained personnel (school nurses and nurse practitioners) should be the first responders to the scene when an emergency is identified. Include alternative personnel for backup if the school nurse is not readily available.

***Key components of the basic emergency plan include*:**

- plans to maintain the school emergency response preparedness and provisions for training the requisite number of staff members in universal precautions, CPR, the abdominal thrusts maneuver, automatic external defibrillators, and basic first aid;
  Note: This training should, as policy, also be offered to other school personnel and to students whenever possible. A list of trained individuals should be kept current and made available to administrators and school personnel.

- policies on first-aid and lifesaving protocols;
  Note: These should be published and widely disseminated.

- provisions for the distribution and posting of a list of life-threatening or potentially life-threatening or disabling situations;
  Note: This list should be provided to all staff members and be posted in visible and appropriate places, especially near entrances and exits and in gyms, hallways, the administrative offices, cafeteria, auditorium, and bathrooms. Protocols should include standards of care for specific and common illnesses and injuries. (Algorithms for an extensive list of specific injuries and conditions are available in the Illinois Emergency

Medical Services for Children document, *Guidelines for the Nursing in the School Setting,* at http://www.luhs.org/depts/emsc/Schl_Man.)

- protocols for the location and use of first aid supplies, as well as who will be responsible for maintaining the inventory of supplies;

- policies and protocols for the implementation of an AED (Automatic External Defibrillator) Program, which must be approved by the school committee;
  Note: These policies and protocols should, at a minimum:
  - meet the requirements of Massachusetts General Laws c.112 section 12V and 12V1/2, relating to public access defibrillation programs (refer to exhibits 2-15 and 2-16 for wording of the law and a sample AED policy);
  - ensure proper training for targeted responders that meets the standards of the American Heart Association or the American National Red Cross;
  - designate individuals responsible for equipment and accessory maintenance and replacement (daily, monthly, yearly);
  - allow for AED placement(s) within each school building with consideration given to convenient access to trained individuals before, during, and after school hours; and
  - identify a targeted source of revenue to assure sustainability of the program.

- provisions for the maintenance of a current emergency card for each student and staff member;
  Note: These cards should be kept in a centralized place, available and accessible to administrative and health care staff in case of emergency. At a minimum, information on the card should include medications, allergies, and a brief past medical history (see exhibits 2-17 through 2-19 for sample student cards). Written parental/guardian permission for emergency treatment of the student should be included, as should written parental/guardian permission to share information. In the case of staff emergency cards, the above information and their permissions should also be obtained. See Exhibit 2-20 for a sample employee emergency information form.

- policies and protocols for a range of possible events requiring a lock-down and the appropriate responses, while adhering to the emergency planning principles described previously;
  Note: A lock-down may occur when there is a potential threat, either internal or external, in accordance with local emergency protocols. Because students and faculty may not be able to leave the premises for an extended period of time, it is critical to pre-plan for meeting their health care and medication administration needs. Sufficient medications and supplies need to be maintained at the school. See Exhibit 2-21 for a sample student 24-hour shelter emergency medication and care plan.

- policies and protocols for dealing with a behavioral health emergency;
  Note: In the event of a behavioral health emergency (e.g., student suicide, attempted suicide), refer to Chapter 11.

- communication plans and protocols for emergencies (e.g., cell phones, walkie-talkies);

- telephone numbers of the local EMS system and the process for accessing an outside telephone line, both of which are to be prominently displayed at all telephones in the school;

- policies for the publishing of emergency plans for special school situations, such as before- and after-school activities, school bus incidents, field trips, and sporting events;
- protocols for adult supervision in both high-risk and normal-risk areas;
- schedules for practice/drills and review of both individual and group emergency procedures (no less than once a year);
- protocols for recognizing signs of impending violence;
- a clearly defined protocol for informing the public and media to: (a) prevent erroneous information from being disseminated and (b) ensure that the public and parents/guardians are receiving accurate and consistent information; and
- language requiring debriefings after the emergent situations are resolved.

Group Emergency (Multicasualty) and Disaster Plans

Planning for group emergencies is a significant component of a school's comprehensive emergency plan. It is critical to have policies and protocols in place to address disasters, such as fires, explosions, gas or hazardous materials leakages, weather hazards, or bioterrorism threats, which may result in multiple casualties. These policies and protocols should be determined in collaboration with community representatives. The local EMS provider, with consultation from state and federal emergency services, and the local board of health, in partnership with the state Department of Public Health, should participate in designing the plan. They should always be notified in the event of a disaster or a large-scale incident. School personnel should learn how to deal with possible casualties, as well as how to provide emotional support for students, families, and staff during and after the disaster. Recent multicasualty experiences have shown that disasters of great magnitude often overwhelm the affected population and invalidate the emergency preparedness plan in place.

The Massachusetts Emergency Management Agency (MEMA) requires every city and town to have a community disaster plan. Schools should contact local boards of health and fire and police departments to assure the school's inclusion in the community disaster plan. School buildings may be designated as evacuation, treatment, or dispensing sites and must be prepared to handle the housing of large numbers of displaced residents, mass immunization, or triage.

Included in schools' plans for group emergencies should be policies governing how a community disaster is determined, how local authorities are contacted, how the school should be organized and evacuated to pre-determined sites, how transportation will be identified and mobilized, and how parents/guardians should be notified about the evacuation. Predetermine the chain of command and identify participants' roles (e.g., who will communicate to the media, who will provide crowd control).

The following websites contain materials to assist schools and communities to plan for multicasualty emergencies:

- http://www.mass.gov/dph/topics/bioterrorism/bt.htm (DPH Emergency Preparedness and Response)
- http://www.mass.gov/dph/fch/emsc/emerplan.htm (DPH *Developing an Emergency Response Plan for Your School: Guidelines***)**
- http://www.ed.gov/admins/lead/safety/emergencyplan/index.html (U.S. Department of Education's emergency planning site for schools)

- http://www.vaers.org
- http://www.bt.cdc.gov/agent/smallpox
- http://www.cdc.gov/smallpox
- http://www.cdc.gov/nip
- http://www2.cdc.gov/nip/isd/spoxsh/launch1.html (CDC Smallpox Vaccine Storing and Handling)

A community listing of Emergency Management Directors may be found on the MEMA website, which can be accessed through the Massachusetts state government portal: http://www.mass.gov.

Special Considerations

Children with special health care needs: Each child who has a critical or potentially life-threatening special health concern should be identified and have an individual health care plan (IHCP) that anticipates possible emergency situations, with a response algorithm to the emergency clearly defined. With parent/guardian permission, inform the local emergency medical service of the above health care plans. Include a plan designating the appropriate hospital of destination for each child (see Chapter 7).

Emergency medications for allergic reactions: *In an emergency in which the child has a known allergy or preexisting medical condition, epinephrine (as prescribed by the child's licensed provider) may be administered by the school nurse or a person authorized to administer epinephrine by auto injector in accordance with 105 CMR 210.000.* (See Chapter 6 for more information on administering medications.) Because of the danger of biphasic reactions, trained emergency medical personnel should transport all individuals receiving epinephrine to the local emergency medical facility (see Chapters 6 and 7 for additional information).

For any individual with *no* previous history of life-threatening allergic reactions, the use of epinephrine as an emergency medication requires *written protocols and a written order from the school physician.* **Each school should ensure that this standing order and protocol are completed, signed, and in place.** Only a licensed person (school nurse) may administer epinephrine to a person who has *no* previous history of a life-threatening allergic reaction. If the school nurse is unavailable, the school must immediately activate the EMS system, provide first aid as applicable, and then notify the school nurse and the parents/guardians. Anyone who has received epinephrine treatment must be transported by trained emergency personnel to a hospital emergency facility immediately, via ambulance. Upon the student's return to school, the school nurse should develop an individual health care plan and ensure that a policy for the care of the child with a life-threatening allergy is in place (see Chapters 6 and 7 for details, including required reporting).

Note: Managing students with life-threatening allergies offers an excellent opportunity for school nurses and emergency room nurses to collaborate.

Use of oxygen in the school setting: Generally, oxygen is not appropriate for emergency use in the school setting. It is a treatment that requires a physician's order for a specific child with a specific diagnosis. In some school districts or communities where emergency medical services may not be readily available, schools may consider protocols, as defined by the Board of Registration in Nursing, which permit oxygen to be used in emergency situations until the emergency medical services arrive. These protocols must be clearly delineated and signed by the school physician. Nurses must be trained in administration of oxygen treatment, the use of pulse oximeters, and recognizing signs of hypoxia.

Oxygen is highly flammable. If it is to be stored in school, the local fire department should be notified and requested to visit the school to make recommendations for storage and maintenance, with appropriate signs posted and precautions in place.

Special populations in a group emergency: As schools work with their local partners (e.g., local emergency management directors, boards of health, police and fire departments) to enhance their community's Comprehensive Emergency Management Plan, it is very important that special populations be included in planning efforts. The Massachusetts Department of Public Health's Center for Emergency Preparedness (DPH CEP), through its Special Populations work group, has developed a guide to assist this process. The guide is intended to be an evolving document and should be revised, based upon community-specific needs and populations. Because hyperlinks are provided for many of the resources, this document is best viewed electronically. It may be found at: http://www.mass.gov/dph/bioterrorism/advisorygrps/pdfs/spop_guidance_5_05.pdf.

Psychosocial implications of responding to an emergency: Emergency planning should also include provisions for any critical event precipitating a widespread psychosocial response. Protocols should be developed for a team approach to respond to the needs of students and staff in the event of a death, serious injury, or serious illness within the school community. As more students with DNR (Do Not Resuscitate) Orders attend school, such planning becomes even more critical (see Chapter 7 for more information about DNR orders and the Comfort Care/DNR Order Verification Program). However, precipitating events may also include suicide; violence in the school; terrorism threats and actions; or the sudden death of a student, faculty, or family member (see also Chapter 11).

The school should determine internal and external resources ready to provide psychological and emotional assistance (e.g., guidance and adjustment school counselors, school nurses, physicians, community mental health counselors, social workers). This group should be convened as an emergency preparedness crisis team on a regular basis to evaluate potential emergencies to which the team would be called to respond. *Establish a communication chain that could be activated with little advance notice. Include participants who would be available during the school day, before and after school hours, and during the weekend, as needs dictate.*

Distributing and Maintaining the Emergency Plan

The emergency plan should be approved by and distributed to all members of the emergency planning committee. After approval by the school committee, it should be distributed to all constituents of the local EMS system.

All school personnel, including temporary or substitute faculty members, should be provided with a copy of the written emergency plan. Provide an annual staff in-service for a review and discussion of life-threatening or potentially life-threatening or disabling situations, with discussion of staff responsibilities and resources available in an emergency.

Review, evaluate, and revise the emergency plan annually, or more often if an emergency has occurred. The school committee, school administrator, and school health personnel should sign and date the approved plans, as should other members of the emergency planning committee.

Conduct periodic drills to determine effectiveness of the plan, identify strengths and weaknesses, and make appropriate modifications. If an actual emergency occurs, the school should conduct a debriefing. This supports the measures taken and provides an opportunity to improve the plan prior to the next event. It also provides an opportunity for participants to share experiences and gain mutual support.

Recordkeeping and Documentation

Recordkeeping is essential to an emergency preparedness program. Records are vital for settlement of insurance claims, to protect school personnel against charges of negligence, and to plan prevention programs. Forms should be developed that include the date, time, place, and nature of the incident; general condition of the victim; what care was administered, by whom, when, and where; and the school's disposition of the case (i.e., to whom referred, if anyone). Forms also should include places for appropriate signatures. Per school policy, forms may be completed in duplicate by school faculty at the scene of the incident and filed in the principal's and nurse's offices. Each report should be placed in the appropriate student's health record. Some school districts require forms to be completed in triplicate, with one copy filed in the superintendent's office. Schools may also wish to provide a copy to the person(s) affected in the emergency. (See discussion of HIPPA and FERPA later on in the chapter.)

Incident reports should be reviewed periodically by school health personnel and administrators to determine the location and nature of incidents. A plan should be developed to prevent or minimize future injuries due to environmental or activity-caused factors. (Please see Chapter 13 for further discussion of injury prevention and risk reduction.) A review of emergency situations could be assigned to a subcommittee of the School Health Advisory Committee, which would then recommend implementation of proposed interventions to both school administrators and school health personnel.

What the Law Says

School personnel who provide first aid in good faith (first aid that is reasonable under the circumstances) to a student in an emergency are protected from civil liability by the following provision of M.G.L. c.71, s.55A:

> "No public school teacher and no collaborative school teacher, no principal, secretary to the principal, nurse or other public school or collaborative school employee who, in good faith, renders emergency first aid or transportation to **a student** who has become injured or incapacitated in a public school or collaborative school building or on the grounds thereof shall be liable in a suit for damages as a result of his acts or omissions either for such first aid or as a result of providing emergency transportation to a place of safety, nor shall such person be liable to a hospital for its expenses if under such emergency conditions he causes the admission of such injured or incapacitated student, nor shall such person be subject to any disciplinary action by the school committee, or board of such collaborative for such emergency first aid or transportation."

***First aid* is defined as immediate, temporary care provided to the victim of an injury or illness, until the service of a physician can be obtained.** This care includes cardiopulmonary resuscitation (CPR), abdominal thrusts for choking victims, and other life-saving techniques, such as the use of Automatic External Defibrillators (AEDs). *As a general rule, there is no legal duty outside the school context to aid a person in distress or danger.* However, within the school setting, school personnel have a duty to provide reasonable assistance to an injured or ill student.

See Chapter 5 for discussion of the State Tort Claims Act, M.G.L. c.258, s.2. This law provides that public employers "shall be liable for injury or loss of property or personal injury or death caused by the negligent or wrongful act or omission of any public employee while acting within the scope of his office or employment..."

SCHOOL HEALTH FACILITIES

The overall environment of the school health facility should be designed to promote the well-being of students, while providing a wide range of services. Students consult with the school nurse about a variety of health concerns, including an assessment of a health issue, medications and/or treatments, educational materials, first aid and/or emergency care, and assistance with psychosocial/behavioral health issues. School health facilities should be designed to meet the increasingly complex and diverse student health needs. They also must be prepared to expand in size if large numbers of students seek health services. Privacy considerations for treatments and counseling are of paramount importance. As the school health service programs are increasingly coordinated with the health service delivery system serving children, school nurses need advanced communication technology to manage information, communications systems, and data systems.

When choosing or renovating a space for the health facility, consideration should be given to a number of factors, including:

- projected school enrollment;
- the number of staff;
- the availability of a nurse's workstation with appropriate electronic communications systems;
- the need for a private treatment and consultation area, with space for clinical technological equipment; and
- the need for storage space.

The ideal location for the health facility is close to the school's guidance and counseling services. Proximity promotes the team concept of health care delivery, facilitates referrals of students, and ensures confidentiality. In planning new facilities, consideration should also be given to making the space flexible, so that additional services (e.g., oral health, behavioral health, and nutrition counseling) may be added.

Functions of a School Health Facility

The school health facility provides a safety net during the school day for children and adolescents with physical and psychosocial/behavioral health needs. In this role it serves multiple functions with specific facility requirements. Functions include:

- office for the school nurse managing the health of the student population;
- assessment area;
- medication dispensing area;
- first aid and emergency care treatment area;
- temporary isolation area for students who are suspected of having a communicable disease or are awaiting transport home or to another facility;
- resting areas for students who are ill or injured (Although most students are returned to class, some must remain, because of illness, in the health suite until the arrival of parents/guardians.);
- a service area for such procedures as immunization administration and vision, hearing, and postural screening;
- a private conference space for counseling and guidance, as well as meetings with parents/guardians, students, and team members;
- a secure area for storing student health records;
- a resource center for health education materials;
- a storage area for health supplies and equipment; and
- a secure area for medication storage.

The following are recommended features of a basic essential school health facility. See Exhibit 2-22 for 2 sample floor plans — one for a school health suite and one for a school-based health center. See Chapter 4 for information on building codes.

Recommended Features of a Basic Essential Health Facility

Ideal Location/Physical Layout:

- is reserved for health purposes only;
- is adjacent to administrative offices and guidance and counseling services;
- is in a quiet part of the school building, away from playgrounds, music rooms, gymnasium, or noisy machinery; and
- allows for individual privacy.

General:

- air-conditioning and adequate ventilation;
- excellent lighting (50 foot-candles or more), with adjustable overhead lights in rest areas, in a closet, and over the first-aid station;
  Note: Lighting may be defused with the use of environmentally approved deflectors.
- natural light from windows;
- private examination and consultation room with examination table;
- adequate private rest areas with beds or cots for students, preferably with washable surfaces;
  Note: The number of rest spaces should be based on student enrollment and frequency of use. Rest areas should be visible from the nurse's station and fitted with an outlet for their own light source. Folding screens or draperies should be available to provide privacy in the rest area.
- an examination room soundproofed for audiometric (hearing) tests;
- sound-absorbing ceilings and walls in all areas, as well as adjustable door closers to eliminate excess noise;
- at least 15 feet of unobstructed space available for screening programs;
  Note: Screenings may take place in another part of the school building that meets these specifications.
- first-aid station with washable (preferably stainless steel) counter tops, under counter drawers for storage, and over counter hanging cabinets with see-through sliding doors; and
- flooring — washable surface, no carpet.

School Nurse Office Space:

- separate furnished office space, preferably with a door that can be closed;
- communication area adjacent to nurse's desk, fully equipped with computer, software, facsimile machine, printer, dedicated telephone line, and additional telephones as needed;
  Note: Consideration should be given to preserving confidential exchange of information.
- bookcase(s) stocked with labeled and accessible health promotion materials, health-related textbooks, and information on referral agencies; and
- filing cabinets that can be secured and locked for storage of current health records, emergency response cards, and daily maintenance files.

Waiting Area:

- adequate seating, based on student enrollment and frequency of use;
- wall space with room for educational posters; and
- rack for pamphlets and other current health information, either fastened to the wall or free-standing.

Plumbing/Sanitation:

- adequate plumbing to ensure hot and cold running water for assessment and treatment area;
- at least one handicapped-accessible toilet facility with hot and cold running water;
- private lavatories adjacent to examination room, with toilets, toilet paper, sinks with hot and cold running water, foot-operated soap dispensers, paper towels, and pedal-controlled waste receptacle lined with polyethylene bag;
- pedal-controlled, covered trash receptacles, lined with polyethylene trash bags at various places throughout the facility;
- hospital faucets (with long handle on/off levers and overhanging spout faucet) in lavatories and first-aid station;
- filled wall-mounted paper towel holders and air hand dryers adjacent to all sinks in lavatories; and
  Note: Motion sensor equipment should be considered for both handwashing and drying.
- easily cleaned hard surfaces on floors and walls, with availability of disinfectant and bleach cleaning materials.

Storage/Supplies:

- storage closet with countertop along one wall and a secure, wall-attached, double-lock medicine cabinet (either inside or outside closet);
- refrigerator specifically designated for storage of medication and cold packs;
- blankets, sheets, pillows, and disposable pillow paper covers; and
- sharps container for disposal of hazardous medical waste.

Electrical:

- double electrical outlets throughout the unit; and
- surge protectors.

Movable Equipment:

- automatic external defibrillator;
- clock with a second hand;
- magnifying light (either table or floor model);
- nebulizer (for inhalation therapy) with disposable accessories;
- oto/ophthalmoscope;
- physician's scale with height rod or stadiometer;
- portable first-aid kit;
- pure tone audiometer;
- sphygmomanometer (calibrated annually) and appropriate cuff sizes;
- stethoscope;
- stretcher;
- two-way communication device (walkie-talkie);
- vision testing equipment, such as Random Dot E and HOTV tests, consistent with current standards (see Chapter 5); and
- wheelchair.

Suggested First Aid and Other Supplies:

- ace bandages;
- airway/Ambu bag;
- baking soda;

- band-aids;
- bandages (various sizes);
- backboard;
- basins;
- batteries;
- cold packs/hot packs/heating pad;
- cotton-tip applicators (swabs);
- cotton balls;
- crutches;
- disinfectant for surfaces and spills (approved by the U.S. Environmental Protection Agency);
- disposable diapers (may be used for compression);
- disposable gowns;
- EpiPens® (adult and junior) with expiration dates checked regularly;
- eye cup;
- eye pads;
- eye wash solution;
- flashlight/penlight;
- latex gloves and nonlatex gloves;
- magnifying glass;
- masks;
- paper cups;
- paper towels;
- peak flow monitors;
- pediculosis combing tools (i.e., LiceMeister®);
- pulse oximeter (optional);
- record forms (emergency cards, physician order forms, medication administration forms, accident/incident reports, asthma action plans, state forms, etc.);
- ring cutter;
- salt;
- sanitary pads, individually wrapped (may be used for compression);
- scissors (blunt end);
- slings;
- soap (preferably in dispenser);
- splints/ finger splints;
- surgipads;
- tape (different widths, as well as nonallergic tape);
- thermometer (disposable) or other mechanism for measuring temperature, such as temp dots;
- tissues;
- tongue depressors;
- triangular bandages;
- tweezers;
- vinyl gloves (for latex allergies);
- walkie-talkies or other communication device; and
- washcloths (disposable).

Note: School nurses may wish to have a portable bag with critical emergency and communication equipment that can be carried to the site of an emergency (e.g., athletic field).

Further guidance regarding these recommended features will be available on the School Health website when the revised regulations are completed: http://www.mass.gov/dph/fch/schoolhealth/index.htm.

General Requirements for a Health Facility Providing School-based Primary Care Services (School-based Health Center)

A school-based health center (SBHC) that is operated by a hospital, clinic, or community health center is licensed (M.G.L. c.111, s.51) as a satellite clinic of that health care facility. The following are the basic physical plant requirements for clinic licensure (which are the responsibility of the licensed entity), as defined by DPH health facility licensing regulations:

- waiting/reception area with public telephone and public drinking fountain;
- offices, including space for secure records storage;
- nurses' area with medicine preparation/storage and hand-wash sink;
- examining room with 80 square feet, hand-wash sink, and privacy for sight and sound;
- utility room with flush rim sink, hand-wash sink, and work counter;
- storage for equipment and linen, with separation of clean and soiled;
- janitor's closet with service sink;
- toilet facilities;
- ventilation for all rooms without operable windows and for janitor and toilet rooms;
- handicapped access;
- corridors 5 feet wide; and
- doors 2 feet, 10 inches wide.

Plans for the SBHC must be sent to the DPH Bureau of Health Care Systems, Division of Health Care Quality, for approval. No renovations should take place until the department approves the plans.

Clinics with existing space, to which renovations are not planned, must provide the following:

- dimensioned plan with all functional areas identified;
- information about heat, light, and ventilation; and
- information about required spaces that are not provided within the clinic.

Clinics planning renovations must provide the following:

- construction documents for the area to be renovated, with functional areas identified;
- architectural, plumbing, mechanical, and electrical plans; and
- copies of plan approval from the Department of Public Safety and the local building inspector.

SCHOOL HEALTH RECORDS

Each student must have a health record. This legal record should contain accurate and complete demographics, immunizations, licensed provider orders, the health care plan, problems or concerns to which plans are addressed, sequential narrative notes, services and treatments provided, and outcomes of specific procedures or interventions. It should contain an accurate and complete database. The format, whether paper or electronic, should be sequential and consistent. See the DPH website for school health record forms in PDF and Word: http://www.mass.gov/dph/fch/schoolhealth/health_record.htm

The value of the health record lies in the information it contains and the manner in which it is used. An effective written account of the facts and events related to the individual's health should focus on

the student and his/her needs. It must be accurate, cumulative, specific, objective, and confidential. A problem oriented health record, sometimes called a positive oriented health record (POHR), establishes a legal, consistent format for documenting and communicating the health status, problems identified, and services provided to the individual student. If immunizations are administered by the school nurse, the records for these immunizations must be kept for 30 years.

What the Law Says

> "Under M.G.L c.71, s.37L, the sending school of any student transferring into a new school district must provide the new district with "a complete school record," which includes the original copy of the student's health record. Student health records (in or out of district) should be sent to the school nurse. This can be facilitated by placing the student health record in a sealed envelope with a notation on the front: "Attention School Nurse: Confidential Records" or "To be opened by the School Nurse of _____ District". A copy may be retained at the sending school to facilitate re-entry of said student at a later date. The original health record and the copy shall be destroyed no later than 7 years after a student transfers, graduates, or withdraws from the school. Written notice to the eligible student and his/her parent of the approximate date of the destruction of the record and their right to receive the information, in whole or in part, shall be made at the time of such transfer, graduation, or withdrawal. (See Massachusetts Department of Education Student Records: Questions, Answers and Guidelines, September 1995, which is available online at http://www.doe.mass.edu/lawsregs/advisory/cmr23qanda.html.)"

If records are computerized, the Massachusetts Department of Public Health recommends that each child should have a paper file that includes at a minimum (a) the Massachusetts School Health Record face sheet with a statement indicating that all pertinent information is electronically filed, (b) the licensed prescriber's physical examination form and medication and treatment orders, (c) parent/guardian consent for treatment and sharing information, if appropriate, (d) incident reports (per school policy), (e) laboratory reports, (f) health-related correspondence, and (g) other paper forms that cannot be electronically transmitted and/or have the original signatures. Student records that are electronically maintained may be retained in electronic form until the student withdraws, transfers, or graduates from the school system, consistent with the DOE Student Record Regulations. When the student transfers or withdraws, the computer printout may go with the student. (For further information on computerization, see section on Systems Development later in this chapter.)

Components of the School Health Record

The following components of the Massachusetts School Health Record are mandated by law (M.G.L. c.71, s.57). The first three (Massachusetts School Health Record and memo; Health Care Provider's Examination Form, memo, and certificate; and Massachusetts Immunization Information System Certificate) can all be found on the DPH website: http://www.mass.gov/dph/fch/schoolhealth/health_record.htm

- *Massachusetts School Health Record (Includes an explanatory memo and face-sheet.* The form is used for all entering students. It documents identifying and emergency information, the results of population-based screenings (vision, hearing, postural, BMI, etc.), referrals for failed screenings, and other pertinent information.
- *Massachusetts School Health Record: Health Care Provider's Examination* is used for all physical exams (initial, subsequent, prior to participation in competitive sports, and prior to obtaining a work permit) performed by the primary care provider. The Health Care Provider's Examination form also includes the record of immunizations. Up-to-date versions of the following forms are found on the DPH website: (a) explanatory memo for use of the form, (b) Sample Health Care Provider's Examination form, and (c) sample immunization certificate.
- *Massachusetts Immunization Information System Certificate or other immunization record*

- *meeting the state requirements:* documents the immunization history.
- *Abnormal Findings Notification* documents parental notification of abnormal findings from school physical exams and feedback from the private physician.
- *Progress Notes* document encounters, communications, and home visits that may impact the student's learning and optimal well-being.
- *Growth Charts or Body Mass Index Records with Referral Information* document height and weight measurements by plotting on a standardized, sex-specific growth chart. The importance of graphing lies in the adequate interpretation of the student's growth status and early identification of those students at risk, who may need referral for further assessment. (See Chapter 5 exhibits for these charts and the growth screening section of that chapter for discussion of screening protocols.)

Other health-related information that may become part of the student's cumulative health record includes any documentation of interventions, services, and communications that may affect his/her learning. Incident/Injury/Crisis Reports may be included, as determined by school policy. See Chapter 6 for medication administration forms and Chapter 7 for Individual Health Care Plan form. Other general health-related documentation that may be maintained by the nurse includes delegations to unlicensed staff; in-service training; building or grounds inspections; health activity assessments, reports, or summaries; data reports; and/or program evaluations.

Documentation of Records

Documentation is the preparing and assembling of written records to authenticate health care provided to the individual student and the reasons for providing such care. According to standards of nursing practice, documentation should be accurate, objective, concise, and well organized. It must be legible, written in ink, have the signature of the person writing the entry, and be current with date and time of each entry. It also must be comprehensive, including all relevant statistics, problem statements, observations, assessments, actions, and outcomes.

Proper documentation is essential to communication and should demonstrate collaboration, coordination, and continuity of health care, including communication with parents/guardians. It is especially useful when:

- a student enters school;
- a student is promoted or transfers from one school to another;
- a student has a health encounter with the school nurse;
- a student's health status changes; or
- a student receives treatments or medications.

In addition, the nurse should document when:

- making referrals to other health care providers or coordinating care with health care agencies or practices, consistent with FERPA and HIPAA regulations;
- conducting personal health counseling or education;
- participating in nurse-parent/guardian or nurse-teacher conferences and team meetings; or
- there are legal issues or concerns.

Documentation organizes material and approaches student health in a systematic and retrievable format that facilitates the application of the scientific process (also called the nursing process). Recognizing the inter-relatedness of problems may help predict and thus prevent problems by highlighting risk factors.

Documentation ensures continuity of care, demonstrates accountability, provides a tool for quality assurance, and substantiates the level of care for legal purposes. Recording care demonstrates

compliance with professional standards described in the Nurse Practice Act, which is applicable to all settings where nurses are employed. The school nurse may be liable if the care provided is not clearly documented. The old adage, “If it's not documented, it was not done" emphasizes the importance of documentation when legal questions arise. Finally, in addition to the necessary recordkeeping for the individual student, documentation also furnishes useful aggregate data for appropriate evaluation and research, thus promoting evidence-based school nursing practice.

Confidentiality of Student Health Information

School health records are temporary records governed by the Massachusetts Department of Education's record regulations: Student Records, 603 CMR 23.00. Maintaining and accessing school health records must also adhere to the federal Family Educational Rights and Privacy Act of 1974 (FERPA). In addition, certain transactions may have Health Insurance Portability and Accountability Act (HIPAA) implications.

The Effect of HIPAA on School Health Programs

Many school nurses have expressed concerns about the effect of the Health Insurance Portability and Accountability Act’s Privacy Rule (HIPAA) on school health programs. Questions have also been raised regarding the interplay of HIPAA and FERPA.

How HIPAA affects a school health program is dependent on whether the program is administered by an education institution that receives federal funds under any program administered by the U.S. Secretary of Education. If so, the privacy of any health information maintained by the program will not be subject to HIPAA’s privacy requirements. Rather, the information will be subject to the requirements of FERPA, and any corresponding state regulations (e.g., 603 CMR 23.000). Thus, for these programs HIPAA does not apply to any health information in the student's health record and in a nurse’s personal notes.

However, educational agencies or institutions that do not receive federal funds are not subject to FERPA’s requirements. Thus, a school health program at a privately funded educational institution may not be covered by FERPA, and under certain circumstances may have to comply with HIPAA’s requirements.

A more complete discussion of HIPAA and FERPA as they relate to school health records, including applicable legal references, any updates, and answers to commonly asked questions about HIPPA, is available at: http://www.mass.gov/dph/fch/schoolhealth/hipaa_info.htm.

The Impact of Confidentiality Requirements on How and Where Records are Documented

Health professionals are legally and ethically bound to document all treatment provided to individuals under their care. Records kept by the school nurse pertaining to a student's health status and medical care may be regarded as medical records or as part of the educational record. Depending upon how a record is characterized, it may be subject to differing requirements as to maintenance and confidentiality. As a consequence, the school nurse needs to consider carefully issues of documentation and confidentiality.

As more health care is delivered in the school setting, the following questions may arise:

- What constitutes a medical record, to which the principles of confidentiality apply, versus an educational record, governed by student record regulations?
- How should school nurses document the care they provide?
- How should nurses ensure confidentiality of this information?

Recognizing the complexity of these issues, both state and national agencies are beginning to address the many questions raised by the schools. In general, records kept by the school nurse

pertaining to a student's health status and clinical care should be documented as either part of the student's health record or as separate documentation to be retained in the school nurse's personal notes. *Depending upon how information is documented, it may be subject to differing maintenance and confidentiality requirements.*

Health Information That Should Be Part of the Student's Health Record

Health care information that is relevant to the student's educational progress should be entered into the student's health record. (See Department of Education regulations governing student records: 603 CMR 23.000). This information includes medication administration, nursing care/treatments, special diet, and impaired vision or hearing — provided such information is not of a type that should be protected from disclosure (see the discussion below on private notes).

Student health records are considered part of a student's temporary record and as such are protected from disclosure to third parties without the written consent of an eligible student or parent/guardian. Consistent with the current temporary records regulations, these records are accessible to an eligible student, the student's parents or guardians, and authorized school personnel as discussed below. Relevant student health information may be disclosed to public health officials if warranted by an outbreak of a serious disease in the school or community.

The school nurse, whether employed by the school committee or board of health, is responsible for keeping these records. For written records, the school should have policies regarding safe storage (locked cabinets) and a protocol for accessing the records. If the student health record is maintained electronically, the record should be protected by security measures, such as the use of passwords, limiting access to authorized school health personnel.

Communication of Student Health Record Information to Other Authorized School Personnel

There may be circumstances in which there is a need to share information in the student health record with authorized school personnel — either to enhance the educational progress of the student or protect his/her safety or well-being. For example, staff may need to be alerted to signs or symptoms of a medical problem and offered a course of action. This type of disclosure should be made only to those authorized school personnel who work *directly with* the student in an instructive, administrative, or diagnostic capacity. It is important to stress that *only the minimum necessary information* should be disclosed to other school personnel under these circumstances. For example, this information should not be shared in a public written list that is posted or circulated to all educators. Finally, authorized school personnel should be instructed not to re-disclose the information.

If there is any question about the sensitivity of the information in the student health record, the permission of the parent/guardian and student, if appropriate, should be sought prior to disclosure to authorized school personnel. Ultimately, however, federal regulations permit information in the student health record to be seen by authorized school personnel, and the basis for such sharing seems even more compelling when necessary to protect the well-being or safety of the student.

Health Information That Should be Documented as Part of the Nurse's Private Notes

Not all health information belongs in the student health record. While it is appropriate practice for a nurse or other health professional to document observable facts with respect to a health condition, health needs, treatment plan, and the care provided, some information is not sufficiently related to the educational progress of a student to be appropriate for documentation in the student record. In addition, health professionals may have an ethical and legal duty to protect certain medical information which they possess. Placement of medical information in the school record, where persons other than the school nurse may see it, may violate this duty.

Specific Statutory Protections for Confidential Information

There are a number of statutes that create a duty to protect the confidentiality of medical information pertaining to diagnosis and treatment of a minor. Most of these statutes do not specifically address the duty of nurses or the provision of care in a school setting. The statutes do indicate a legislative intent to encourage minors to promptly seek certain types of medical diagnosis and treatment, in part by their being assured that information related to that treatment will be protected as confidential.

For example, M.G.L. c.111, s.70F, prohibits health personnel, including nurses, from disclosing HIV test results, or even the fact that someone has been tested, without the consent of the test subject. Similarly, M.G.L. c.112, s.12F, creates a category of "emancipated minors" who are given legal authority to make decisions about their own medical diagnosis and treatment. For example, a minor who believes s/he has been exposed to a dangerous disease (e.g., a sexually transmitted disease) or a minor who believes she is pregnant may legally consent to diagnosis and treatment without parental involvement. In such cases, the statute requires that the information be held confidential between the treating physician and the minor. Such information may be released only with consent of the minor or a judicial order; it must be disclosed if the life or limb or the minor is endangered. Other sensitive information (e.g., treatment for substance abuse) has similar protection.

Use of a Health Professional's Personal Notes

Many of these laws do not specifically apply to nurses or many school nursing activities, but still indicate a general legislative intent to protect the confidentiality of certain types of information pertaining to care of minors. In addition, there is a statute (M.G.L. c.214, s.1A) that protects everyone in the Commonwealth from an “unwarranted” invasion of privacy. The wording of the statute suggests that there must be a solid justification for disclosure of personal information, particularly if it is of a sensitive nature.

Given these statutes concerning confidentiality, it is recommended that information of the types covered by the statutes (and other sensitive material) be placed in a nurse's personal files and regarded as confidential. According to Department of Education regulations, 603 CMR 23.04, information maintained in the personal files of a school employee, if not accessible to or revealed to school personnel or third parties, is not considered part of the school record. Such information may be shared with the student, parent, or a temporary substitute of the maker of the record but otherwise should be released only with proper consent or court order. Such records should be kept in a separate locked file, accessible only to the nurse or the nurse's substitute. Federal regulations provide that once information in a nurse’s personal files is disclosed to a third party, it must afterwards be included as part of the student’s health record and will subsequently be subject to all the provisions of 603 CMR 23.00

Note: Physician's records and records of school-based health centers are not considered school health records and are subject to unique confidentiality protections afforded medical records.

Disclosing Information to Protect Health or Safety

Regardless of the discussion above, there may be times when a school nurse has the legal obligation to disclose health or related information to protect a student’s health or safety. In particular, M.G.L. c.119, s.51A, requires a school nurse to file with the Department of Social Services a report when there is “reasonable cause to believe” that a student under 18 “is suffering physical or emotional injury resulting from abuse inflicted upon him which causes harm or substantial risk of harm to the child’s health or welfare including sexual abuse, or from neglect, including malnutrition…” (see also Chapter 13). The statute provides that school staff shall immediately notify the school department or person in charge of the school.

In addition, for a minor who obtains medical care as an "emancipated minor" under M.G.L. c.112, s.12F (see above), there is a legal requirement that the physician notify the parents or legal guardian of the minor if the physician "reasonably believes the condition of said minor to be so serious that his life or limb is endangered." As noted above, the statute does not specially address the duties of a nurse in this situation but does indicate a legislative intent to protect a minor facing an immediate threat to life or limb.

This approach seems consistent with a decision of the Massachusetts Supreme Judicial Court, Alberts v. Devine, 479 N.E. 2d 113 (Mass., 1985), which held that a physician generally owes a patient a duty not to disclose medical information about the patient without consent. The court, however, recognized an exception allowing (but not requiring) disclosure when there is a "serious danger to the patient or to others." While there is no comparable case law with respect to nurses, the case suggests that public policy requires the protection of a patient's right to privacy by medical professionals, unless there is an immediate threat of serious harm to the student or others.

Impact of Computerized Systems on Health Record: Benefits and Additional Confidentiality Issues

Computerization of school health data improves management of school health records in a number of ways. Computerization:

- enables standardization of documentation through common interfaces and standard menu selections;
- facilitates retrieval of student information (e.g., encounter histories, health status, phone numbers);
- facilitates tracking of referrals and follow-ups;
- facilitates problem identification through creation of exception reports (e.g., students missing immunizations);
- facilitates practice management and quality improvement (daily medication schedules help prevent missed doses);
- automates mathematical calculations and charting for tasks such as multiyear BMI-for-age charting;
- tracks risk factors (e.g., weight, behavioral health) and chronic health conditions (e.g., asthma, diabetes) over time; and
- helps ensure that appropriate security measures are taken to protect confidential information (e.g., password protection, automated audit trails).

Because computerized school health information systems make the collection and sharing of data much easier, they also raise many issues related to the privacy and security of school health information. This manual's section on the confidentiality of school health information addresses these issues at a basic level. However, schools developing computerized school health information systems should conduct a thorough analysis of system-specific privacy and security concerns. This would include an analysis of the regulations affecting collecting and sharing information (e.g., FERPA), and the technological risks and vulnerabilities of the proposed system (e.g., system access security).

SCHOOL HEALTH DATA AND SCHOOL HEALTH INFORMATION SYSTEMS

Categories of Data Collected

There are 5 basic categories of data collected in any comprehensive school health and human services program:

1. *Health status indicators*. These include chronic illnesses or conditions (e.g., asthma, diabetes, mental retardation), injuries (intentional and unintentional), and functional levels (e.g., physical limitations, behavioral problems, cognitive levels). Data on the number and types of diagnoses of children with special health care needs have implications for staffing and program development.
2. *Service provision measures*. These include information on the number and type of health encounters, as well as the specific interventions performed by the school nurse (e.g., medication administration, clinical procedures such as glucose monitoring, case management activities). These data are essential for defining the role of school nurses in the provision of student health services.
3. *Service utilization measures*. These include information on the utilization of health and human services programs within the community, such as the use of emergency room services; participation in Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program; and hospitalizations. The number of students who lack a primary care provider or regular source of medical care may have implications for the types of services offered by the school.
4. *Sociodemographic and environmental measures*. These include variables such as race/ethnicity, number of siblings and family structure, air and water quality indexes, and neighborhood characteristics.
5. *Behavioral risk indicators*. These include indicators on smoking, alcohol and drug use, seatbelt usage, sexual behavior, and nutritional intake, among others.

Accurate and timely data are critical to reflect the nature of school health services and document the impact of these services on the student population. School health programs perform data collection for a variety of reasons. Data are used to:

- conduct local and state needs assessments;
- track health status indicators;
- direct program planning;
- monitor program management;
- identify opportunities for improvement;
- develop policy directions and initiatives;
- evaluate programs and services;
- educate the public on school health services; and
- comply with federal reporting requirements.

Program Monitoring and Surveillance

Program monitoring is a crucial aspect of a school health program and involves the systematic collection of data for the purpose of determining the quantity of service provision. This information is essential for documenting need and also contributes to the evaluation process. Examples of the data collected for program monitoring include:

- the number of school health advisory meetings conducted per year, as well as attendees;
- the number of school buildings with a full-time school nurse and nurse/student ratios;
- the number of medications administered in schools; and
- health and/or education needs.

Program surveillance is the systematic collection and interpretation of data on specific indicators related to health. Examples are:

- the number of students in a school district with asthma;
- the number of students who report using tobacco;
- the number of playground injuries; and
- BMIs.

Program monitoring and surveillance are frequently used interchangeably, and both assess the activities of the school health program. Program monitoring usually deals with what is being done, whereas surveillance usually tracks health status indicators for populations of children.

Computerized Systems and School Health Data

School health data can quantify the scope and extent of health services provided in schools. It also provides information about the make-up and health of the ever-changing school-age population. It may demonstrate the extent to which environmental factors (such as air quality) and school and community influences (such as the availability of healthy nutrition and physical activity choices) impact student health.

The primary method for collecting school health data is the use of computerized data collection systems. Computerized school health data facilitates more informed program planning and management in the following areas:

- completion of local and state needs assessments;
- application of utilization and productivity measures to improve resource allocation;
- development of evidence-based programs, policy directives, and initiatives;
- evaluation of programs and services; and
- identification of opportunities to improve practice, including implementation of systematic continuous quality improvement programs.

Computerized school health data systems facilitate improved local, state, and federal reporting through the:

- creation of annual reports for local school committees, administrators, and community leaders;
- ability to monitor state-mandated programs and screenings;
- supplementation of existing statewide public health surveillance of the school-age population;
- ability to comply with federal reporting requirements; and
- tracking of infectious disease outbreaks.

In addition to school health data, there are other sources of data that computerized systems make accessible and that nurses may find useful for purposes of program planning, development, and implementation. MassCHIP includes data from over 28 data sources, including the U.S. Census, Hospital discharge data, and the Behavioral Risk Factor Surveillance System. The Youth Risk Behavior Survey and the Massachusetts Youth Health Survey provide statewide (and, in some cases, regional) estimates of levels of risk behaviors such as smoking, alcohol and drug use, seatbelt usage, sexual behavior, and nutritional intake.

While data collection and analysis may prove useful for purposes of program planning and development, school nurses should consider the cost of collecting and using data, including equipment, training, maintenance, and human resources. It is preferable to collect fewer pieces of data and conserve resources to carry out the proper analysis and reporting steps.

Continued Development of Computerized School Health Information Systems

Computerized school health information systems have been in widespread use for a relatively short period of time. The technology is still evolving, but the direction of development is clearly toward more complex and integrated systems that allow for greater data sharing and manipulation. This is inevitable, because capturing more and better information about student health status and school nursing services requires increasing the quantity of data elements. Making efficient and effective use of the information collected also requires integration of the multiple, overlapping systems used by different schools, governmental offices, and agencies. For example, district-wide health reporting and maintenance of information relating to individual students throughout their school years could be greatly simplified by all the schools in a district using standardized network software.

Integration can be achieved in a number of ways. One method involves increasing the capability to exchange data across different systems. For example, school health software vendors have been creating and improving tools for importing data from a school district's administrative system into the school health information system. Another method involves creating a single unified or centralized data system. Some school districts do this by using a "modular" administrative information system that includes school health data as one module. The continued evolution of these systems could eventually lead to a further integration of school health data across various local and state agencies, perhaps through a single point of entry (such as a Web application). However, such a system may be several years away.

Identifying all of the factors one should consider in the selection of a school health software package is beyond the scope of this manual. School nurses should be involved in the selection of software and need to be informed about the issues involved. Sources of information about selecting school health software include the *School Health Data Systems Resource Guide* (Massachusetts Department of Public Health, 1999) and contact with other local school nurses who have used various data systems.

The greatest challenge to developing and maintaining local school health information systems is the availability of technical expertise for ongoing support and development. School nurses should be an integral part of the development of screening and reporting design as their local system is developed. Computer coordinators should be knowledgeable concerning hardware and software acquisitions and locally sited to provide technical assistance and consultation, as needed.

ESTABLISHING COMMUNITY CONNECTIONS

Accessing key decision makers, stakeholders, organizations, and communications systems within the community can be a challenge for the school health program leadership. Because each community is unique, strategies that are effective in one community may need to be altered dramatically in another. The following recommendations address various community stakeholders and focus on developing "connectivity," which the Harvard Center for Public Health Preparedness defines as the development of "a seamless web of organizations, people, resources, and information" across the community to promote positive outcomes.

- **School Committee:** As representatives of the community, school committee members have a stake in both the health and education of youth. It is important for school health personnel to share school health data, including service data, with school committee members on a regular basis, highlighting health trends and issues in the school population.

- **School Health Advisory Committee:** Critical to a quality comprehensive health program, this committee should include a range of community representatives as well as school personnel, students, and parents. The committee offers a structure for discussing youth health issues in depth and obtaining advice from community members. (See Chapter 2 for more detail.)
- **Board of Health (BOH):** The BOH is responsible for the health of the community's population. Among its responsibilities affecting schools are enforcing isolation and quarantine regulations and leading the community's planning for emergency preparedness, including flu pandemic and bioterrorism. The BOH and school health personnel should act as partners in addressing communitywide issues such as indoor air quality and overweight prevention. In addition, schools need to share aggregate information such as asthma surveillance data.
- **Parent/Teacher Organizations and School Site Councils**: Parents can be the greatest supporters of quality school health programs. Regular presentations about the issues can be a vehicle for securing their support.
- **Public Safety and Emergency Medical Services:** Schools need to form working relationships with public safety services on a variety of issues, such as response to individual and group emergencies and prevention of violence.
- **Coalitions and Committees Addressing Health Issues Affecting the Student Population:** A school nurse or other member of the school health program can assist these groups by offering unique insights into such areas as teen pregnancy, violence, tobacco use, behavioral health, or drug abuse. Conversely, the school's participation may lead to new resources and relationships to assist students in these areas.
- **Key Leaders in Civic, Faith, and Business Organizations:** School health personnel are encouraged to seize opportunities to meet with key leaders in these organizations to interpret the school health program's mission and goals. Presentations at local meetings of these groups may also garner resources and support for efforts on behalf of the community's youth.
- **Representatives of Local Hospitals and Community Health Centers:** Collaborations and communication systems developed with local hospitals and community health centers are mutually beneficial in many ways. Communication on behalf of clients may be enhanced. Sharing continuing education offerings may benefit both groups. Presentations by school personnel at hospital rounds may emphasize that the school health program is an extension of health care into the community.
- **Primary Care Providers:** Inviting local pediatricians and other medical providers to visit the school and learn about the health program may enhance collaboration and lead to development of effective communication systems. Schools have used a variety of methods to improve collaboration, such as inclusion of providers on the health advisory committee, sharing the names of school nurses who cover each building, and holding an annual breakfast for local primary care providers.
- **Dental Providers:** As oral health is increasingly recognized as critical to health and well-being, school health programs have established creative collaborations to address this issue. In some communities, local dentists and dental hygienists have contributed time for oral health education, assessments, application of dental sealants, and treatment of children who lack dental providers.
- **Local Universities and Schools of Medicine and Nursing:** School health programs offer clinical practice opportunities for educating nurses and physicians. Collaborations with these institutions also may provide the impetus for much-needed research into the outcomes of school health programs.
- **Local Media:** Forging positive relationships with the media (e.g., newspaper or cable television) offers many opportunities for sharing important health promotion messages. In addition, as schools expand the use of technology, they are developing comprehensive websites accessible to a large percentage of the population.

As communities continue to develop comprehensive coordinated school health programs, they may discover unique opportunities to promote the health of their children and youth.

EVALUATION OF THE HEALTH PROGRAM

In order to determine the school's effectiveness in meeting the health needs of students and staff, it is essential to evaluate the comprehensive health service program. The purpose of program evaluation is to assess whether or not the goals and objectives of the school health program are being met.

School Nursing Research Agenda and Desired Outcomes

Many priorities around school nursing research and desired outcomes for school nursing practice have been identified over the years. Following are a few examples that may be useful to schools as they determine design and implementation of appropriate evaluation plans.

The National Nursing Coalition for School Health has developed a school nursing research agenda (Edwards, 2002). The top 3 research issues for school nursing were prioritized as follows:

- impact of school nurse services on student health;
- relationship between school nurse practice and educational outcomes; and
- benefits and cost-effectiveness of school health services.

Ten broad categories of desired outcomes for school nursing practice have been identified and prioritized by a group of school nurses representing all regions of the country (Selekman & Guilday, 2003). These originally appeared in the *Journal of School Nursing:*

- Students have increased time in the classroom;
- Students receive first aid, emergency services, and services for their acute care needs;
- Students receive needed, competent health-related interventions;
- Students with chronic conditions have their health care needs met;
- Overall health of the school is enhanced by wellness promotion and disease prevention measures;
- Students receive appropriate referrals related to the assessments made;
- The environment in which students learn is safe;
- Overall health of the school is enhanced by community outreach to meet student needs;
- School nursing services are cost-effective; and
- Parents, educators, administration, and staff express satisfaction with health-related services.

Types of Evaluation

Ongoing data collection and evaluation are central to promoting responsiveness in programs, staffing, funding, and resources. The results and recommendations that come from an evaluation then become input for subsequent planning. This feedback loop allows plans to be revised as needed in order to keep programs appropriate, realistic, and effective. It also provides the health team with measures of accountability.

There are several ways to design an evaluation, depending on the questions that are being asked about the program, and each design has a different name. For example, evaluations can be referred to as Continuous Quality Improvement projects, formative evaluation, process evaluation, and outcome evaluation. Each type is discussed briefly below.

Continuous Quality Improvement (CQI)

A continuous quality improvement (CQI) project is a type of evaluation that focuses on monitoring one aspect of a program with the intent of improving that particular program component. Specific indicators are developed to measure performance; activities are implemented; indicators are monitored; changes are documented; and progress toward an established goal is measured. Once improvement has occurred and the goal has been achieved, another aspect of the program is selected for monitoring. As the name implies, this is a dynamic and ongoing process of constantly striving for performance improvement.

Formative Evaluation

Formative evaluation is an ongoing type of evaluation that is carried out while a program or materials are being developed. The assumption is that the results of an evaluation performed during this phase will be used to help improve the program or materials being designed. It begins at the start of the program planning and design and continues during development and implementation.

The first phase is *needs assessment*, which establishes baseline data on the need for a service, a program, a curriculum, or materials. It should always take place before embarking on a project. The *School Health Index* (SHI) is a self-assessment and planning guide developed by the Centers for Disease Control and Prevention (CDC) that may be used as part of the assessment process (see Exhibit 2-2).

During *field testing*, the program or materials are tested for effectiveness. Data collected will help fine-tune materials, pinpoint any problems, aid in the revision of process, and assist in the development of new materials. Developers should use different situations or settings (reflective of the target audience) to try out the program, whether it be students, faculty, parents, or all of them.

Process Evaluation

Another type of evaluation is process evaluation, which seeks to answer the question “Is the program or project being implemented as planned?” As the program is implemented, process evaluation helps staff answer questions such as: "Is the program being used?", "How?", "Is what we're assessing what was planned?", "Are we reaching our intended targets?", and "What should we be monitoring in our program?". This type of evaluation should be used as an ongoing self-assessment management tool that explores program process from beginning to end.

Outcome Evaluation

Outcome evaluation (also called summative evaluation) examines the success of the program in meeting specific objectives, such as whether there were changes in the health behavior or health status of students and/or staff. It may look at participant satisfaction, numbers served, and objective measures of change. Did the program make a difference? What are immediate changes as a result of the program? For instance, as a result of a program to improve food in vending machines, did students eat less junk food? What can be done to improve the program? Should it be continued?

Impact evaluation looks at longer-term changes that can help answer the question of overall program effectiveness. Some examples may include reducing costs, improvement in student health or productivity, or lower rates of school violence over an extended period of time.

For both outcome and impact evaluations, it may be helpful to consult a skilled, experienced external evaluator who has some medical knowledge and understands the mechanics behind day-to-day triage in a health office. More rigorous evaluations have a control or comparison group. The basis of any good outcome evaluation is a good management information system for all children in the program.

SUMMARY

Establishing an effective school health program maximizes students' educational experience, while providing a safe, caring, and healthful environment for both students and staff. Because of the important role that health plays in educational achievement, health services are critical elements of a comprehensive, coordinated health and human services program. School health service programs continue to serve traditional roles of infection control and health screenings. However, the increasingly complex and diverse health conditions presented by students demand extensive and rapidly expanding services, many of which were formerly provided only in formal health care settings, such as hospitals and clinics. Furthermore, because of societal changes and the restructuring of the health care system, schools and school nurses now serve as a health safety net for all children, often providing the point-of-entry for obtaining health care. In this role, school nurses have become critical components of community health care delivery systems serving children.

As school health needs grow and more children are served, health service programs must establish the infrastructure and standards to support high-quality practice. Highly qualified professional school nurses form the basis of the program and provide the services necessary to permit many children to attend school. Additional key elements include: a vision of school health, a nursing leader, student health needs assessment, an advisory committee, policies and programs, protocols, emergency planning, well equipped health care facilities, documentation and recordkeeping, computerized data systems, a mechanism for evaluation, and coordination with community youth-serving agencies and providers.

Although this chapter has focused on the health care service component of the comprehensive, coordinated school health program, many of the same elements and principles may be applied to other components (e.g., an advisory committee, policies). Highly qualified staff in all areas must work together to ensure that the infrastructure is functioning smoothly and that the systems facilitate close coordination and communication, to avoid duplication.

RESOURCES: MASSACHUSETTS AGENCIES AND ORGANIZATIONS

American Heart Association (AHA)
20 Speen Street
Framingham, MA 01701
Phone: 508-620-1700
Fax: 508-620-6157
(The office above is the headquarters of the Northeast Affiliate. For information on other AHA offices throughout Massachusetts, call here or go to http://www.americanheart.org/presenter.jhtml?identifier=10000028)

American Red Cross
Website: http://www.redcross.org/where/chapts.asp#MA
There are multiple local chapters across Massachusetts. Use this website to find the closest.

Boston Area Nursing Informatics Consortium (BANIC)
Website: http://www.baniconline.org
A not-for-profit organization that provides a forum for resource and information exchange in the field of clinical informatics.

Massachusetts School Nurse Organization (MSNO)
P.O. Box 1287
Marblehead, Massachusetts 01945
E-mail: thomson@msno.org
Website: http://www.msno.org
Founded in 1970, the Massachusetts School Nurse Organization (MSNO) has been a strong voice for school nurses throughout the Commonwealth. MSNO is a growing nonprofit organization with approximately 800 members, including school nurses, school administrators, public health nurses, practitioners, consultants, educators, and retired school nurses. MSNO promotes and advances the professional practice of school nursing throughout Massachusetts. Members are encouraged to take an active stance in decisions directly impacting school nursing, especially in the legislative, economic, and educational arenas.

Massachusetts Organization of Nurse Executives (MONE)
101 Cambridge Street, Suite 220
Burlington, MA 01803
Phone: 781-272-3500
Fax: 781-272-3505
E-mail: info@massone.org
Website: http://www.massone.org/
MONE represents over 500 nursing leaders from diverse practices across Massachusetts. The mission of the organization is to provide direction and leadership for the advancement of professional nursing and patient care, and for the achievement of excellence in nursing management practice.

Massachusetts Coalition of School-Based Health Centers
95 Berkeley Street, Suite 201
Boston, MA 02116
Phone: 617-451-0049
Fax: 617-451-0062
E-mail: mcsbhc@tmfnet.org
Website: http://www.mcsbhc.org
School-based health centers are places where children have access to quality health care in school. There are over 10 such centers in Massachusetts and the Massachusetts Coalition for School-Based Health Centers' (MCSBH) website provides a summary message of efforts and goals for these centers from the executive director.

Massachusetts Department of Public Health
Center for Emergency Preparedness
250 Washington Street, 2nd floor
Boston, MA 02108
Phone: 617-624-5275
Fax: 617-624-5587
Special Populations guidance for Local Boards of Health

Massachusetts Department of Public Health
Coordinated School Health Program
250 Washington Street
Boston, MA 02108
Phone: 617-624-5537
Fax: 617-624-6062
TTY: 617-624-5992
Website: http://www.mass.gov/dph/fch/schoolhealth/cshp.htm
The Coordinated School Health Program is a collaborative effort between the Massachusetts Department of Education (DOE) and the Massachusetts Department of Public Health (DPH) to improve the health of K-12 students in order to advance their academic performance.

Massachusetts Department of Public Health
School Health Services
250 Washington Street
Boston, MA 02108
Phone: 617-624-6060
Fax: 617-624-6062
TTY: 617-624-5992
Website: http://www.mass.gov/dph/fch/schoolhealth/index.htm
School Health Services is a collaborative effort between professional staff and other Department of Public Health and Massachusetts Department of Education personnel to improve school health services, develop policies, and provide information about health issues and needs.

Massachusetts Emergency Management Agency (MEMA)
400 Worcester Road (Route 9)
Framingham, MA 01702-5399
Phone: 508-820-2000
Website: http://www.mass.gov/?pageID=eopsagencylanding&L=3&L0=Home&L1=Public+Safety+Agencies&L2=Massachusetts+Emergency+Management+Agency&sid=Eeops

Region 1
365 East Street, Tewksbury, MA 01876
Phone: 978-328-1500

Region 2
12 I Rear, Administration Road
Bridgewater, MA 02324-0054
Phone: 508-697-3111

Regions 3 & 4
7 Berkshire Avenue
Belchertown, MA 01007-8900
Phone: 413-323-6306

The MEMA website also provides a list of Emergency Management Directors by town.

RESOURCES: NATIONAL AGENCIES AND ORGANIZATIONS

AED Instructor Foundation
600 N. Jackson Street, Suite 1
Media, PA 19063
Phone: 800-572-2227 or 610-566-2824
Fax: 610-566-2826
E-mail: director@aedif.org
Website: http://www.aedif.org
The AED Instructor Foundation was created to assist and support instructors in preparing communities and workplaces — especially public gathering places and small businesses — for appropriate and effective emergency medical response. The Foundation provides resources, educational seminars, and promotional tools to help instructors provide critical training in CPR and early defibrillation. It also maintains a searchable online database of qualified, Foundation-affiliated AED instructors.

American Heart Association (AHA)
National Center
7272 Greenville Avenue
Dallas, TX 75231
Phone: 800-AHA-USA-1 or 800-242-8721
Website: http://www.americanheart.org
AHA is a national voluntary health agency whose aim is to reduce the incidence of cardiovascular disease and stroke.
Materials: *Medical Emergency Response Plan for Schools (MERPS) Sample Plan* — a model plan developed as a starting point and resource for schools developing a Medical Emergency Response Plan. Available at: http://www.americanheart.org/presenter.jhtml?identifier=3018039

American Nursing Informatics Association (ANIA)
PMB 105
1908 Foothill Blvd., Suite H
San Clemente, CA 92672
Website: http://www.ania.org
ANIA was created in 1992 as a networking organization for informatics nurses in Southern California. It has since grown as a non-profit organization with members across the U.S.

The American Organization of Nurse Executives (AONE)
Liberty Place
325 Seventh Street, NW
Washington, DC 20004
Phone: 202-626-2240
Fax: 202-638-5499
Website: http://www.aone.org
Official publications are: *Nurse Leader, as well as AONE eNews Update* and *Voice of Nursing Leadership.*™

American Red Cross
National Headquarters
2025 E Street, NW
Washington, DC 20006
Phone: 202-303-4498
Website: http://www.redcross.org
Founded in 1881 by Clara Barton, the American Red Cross is the nation's premier emergency response organization. In addition to its original purpose of providing disaster relief, the American Red Cross now offers services in five other areas: community services for the needy, support for military members and their families, processing and distribution of lifesaving blood, educational programs advancing health and safety, and international relief and development programs.

Publications: *Emergency Supplies for Schools* contains information on recommended supplies for schools, classrooms, and students. It includes instructions on assembling supplies and provides background information, as well as specific listings of suggested items that schools and schoolchildren should have. This list was developed from lists created by the California Senate Select Committee on the Northridge Earthquake, Task Force on Education, and updated October, 2000, by the American Red Cross. Available online at http://www.redcross.org/disaster/masters/supplies.html

Videos: Y*our Guide to Home Chemical Safety and Emergency Procedures*. A 22-minute video that provides visual description of chemical emergency response procedures. Local Red Cross chapters can order as stock number A5045V. *Adventures of the Disaster Dudes.* Video-based program comes with a Presenter's Guide and a 14-minute video. The video is designed to be shown in 3 segments that feature children describing what a disaster really is, information on correct response, and how to create a family disaster plan. Local Red Cross chapters can order as stock number A5024 for a nominal fee.

American School Health Association (ASHA)
7263 State Route 43
P.O. Box 708
Kent, Ohio 44240
Phone:330-678-1601
Fax: 330-678-4526
E-mail: asha@ashaweb.org
Website: http://www.ashaweb.org/

Publication: *Health in Action*, a quarterly newsletter for school health professionals.

Bureau of Primary Health Care (BPHC), Healthy Schools, Healthy Communities Program
Health Resources and Services Administration
U.S. Department of Health and Human Services
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857
Website: http://bphc.hrsa.gov/
BPHC is one of four Bureaus of the Health Resources and Services Administration (HRSA), an agency in the Department of Health and Human Services. Healthy Schools, Healthy Communities was established in 1994 to encourage the development of new, comprehensive, full-time, school-based primary care programs that serve high risk children. This website includes project files, full text publications, and links.

The Center for Health and Health Care In Schools
2121 K Street, NW Suite 250
Washington, DC 20036
Phone: 202-466-3396
Fax: 202-466-3467
E-mail: chhcs@gwu.edu
Website: http://www.healthinschools.org
Publication: *Health and Health Care in Schools,* a monthly online report on “the policies, politics and financing of health programming in schools.”

Drugs @ FDA
Website: http://www.accessdata.fda.gov
A searchable database that includes information on approved prescription drugs, over-the-counter drugs and discontinued drugs. Located on the website of FDA's Center for Drug Evaluation and Research (CDER), it is the first Web resource to offer a comprehensive overview of a drug product's approval history.

Emergency Medical Services for Children (EMSC)
Phone: 202-884-4927 (main) or 703-902-1203 (EMSC Clearinghouse-product orders)
Fax: 202-884-6845
E-mail: information@emscnrc.com (general) or emsc@circlesolutions.com (Clearinghouse)

Website: http://www.ems-c.org/contact/framecontact.htm

The Emergency Medical Services for Children Program is a national initiative designed to reduce child and youth disability and death due to severe illness and injury. Medical personnel, parents and volunteers, community groups and businesses, and national organizations and foundations all contribute to the effort. HRSA administers the program in partnership with the U.S. Department of Transportation's National Highway Traffic Safety Administration.

Publications:

- *Disaster Preparedness for School Nurses: Instructor Manual*. (001039)
- *Guidelines for the Nurse in the School Setting*. Revised. (001040)

FEMA Region 1
99 High Street
6th Floor
Boston, MA 02110
Website: http://www.fema.gov/regions/i/index.shtm

National Assembly on School-Based Health Care
666 11th Street NW
Washington, DC 20001
Phone: 202-638-5872
Fax: 202-638-5879
E-mail: info@nasbhc.org
Website: http://www.nasbhc.org/
The National Assembly is a not-for-profit membership association whose mission is to promote interdisciplinary school-based health care.

National Assembly on School-Based Health Care
Center For Technical Assistance & Training
Website: http://www.nasbhc.org/TAT/Index.htm
The National Assembly strives to serve as the premiere professional development and information arm of the school-based health care field. Its Center for Technical Assistance & Training offers tool kits on creative financing and operations, training opportunities, a virtual tour of an SBHC, links and general resources.

National Association of School Nurses (NASN)
8484 Georgia Avenue, Suite 420
Silver Spring, Maryland 20910
Phone: 866-627-6767 or 240-821-1130
Fax: 301-585-1791
E-mail: nasn@nasn.org
Website: http://www.nasn.org
NASN was founded in 1968 by the National Education Association (NEA) as an association committed to the betterment of school nursing practice and the health of school-aged children. Originally established as the Department of School Nurses (DSN), NASN formally separated from the NEA in 1979 and now continues to be the largest national association for school nurses. NASN partners with national health organizations to develop educational programs, publishes issue briefs on subjects affecting student health and school nursing, and maintains a legal representative in Washington, D.C. to promote school nurse issues.

National Clearinghouse for Educational Facilities (NCEF)
Website: http://www.edfacilities.org/rl/health_centers.cfm
Created by the U.S. Department of Education, NCEF is a free public service that provides information on planning, designing, funding, building, improving, and maintaining schools. The Web address above connects to NCEF's resource list of links, books, and journal articles on the planning, design, furnishings, and equipment of school-based health facilities, including health centers, health suites, clinics, or a health room.

National School Boards Association — School Health Programs
1680 Duke Street, Alexandria, VA 22314
Phone: 703-838-6722
Fax: 703-683-7590

E-mail: Schoolhealth@nsba.org
Website: http://www.nsba.org/site/page_SH_home.asp
The website supports NSBA's commitment to help school policy makers and educators make informed decisions about health issues affecting the academic achievement and healthy development of students and the effective operation of schools. Project staff are able to assist with development and technical review of local district policies. The School Health Resource Database contains sample policies, journal articles, program descriptions and more.

Northeast States Emergency Consortium (NESEC)
1 West Water Street, Suite 205
Wakefield, MA 01880
Phone: 877-99-NESEC (877-996-3732)
Fax: 781-224-4350
Website: http://www.nesec.org
NESEC is a non-profit organization dedicated to hazard mitigation and emergency management. It is the only organization of its kind in the country and is funded by The Department of Homeland Security (DHS) Federal Emergency Management Agency (FEMA).

Office of School Health
University of Colorado Health Sciences Center
School of Nursing
Campus Box F-541
P.O. Box 6508
Aurora, CO 80045
Phone: 866-724-0645 (toll-free) or 303-724-0643 (direct to librarian)
Fax: 303-724-0905
E-mail: osh.librarian@uchsc.edu
Website: http://www.uchsc.edu/schoolhealth/index.htm
Course offerings include: Fundamentals in School Health and School Nursing; Certificate Program for School Health Coordinator; School Nurse Achievement Program; and Center City USA, a course that provides nurses with necessary skills to develop a strategic management plan for a comprehensive school health program.

School Health Alert Newsletter
P.O. Box 150127
Nashville, TN 37215
Phone: 615-370-7899
Fax: 615-370-9993
E-mail: cs@schoolnurse.com
Website: http://www.schoolnurse.com
This website is an online version of *School Health Alert*, a monthly newsletter intended to keep school nurses and other relevant health professional up-to-date on the latest developments in student health services, health education, and safe school environment.

School Health Evaluation Services (SHES)
Office of School Health
University of Colorado Health Sciences Center
School of Nursing
Campus Box F-541
P.O. Box 6508
Aurora, CO 80045
Phone: 303-724-0644
Website: http://www.uchsc.edu/schoolhealth
School Health Evaluation Services (SHES) provides technical assistance, training and onsite services to educational administrators, health professionals, and community groups in managing data related to all aspects of school health services. The data may include school health records, health needs assessment/surveys, program evaluation and report generation, and continuous quality improvement efforts.

School Health Resource Services (SHRS)
Office of School Health
University of Colorado Health Sciences Center
School of Nursing
Campus Box F-541
P.O. Box 6508
Aurora, CO 80045
Phone: 866-724-0645 (toll-free) or 303-724-0643 (direct to librarian)
Fax: 303-724-0905
E-mail: osh.librarian@uchsc.edu
Website: http://www.uchsc.edu/schoolhealth/index.htm
School Health Resource Services (SHRS) is a network of services designed as a coordinating link between school health services professionals and the information available from school health, maternal and child health, education, and other disciplines. SHRS provides technical information, resource materials, and research assistance, along with full service library and database of school health and related information, including commercially available databases such as Medline, CINAHL, ERIC, PsycInfo, and other biomedical and evidence-based resources.

Materials: *School Health Needs Assessment: A Starter Kit*. The kit is a notebook containing information and step-by-step worksheets to guide school health professionals through the process of needs assessment.

TrainingFinder.org
Public Health Foundation
1220 L Street, NW Ste. 350
Washington, DC 20005
Phone: 202-898-5600
Fax: 202-898-5609
Website: http://www.trainingfinder.org
The Public Health Foundation, with funds from the Health Resources and Services Administration, offers a one-stop, online central repository of distance learning material. At no cost, users can search the site containing more than 200 courses by subject, target audience, credit type, or keyword.

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Note: Articles with PMID number have been indexed by PubMed for MEDLINE.

EXHIBITS

Exhibit 2-1 Sample School and Community Needs Assessment

I. Describing the Student Population of Your School

1. Grades the school(s) include:

2. Total school(s) population:

3. Number of students in each age group that you serve?

Pre-kindergarten (4 yrs and under): _____
Ages 5-7: _____
Ages 8-10: _____
Ages 11-14: _____
Ages 15-17: _____
Ages 18 and over: _____

4. Description of community (e.g., urban, suburban, rural, mixed):

5. a) Racial composition of the student body (percentage of following)

White: _____ African American: _____ Asian/Pacific Islander: _____ Hispanic: _____ American Indian/Alaskan Native: _____
Other: _____ (specify: _____) Unknown: _____

b) Ancestry (check each that is represented in your school):

___ Puerto Rican
___ Dominican
___ Central American
___ Other Hispanic
___ Brazilian
___ Cape Verdean
___ Other Portuguese
___ Haitian
___ West Indian
___ Chinese
___ Cambodian
___ Vietnamese
___ Laotian (including Hmong)
___ Other Asian (including Pacific Islander)
___ Pakistani/Asian Indian
___ European
___ African
___ North American
___ Other (specify)
___ Unknown

6. Languages spoken by students at your school(s):
   a) percentage of the student body that does not speak English: _____ b) percentage speaking English as a second language: _____

7. Socioeconomic status of students at your school(s):
   a) average family income (or range of family incomes) of the students at the school: _____
   b) percentage of student body eligible for the free-lunch program: _____
   c) percentage of parents/guardians currently unemployed: _____

Source: Education Development Center, Newton, MA., 1993. Adapted with permission.

II. Assessing the Capacity of Your School(s) in Comprehensive School Health

1. Reproduce as many copies of this page as you need. You may wish to conduct this assessment using the 3 components of health education, health and human services, and school health environment, or you may wish to break them down into more areas.

Comprehensive School Health Area*	Person(s) in charge in your school	Your working relationship with this person: good, average, no relationship	Activities you have carried out in past in this area	School resources (e.g., human, $, info, and material resources, existing collab or committees	School needs (e.g., human, $ info, material, collaborative)	Local, county, or state regs. or policies related to this area (describe)

Source: Education Development Center, Newton, MA., 1993. Adapted with permission.

2. Is there a school health advisory council, committee, or board in your school(s)? What does it do?

3. Based on the capacity of your school (district) as described above and the direction in which you want to move, what are the next steps you might take to expand the comprehensive school health program for students in your school(s)?

III. Assessing the Health-Related Needs of the Students in Your School(s)

1. Which of the following are major health-related problems or issues among the students in your school(s)?

Rank Top Five	PROBLEMS/ISSUES	NO	YES	ESTIMATED PREVALENCE*	SERVICES/SUPPORT FOR STUDENT AVAILABLE IN YOUR SCHOOLS(S)
	Absenteeism				
	Nutrition/eating disorders				
	Sexually transmitted diseases				
	HIV/AIDS				
	Pregnancy				
	Chronic illness				
	Children assisted by medical technology				
	Unintentional injuries				
	Depression				
	Stress				
	Suicide				
	Relationships with family and friends				
	Sexual identity issues				
	Alcohol and other drug abuse				
	Sexual assault/rape				
	Acquaintance violence				
	Family violence and abuse				
	School dropout				
	Parental substance abuse				
	Runaway				
	Lack of regular physical activity				
	Other (describe:)				

2. In the column to the left on the above chart, rank the 5 most important health-related problems or issues for students in your school(s). (1 = most important, 2 = second most important, etc.)

Source: Education Development Center, Newton, MA., 1993 * Number of persons who have a stated problem at a given time.

IV. Assessing the Community's Capacity to Provide Comprehensive Health Services to Students

1. List below the 5 student health problems or issues you rated as most important on the previous page and provide the following information about related services available in your community.

PROBLEMS/ ISSUES	Community Services Available Yes	No	Name, Address, & Phone Number of Agency(s)	Name of Contact Person(s)	Criteria Students Must Meet to Obtain Services	Days & Hours Services Available	Fees for Services ($)	Are Available Services Adequate & Appropriate for Students	If services are not adequate or appropriate, what needs can you identify?

Source: Education Development Center, Newton, MA., 1993.

2. In general, do students in your school(s) know they can get information and/or health services from the agencies you listed on the previous chart?

3. List community coalitions or task forces that have been active in school-age or adolescent health issues.

4. What does each coalition or task force do? (For example, name a concrete product, goal, or outcome.)

5. Are you or any other school staff involved with each coalition or task force?

6. If *yes*, describe the involvement:

7. How could your school(s) and the community work together more effectively to meet students' health needs?

Source: Education Development Center, Newton, MA., 1993

Exhibit 2-2 The School Health Index

Promoting healthy behaviors among students is a critical component in helping schools achieve their central mission of providing youth with the knowledge and skills they need to become healthy and productive adults.[1] The *School Health Index* (SHI) is a self-assessment and planning guide developed by the Centers for Disease Control and Prevention (CDC). This tool will enable schools to:

1. identify the strengths and weaknesses of a school's health promotion programs and policies;
2. develop an action plan for improving student health as a result of the self-assessment, and
3. use a team approach, involving administrators, teachers, school staff, parents, and students in improving the school health promotion programs and policies

The *School Health Index* seeks to improve the overall school health environment to support the health of students and staff through the commitment and involvement of the entire school community. The SHI is composed of 8 modules that correspond to the Coordinated School Health Program model. These modules are:

1. school health policies and environment;
2. health education;
3. nutrition services;
4. physical education;
5. school health services;
6. counseling, psychological, and social services, and
7. health promotion for staff and family and community involvement.

The SHI is intended for use at the school level. However it may be used on a district level, if the school district has a few schools and the health promotion policies and programs at those schools are similar. The SHI has 2 versions, one for elementary school and one for middle school and high school. The most recent version of the SHI (2004) addresses school policies and programs related to physical activity, healthy eating, a tobacco-free lifestyle, and safety (unintentional injury and violence prevention). Subsequent versions will address school policies and programs related to the use of alcohol and other drugs and sexual health.

The School Health Index is available free of cost from the CDC through the following options:

- Download from the CDC website: http://www.cdc.gov/nccdphp/dash/SHI/index.htm
- Request by e-mail: healthyyouth@cdc.gov
- Request by phone: 888-231-6405
- Request by fax: 888-282-7681

1 Centers for Disease Control and Prevention. *School Health Index for Physical Activity, Healthy Eating and a Tobacco-Free Lifestyle: A Self-Assessment and Planning Guide*. Middle school/High school version. Atlanta, GA. 2002.

Exhibit 2-3 Logic Model of School-Based Asthma Program

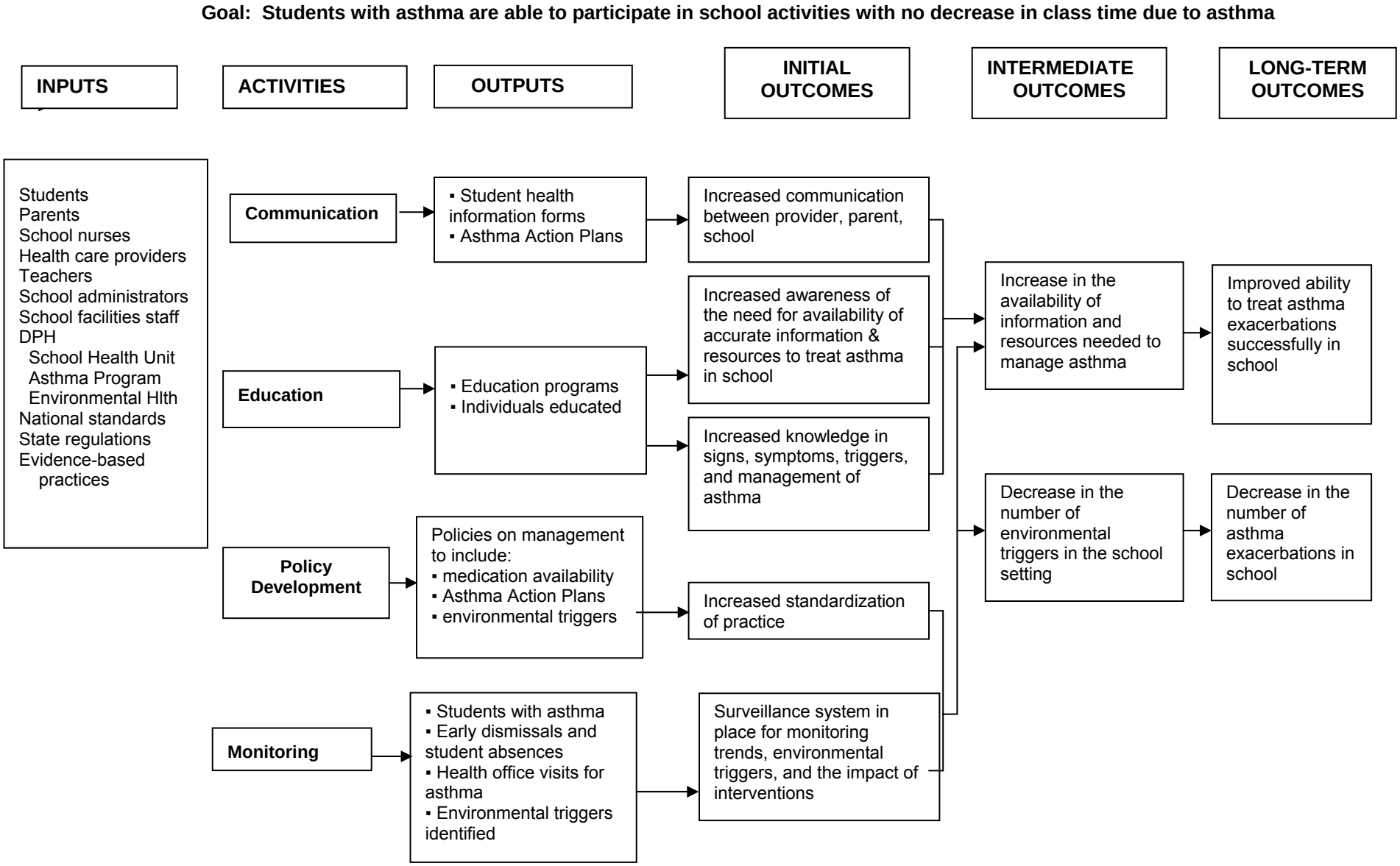


Exhibit 2-4 Sample Action Plan

Here is an example of an issue and its actions for the action plan form on the next few pages:

Issue/Problem	Component(s) of Comprehensive School Health Program Involved	Vision Statement*
1) "50% of students have no access to primary care."	Health Services	"100% of students will have access to quality health care within 2 years."

* A vision statement is a broad, general statement describing a desired change or goal.

Outcome Objectives

"Coordinate access to health services for all students"

Related Strategies
- Needs assessment
- Program development
- Outreach

Exhibit 2-5 Action Plan: Sample Form

The 4 most important issues/problems relating to comprehensive school health for students in our school that we feel a need to address now are:

Issue/Problem	Component(s) of Comprehensive School Health Program Involved	Vision Statement*
1)		
2)		
3)		
4)		

* A vision statement is a broad, general statement describing a desired change or goal.

5) The single most important issue/problem relating to comprehensive school health and human services in our school that we feel a need to address now is: (choose 1 from the above)

6) Describe the situation:

7) Our vision statement related to this issue/problem:

Exhibit 2-6 Identification and Referral Program (Student Assistance Program)

A Student Assistance Program identifies and helps students with health or behavior problems. It provides a structure, which promotes effective and efficient use of resources within the school and linkages with community-based health and human service agencies. It strives to prevent duplication of services and provide support to students with a range of problems.

Many schools have established student assistance or intervention programs that focus on alcohol and other drug issues. One out of four students is a child of alcoholic and/or drug-addicted parents. Studies indicate that support programs for these students can be quite effective and may be expanded to deal with other health issues such as suicide prevention, child and sexual abuse, eating disorders, and teen parenthood.

- The school agrees on policies, which address how it will identify and refer students.
- A school team is designated as the overall coordinating body, consisting of school administrative, counseling, nursing, teaching, and support staff, as well as community agencies where appropriate. A clinically trained coordinator serves as key contact and is typically either on staff or employed by contract with a community agency. Team members participate in specialized training on methods of designing and implementing programs.
- Appropriate case identification is key. In some cases, teachers easily recognize that student behavior has changed. They dress differently, may change class work habits, fall asleep in class, or are increasingly absent. School nurses may note students appearing in the health room or school-based health center on a regular basis. Students may seek out staff to talk frequently.
- Teachers, school nurses, parents, or students recommend and encourage students to seek help and contact the team coordinator. Some students may refer themselves for help. The team and/or coordinator receives the referral, consults with appropriate professionals, meets with the student and his or her parent (if appropriate), and refers the student to an appropriate program. Some schools provide support groups and individualized counseling by specially trained school personnel, or through linkages with community-based agencies that provide services onsite in the school building. *Student confidentiality is maintained in these groups and individual counseling sessions.*

Exhibit 2-7 Sample Position Description

SCHOOL NURSE LEADER

Scope of Responsibilities

The School Nurse Leader manages the total school health service program, providing nursing leadership within the school system. The Nurse Leader develops a needs assessment, plans and implements programs, and provides for continuous quality assurance and evaluation. She/he coordinates the clinical aspects of the comprehensive school health program, collaborating with other members of the health services and health education team, The Nurse Leader collaborates with community providers, other community organizations, and coalitions addressing health issues of children and adolescents. The School Nurse Leader should be freed from direct clinical care in order to fulfill her/his management and coordination responsibilities.

As a nurse registered through the Massachusetts Board of Registration in Nursing (BORN), the Nurse Leader must adhere to the Nurse Practice Act, pertinent regulations governing nursing practice and standards of care established by the professional organizations.

Supervision Received

The School Nurse Leader reports to the school administrator as defined in her/his position description, is a member of the school management team, and collaborates with the designated School Physician in developing and implementing the school health service program. Because of the multifaceted nature of the role, and its relationship to all school divisions, the School Nurse Leader may have reporting responsibilities to the Superintendent.

Supervision Given

The School Nurse Leader supervises and clinically evaluates all clinical nursing staff providing services in the school health program, as well as those unlicensed personnel (e.g., health aides) as designated in the organizational chart.

Required Qualifications

The School Nurse Leader must:

- have a valid license to practice as a Registered Nurse in Massachusetts;
- possess a minimum of a baccalaureate in nursing from an accredited nursing program (a masters degree in nursing or related field is preferred);
- be licensed as a school nurse by the Massachusetts Department of Education;
- have a minimum of 3 years of experience in school nursing or a related field, one of which is in a management position;
- maintain certification in cardio-pulmonary resuscitation, including AED training (trainer's certification for the Nurse Leader or her delegatee is recommended);
- assume responsibility for updating knowledge and skill in community health, management, and related fields as new information emerges; and
- complete ongoing continuing education programs pertinent to the evolving specialty area of school health and school nursing practice, as well as meet the continuing education requirements for licensure in Massachusetts.

Responsibilities

Needs Assessment

- using available demographic, health, school system, and community data, identifies health needs of the student population;
- collaborates with the school health advisory committee, local board of health, and other community agencies in developing the needs assessment; and
- develops surveys, questionnaires, and other tools for obtaining information; compiles data and presents it to decision makers (e.g., school health advisory committee, superintendent, school committee, mayor's office), as appropriate.

Planning

- assumes leadership in the establishment of a school health service advisory committee, consisting of representation from such groups as school administration, faculty, students, parents, and community providers based on needs assessment; develops program goals, objectives, and action steps; and
- coordinates planning with interdisciplinary colleagues in the comprehensive school health education and human services program and community agencies, as appropriate.

Implementation

- employs, orients, assigns, and supervises qualified personnel to implement the school health program;
- implements communication systems which promote participatory management, such as regularly scheduled meetings and e-mail systems;
- participates in the development of an interdisciplinary plan *for each building* to ensure that students in need of services are identified in a timely manner and appropriate intervention is initiated;
- develops and implements written policies and protocols (with staff assistance) for the clinical services and programs addressing health issues (e.g., immunizations, medication administration, services for children with special health care needs, schoolwide injury prevention programs) and special programs groups (e.g., overweight prevention, asthma management, eating disorders, smoking cessation, violence prevention);
- develops and implements documentation systems at both the individual student and programmatic level;
- develops and implements data systems to review trends in health status indicators, make adjustments in the health service program, and provide the required aggregate data for local and state agencies;
- provides clinical consultation to the health education staff, physical educators, and other administrative and teaching staff;
- participates in interdisciplinary teams, (e.g., crisis, child abuse, emergency planning) to ensure that integrated systems are in place which address the comprehensive health needs of the student population;
- serves as the school health spokesperson on community initiatives such as skin cancer prevention;
- carries out communicable disease prevention and infection control based on current guidelines for universal precautions, prevention of bloodborne pathogens exposure, and hazardous medical waste disposal;
- ensures that there is an emergency care plan in place, which is communicated to all staff and is closely coordinated with community emergency care protocols;
- participates in communitywide bioterrorism and emergency response planning with other members of the multidisciplinary team; provides leadership in the school for bioterrorism preparedness and is linked to the Health and Homeland Alert Network (HHAN);
- collaborates with other school administrators and teachers to promote a physically and psychologically healthy school environment;
- promotes positive linkages and referral mechanisms to community providers for a range of services dealing with child and adolescent health;
- seeks opportunities to interpret the health needs of school-age children and adolescents, the goals of the health service program, & the importance of health education to administrators, school committee members, faculty, families, the general community, local and state decision makers, through special reports, the media, health fairs and other special events;

- prepares and administers the health services budget; seeks opportunities to apply for grants and other external sources of funding for the school health service program;
- implements a school health service data system, capable of tracking trends, activities and outcomes;
- uses the media (local cable stations, newspapers, and bulletin) and school health service website to share health promotion information, as well as to interpret the role of the school health service program;
- presents written and oral reports regarding the school health program to the superintendent, school committee, and other stakeholders; and
- seizes opportunities to present the challenges and opportunities of school health to other members of the health care delivery system.

Evaluation

- compiles statistical reports as required by the school system and by state agencies;
- completes ongoing continuous quality improvement programs and adjusts school nursing practice based on findings;
- evaluates nursing and other health service staff;
- actively participates in the accreditation process of the school;
- implements a client satisfaction feedback system;
- reviews changing trends in health needs and the outcomes of programs to determine need for revision of goals and objectives; and
- develops partnerships with local colleges and universities to (a) provide student practice in the school health programs, (b) obtain assistance with continuing education, (c) develop nursing research aimed at enhancing the body of evidence-based practice; and (d) publish in professional journals when possible.

Staff Development

- implements an ongoing continuing education program for staff to facilitate their meeting of the requirements for licensure through the Massachusetts Department of Education and maintain and expand clinical skills;
- encourages staff to participate in pertinent conferences and workshops addressing a range of school health issues; and
- provides ongoing formal and informal feedback to staff about their progress in achieving the goals of the program, encouraging their continued educational and professional development.

Exhibit 2-8 Sample Position Description

SCHOOL NURSE

Recommendation: The Nurse Leader and school nurse should review and revise the position description at a minimum of every 2 years based on changing student health needs.

Scope of Responsibilities
The school nurse is responsible for developing, implementing, and managing a school health program for a school population as defined by the school district. Responsibilities include program management, nursing services, collaboration, health education, community health and emergency planning, and professional practice.

As a nurse registered through the Massachusetts Board of Registration in Nursing (BORN), the Nurse Leader must adhere to the Nurse Practice Act, pertinent regulations governing nursing practice and standards of care established by the professional organizations.

Supervision Received
The school nurse reports to the School Nurse Leader and to the chief administrator of the school building. In some cases, the school nurse reports to the board of health administrator or nursing supervisor. School physicians are also available for consultation.

Supervision Given
The school nurse supervises the health aide/technician and others as defined by the position description (e.g., licensed practical nurse, health services secretary).

Required Qualifications:
Be licensed as a school nurse by the Massachusetts Department of Education.

Initial License

- valid license to practice as a Registered Nurse in Massachusetts;
- a bachelor's or master's degree in nursing;
- a minimum of 2 full years of employment as a Registered Nurse in a child health, community health, or other relevant clinical nursing setting;
- completion of an orientation program based on the requirements for delivery of school health services as defined by the Department of Public Health; and
- passing score on the Communication and Literacy Skills test.

Professional License

- possession of an Initial license;
- three years of employment as a school nurse; and
- completion of one of the following:

  a) Achievement and maintenance of certification or licensure by a nationally recognized professional nursing association as a school nurse, community health nurse, or a pediatric/family/school nurse practitioner.

  b) A master's degree program that may include credits earned in a master's degree program for the Initial License in community health, health education, nursing, or public health. Achievement of certification by a nationally recognized professional nursing association as a school nurse, community health nurse, or a pediatric/family/school nurse practitioner.

Responsibilities
Program Management establishes and manages a comprehensive school health program consistent with the Massachusetts guidelines, regulations and statutes governing nursing and school health, and local school district policy:

- participates in the school health advisory committee that is appointed by the school committee or designee;

- consults with the Nurse Leader, school physician, school administrators, and others to establish, review and revise policies, protocols, and specific programs for comprehensive school health education and services;
- works with others to develop a needs assessment and data collection protocols;
- ensures the orientation, training, supervision, and evaluation of paraprofessionals as needed to comply with the Nurse Practice Act and other relevant statutes and regulations;
- organizes and implements state-mandated programs such as immunization surveillance and screening programs;
- promotes positive safety practices both within and outside of school buildings, and ensures that the school has an emergency plan that is communicated to personnel and students;
- participates in the community emergency planning, including bioterrorism planning as appropriate;
- maintains comprehensive school health records;
- collaborates with school administrators and personnel in assessing and improving the social and emotional climate of students and faculty; involves them in maintaining a healthful school environment;
- uses population-based data to plan and evaluate the school health program; completes continuous quality improvement programs as needed to improve practice and outcomes;
- prepares regular written reports for school officials, the school committee, and DPH and other agencies describing the services provided by the program, numbers of students served, and so forth; interprets school health service needs and the role of the school nurse to the school and community;
- implements communicable disease prevention and infection control based on current guidelines for universal precautions, prevention of bloodborne pathogens exposure, and hazardous medical waste disposal; coordinates activities with the local board of health.

Nursing Services

Using the nursing process, collaborates with the parent/guardian and student, where appropriate, to develop and implement an individualized health care plan for the student:

- collects information about the health and developmental status of the student, his/her family, and significant others, in a systematic and continuous manner including health and social histories, screening results, physical assessment, emotional status, performance level and health goals; makes home visits as needed;
- develops a nursing diagnosis and care plan with specific goals and interventions delineating school nursing actions specific to student needs and coordinated with the efforts of other providers and school personnel; implements plans in a manner aimed at improving health and educational status;
- provides medically prescribed interventions, including medication administration (based on state regulations), and provides care to ill children on a daily basis;
- responds to frequently encountered health issues, providing counseling and crisis intervention when required (e.g., adolescent pregnancy, substance abuse, death of a family member, suicide); responds to child neglect or abuse issues (as required by Massachusetts statute);
- assesses student response to nursing actions in order to revise the database, nursing diagnoses, and nursing care plan and to determine the progress made toward goal achievement; documents pertinent information in student records or confidential nursing notes;
- provides first aid to injured children and staff; provides everyday care of acutely ill children; manages children with communicable disease;
- administers CPR; and
- responds promptly to emergencies.

Collaboration

Collaborates with other professionals, team members and community providers in assessing, planning, implementing, and evaluating programs and other school health activities, so as to maximize and coordinate services and prevent duplication:

- establishes a process to identify students at risk for physical and psychosocial problems, communicates health needs to other school personnel as appropriate, and establishes a referral system using both internal and community resources;
- participates as a team member; with parental consent when indicated, shares information with other team members about children with special health care problems which affect their safety, learning and growth; acts as an advocate for the student and family when appropriate; attends Special

Education Team meetings;
- includes the student and parent in the team conference whenever possible and appropriate;
- identifies health-related needs for inclusion in the individual education plan;
- serves as a member of pertinent committees and teams (e.g., crisis intervention team, support groups for grieving students);
- when the school is planning or implementing a school-based health center, participates on both the planning committee and the SBHC advisory committee; and
- serves as the school representative on appropriate community committees (e.g., those addressing overweight, teen pregnancies, violence prevention).

Health Education
Assists students, families, and groups to achieve optimal levels of wellness through health education and promotion:
- serves as a member of the curriculum committee for health education;
- identifies need for health education; teaches the basic principles of health promotion and disease prevention to students and staff, using principles of learning and appropriate teaching methods;
- assumes responsibilities for in-service programs for school personnel for first aid, emergency care protocols (including CPR and the use of the automatic external defibrillator), and current health issues; and
- acts as a resource in health education to school personnel, students, and families.

Community Health Planning
Participates with other members of the community to assess, plan, implement, and evaluate school health services and community services which include the broad continuum of primary, secondary and tertiary prevention:
- uses population-based data;
- understands and applies core public health functions of assessment, policy development, and assurance;
- uses community resources for referral of students with unmet health needs, including the need for a primary care provider; participates in the planning and implementation of new services;
- establishes working relationships with community providers and organizations (e.g., hospitals, primary care providers, boards of health, civic associations) and communicates the role and scope of school health to other community providers and organizations; and
- uses the media (newspapers, cable television, etc.) to convey important health information and advocate for the role of the school health program in promoting the health of the student population.

Professional Practice
Applies appropriate nursing theory as the basis for decision making in the school setting while expanding knowledge and skills in response to the student health needs and participating in research:
- demonstrates current knowledge in such areas as (a) professional issues in school nursing, (b) school and community health, (c) communicable disease control, (d) growth and development, (e) health assessment, (f) special health conditions, both chronic and acute, (g) injury prevention and emergency care, including bioterrorism planning, (h) health counseling, health education and promotion, and (i) current adolescent issues;
- assumes responsibility for continuing own education; obtains expert consultation, supervision, and peer review as needed;
- collaborates with local schools of nursing to provide student practice in community health, as well as to obtain nursing education resources; and
- forms partnerships with colleges and universities to identify topics for study and research in order to expand the scope of evidence-based school health and school nursing practice.

Adapted and updated from American Nurses' Association *Standards of School Nursing Practice*, 2001.

Exhibit 2-9

TEMPLATE FOR MASSACHUSETTS SCHOOL PHYSICIAN/MEDICAL CONSULTANT ROLE

Introduction: The school physician/medical consultant role is continuing to evolve in Massachusetts. Recently, in response to questions as to what constitutes the role, the Massachusetts School Physician Committee, collaborating with the Massachusetts Department of Public Health School Health staff, drafted the following template containing a composite list of certain responsibilities included in various communities throughout the Commonwealth. The template is intended to offer guidance to the school administrator and physician as they define the role for their specific school district and student population.

The school physician functions as part of a health team addressing the health issues of the students in each school district. In this unique position the school physician has opportunities to affect the health of large numbers of children and adolescents in many ways. Coordinated, comprehensive school health programs, as defined by the United States Centers for Disease Control and Prevention, include the following components: health education, health services, social and physical environment, physical education, guidance and support services, food service, school and work-site health promotion, and integrated school and work-site health promotion. Depending on the school district, the school physician may play a role in any or all of these components. In addition, the school physician may act as a liaison to community providers. As the health care system undergoes dramatic restructuring, the school (the place where children spend many hours each day) offers unique opportunities for the school physician to join the school nurse in developing coordination and communication systems with local primary care providers, thus ensuring continuity of care.

While the school physician in most school districts will continue to work most closely with the school nurse, who is responsible for the daily management of the health service program, additional health team members may include, but not be limited to, the health coordinator/educator, social worker and other mental health professionals, food service directors, athletic directors, and so forth. The role of the school physician will continue to expand in different ways in different school districts. The template, which will continue to grow and change, offers some concrete choices based on the needs of the specific school district, its student population, and the community, which it serves.

The depth and breadth of the physician role can be categorized into 9 different functions: administration and planning, liaison to community physicians, direct service, clinical consultation, policy consultation, health education, public relations, advocacy, and systems development consultation.

Administration and Planning[2]: In collaboration with the school nursing leader and other staff who administer components of the comprehensive school health program, the school physician:

- supports the school nursing leader and school nursing staff in planning and implementing the school health service program;
- assists in administering the program cooperatively with the school nursing leader, administration and local school committee;
- meets on a regular basis[3] with the school nursing leader (and school nurses as appropriate) to review, evaluate and revise the program as needed;
- participates as an active member of the school health advisory council/committee, which meets quarterly, assists in emergency care planning for the school district; and
- participates in professional development relevant to school health.

In addition, the school physician may:

- assist in writing applications for health-related grants;
- assist in employing, supervising and evaluating school health personnel, as appropriate.

[2] This section adapted from the Connecticut document by Martin Sklaire, M.D., “Suggested Qualifications and Role of the School Medical Advisor.

[3] Meetings should occur, at a minimum, on a monthly basis.

Liaison to Community Physicians: Because the school health service program emphasizes health promotion and is an important part of the health care delivery system serving children in the community, the school physician:

- interprets the importance of the school's health education program for children, adolescents, and their families;
- interprets the role of the school health program in the continuum of health services for children, (e.g., medication management of ADHD, asthma, diabetes);
- interprets federal and state school health regulations to community primary care providers; (These regulations include but are not limited to the regulations governing physical examinations, immunizations, medication administration in the schools, and the rights of the disabled students.)
- consults with local providers on pertinent medical issues of individual students as they affect the child's performance in the educational environment (e.g., a child with a complex medical need);
- collaborates with local providers to prevent duplication of services between the school health program and the primary care providers (e.g., annual physical examinations for students participating in competitive sports, vision and hearing screening); and
- promotes communication and exchange of pertinent medical information (with parental consent) between the school health program and the primary care providers.

Direct Service: Every child and adolescent in Massachusetts should have a designated primary care provider. As more primary care providers are identified, the role of the school physician is moving from a direct service provider (e.g., performing physical examinations) to that of a medical consultant to the school and particularly to the school nurse. Based on the change in emphasis, the school physician:

- provides physical examinations (entry, every 3–4 years thereafter, annually prior to participation in competitive sports, and ages 14–16 prior to obtaining a work permit as per M.G.L. c.71, s.57, and 105 CMR 200.200) for only those students who lack a primary care provider; and
- may assume the role of sports team physician or assumes the responsibility for identifying a physician for coverage of school-sponsored sports events.

Clinical Consultation: As the role changes and the health needs of the students and staff become more complex, the school physician:

- consults on a regular basis with the school nurse; and
- consults with school administrators and other school personnel, as needed.

Examples of issues where school physician consultation may be useful include but are not limited to:

- ✓ students with special health care needs;
- ✓ students with individualized educational plans (IEP); individual health care plans (IHCP), and Section 504 plans as needed;
- ✓ immunizations or implementation of state mandated immunization regulations;
- ✓ infection and outbreak control (e.g., pertussis, meningitis, pediculosis);
- ✓ vision, hearing, and postural screening;
- ✓ staff health, wellness, and disability issues;
- ✓ mental health issues;
- ✓ classroom management of the child with physical or emotional issues (as requested by the school nurse, teacher, or parent);
- ✓ medical transportation issues for children with special health care needs;
- ✓ school environmental issues as they arise (e.g., air quality, building safety, playground safety, "sick building syndrome");
- ✓ school sports medicine program;
- ✓ medical orders for emergency medications (e.g., over-the-counter medications or epinephrine for children with undiagnosed life-threatening allergic conditions, immunization clinics);
- ✓ nutrition issues as they relate to such areas as the food service, eating disorders, and so forth; and
- ✓ health room facilities and equipment.

Policy Consultation: The school health program offers many opportunities to promote the health of large populations of children. To do this effectively, the school must have effective evidence-based policies. In the school physician's policy consultation role, he/she:

- participates in the school health advisory council/committee;
- collaborates with the school nurse, provides consultation on policies pertaining to the health and safety of school students and staff.

Policies may include but are not limited to:

- ✓ crisis intervention (depression, suicide, and violence);
- ✓ emergency and disaster planning and preparedness (collaborating with local emergency medical services);
- ✓ immunization policies;
- ✓ substance use/abuse, including tobacco;
- ✓ medical transportation;
- ✓ healthy school environment (both physical and social);
- ✓ nutrition issues including food services;
- ✓ infection control and universal precautions;
- ✓ attendance, including exclusion for illness;
- ✓ medication administration, including nonprescription medications;
- ✓ management of children with chronic illnesses (e.g., asthma, diabetes); and
- ✓ child abuse/neglect.

Health Education: The school offers many opportunities to encourage students to obtain information about health and learn skills, which promote healthy behaviors. The school physician:

- provides consultation, as needed, on health education curricula in grades PreK–12;
- presents classroom lectures on relevant topics;
- provides education to staff and athletes on issues relating to sports medicine and injury prevention;
- provides medical information and health education for parents as appropriate; and
- participates in school-sponsored health fairs.

Public Relations: The school physician:

- interprets health issues to the community (e.g., contributes articles to the local newspaper, provides health education); and
- may represent the school on health issues in the media (as requested by school administration) when a crisis occurs in the school or regarding the school-age population.

Advocacy: As the comprehensive school health programs continue to grow and change to meet the needs of the student populations in modern society, there is an increasing demand for advocacy from the medical profession. As a respected medical professional in the community, the school physician:

- supports comprehensive health education, grades kindergarten through 12;
- advocates for additional resources as needed;
- testifies at public hearings regarding school health issues (e.g., immunizations); and
- is in contact with policy makers (local, state, and national) about issues pertaining to the health of children and adolescents and the role of the comprehensive school health program.

Systems Development Consultation: As the health care delivery system caring for children continues to incorporate the school health program as an active partner, some school districts are exploring organizational structures and mechanisms to enhance access and efficiency by providing onsite services and/or arrangements with local agencies to provide services. In these schools, the school physician, in collaboration with the school nursing leader, administrators, and other appropriate staff, may:

- provide consultation on the development of a system of mental/behavioral health services delivered in the school and linked to local providers;
- identify new programs for integrating and coordinating services with both internal and external providers;
- establish an ongoing system to identify students at risk for health or education issues;
- establish standards and quality assurance programs for the provision of services by external providers in the school;

- identify the need for a school-based health center, if access to health care is an issue in the community;
- play an active role in coordinating services and developing collaborative arrangements with other municipal agencies having a role in school health (e.g., the local health department); and
- provide consultation on implementing school health data systems and data analysis, as well as information tracking systems (e.g., the Massachusetts Immunization Information System).

Minimum Qualifications

- a license to practice medicine in the Commonwealth of Massachusetts (M.G.L. c.71, s.53b); and
- knowledgeable about the health needs of children and adolescents.

Additional Preferred Qualifications: The school physician/medical consultant should, in addition, be board certified or board eligible in pediatrics or family practice. When the primary student population includes adolescents, the school physician/medical consultant should have additional education in the subspecialty of adolescent medicine.

Exhibit 2-10 Sample Position Description

SCHOOL HEALTH AIDE/ASSISTANT

Scope of Responsibilities

The school health aide assists in the school health program as determined by the school nurse (who is a registered nurse). Therefore the scope of responsibilities will vary according to school health program needs, the capabilities of the school health aide, and the availability of the school nurse to provide supervision. When the school nurse determines that certain tasks may be delegated to the school health aide, such delegation shall be under the supervision of the school nurse and consistent with the Board of Registration in Nursing regulations (244 CMR 3.05). (See also Chapter 6 for Regulations Governing the Administration of Prescription Medications in Public and Private Schools.)

Recommended Minimum Qualifications

- possess a high-school diploma or its equivalent;
- demonstrate sound judgment;
- be able to read and write English;
- respect and protect the confidentiality of students, staff, families, and others;
- be willing to accept nursing supervision;
- complete training in both cardio-pulmonary resuscitation and a basic first aid program, and maintain the necessary certifications;
- complete the Department of Public Health training program for vision and hearing screening; and
- demonstrate clerical proficiency.

Supervision Received

The Health Aide receives supervision from the school nurse appointed under the provisions of M.G.L. c.71, s.53.

Responsibilities

To be assigned by the school nurse, these responsibilities may include but are not limited to:

Assisting in Health Care Activities

- performs vision and hearing screening and related tasks (e.g., recording results, sending letters to parents/guardians);
- weighs and measures students; completes graphs of heights and weights;
- assists with preparation for health activities (e.g., physical examination of students, immunizations, Mantoux testing);
- administers medications as delegated by the school nurse, after having received the required training and according to the Regulations Governing the Administration of Prescription Medications in Public and Private Schools (105 CMR 210.00). (This is applicable only in school districts registered with the Department of Public Health for delegation of prescription medication administration.);
- provides first aid care to students with minor injuries;
- reports all illnesses/injuries to the school nurse for professional review, care and/or follow-up; and
- contacts parents of ill or injured children.

Performing Clerical Functions

- records health information (e.g., results of various screening tests, immunization information, BMIs);
- maintains an up-to-date master file (e.g., student health emergency information);
- sends notices to parents, tabulates returns, and follows up on nonrespondents;
- provides ongoing communication to the school nurse regarding the status of health notices;
- distributes information (e.g., forms) to teachers and administrative staff; and
- develops computer skills as needed.

Exhibit 2-11 Sample Position Description

SCHOOL NURSE PRACTITIONER
(Family Nurse Practitioner, Pediatric Nurse Practitioner)

Scope of Responsibilities
The Nurse Practitioner's responsibilities vary according to the specific school system. In some school systems, the Nurse Practitioner will be the primary care provider for the students registered in the school-based health center. In other systems where there is no school-based health center, she/he practices in an expanded role for the general student population.

Supervision Received
The Nurse Practitioner receives clinical supervision from a designated physician. When functioning as part of the school health service team, she/he receives administrative supervision from the manager as defined in the specific position description.

Supervision Given
The Nurse Practitioner functioning as the primary care provider within a school-based health center gives supervision to those licensed and unlicensed persons functioning within the SBHC and as defined by her/his position description. If the Nurse Practitioner functions within the general school health program, she/he likewise is responsible for those licensed and unlicensed personnel as defined by the position description.

Recommended Qualifications
- must have a valid license to practice as a Registered Nurse **in the Expanded Role** in Massachusetts (required); see M.G.L. c.112 — the Nurse Practice Act — for a description of this expanded role;
- possess a minimum of a baccalaureate in nursing from an accredited nursing program; (A Master's degree in nursing is preferred); possess/maintain certification as a School/Pediatric or Family Nurse Practitioner;
- have a minimum of 3 years experience in school nursing or a related field;
- maintain certification in cardio-pulmonary resuscitation, including AEDs, and first aid;
- have an identified physician who provides consultation;
- assume responsibility for updating knowledge and skill in community health, management and related fields as new information emerges; and
- complete ongoing continuing education programs pertinent to the evolving specialty area of school health and school nursing practice, as well as meet the continuing education requirements for licensure in the expanded role in Massachusetts.

Responsibilities
The Nurse Practitioner practicing within the school setting is responsible for many of those areas listed in the position description for the school nurse. In addition, her/his role includes:
- consulting and collaborating with a pediatrician, medical specialist in adolescent medicine, or other related field in addressing medical issues presented by the students and in developing practice guidelines;
- providing primary care to students;
- managing the health care of students with chronic and acute conditions while providing intervention and/or referral as necessary;
- providing physical examinations to identified students at appropriate intervals (prior to participation in sports, prior to obtaining work permits, etc.).
- establishing close communication and coordination systems with the school health service program, specifically the school nurse;
- consulting with teachers on health issues and provision of clinical in-service education as needed;
- participating in schoolwide programs addressing health (e.g., health fairs, overweight prevention, asthma management, tobacco cessation);
- participating in communitywide initiatives such planning for a bioterrorism event; and
- maintains data systems and provide ongoing data reports as required by the school, the parent organization, and the state.

Exhibit 2-12 Sample Position Description

HEALTH EDUCATION AND HUMAN SERVICES COORDINATOR

Please note: this position description applies to the Nurse Leader who is also the HEHS Coordinator.

Scope of Responsibilities

In addition to the position description of the Nurse Leader, the HEHS Coordinator (in the dual role) is responsible for planning, implementing, and evaluating the comprehensive health education and human services program in a school district.

Supervision Given

The Health Education and Human Services Coordinator reports to the Assistant Superintendent as defined in her or his position description.

Recommended Qualifications

- a Master's degree in education and have a valid license to practice as a Registered Nurse in Massachusetts or have an R.N. with Master's degree in education, public/community health, or nursing;
- strong managerial skills;
- experience with coordination of health education programs;
- experience with supervision and administration;
- highly organized, efficient, and thorough;
- ability to work independently to achieve goals and responsibilities;
- skilled and experienced in group facilitation and planning with diverse populations; and
- demonstrated ability to work effectively with school and agency personnel.

Responsibilities

- administer health-related grants and assist with preparation of health-related grant proposals;
- supervise the implementation of the early childhood through grade 12 health education curriculum;
- facilitate an interdisciplinary team approach to identify and respond effectively to student health issues;
- expand coordination of available health and human services within the school district and the community;
- work with consultants and staff to (a) research and investigate model programs; (b) assess student health needs; (c) evaluate comprehensive school health education and human services; and (d) develop a long-range plan with the goal of significantly reducing participation in high risk behaviors by staff, students, and families, and significantly increasing health promoting behaviors;
- participate in all surveys, studies, and evaluations on comprehensive school health education and services requested by the DPH and DOE;
- participate in community network activities and develop links with appropriate health care providers;
- participate, with appropriate clinical consultation, in the formation and revision of school health policies and protocols;
- prepare and administer school health budget as appropriate;
- oversee comprehensive school health program data collection as appropriate; and
- actively participate in School Health Advisory Committee.

Exhibit 2-13 Sample Agreement

FORMAL WRITTEN AGREEMENT WITH THE LOCAL BOARD OF HEALTH

_____ School Department agrees to contract with

_____ Board of Health to provide the following:

- all required school health services or selected school health and human services
- mandated immunizations
- mandated physical examinations and screenings for the following (check applicable examinations and screenings and fill in grades):
  - ❒ physical examinations, grades: _____
  - ❒ vision screening, grades: _____
  - ❒ hearing screening, grades: _____
  - ❒ scoliosis/kiphosis, grades: _____
- maintenance of school records
- care of children with special health care needs
- health education
- emergency care planning and provision
- case finding, referral, and follow-up
- health counseling
- tuberculosis screening
- communicable disease control, including prevention, case finding, and follow-up

The _____ School Department will provide the following services (if applicable):

Staffing

The _____ Board of Health will provide the following staff (FTE's):

- ❒ Registered Nurses/Public Health Nurses/School Nurses
- ❒ School Physician
- ❒ School Health Assistants or Aides
- ❒ Dental Hygienist
- ❒ Vision and Hearing Screeners
- ❒ Clerical Assistants
- ❒ Other (Specify):

Supervision

Supervision will be provided by:

Equipment and Space
The _____ Board of Health will provide:

The _____ School Department will provide:

Maintenance of records and policies regarding confidentiality (include responsibilities for computerization, technology assistance, and sharing of demographic data):

Mutual Responsibilities for Coordination and Cooperation
- To evaluate the program, plan for the future, and address any problems that have arisen, regular meetings (2-4 times per year) that include leading members from both parties will be held.
- Each board of health/school department will agree to appoint one person as liaison:

School Department liaison: _____

Board of Health liaison: _____

Terms of Agreement: (includes monthly and/or annual reporting of services provided and fees, if any)

Termination of Agreement
The following notice is required prior to termination of the agreement by either party:

Effective Date of Agreement: _____

Renewal Date: _____

_____ _____
Signature (Agency/Board of Health) ***Signature*** (School Department)

Exhibit 2-14 Sample Content Outline

POLICIES AND PROTOCOLS MANUAL

1. Purpose of Manual (including plans for review and revision)
2. Philosophy of the School Health Program
3. Program goals
4. Laws relevant to the School Health Program
5. Organizational Chart
    a.) In-school coordination and how it relates to the community
    b.) School Department (and Health Department)
    c.) School Health Services
6. Memorandum of Agreement or contract, if Board of Health provides school health services
7. Memorandum of agreement if the public school district provides school health services to the community nonpublic schools
8. Memorandum of agreement identifying the role of the public school in the agencies using the school facility (e.g., collaboratives, child care programs, before- and after-school programs)
9. Job Descriptions
    a.) Nurse Leader
    b.) School Nurse and/or School Nurse Practitioner
    c.) School Physician
    d.) School Health Assistant
    e.) Mental health providers
    f.) Nutritionist
    g.) Other clinical personnel (e.g., speech therapist, physical therapist)
    h.) Vision/Hearing Technician
10. Personnel policies as they relate to health, such as emergency contact information, immunization status and special health conditions
11. Professional Development Policies as they pertain to DOE licensure and currency of clinical and public health practice
12. Policies for health assessment and follow-up of students
    a.) Preschool
    b.) School entry, re-entry, and transfer
    c.) Physical examinations, including prior to participation in interscholastic sports and obtaining work permits
    d.) Screenings (e.g., vision, hearing, postural, growth (height/weight/BMI)).
13. Policies for Prevention and Control of Communicable Diseases
    a.) Handwashing as a control measure
    b.) Universal Precautions
    c.) Immunizations
    d.) Reportable infectious diseases, including surveillance and outbreak response measures
    e.) Policies pertaining to specific conditions (e.g., pediculosis, scabies, ringworm)
    f.) Disposal of medical waste
14. Policies for Provision of Emergency Care (individual and multicasualty)
15. Policies for the Care of a Sick Child in a Non-emergency Situation
16. Attendance Policies (including dismissal for health reasons)
    a.) Release or exclusion of student
    b.) Release of students to authorized persons or emergency transport personnel

17. Administration of Medication Policies (see Chapter 6)
18. Special Education Protocols: IEPs, 504 Plans, IHCPs
19. Policies for Management of Students with Chronic Illnesses
    a.) Asthma
    b.) Diabetes
    c.) Seizure disorders
    d.) AIDS
    e.) ADHD/ADD
    f.) Life-threatening allergies
    g.) Other, as unique to the school district
20. Policies for Response to Frequently Encountered Health Problems
    a.) Child abuse and neglect (including reporting)
    b.) Substance use and abuse
    c.) Injuries (orthopedic, etc.)
    d.) Violence (including bullying, date rape, homicide, suicide)
    e.) Pregnant students and school-age parents
    f.) Eating disorders and other nutritional concerns
    g.) Behavioral Health problems
        1.) Crisis intervention (e.g., death of a member of the school community)
        2.) Suicide prevention
21. Policy for Adherence to a Do Not Resuscitate/Comfort Care Only Order
22. Health Counseling Policies (e.g., pregnant or parenting teens)
23. Physical Education (e.g., requirement for medical recommendation for modified gym)
24. Athletic Participation (e.g., return after injury)
25. Policies for Maintenance of Student Health Records, including transfer and destruction
26. Policies for School Nurse-Teacher Conferences
    a.) Annual scheduled conferences for the total school population
    b.) Individual nurse-teacher-parent-student health conferences
27. Policies regarding health services for staff; staff wellness
28. Policies for Coordination of School Health Services with Community Resources (e.g., local board of health, health centers, primary care providers)
29. Health Education Policies
30. Food Services, such as nutritious food choices, use of vending machines and plans for students with life-threatening food allergies
31. Responsibilities for a Safe, Healthy School Environment
    a.) Injury prevention
    b.) Tobacco-free schools
    c.) Indoor air quality
32. Health Suite
    a.) Protocol for use by students, faculty, and visitors
    b.) Health education materials
    c.) Equipment
    d.) Emergency supplies, including availability of EpiPens®, AEDs
    e.) Information technology (e.g., computers, dedicated facsimile machine)
33. Health Services Budget
34. List of Community Resources

Exhibit 2-15

GENERAL LAWS OF MASSACHUSETTS

PART I.
ADMINISTRATION OF THE GOVERNMENT

TITLE XVI.
PUBLIC HEALTH

CHAPTER 112. REGISTRATION OF CERTAIN PROFESSIONS AND OCCUPATIONS

REGISTRATION OF PHYSICIANS AND SURGEONS

Chapter 112: Section 12V Exemption of certain trained individuals rendering emergency cardiopulmonary resuscitation from civil liability

Section 12V. Any person who is trained according to the standards and guidelines of the American Heart Association or the American National Red Cross in cardiopulmonary resuscitation or the use of semi-automatic or automatic external defibrillators or any person who has successfully met the training requirements of a course in basic cardiac life support, conducted according to the standards established by the American Heart Association, who in good faith and without compensation renders emergency cardiopulmonary resuscitation or defibrillation in accordance with his training, other than in the course of his regular professional or business activity, to any person who apparently requires cardiopulmonary resuscitation or defibrillation, shall not be liable for acts or omissions, other than gross negligence or willful or wanton misconduct, resulting from the rendering of such emergency cardiopulmonary resuscitation or defibrillation.

Exhibit 2-16 Sample Policy — Procedures for Automated External Defibrillator (AED)

Newton Public Schools

School-Based Public Access Defibrillation Program

POLICIES AND PROCEDURES

(PROCEDURES EXCERPT ONLY)

IV. PROCEDURES

A. Location, Mobility of Device(s):

The AED devices shall be at the sites and specific locations listed on Attachment IV.A. Each AED will be the responsibility of the Site Leader or a designee (indicated in writing), or his/her designated back up.

B. Maintenance:

See the AED manufacturer's Operating Instructions Manual for detailed maintenance information and instructions. The Site Leader or designee responsible for an AED will perform and document as follows:

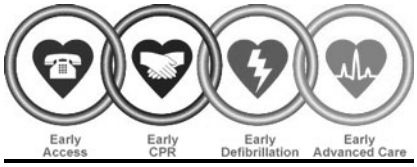
- Daily and after each use (see Attachment IV.B.1)
  - Check readiness display for 'OK' and confirm no battery indicator or service indicator displayed
  - Visually inspect AED: proper location, clean, no tampering
  - Initial daily log (Attachment IV.B.1)

- Monthly and after each use (see Attachment IV.B.2)
  - Inspect AED, case, connectors, battery according to Operator's Checklist
  - Check station against AED Station Inventory, and restock as needed
  - Enter date, print and sign name on monthly log (Attachment IV.B.2)

- After each use
  - Inspect exterior for dirt or contamination and clean if needed (see Operating Instructions)

Whenever results of inspection require action (per manufacturer's Operating Instructions Manual or these procedures) and after each dispatch or use (anytime defibrillator pads are attached to a patient), document in the AED General Log (Attachment IV.B.3). If the unit needs immediate service or supplies, remove from service and notify the Program Coordinator immediately. If the unit is still operational but requires service or supplies will expire soon, Site Leader should notify the Program Coordinator promptly.

C. Use of AED:



1. Early access to EMS (911)

- *Assess responsiveness – tap victim and shout "Are you OK?"*
- If unresponsive, activate emergency response system
  - If alone, activate EMS by calling 911∗ and get AED*
  - If not alone, stay with victim and assign someone to activate EMS by calling 911*
  - get AED*

∗ See site-specific response plan for procedures to activate EMS and retrieve AED.

When activating 911, provide: location, telephone number, nature of emergency, what aid is being provided (ex. “we’re using an AED”).

2. Early CPR

- Check ABC’s (Airway, Breathing, Circulation)
- If no breathing, provide rescue breathing
- If no circulation
    - if AED is immediately available, attempt early defibrillation
    - if AED is not immediately available, perform CPR and prepare to attempt defibrillation when AED arrives

3. Early defibrillation

NOTE: • DO NOT USE AED ON VICTIM <8 YEARS OLD OR <55 LBS/25 KGS
• REMOVE VICTIM FROM CONTACT WITH WATER AND DRY CHEST

- Power on AED
- Attach AED electrodes to victim’s bare chest
- Allow AED to analyze (do not touch victim)
    - Clear victim during analysis (“I’m clear, you’re clear, everyone’s clear”)
- If advised to shock (do not touch victim)
    - Clear victim (“I’m clear, you’re clear, everyone’s clear”)
    - Press shock button
- Continue to follow AED prompts until EMS arrives

4. Early advanced care

- EMS takes charge of victim upon arrival
- Provide victim information to EMS: name, age, known medical problems, details of incident, victim condition and aid provided (incl. number of shocks administered)
- Electrodes remain in place on victim (detached from device); school’s AED remains with representative of school who returns device to Site Leader as soon as possible

D. Post-incident:

Any time that defibrillator pads are attached to a patient and when otherwise appropriate:

- Targeted responder notifies Site Leader. Site Leader notifies Director of Clinical Services, who notifies Medical Director and Program Coordinator.
- AED responder must complete the event summary form (Attachment IV.D.) and return to Site Leader or provide the same information to Site Leader (who completes the form). Site Leader forwards copy to Program Coordinator, who retains one copy and forwards a copy to Medical Director. Site Leader documents additional information relating to incident as appropriate.
- Site Leader or designee takes AED out of service. Any AED data will be downloaded or printed from AED by or under the direction of the Program Coordinator. The Program Coordinator will retain one copy of the data report, and forward one copy to the Medical Director.
- Before AED is entered back into service, Site Leader will inspect, clean if needed and re-stock AED station (according to “Maintenance” above).
- The Medical Director will conduct a post-incident review (including quality improvement) and debrief program staff and those involved in the incident. As appropriate, the Medical Director will also ensure patient outcome monitoring and a trained rescuer emotional support process

Exhibit 2-17 Student Health Memo to Parents/Guardians

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURPHY
LIEUTENANT GOVERNOR

JUDYANN BIGBY, M.D.
SECRETARY, EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

JOHN M. AUERBACH
COMMISSIONER, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

MEMO

Student Health and Emergency Information Form

As one of the Massachusetts Department of Public Health's continuing efforts to ensure that every child in Massachusetts is enrolled in a health care plan, two prototypes of *Student Health and Emergency Information Forms* were developed. The prototypes contain a space for the child's health insurance and a statement that, if a child lacks health insurance, the parent should call the school nurse for information about public health insurance plans.

The following forms may be reproduced. Each school district may wish to customize the form according to its individual needs. The school district should carefully determine which form to use depending on the storage location of the completed forms and the need to protect confidential information shared by the parent.

We recommend that school districts follow the same protocols as those for implementation of other new forms. This may include review by school nursing staff, administration, legal counsel and others.

We hope this information proves helpful.

Sincerely,

Exhibit 2-18 (Form A)

Student I.D. # _____ **Home Room** _____

STUDENT HEALTH AND EMERGENCY INFORMATION FORM

Please complete the following information below and return to school immediately. Please contact school nurse if assistance is needed to complete form.

Student's Name_____
Last First Middle

Street Address_____ **State** _____ **Zip Code** _____

Home Phone _____
(area code)

Grade_____ **Sex:** ❒ **Male** ❒ **Female** **Date of Birth** _____

Primary Language_____

Does your child have Health Insurance? ___ Yes ___ No

Health Insurance Company_____

Policy Number _____

If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact the school nurse for more information about these programs.

All communications will be confidential.

Name of Parent 1/Guardian/Other_____ **Place of Employment** _____

Home Address_____ **State** _____ **Zip Code** _____

Work Address_____ **State** _____ **Zip Code** _____

Phone:

Home_____ **Work**_____ **Pager**_____
(area code) (area code) (area code)

Name of Parent 2/Guardian/Other_____ **Place of Employment** _____

Home Address_____ **State** _____ **Zip Code** _____

Work Address_____ **State** _____ **Zip Code** _____

Phone:

Home_____ **Work**_____ **Pager**_____
(area code) (area code) (area code)

Name/Grade of sisters/brothers in school building _____

Please indicate names of others who will assume responsibility and provide transportation for your student in case of illness/injury/emergency evacuation:

Name _____ **Relationship** _____

Daytime Phone_____
(area code)

Name _____ **Relationship** _____

Daytime Phone_____
(area code)

In case of medical emergency, the school will attempt to contact parent/guardian before calling student's primary care provider (physician). Your child will be transported by ambulance to an emergency care facility if necessary.

Physician Name_____ **Telephone Number** _____

Dentist Name_____ **Telephone Number** _____

Please list all medications that your child takes:

I understand that this information is confidential. However, federal law permits information in the school health record to be shared with school officials on a "need to know" basis and with a very limited number of other persons, including those who could help in an emergency. In other circumstances, my consent will be required. **I give permission to exchange information with my child's health care provider. I understand that I can limit or revoke this consent at any time**.

Signature_____ **Date** _____

2005A (DPH)

Exhibit 2-19 (Form B)

Student I.D. # _____ **Home Room** _____

STUDENT HEALTH AND EMERGENCY INFORMATION FORM

Please complete the following information below and return to school immediately. Please contact school nurse if assistance is needed to complete form.

Student's Name_____
Last First Middle

Street Address_____ **State** _____ **Zip Code** _____

Home Phone _____
(area code)

Grade_____ **Sex: ❒ Male ❒ Female Date of Birth** _____ **Primary Language**_____

Does your child have Health Insurance? ___ Yes ___ No

Health Insurance Company_____

Policy Number _____

If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact the school nurse for more information about these programs.

All communications will be confidential.

Name of Parent 1/Guardian/Other_____ **Place of Employment** _____

Home Address_____ **State** _____ **Zip Code** _____

Work Address_____ **State** _____ **Zip Code** _____

Phone:

Home_____ **Work**_____ **Pager**_____
(area code) (area code) (area code)

Name of Parent 2/Guardian/Other_____ **Place of Employment** _____

Home Address_____ **State** _____ **Zip Code** _____

Work Address_____ **State** _____ **Zip Code** _____

Phone:

Home_____ **Work**_____ **Pager**_____
(area code) (area code) (area code)

Name/Grade of sisters/brothers in school building _____

Please indicate names of others who will assume responsibility and provide transportation for your student in case of illness/injury/emergency evacuation:

Name _____ **Relationship** _____

Daytime Phone_____
(area code)

Name _____ **Relationship** _____

Daytime Phone_____
(area code)

In case of medical emergency, the school will attempt to contact parent/guardian before calling student's primary care provider (physician). Your child will be transported by ambulance to an emergency care facility if necessary.

Physician Name_____ **Telephone Number** _____

Dentist Name_____ **Telephone Number** _____

Please list all medications that your child takes:

To better serve your child's medical/physical/emotional/educational/social needs, please check the following that pertain to your child:

❒ Heart Condition ❒ Diabetes ❒ Asthma ❒ Seizure Disorder ❒ ADD/ADHD ❒ Migraines

❒ Depression ❒ Other; Specify: _____ **❒ Allergies: To what (for example, food, insects, medication, environment):** _____

Does your child have hearing problems? ❒ Yes ❒ No If yes, ❒ Left ear ❒ Right ear ❒ Hearing Aids

Does your child have vision problems? ❒ Yes ❒ No If yes, ❒ wears glasses ❒ contact lenses ❒ preferential seating

---

I understand that this information is confidential. However, federal law permits information in the school health record to be shared with school officials on a "need to know" basis and with a very limited number of other persons, including those who could help in an emergency. In other circumstances, my consent will be required. **I give permission to exchange information with my child's health care provider. I understand that I can limit or revoke this consent at any time.**

Signature_____ **Date** _____ **2005B**

Exhibit 2-20 Sample Employee Emergency Information Form

Confidential
Employee Emergency Information
_____ School District
(*Optional)*

NAME _____

ADDRESS _____

_____

SCHOOL _____

ASSIGNMENT_____ _____

In case of emergency, please notify:
Name _____ **Relationship** _____
Day Address_____
Evening Address_____
Home Number _____ **Work Number** _____
Cell _____ **Other** _____

Please list any medical conditions (e.g., diabetes, heart disease, allergies, asthma, seizure disorders, mobility limitations):

Please list any medications (prescription and non-prescription) taken on a regular basis:

Primary Care Provider _____
Telephone Number(s) _____
Health Insurance _____

Dental Care Provider _____
Telephone Number(s) _____
Dental Insurance _____

Preferred Hospital (Medical Facility) _____
Date of last Vaccine: _____
Tetanus _____ **Varicella** _____ **MMR** _____ **Pneumococcal** _____ **Influenza** _____

Signature _____ **Date** _____

Exhibit 2-21 Sample 24-Hour Shelter Emergency Medication and Care Plan

CONFIDENTIAL

_____ SCHOOL DISTRICT

STUDENT 24-HOUR SHELTER EMERGENCY MEDICATION AND CARE PLAN

Certain emergency situations may indicate that students are best protected by remaining in their school buildings for an extended period of time, which may include overnight shelter. If such an emergency occurs, every attempt will be made to provide a safe environment. Therefore it is important for parents to complete and return this form, together with the required medication to your student's school nurse at the beginning of each academic year. (Please provide updated information to the school nurse as needed throughout the year.)

STUDENT NAME _____ **DOB** _____
SCHOOL _____ **GRADE** _____

In case of extended time in school due to an emergency situation, please notify:
(1) Name _____ **Relationship**_____
Home Number _____ **Work Number** _____
Cell _____ **Other** _____
In case of extended time in school due to an emergency situation, please notify:

(2) Name _____ **Relationship**_____
Home Number _____ **Work Number** _____
Cell _____ **Other** _____

Special Health Issues (Diabetes, Asthma, Allergies, Seizure Disorders, Mobility Limitations, Behavioral/Emotional, etc.)

Special Services Required (Nebulizer Treatment, Sleep Monitoring, Eating Habits, Etc.)

(1) Medication _____**Date Prescribed** _____
Dosage_____ **Frequency**_____ **Rte of Administration** _____
Reason for Medication: _____ **Possible Side Effects:** _____
Specific Directions:

Licensed Prescriber: _____ **Telephone Number** _____

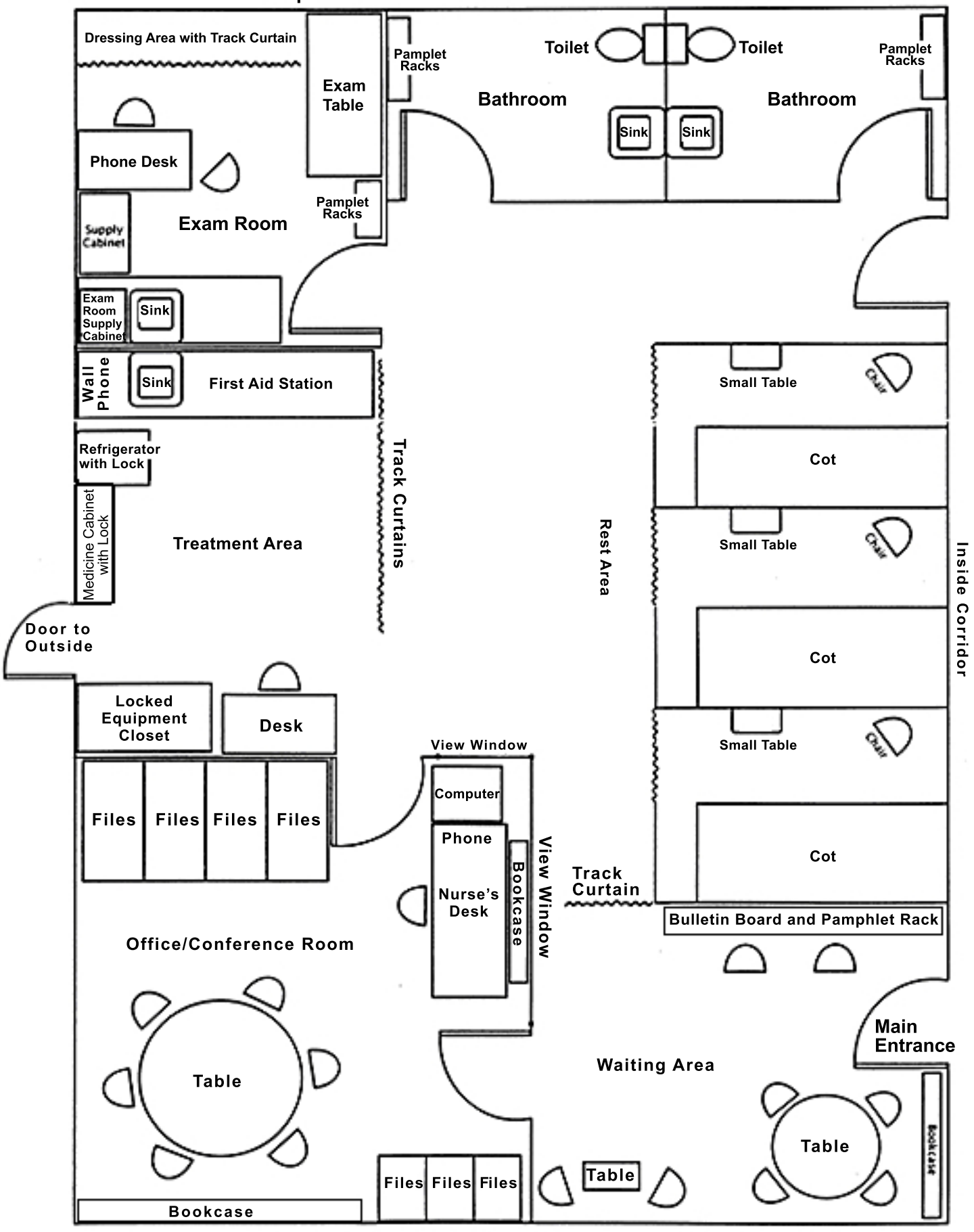
(2) Medication _____**Date Prescribed** _____
Dosage_____ **Frequency**_____ **Rte of Administration** _____
Reason for Medication: _____ **Possible Side Effects:** _____
Specific Directions:

Licensed Prescriber: _____ **Telephone Number** _____
Please provide further information on the bottom of this form (Additional medications, Special sleep aids, etc.).

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I also give permission to the school nurse and/or his/her designee to administer the medication and/or care plan as indicated.

Parent/Guardian Signature_____ **Date**_____
(4/07/05)

Exhibit 2-22 Sample Floor Plans for School Health Suite and Center



Sample Floor Plans for School Health Suite and Center