

COMMUNITY / PUBLIC HEALTH

Chapter 3

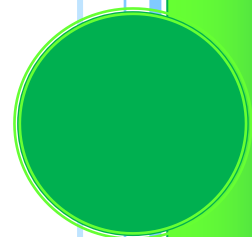
This chapter provides information and guidelines on school health services and programs that support the safety and well-being of all Delaware students. Community/Public Health is a principle within the Framework for 21st Century School Nursing Practice™ developed by the National Association of School Nurses. School entry requirements, mandated screenings, and addressing at-risk issues provide a holistic approach to working with students. Collaboration with the community is critical to provide comprehensive interventions and services. Regulations must be followed as specifically written, but further guidance and resources are provided in this chapter. Further, the school nurse's knowledge and skills are critical in supporting the holistic needs of a school community and will vary from one school to another. As the health resource within the school facility, it is important for the school nurse to be knowledgeable of local resources and current trends in community & public health.

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Community/ Public Health

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Community /Public Health

Components

Access to Care, Cultural Competency, Health Equity, and Social Determinants of Health

Disease Prevention, Population Based Care, and Surveillance

Environmental Health

Health Education, Health Promotion and Outreach

Healthy People 2020

Risk Reduction

Screenings/Referral/Follow-up

School Nursing is a specialized practice of nursing whose roots are in community health. The founder of public health nursing, Lillian Wald, introduced school nursing in 1902 in New York City to meet the public health need to address a growing health epidemic amongst immigrants and the educational need to reduce truancy due to illness. Twenty-first century school nursing practice is student centered, occurring within the context of the student's family and school community. (National Association of School Nurses [NASN], 2016b).

Community/Public Health is one of the five foundational principles within NASN's Framework for 21st Century School Nursing Practice™ (NASN, 2016a). This principle recognizes the impact school nursing practice has on students and their families, staff, and the school community. This approach to healthcare parallels the mission of Public Health that "promotes and protects the health of the people and the communities where they live, work, and play" (American Public Health Association, 2016). Public health workers, including school nurses, seek to "prevent people from getting sick or injured in the first place . . . promote wellness by encouraging healthy behaviors" (APHA, 2016) and reduce the impact of illness when it does occur.

Community/Public Health focuses on health promotion, disease prevention, and early identification. This upstream approach seeks to "protect the health of entire communities . . . as small as a local neighborhood" (CDC Foundation, 2016). It recognizes that the overall health of the community directly impacts, and reflects, the health of individuals. The components and activities within the Community/Public Health principle illustrate approaches to reaching *all* students and the school community, e.g., immunizations, health screenings, health education, risk reduction, nutrition and environmental health.

Much of the work of the Delaware school nurse, that is not direct care, falls within the principle of Community/Public Health. The school nurse will often be the first to identify an outbreak in a community (Surveillance) and will begin coordination with appropriate school and public health, personnel, and medical providers to reduce the impact of illness through messages to parents and

students (Health Promotion), referrals (Access to Care), or changes to the school environment (Environmental Health). School nurses are often the trusted adult that many turn to as they deal with lifestyle and risk reduction for themselves.

The terms “community health” and “public health” are almost always used interchangeably. Mosby’s Medical Dictionary makes the distinction that community health nursing is a “blend of primary health care and nursing practice within public health” whereas public health nursing “is concerned with the health needs of the community as a whole” (2009). It follows that the practice of school nursing clearly falls within this area of nursing. The Community/Public Health principle uses resources from across the health care, education, and social service spectrum, e.g., Division of Family Services, Division of Public Health, oral health services, and others. NASN’s 2013 Resolution recognizes that school nurses “are a channel for integrating public health into communities to improve population health” (NASN 2013). Further, “school nurses are uniquely positioned to engage a large percentage of our nation’s youth, their families and school community to promote health and prevent disease” (NASN, 2013).

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Access to Care, Cultural Competency, Health Equity, and Social Determinants of Health

A student's health is determined by many factors, some of them family and genetic, but many that are social in nature. Social Determinants of Health are important to consider because they are estimated to cause 75% of health concerns (CDC, 2014). These factors include neighborhoods, transportation, housing, income, social status, supports, safety and culture. The school nurse must be aware of social determinants when making assessments and plans for student care and follow-up. Access to Care also impacts students' health. Without access to health care for preventive and acute care, they are more likely to present with illness to the school nurses office or have limited contact with healthcare providers. Access includes the ability to pay for and/or have insurance coverage for care, transportation to care, and timeliness of care. Culture plays an important role for every individual, family and community. The school nurse must be able to deliver care in a culturally congruent manner to enhance trust and communication. Health disparities are significant. Data suggests that racial minority students have more untreated asthma and obesity. Health disparities parallel education disparities further illustrating the link between health and education. School nurses are uniquely positioned to provide equitable health services because of their familiarity with the families, communities and the accessibility.

School Nurse Role

- Refer to the [Care Coordination](#) Chapter and the [Standards of Practice](#) Chapter.
- Referrals to Social Services Assistance Programs, including but not limited to State Children's Health Insurance Program (SCHIP), Medicaid, Marketplace, and the Federally Qualified Health Centers.

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Disease Prevention, Population-based Care and Surveillance

School Nurse Practice is grounded in community/public health. This expands the focus beyond the individual student to the family and the community. Population-based care includes interventions for the entire school population or sections of it to assess and promote health and prevent disease. Examples of this may be a health fair for students, a flu clinic for staff, or substance abuse education for the school community. Disease Prevention is a significant issue in the school setting due to the proximity of many people. Communicable Disease Prevention and Surveillance are primary roles of the school nurse and are described in detail in the next sections. Prevention includes maintaining a healthy school environment and conducting activities to prevent disease, such as immunization requirements. Implementation of the immunization regulations is a major responsibility of the school nurse. Surveillance is the ongoing systematic collection and analysis of health related data. It includes disseminating this data to those that can assist in the effort and thus enhance the prevention and mitigation focus, e.g., flu symptom monitoring, or communicable disease monitoring. It is important to establish and maintain close contact with the Delaware Division of Public Health Epidemiology Section for questions, reporting, and management. Requirements for Health Assessments by the school nurse or other providers are set in Department of Education regulations.

School Nursing Practice Areas

- Communicable Disease Prevention
- Health Examinations
- Immunizations
- Surveillance

Communicable Disease Prevention

Overview

As the law compels the student to attend school, the school must make a system-wide effort to protect the student against preventable diseases which might be acquired in connection with the school program. General control measures include policies with respect to exclusion of the sick student, readmission after illness, and immunizations against diseases. Environmental control measures are the responsibility of the school. Specific control measures vary for different diseases.

Activities

- Education
- Standard Precautions
- Transmission Concerns in the School Setting
- Interpretive Guidelines for Infectious Waste
- Meningitis Action Plan
- Pediculosis Control

School Nurse Role

School nurses provide leadership in promoting health and safety, including a healthy environment. The school nurse provides health-related education to students and staff in individual and group settings and provides consultation to other school professionals, including food service personnel, physical education teachers, coaches, and counselors. Responsibilities in the provision of a safe and healthy school environment include the school nurse's monitoring of immunizations, managing communicable diseases, assessing the school environment for safety to prevent injury and spearheading infection control measures (American Nurses Association & National Association of School Nurses, 2011).

The school nurse is often the first health professional to notice an increase in a particular communicable disease. Whereas, it is difficult for a pattern to emerge from individuals in a school population with a number of medical homes. The school nurse provides passive surveillance and reports findings to the Division of Public Health (DPH) according to established procedures. The public health role of the school nurse is further accomplished through immunization monitoring, tracking, reporting and excluding for non-compliance. When a threatening disease is present in the school, the school nurse notifies the clients (or patient/guardian as appropriate) who may be at heightened risk: individuals with immunodeficiencies, chronic or debilitating illness, or who are pregnant. The school nurse collaborates with agencies as needed under state guidelines for the prevention of transmission of disease. If necessary, the school nurse informs administrators of communicable disease in the school and offers professional consultation regarding the need for communication with parent/guardian/Relative Caregiver on a limited or widespread basis.

- The school nurse assures compliance with standard precautions and hand washing. Health education regarding hygiene and safe handling is provided informally.
- It is the school nurse who excludes students and staff for communicable disease and allows re-entry after treatment by a licensed healthcare provider or when symptoms no longer indicate a threat to others in the school environment. Careful documentation of the nursing

process, using a retrievable method and standardized or recognized language supports continuity of care.

Exclusions – DPH regulations allow for the exclusion of students who have a communicable disease. Any student with suspicious symptoms should be isolated until released in the custody of the family or other accountable person and then excluded pending a diagnosis. In the event DPH declares that there is an outbreak of a vaccine preventable disease or if DPH determines any child has had or is at risk of having an exposure to a vaccine preventable disease, it is mandated that any child who is enrolled in a public school and has been exempted from the immunization program for any cause shall be temporarily excluded from attendance at the public school. Rules and regulations of the Delaware Department of Education provide that in the event of such temporary exclusion, it will be the responsibility of the school and the parents or legal guardian of the student to assist in keeping up with school work. No academic penalty shall be suffered if the student has maintained a relationship with the school through the prescribed assignments.

Readmissions - The readmission to school of a student having had a communicable disease is governed by guidelines in the most recent editions of the Control of Communicable Diseases Manual, the Red Book, the student's healthcare provider and any specific school requirements. An enrollee temporarily excluded due to an outbreak of a vaccine preventable disease, or who is at risk of having an exposure to a vaccine preventable disease, shall be authorized to return to school once approved by the DPH. If questions arise regarding the exclusion or return, DPH should be consulted. The Office of Infectious Disease Epidemiology (OIDE) can be contacted at 302-744-4990 or 888-295-5156.

Communicating about Communicable Disease in Schools - At times the presence of a communicable disease, whether with one person or more, in the school setting may pose a risk to the larger school community. It is recommended that schools work closely with the DPH to coordinate any communications with parents or the school community regarding exposure or outbreaks. Communication can occur in a variety of ways, from one-on-one conversation with a parent of a child who is immunosuppressed to a Press Release, depending upon the urgency of the message and the best method for an individual school. If recommended, epidemiologists will draft letters for the school, depending on the specific situation.

Managing an Outbreak at School – Guidelines provided by DPH (Zambri & Irini, 2016):

- Notify Public Health
- Investigate and perform surveillance
- Reemphasize hand hygiene
- Post signage (based on DPH recommendations)
- Environmental cleaning
- Education for all staff (consider students and families)
- Communicate outbreak and control measures (based on DPH recommendations)

Laws & Regulations

- Public school enrollees' immunization program; exemptions ([§ 131](#))
- Immunizations ([Regulation 804](#))
- School Attendance – contagious disease ([§ 2706](#))

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Reviewed and revised by Paula Eggers, R.N., Division of Public Health Infectious Disease Epidemiologist. March 2016

Standard Precautions

(Previously called Universal Precautions)

Purpose – To insure that all blood body fluids are handled properly.

Those Affected – All school staff should be alerted to dangers of infections from body fluids. School nurses, custodians and teachers should be particularly alert to the proper techniques in handling and disposal of materials.

Equipment Needed

- | | | |
|--------------|---------------|------------------------|
| Soap | Disposal Bags | Disposable gloves |
| Water | Dust pans | Mops |
| Paper towels | Buckets | Protective eyewear PRN |
- Disinfectants - should be one of the following classes:
- a. Ethyl or isopropyl alcohol (70%)
 - b. Phenolic germicidal detergent in a 1% aqueous solution (e.g. Lysol*)
 - c. Sodium hypochlorite solution (household bleach), 1 part bleach to 10 parts water. (Example 1-1/2 cups bleach to one (1) gallon of water. Needs to be prepared each time used.)
 - (1) Handle carefully, avoid skin contact.
 - (2) Will corrode metal.
 - (3) Will discolor materials such as rugs, clothing.
 - d. Quaternary ammonium germicidal detergent in 2% aqueous solution (e.g. Triquat*, Mytar*, or Sage*).
 - e. Iodophor germicidal detergent with 500ppm available iodine (e.g. Wescodyne*).
- *Brand names are used as examples and are not endorsement of products.

Procedures

General

- a. Wear disposable gloves before making contact with body fluids.
- b. Wear protective eyewear if blood or body fluid may come in contact with eyes.
- c. Discard gloves after each use.
- d. Wash hands after handling fluids and contaminated articles, whether or not gloves are worn.
- e. Discard disposal items including tampons, used bandages and dressings in plastic-lined trash container with lid. Close bags and discard daily.
- f. Do not reuse plastic bags.
- g. Use disposable items to handle blood and body fluids whenever possible.
- h. Use paper towels to pick and discard any solid waste materials such as emesis or feces.
- i. Double-bag soiled clothing and send home with student.

Handwashing

- a. Use soap and warm running water. Soap suspends easily removable soil and microorganisms allowing them to be washed off.
- b. Rub hands together for approximately 20 seconds to work up a lather.
- c. Scrub between fingers, knuckles, backs of hands, and nails.

- d. Rinse hands under warm running water. Running water is necessary to carry away debris and dirt.
- e. Use paper towels to thoroughly dry hands.
- f. Discard paper towels.

Cleaning the Environment

Cleaning is a form of disinfection that renders environmental surfaces safe to use or handle by removing organic matter, salts, and visible soils. All of these interfere with microbial inactivation. The physical action of scrubbing with detergents and surfactants and rinsing with water removes large numbers of microorganisms from surfaces.

Although contaminated surfaces can serve as reservoirs of potential pathogens, these surfaces generally are not directly associated with transmission of infections. The transferal of microorganisms from environmental surfaces to patients is largely via hand contact with the surface. Hand washing is imperative to minimize the impact of this transfer; however, cleaning and disinfecting environmental surfaces as appropriate is fundamental in reducing their potential contribution to the incidence of healthcare-associated infections.

Most, if not all, housekeeping surfaces need to be cleaned only with soap and water or a detergent/disinfectant depending on the nature of the surface and the type of contamination. The first step is always to remove any visible soil. The actual physical removal of microorganisms and soil by wiping or scrubbing is probably as important, if not more so, than any antimicrobial effect of the cleaning agent used. When using a detergent/disinfectant, the manufacturer's instructions for appropriate use of the product should be followed. [CDC guidelines](#) are available.

For washable surfaces

- a. For tables, desks, etc.:
 - (1) Use ethyl or isopropyl alcohol (70%), Lysol, or household bleach solution of 1 part bleach to 10 parts water, mixed fresh.

1 part bleach
10 parts water
 - (2) Rinse with water if so directed on disinfectant.
 - (3) Allow to air dry.
 - (4) When bleach solution is used, handle carefully.
 - (a) Gloves should be worn since the solution is irritating to skin.
 - (b) Avoid applying on metal since it will corrode most metals.
- b. For Floors:
 - (1) One of the most readily available and effective disinfectants is the bleach solution (1-1/2 cups bleach to one [1] gallon water.)

1 part bleach
10 parts water
 - (2) Use the two bucket system--one bucket to wash the soiled surface and one bucket to rinse as follows:
 - (a) In bucket #1, dip, wring, mop up vomitus, blood.
 - (b) Dip, wring and mop once more.
 - (c) Dip, wring out mop in bucket #1.

- (d) Put mop into bucket #2 (rinse bucket) that has clean disinfectant (such as Lysol or bleach solution).
- (e) Mop or rinse area.
- (f) Return mop to bucket #1 to wring out. This keeps the rinse bucket clean for second spill in the area.
- (g) After all spills are cleaned up, proceed with #3.
- (3) Soak mop in the disinfectant after use.
- (4) Disposable cleaning equipment and water should be placed in toilet or plastic bag as appropriate.
- (5) Rinse non-disposable cleaning equipment (dust pans, buckets) in disinfectant.
- (6) Dispose disinfectant solution down a drainpipe.
- (7) Remove gloves, if worn, and discard in appropriate receptacle.
- (8) Wash hands thoroughly.

For non-washable surfaces (rugs, upholstery)

- a. Apply sanitary absorbing agent, let dry, vacuum.
- b. If necessary, use broom and dust pan to remove solid materials.
- c. Apply rug or upholstery shampoo as directed. Re-vacuum according to directions on shampoo.
- d. If a sanitizing carpet cleaner (only available by water extraction method) is used, follow the directions on the label.
- e. Clean dustpan and broom, if used. Rinse disinfectant solution.
- f. Air dry.
- g. Wash hands thoroughly.

For soiled washable materials (clothing, towels, etc.)

- a. Rinse item under running water using gloved hands if appropriate.
- b. Place item in plastic bag and seal it until item is washed.
- c. Wash hands.
- d. Wipe sink with paper towels. Discard towels.
- e. Wash soiled items separately, washing and drying as usual.
- f. If material is bleachable, add 1/2 cup bleach to the wash cycle. Otherwise, add 1/2 cup non-chlorine bleach (Clorox II, Borateem) to the wash cycle.
- g. Discard plastic bag.
- h. Wash hands thoroughly after handling soiled items.

Special Considerations for the School Setting

Cleaning medical equipment

Reusable medical devices, e.g., stethoscopes, blood pressure monitor, oxygen saturation sensors, must be cleaned prior to use on another patient. Manufacturers of medical equipment provide care and maintenance instructions specific to their equipment. These instructions should be accessible. They should indicate compatibility with chemical solutions for cleaning, whether the equipment is water-resistant or can be safely immersed for cleaning, and how the equipment should be decontaminated if the need arises.

Specialized environmental and reusable instrument cleaning

Disinfection and sterilization principles are available at:

<http://www.apic.org/AM/Template.cfm?Section=Search§ion=Brochures&template=/CM/ContentDisplay.cfm&ContentFileID=238>

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Transmission Concerns in the School Setting

Body Fluid Source of Infectious Agents

Body Fluid-Source	Organism of Concern	Transmission Concern
Blood <ul style="list-style-type: none"> - Contaminated needle - Cuts/abrasions - Menses - Nosebleeds 	Cytomegalovirus Ebola Hepatitis B virus Hepatitis C HIV Zika	Bloodstream inoculation through cuts and abrasions on hands. Direct blood stream inoculation
Enteric Pathogens <ul style="list-style-type: none"> - Emesis - Feces 	Ebola Gastrointestinal viruses/bacteria Hepatitis A Norovirus Rotavirus Salmonella Shigella	Oral inoculation from contaminated hands
Urine* <ul style="list-style-type: none"> - Incontinence 	Cytomegalovirus Ebola	Bloodstream, oral and mucus membrane inoculation from hands
*Respiratory Secretions <ul style="list-style-type: none"> - Saliva - Nasal discharge 	Common cold virus Influenza virus Mononucleosis virus Ebola Hepatitis B virus Tuberculin microbacterium	Bloodstream inoculation through bites Oral inoculation from contaminated hands
Semen & Vaginal Fluids	Ebola Hepatitis B HIV Gonorrhea Zika	Sexual Contact (intercourse)

*Possible transmission of HIV is currently thought to be of little concern from these sources except in the cases of needle sticks or serious cuts.

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Interpretive Guidelines for Infectious Waste*

These guidelines are intended to assist persons who work in situations where they must make daily decisions concerning the disposal of medical waste. Items considered non-infectious waste for disposal purposes may carry a risk of disease transmission in the school setting. Therefore, workers are encouraged to use good infection control practices and exercise good judgment at all times.

1. The following items should NOT be disposed of as infectious waste and should be discarded in a plastic trash bag:
 - used gloves, masks, gowns (unless dripping)
 - dressings, bandages (unless saturated)
 - disposable temperature probe covers
 - dental care swabs
 - Fleets enema containers
 - clothing, sheets, blankets (unless saturated)
2. Sponges, bandages, gauze, paper towels, sanitary pads, tampons, and other items with absorbed or dried blood should be placed in double bags and discarded like other waste.
3. Containers, including IV tubing and suction canisters, holding more than a few milliliters of blood or other body fluids should be first emptied by carefully pouring down a sink drain or toilet and then double bagged for trash. If this is not possible, the container should be disposed of as infectious waste.
4. Stool in disposable diapers should be flushed. The remaining diaper need NOT be disposed of as infectious waste, but should be double bagged in a plastic bag and discarded in the trash.

Based on the “Interpretive Guidelines for Infectious Waste,” there will be very little infectious waste generated in the school health room with the exception of sharps. By definition, a sharp is anything capable of inflicting a puncture wound or infection. Examples are needles, scalpels, razorblades, pipette tips and other sharp metallic or plastic objects. Such objects must be disposed of properly to prevent injury. School nurses should actively implement safe disposal practices that maximize the protection from sharp injuries. These include:

- Sharps must be stored in red plastic labeled boxes and discarded as infectious waste when the container is full.
- Sharp containers must be located in the immediate area where sharps are used.
- When disposing of a needle, drop the needle and syringe assembly into the container.
- **Never recap a needle.**
- When containers are full, follow the biohazardous waste disposal protocol.
- Any sharp injury must be documented and reported for proper follow-up medical care.

Medical waste (items 2-4 above) should be double bagged in plastic bags and discarded in the trash. Each district should have a waste disposal plan and a designated person to arrange for pick-up of infectious waste.

*According to Division of Public Health Guidelines

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Meningitis Action Plan for Delaware School Nurses

A suspected or confirmed case of meningitis in your school will cause concern among students, teachers and families. It is not uncommon for TV, radio and newspapers to follow up on the story. The Division of Public Health (DPH), Office of Infectious Disease Epidemiology (OIDE) can help you prepare for, confirm and deal with a meningitis case. It should be noted that there are different forms of meningitis. *Neisseria meningitidis* is highly contagious. Other forms, while serious to the individual, are not transmissible person-to-person. In the case of *Neisseria meningitidis*, early identification of close contacts is critical. *Neisseria meningitidis* is currently the only form of meningitis that requires a letter to be sent home.

Things to do before a case of meningitis occurs:

1. Identify and contact key experts. The Lead School Nurse Liaison and at least one other school official should be included. DPH Nursing and OIDE staff will help draft two generic form letters, one for meningococcal (bacterial) and one for viral meningitis.
2. Choose a contact person. This person will coordinate activities with the OIDE epidemiologist and other public officials.
3. Ask administration to identify a school spokesperson in the event media requests information or an interview. Include your school district's public information officer.
4. Establish a phone response team. These individuals are responsible for answering questions from concerned families and students. You may consider referring these questions to DPH, OIDE, if previously coordinated.
5. Choose a spokesperson to reassure the students.

Things to do when a meningitis case occurs:

1. Inform your principal and your meningitis "experts." Immediately contact DPH, OIDE at 302-744-4990 or 888-295-5156.
2. Provide the following information to the Epidemiology Branch staff:
 - Child's name;
 - Date of birth;
 - Date last attended;
 - Grade;
 - Parent/guardian/Relative Caregiver name and phone number;
 - If the child is hospitalized, give the hospital name and location.

The DPH, OIDE will verify the diagnosis and the type of meningitis (bacterial vs. viral), then telephone you and your contact person with this information. The OIDE epidemiologist will also alert the DPH Public Information Officer (PIO), as warranted. The OIDE epidemiologist will arrange for prophylaxis of legitimate contacts if a contact of a case, but not the case, attends your school, reassure the students that they are not at risk. Contact OIDE epidemiologist if you need support.

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Pediculosis Control

Resources

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Health Examinations

Overview

Health examinations/assessments are required prior to entry into a Delaware public school and upon entry into Grade 9 in accordance with [Regulation 815](#). The health examination must have been completed within two years prior to school entry and Grade 9.

A health examination must be conducted and documented by a medical physician, nurse practitioner, or physician's assistant on an acceptable form. The Department of Education provides [age appropriate forms](#) and a sample parent letter, which is included after the Immunization section in this chapter. The [DIAA Pre-Participation Physical Evaluation](#) is another form that may be used. (Note: DIAA requires an annual examination for all interscholastic sports participation.) The healthcare provider may also use his/her own form if it is acceptable to the school and includes specific elements outlined in the regulation: health history, immunizations, results of medical testings and screenings, medical diagnosis, prescribed medications and treatments.

Health examination findings should be recorded in the student's Electronic Health Record (EHR) under Physical Exam for either the "Athletic Exam" (if recording information from a DIAA form) or the "Normal Exam" (for all other health examination reports). The nurse may also enter the date of the examination in the Comment Box of the Immunization Page; however, this does not replace the correct documentation under Physical Exam. A Sample letter for informing families of school entry requirements including health examinations is under the Immunizations section.

Activities

- Education
- Coordination
- Documentation

School Nurse Role

- Work with families and administration to collect health examinations.
- Use appropriate forms; e.g., age-appropriate or DIAA form.
- Document findings into EHR

Overview

All students are required to have completed a series of immunizations prior to entering a Delaware school. Public school students are mandated through the Delaware Department of Education [Regulation 804](#). Private school students are mandated through the Delaware Division of Public Health (DPH) Regulation 4202, [Control of Communicable and Other Disease Conditions](#). These two regulations are comparable and are based on the [recommended immunization schedule](#) per American Academy of Pediatrics (AAP) and the Center for Disease Control (CDC). Schedules are available for [children, 0 – 6 years](#) and [children 7 - 18 years](#). These schedules are also available in Spanish for both [children 0 – 6 years](#) and [children 7 – 18 years](#).

CDC also sets criteria for vaccines required as part of the immunization process. Immigrant applicants who are already in the United States and are changing their visa status to become permanent residents also must meet the same requirements. Applicants need to get only one dose of each vaccine during their medical exam. The only exception is if an immigrant applicant can show proof of having already received a given vaccine or if the vaccine is not medically advised. Applicants are *encouraged* to get other doses of a vaccine to finish each series. Therefore school nurses should not assume vaccines are complete and should obtain documentation. As of January 2017, the following are required for U.S. immigration:

- Mumps
- Measles
- Rubella
- Polio
- Tetanus and diphtheria
- Pertussis
- Haemophilus influenzae type B (Hib)
- Hepatitis A
- Hepatitis B
- Rotavirus
- Meningococcal disease
- Varicella
- Pneumococcal disease
- Seasonal influenza

Activities and Documents

- School Entry Letter
- Varicella Immunity Statement
- Medical Exemptions, Alternate Doses, and Alternate Schedules
- Notarized Affidavit for Religious Exemption

School Nurse Role

Immunization records should be reviewed and updated by the nurse upon school entry (at any age), upon entry into Grade 9, and whenever new information is received from the primary healthcare provider. The school nurse reviews immunization at school entry and works with families to ensure children are fully immunized. A sample School Entry Letter follows this introduction. The school nurse should confirm that the schedule of the immunizations is correct per CDC guidelines. Immunizations must be entered into the EHR. Immunization records for students can also be accessed through the [Immunization Registry \(DelVAX\)](#).

The nurse is a critical advocate for families and can assist them to find healthcare resources, such as medical providers and insurance. They also offer education to families about the benefits of immunizations and the significant risks of choosing not to vaccinate. This later activity is required under Delaware law for families submitting exemptions. CDC offers [educational brochures for families](#) on vaccines. Additional [educational materials for all ages](#) can also be found.

Delaware law only allows two types of immunization exemptions, medical and religious.

Medical Exemptions to the recommended childhood and adolescent immunization schedule, which have been approved by the DPH, are included in the following pages. The medical exemption must be submitted in writing by the healthcare provider on the *School Vaccination Medical Exemption Form*. If the waiver is not for one of the situations listed on the next page, the healthcare provider must complete the *Supplemental School Vaccine Medical Exemption Form*, which also is included in this manual. The student's EHR should document that a medical exemption is granted by DPH based on the list provided in this manual or by the submitted documentation, which was approved by DPH. Questions about exemptions should be directed to the DOE Program Manager for School Health Services.

Religious Exemptions must be submitted by the parent, legal guardian, Relative Caregiver, student (if 18 year of age or older), or unaccompanied homeless youth. The law requires the submittal of a notarized form, Affidavit of Religious Belief. Further, to anyone submitting the notarized form, the school is required to: 1) offer information on the "medical benefits and risks in choosing whether to have the child participate in the immunization program" and 2) to inform him/her/them that the child will be excluded from school in the event of an outbreak of a vaccine preventable disease, as determined by DPH. Educational materials, on the "medical benefits & risks" for parents, have been approved by DPH.

The recommended flyer to share with families seeking exemptions is CDC's [If You Choose Not to Vaccinate Your Child, Understand the Risks and Responsibilities](#).

Resources

Centers for Disease Control [CDC]. (2016) [Vaccines & Immunizations](#).

Delaware Department of Health & Social Services, Division of Public Health [DPH]. (n.d.) [Immunization Program](#).

[Immunization Coalition of Delaware](#)

National Association of School Nurses [NASN]. (2015). [Position Statement – Immunizations](#).

Sample School Entry / Grade 9 Letter

<District Letterhead>

<Date>

Dear Parent/Guardian of _____:

According to Delaware laws and regulations, all children entering school for the first time are required to have proof on file of the following:

Immunizations¹

- 5 or more doses of DTaP or DTP Td vaccine (unless 4th dose was given after the 4th birthday)
- 4 doses of IPV or OPV (unless the 3rd dose was given after the 4th birthday)
- 3 doses of Hepatitis B vaccine
- 2 doses of measles, mumps and rubella vaccine
- 2 doses of Varicella or a written disease history by a licensed healthcare provider
- In August 2016, entering 9th Graders must additionally have 1 dose Tdap (adult booster) and 1 dose meningococcal² (In 8/2017 - Grades 9 & 10; in 8/2018 - Grades 9 - 11; 8/2018 - Grades 9 – 12)

Health Examination³

- Current, within the two years prior to school entry **and** entry to 9th Grade (30 days from entry into 9th Grade)

Tuberculosis⁴

- Results of Mantoux or risk assessment completed **within 12 months prior to school entry**

Lead blood test⁵

- Documentation of test for children entering kindergarten or pre-school program (60 days from enrollment)

YOUR STUDENT IS MISSING THE ITEMS CIRCLED BELOW:

<u>DTAP</u> 1 st 2 nd 3 rd 4 th 5 th 6 th	<u>IPV</u> 1 st 2 nd 3 rd 4 th	<u>HEPB</u> 1 st 2 nd 3 rd	<u>MMR</u> 1 st 2 nd
<u>VAR</u> 1 st 2 nd	<u>PHYSICAL</u>	<u>TB</u>	<u>LEAD</u>
<u>MENINGOCOCCAL</u> 1 st 2 nd			

Beginning with the date of this letter, you have a period of (14) calendar day⁶ to produce evidence to the school that the basic series of immunizations has been initiated or completed. Please make every effort to resolve this issue as soon as possible so your student's education will not be interrupted.

Please provide the school nurse with the necessary information. We appreciate your cooperation in complying with the law.

Sincerely,
(Superintendent or Principal)

School: _____
Nurse: _____
Phone: _____ Fax: _____

¹ Department of Education Regulation 804

² DPH recommends Tdap and meningococcal at age 11-12

³ Department of Education Regulation 815

⁴ Department of Education Regulation 805

⁵ Delaware Code, Title 16, Chapter 26

⁶ Children of active military duty have 30 days

Medical Exemptions, Alternative Doses, and Alternate Schedules

The following has been reviewed by the Division of Public Health (DPH) and is current as of 09-01-2016:

Alternative schedules

DPH follows the ACIP Catch-Up and Accelerated or Minimum Interval immunization [schedules](#) for students who are behind in vaccinations. Accelerated schedules should not be used routinely.

Lost Records

For situations where immunization records have been lost:

1. Unequivocally positive IgG serology for tetanus, diphtheria, polio, measles, rubella, varicella, and hepatitis A and B is acceptable. The physician must write and sign an official letter indicating that in their capacity as the physician responsible for the patient, their medical opinion is that the child is fully protected and that additional immunization is not required. This will form the basis of a medical exemption to be held in the child's file. If the physician is unable to commit as above, age appropriate re-vaccination is recommended.
2. If there are records of some shots, these should be taken as #1, #2, etc.

Diphtheria, Tetanus (DT) Vaccine

DT vaccine (in lieu of DTaP) is applicable to children with contraindications to receiving the pertussis component of DTaP.

MMR

A second MMR given prior to the fourth birthday is accepted, (although not recommended as standard protocol) provided. The first dose was not administered earlier than the first birthday, and there is a minimum 28-day interval between doses.

Polio

Students who are 19 years of age or older, do not require the polio vaccine. (DPH, 1/27/15)

Medical Exemptions

The following medical diagnoses are NOT accepted as a medical exemption:

Autism

Medical exemptions must be approved by DPH using the form on the following pages.

The medical exemptions must be provided by a licensed physician, nurse practitioner, or advanced practice nurse. A parent/guardian report of a contraindication or concerns regarding immunizations cannot be accepted. If the exemption is based on the child's adverse reaction to a vaccine or a medical contraindication, the healthcare provider must document the details, e.g., swelling of throat and mouth that constituted the reaction or medical contraindication, and what specific vaccine or vaccine component was involved. Documentation from a healthcare provider that does not detail a medical justification or only indicates the parent's reluctance or concern is not acceptable.

Most contraindications are temporary and the vaccine can be given at a later time. The healthcare provider must document when the dose will be administered or reconsidered, (e.g. withhold indefinitely or until child is in remission for six months). Children who are immunosuppressed, should follow the recommendations of their physician regarding immunization.

VARICELLA (Chickenpox) IMMUNITY STATEMENT

(School/School District Name)

Name: _____ Birthdate: _____
Please Print

Check one of the following boxes regarding Varicella (Chickenpox) Immunity:

- ☐ Varicella Vaccine Date Given: _____
- ☐ Varicella Lab Evidence Date: _____ Test: _____
- ☐ Varicella Disease Age of child when he/she had Chickenpox: _____

Name: _____
Licensed healthcare provider

Signature: _____ Date: _____



School Vaccination Medical Exemption Form

The School Vaccination Medical Exemption Form is the official Division of Public Health (DPH) document to be completed by a currently licensed physician, advanced practice nurse, nurse practitioner, or physician's assistant to exempt a child from childcare or school immunization requirements. The clinician certifies that due to the child's health or medical condition, the child may be adversely affected on a temporary or permanent basis by one or more of the required vaccines. The signed medical exemption statement verifying true contraindications/precautions is submitted to and accepted by Delaware schools, child care programs, and other agencies that require proof of immunization. The signed form does not require further approval from the Delaware Division of Public Health.

For exemption of medical conditions not listed on this form, the clinician must submit the Supplemental School Vaccine Medical Exemption Form to DPH for approval.

A **contraindication** is a condition in a recipient that increases the risk for a serious adverse reaction. A vaccine will not be administered when a contraindication exists.

A **precaution** is a condition in a recipient that might increase the risk for a serious adverse reaction or compromise the ability of the vaccine to produce immunity. Under normal conditions, vaccinations should be deferred when a precaution is present. Indicate if an exemption is permanent or temporary.

Vaccine medical contraindications are determined by the Advisory Committee on Immunization Practices (ACIP).

Please return the form to:

School: _____

Address: _____

Fax Number: _____

School Vaccination Medical Exemption Form 073115



Please indicate whether the exemption is: ☐ **permanent** or ☐ **temporary**

For **temporary** exemption, list the date the exemption ends: ____/____/____

Vaccine	Check if Applicable		Contraindications/Precautions
DTaP	Permanent	Temporary	Contraindications
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Encephalopathy within seven days after receipt of previous dose of DTP or DTaP
			Precautions
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Progressive neurologic disorder, including infantile, spasms, uncontrolled epilepsy, progressive encephalopathy: defer DTaP until neurologic status clarified and stabilized
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Fever greater than 104.9°F (40.5°C) within 48 hours after vaccination of previous dose of DTP/DTaP
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Guillain-Barre syndrome within 6 weeks after a previous dose of tetanus toxoid-containing vaccine
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Hypotonic-hyporesponsive episodes within 48 hours after vaccination of previous dose of DTP or DTaP
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Seizure within 72 hours after vaccination of previous dose of DTP or DTaP
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Persistent, inconsolable crying lasting three hours or more 48 hours after receiving a previous dose of DTP or DTaP
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> History of arthus-type hypersensitivity reactions after a previous dose of tetanus or diphtheria toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus-toxoid containing vaccine
Tdap			Contraindications
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Encephalopathy within seven days after receipt of previous dose of DTP or DTaP
			Precautions
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Progressive neurologic disorder, uncontrolled seizures or progressive encephalopathy; defer vaccination until treatment regimen is established and condition stabilized.
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Guillain-Barre syndrome within 6 weeks after a previous dose of tetanus toxoid-containing vaccine
DT/Td			Contraindications
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
			Precautions
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Guillain-Barre syndrome within 6 weeks after a previous dose of tetanus toxoid-containing vaccine
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Varicella			Contraindications
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component

	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, primary or acquired immunodeficiency, long-term immunosuppressive therapy, or patients with HIV infection who are severely immunocompromised)
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Pregnancy
			Precautions
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product)
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination; if possible, delay administration of these antiviral drugs for 14 days after vaccination.
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Documented past history of Varicella disease.

School Vaccination Medical Exemption Form 073115



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Immunization Program

IPV			Contraindications
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
			Precautions
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Pregnancy
Hepatitis B			Contraindications
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
			Precautions
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Infant weighing <2,000 grams if mother has documented hepatitis B surface antigen (HbsAg)-negative at the time of the infant's birth
MMR			Contraindications
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Pregnancy
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Known severe immunodeficiency (e.g., hematologic and solid tumors, or severely symptomatic infection)
			Precautions
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Recent (11 months) receipt of antibody-containing blood product (specific interval depends on product)
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> History of thrombocytopenia or thrombocytopenic purpura
Meningococcal			Contraindications
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
			Precautions
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Moderate or severe acute illness with or without fever
Haemophilus influenzae type b (Hib)			Contraindications
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
			Precautions

	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> • Age younger than 6 weeks
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> • Moderate or severe acute illness with or without fever
Pneumococcal Disease			Contraindications
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> • Severe allergic reaction (e.g., anaphylaxis) after a previous dose of PCV7 or PCV13 or to a vaccine component, including to any vaccine containing diphtheria toxoid
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> • For PPSV23, severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component
			Precautions
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> • Moderate or severe acute illness with or without fever

I am aware that in the event that the Division of Public Health (DPH) declares an outbreak of a vaccine preventable disease, or if in the estimation of DPH, my child has had, or is at risk of having an exposure to a vaccine preventable disease, my child shall be temporarily excluded from attendance at the childcare and/or school until the risk period ends, which may be three weeks or longer. My child shall be authorized to return to school once approved by DPH.

Name of Patient _____ DOB ____/____/____

Name of Parent/Guardian _____

Signature (Patient/Parent) _____

Provider Information:

Clinician Name (print) _____ MD/DO/APRN/PA

License #: _____

Signature _____ Date ____/____/____

Address _____ Phone # _____

School Vaccination Medical Exemption Form 073115



Supplemental School Vaccine Medical Exemption Form

The Supplemental School Vaccine Medical Exemption Form is the official Division of Public Health (DPH) document to be completed by a licensed physician or advanced practice registered nurse practitioner to exempt a child from childcare or school immunization requirements. The health practitioner certifies that due to the child's health or medical condition, the child may be adversely affected on a temporary or permanent basis by one or more of the required vaccines. The exemptions to be included on this form are those not listed in School Vaccine Medical Exemption Form.

This form will also be used to document when a child has laboratory evidence of adequate immunity to one or more specific vaccine-preventable disease (lab results must be attached).

The completed and signed form must be submitted to the child's school, which will in turn submit to DPH for review and approval or denial.

To be completed by a currently licensed physician, advanced practice nurse, nurse practitioner, or physician's assistant to exempt a child from childcare or school immunization requirements.

Name of Patient _____ DOB _____

Name of Parent/Guardian _____

Signature (Patient/Parent) _____

Provider Information:

Clinician Name (print) _____ MD/DO/APRN

License #: _____

Signature _____ Date _____

Address _____

Phone # _____

A **contraindication** is a condition in a recipient that increases the risk for a serious adverse reaction. A vaccine will not be administered when a contraindication exists.

A **precaution** is a condition in a recipient that might increase the risk for a serious adverse reaction or compromise the ability of the vaccine to produce immunity. Under normal conditions, vaccinations should be deferred when a precaution is present.

Vaccine medical contraindications are determined by the Advisory Committee on Immunization Practices (ACIP).



Please list each vaccine included in the exemption and the reason for the exemption:

Please indicate whether the exemption is:

☐ **Permanent** or ☐ **Temporary**

For **temporary**, list the date the exemption ends: ____/____/____

Parent/Guardian Section:

I am aware that in the event that the Division of Public Health (DPH) declares an outbreak of a vaccine preventable disease, or if in the estimation of DPH, my child has had, or is at risk of having an exposure to a vaccine preventable disease, my child shall be temporarily excluded from attendance at the childcare and/or school until the risk period ends, which may be three weeks or longer. My child shall be authorized to return to school once approved by DPH.

Parent/Guardian Signature _____ Date ____/____/____

Please return the form to:

School: _____

Address: _____

Phone Number: _____

Fax Number: _____

For School Only:

Received: _____ (date) Submitted to DPH: _____

Mail/fax to: The Division of Public Health
Bureau of Communicable Diseases
Attention: Carolyn Brown
Thomas Collins Building, Suite 12
540 South DuPont Highway
Dover, Delaware 19901
302-744-1050 (phone)
302-739-2548 (fax)

School Vaccination Supplemental Medical Exemption Form 073115

NOTARIZED AFFIDAVIT FOR RELIGIOUS EXEMPTION – IMMUNIZATION
Required per 14 Del. Code § 131

AFFIDAVIT OF RELIGIOUS BELIEF
STATE OF DELAWARE
..... COUNTY

1. (I) (We) (am) (are) the (parent[s]) (legal guardian[s]) of _____
Name of Child
2. (I) (We) hereby (swear) (affirm) that (I) (we) subscribe to a belief in a relation to a Supreme Being involving duties superior to those arising from any human relation.
3. (I) (We) further (swear) (affirm) that our belief is sincere and meaningful and occupies a place in (my) (our) life parallel to that filled by the orthodox belief in God.
4. This belief is not a political, sociological or philosophical view of a merely personal moral code.
5. This belief causes (me) (us) to request an exemption from the mandatory school vaccination program for Name of Child, _____.
6. (I) (We) acknowledge that, in the event that the Division of Public Health declares that there is an outbreak of a vaccine preventable disease, or if in the estimation of the Division of Public Health, (my) (our) child has had, or is at risk of having an exposure to a vaccine preventable disease, (my) (our) child shall be temporarily excluded from attendance at the public school, in which case, it will be (my) (our) responsibility, along with the school, to assist (my) (our) child in keeping up with school work, and (my) (our) child shall be authorized to return to school once approved by the Division of Public Health.
7. (I) (We) acknowledge that (I) (we) have been given the opportunity to receive from the school district information regarding the medical benefits and risks in choosing whether to have the child participate in the immunization program, and if (I) (we) have not taken that opportunity, it is hereby waived.

Signature of Parent(s) or Legal Guardian(s)

SWORN TO AND SUBSCRIBED before me, a registered Notary Public, this _____
day of _____, _____.

(Seal)
Notary Public

My commission expires: _____

Surveillance

School Nurse Passive Syndromic Surveillance

Surveillance (active or passive) is an ongoing process that involves the systematic collection, analysis, and distribution of information regarding the occurrence of diseases in defined populations. In general, surveillance is designed to provide practical and uniform results in a timely fashion so that trends can be detected and appropriate interventions implemented. In this case, the defined population is that of the student body/staff within a specific school or district.

Delaware school nurses participate in “passive” surveillance. Passive surveillance does not necessitate routine reporting of symptomology or disease conditions. Instead, reporting only occurs when unusual symptomology or events occur. For instance, if the school nurse were to observe an unusually high number (above normal and expected baseline) of children presenting with GI-related illness or influenza-like-illness (especially out of season) during the course of a day, week, or several weeks, he/she would report this occurrence to the Delaware Division of Public Health, Office of Infectious Disease Epidemiology (OIDE) at 888-295-5156 or 302-744-4990. *Hence, it will be necessary for the school nurse to have a working knowledge of the baseline of usual and customary illness for his/her school population.*

In the event the school nurse feels the need to call the OIDE, he/she should be prepared to answer a few questions presented by a member of the OIDE. This information will assist the epidemiologist in analyzing the situation and determining whether further investigation is necessary. Strict confidentiality of student identifiers will be maintained unless public health concerns are compromised. In this case, the matter will be thoroughly discussed with school administration. School nurses should continue to follow their normal internal communication procedures.

The following is a list of questions the school nurse may be asked by the epidemiologist. It should be noted that each particular circumstance will warrant a unique set of questions and this should only be considered as a general guide.

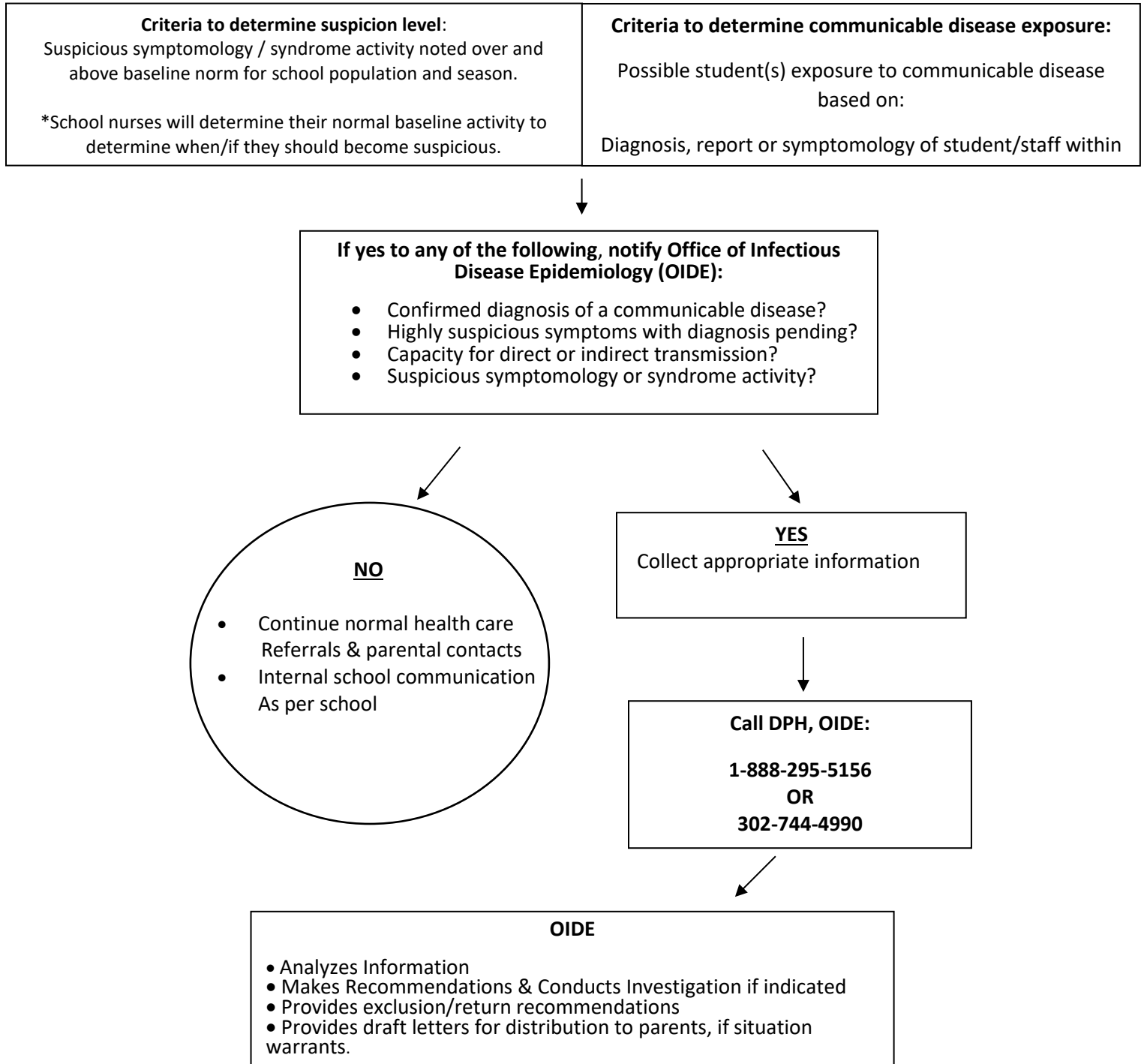
- 1) What is the detailed symptomology?
- 2) Who is affected? (i.e., Confined to a single classroom? Specific grade? Number of cases by grade?)
- 3) When were the first symptoms noted?
- 4) How long have symptoms lasted?
- 5) How many children are symptomatic?
- 6) If a single child, are family members symptomatic?
- 7) If a single child, who are their closest contacts? (Whom do they sit beside in class? Who are their closest friends?)
- 8) Is any school staff symptomatic?
- 9) Is the illness confined to one classroom? One region of the school? School-wide?
- 10) Do those presenting with symptomology share a common restroom?
- 11) Do those presenting with symptomology share common meals?
- 12) Do those presenting with symptomology share a common bus to and from school?
- 13) Is the child on any medication?
- 14) What is the name of the child’s physician?
- 15) Is the child/ren involved in any extracurricular activities?
- 16) Did the child/ren become ill after playground activities?
- 17) Has there been any unusual activity on or around school property?

Reviewed and revised by Paula Eggers, R.N., Division of Public Health Infectious Disease Epidemiologist. March 2016 (see page 8)

SCHOOL NURSE / PUBLIC HEALTH COMMUNICATION

For Disease Surveillance & Possible Communicable Disease Exposure

Control of Communicable Diseases Manual, David I. Heymann MD Editor, 20th Edition, (2015)



Refer to Control of Communicable Diseases Manual, 20th Edition.

Refer questions regarding this process to

Jane C. Boyd, DOE, at 857-3356 or Director of Nursing, Rebecca King, DPH, at 744-4702.

Environmental Health

Environmental health is a branch of public health that is concerned with all aspects of the natural and built environment. In the school setting, environmental health is concerned with, but not limited to: the building, location, occupants, supplies and materials used in maintenance and classrooms, pest management, heating, cooling, and outdoor spaces.

The environment plays a significant role in health issues of students and staff in the school. It may be the environment of the school itself or the effects of home or community that cause or exacerbate health issues. When children are growing, they are particularly susceptible to environmental stressors and at higher risk of exposure to toxic substances. A recent example was the lead exposure to children from drinking water in Flint, Michigan starting in 2014. Indoor air quality and other exposures around the school are issues that must be considered for a safe and healthy school. Lead poisoning prevention is a major preventative environmental health issue that involves schools in Delaware. Information on Lead Screening in Delaware is under the section Screenings/Referral/Follow-up of this chapter. The school nurse role will vary based on the student and staff needs. School Nurses monitor lead risk and exposure before children start their school experience.

School Nurse Role

- Be familiar with the impact of the environment on health
- Advocate for quality conditions in school, at home, and in the community

School Nurse Practice Areas

- Lead Program – see Lead Screening under Screenings/Referral/Follow-up later in this chapter
- Indoor Air Quality (IAQ)
- See Care Coordination for condition specific environmental health information

Resources

Centers for Disease Control (CDC). (2016). [*CDC's Childhood Lead Poisoning Prevention Program*](#).

Environmental Protection Agency (EPA). (2009). [*Indoor Air Quality Tools for School Action Kit*](#).

National Association of School Nurses (NASN). (2014). [*Position Statement – Environmental Health in the School Setting: The Role of the School Nurse*](#).

Indoor Air Quality

Overview

“Indoor air quality [IAQ] is a term which refers to the air quality within and their surroundings as it relates to the health and comfort of the building occupants” (U. S. Environmental Protection Agency [EPA], 2016a). “Good indoor air quality contributes to a favorable environment for students, performance of teachers and staff and a sense of comfort, health and well-being. These elements combine to assist a school in its core mission - educating children” (EPA 2016c).

Basic components of IAQ in the school include:

- Control of airborne pollutants;
- Introduction and distribution of adequate outdoor air; and
- Maintenance of acceptable temperature and relative humidity (EPA 2016c).

The EPA notes that the lack of good IAQ can increase or aggravate health problems such as asthma, cough, eye irritations, headaches, allergic reactions. and in rare cases life threatening conditions (EPA, 2016b). Of particular concern is asthma, which is a leading cause of absenteeism due to chronic conditions and impacts nearly 1 in 13 school children (EPA, 2016c). Many asthma triggers are directly related to IAQ, e.g., mold, dust. (Refer to [Care Coordination](#) chapter for more information on caring for a student with asthma.)

Schools face unique challenges to good IAQ within their own facilities because they have many more people per building than an average office space, budgets and other resources are more limited, and there are many sources of pollution due to the nature of education (labs, art rooms, diesel fuel, locker rooms, etc.). The surrounding school community may also be challenged to adequately address IAQ, too. Children living in poverty are often more exposed to environmental issues because of aging housing and resources.

Resources for schools are available through the [American Lung Association](#) and the [Environmental Protection Agency](#) in the form of tool kits, like [IAQ Tools for Schools](#), that provide common sense measures for preventing, identifying, and resolving most indoor air problems with minimal cost and involvement. Tools for Schools has been used in Delaware.

Role of the School Nurse

- Coordinate with the Facilities/Maintenance staff to implement the IAQ Tool kits for schools.
- Participate in school committees that address environmental health concerns.
- Be alert to maintenance in the building and outside spaces of concerns that could contribute to environmental health issues- notify appropriate staff
- Track trends in health problems if environmental health issue is suspect for individual or group
- Advocate for moderate use of fragrances
- Monitor students identified with health problems attributable to poor indoor air quality

References & Resources

American Lung Association (2016). Healthy Air in Schools. Retrieved from <http://regulations.delaware.gov/AdminCode/title16/Department%20of%20Health%20and%20Social%20Services/Division%20of%20Public%20Health/Health%20Promotion%20and%20Disease%20Prevention/4202.shtml> on November 5, 2016.

National Association of School Nurses (2014). *Environmental health in the school setting: The role of the school nurse, Position Statement*. Retrieved from <https://schoolnursenet.nasn.org/blogs/nasn-profile/2017/03/13/environmental-health-in-the-school-setting-the-role-of-the-school-nurse>.

U.S. Environmental Protection Agency [U.S. EPA] (2016a). An introduction to indoor air quality. *Indoor Air Quality (IAQ)*. Retrieved from <https://www.epa.gov/indoor-air-quality-iaq/introduction-indoor-air-quality> on September 15, 2016.

U.S. EPA. (2016b). *Managing Asthma in the School Environment*. Retrieved from <https://www.epa.gov/iaq-schools/managing-asthma-school-environment> on September 15, 2016.

U.S. EPA. (2016c). *Why is Indoor Air Quality Important to Schools?* Retrieved from <https://www.epa.gov/iaq-schools/why-indoor-air-quality-important-schools> on September 15, 2016.

U.S. Environmental Protection Agency [EPA] (2009). *IAQ Tools for Schools Action Kit*. Retrieved from <https://www.epa.gov/iaq-schools/indoor-air-quality-tools-schools-action-kit> on September 15, 2016.

Health Education, Health Promotion, & Outreach

There are two approaches to health education in the school setting. The first is the health education provided in the classroom and based on state standards. The primary responsibility for this activity is not the school nurse but the health education teacher. However, “the school nurse provides health education by providing health information to individual students and groups of students through health education, science, and other classes. The school nurse assists on health education curriculum development teams and may also provide programs for staff, families, and the community. Health education topics may include nutrition, exercise, smoking prevention and cessation, oral health, prevention of sexually transmitted infections and other infectious diseases, substance use and abuse, immunizations, adolescent pregnancy prevention, parenting, and others” (American Academy of Pediatrics [AAP]. 2008). Information in this chapter includes the standards and the curriculum because the school nurse may serve as an advisor, a guest, instructor in providing some portion of the health education curriculum, or a resource for identifying guest speakers on health issues. The second form of health education is when school nurses provide one-on-one instruction. This occurs at almost every encounter with a student or family member and is a basic primary prevention effort. Information on one-on-one health education is included in the [Care Coordination](#) chapter. Health promotion is advocating and providing programs or actions that will enhance the health of the school, the students and staff in the school and community. Another focus of the school nurse is outreach. This is a proactive approach and involves identifying persons at risk and finding referral services for treatment or assistance. This is also further described in the [Care Coordination](#) chapter with information on acute and chronic conditions.

School Nursing Practice Areas

- Driver’s Education
- Health Education
- Nutrition Services
- Oral Health Services
- Outreach- (See Care Coordination)

Resources

American Academy of Pediatrics (AAP). Council on School Health. (2008). Policy statement: Role of the school nurse in providing school health services. *Pediatrics* 121(5), 152-156.

Bobo, N., Kimel, L., & Bleza, S. (2013). Promoting Health at School. In J. Selekman, *School Nursing: A Comprehensive Text* (2nd ed.), pp. 404-472. Philadelphia: F. A. Davis.

Cornell, M. & Selekman, J. (2013). Collaboration with the Community. In J. Selekman, *School Nursing: A Comprehensive Text* (2nd ed.), pp. 163-195. Philadelphia: F. A. Davis.

Driver's Education

Overview

Delaware public schools are mandated to provide Driver's Education as a part of the high school curriculum. At the beginning of each school year, driver education teachers are required to ask the school nurse for assistance in working with students with physical and mental disabilities. A roster of all driver education pupils will be presented to the school nurse for review and particular emphasis on identifying those pupils with extreme visual difficulties including color blindness, physical and or mental disabilities. If the nurse is aware of any condition that will affect a pupil's ability to drive, he/she should assist the driver education teacher in a follow-up of the situation. This cooperation has been most helpful to the driver education teachers, pupils, parents and the Motor Vehicle Department.

School Nurse Role

The school nurse works closely with the driver education teacher and families to support the student's successful participation in this program. School nurse coordinate the vision and hearing screening to ensure that the student is screened close, but prior to, the driving experience. For this reason, [Regulation 815](#), Health Examinations and Screenings, allows for the screening in either grade 9 or 10.

Laws & Regulations

- [License Qualifications](#)
- [Regulation 540, Drivers Education](#)

Resources

[Office of Highway Safety: GDL/Teen Driving](#)

State of Delaware Department of Public Safety, Division of Motor Vehicles, [Medical Report of Physicians Findings](#)

Reviewed by Dean Betts, Drivers Education, Delaware Department of Education. June 2016

Health Education

Overview

Effective health education curricula should reflect the growing body of research that emphasizes teaching functional health information (essential concepts); shaping personal values that support healthy behaviors; shaping group norms that value a healthy lifestyle; and developing the essential health skills necessary to adopt, practice, and maintain health-enhancing behaviors. Less effective curricula often overemphasize teaching scientific facts and increasing student knowledge, rather than changing behavior. The Centers for Disease Control and Prevention (CDC) identifies the characteristics of [effective health education curricula](#).

Delaware Health Education Standards are based on national standards.

1. Students will *understand essential health concepts* in order to transfer knowledge into healthy actions for life.
2. Students will *analyze the influence* of family, peers, culture, media, technology and other factors on healthy behaviors.
3. Students will demonstrate the ability to *access information*, products and services to enhance health.
4. Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.
5. Students will demonstrate the ability to use *decision-making skills* to enhance health.
6. Students will demonstrate the ability to use *goal-setting skills* to enhance health.
7. Students will demonstrate the ability to *practice health-enhancing behaviors* and avoid reduce health risks. (self-management)
8. Students will demonstrate the ability to *advocate* for personal, family and community health.

School Nurse Role

- Collaborate with health education staff as appropriate
- Provide community partner contact information as requested and appropriate
- Use DOE Health Education Lesson Plan templates for grade levels: [K-2](#), [3-5](#), [6-8](#), and [9-12](#)

Laws & Regulations

- [Regulation # 851, K-12 Comprehensive Health Education Program](#)

Resources

Bobo, N., Kimel, L., & Bleza, S. (2013). Promoting Health at School. In J. Selekman, *School Nursing: A Comprehensive Text* (2nd ed.), pp. 404-472. Philadelphia: F. A. Davis.

[Delaware Department of Education's Health Education webpage and resources](#)

[Healthy Steps For Healthy Lives](#)

Praeger, S. (2013). The School Nurse's Role as Health Educator. In J. Selekman, *School Nursing: A Comprehensive Text* (2nd ed.), pp. 109-141. Philadelphia: F. A. Davis.

Reviewed by: Peg Enslen, Education Associate, Health Career Sciences, Delaware Department of Education. June 2016.

Nutrition Services

Overview

The Delaware Department of Education Nutrition Programs administers several programs that provide healthy food to children. In schools, the USDA School Nutrition Program (SNP) provides nutritious meals through five sub-programs: National School Lunch Program, School Breakfast Program, Special Milk Program, After School Snack Program, and Fresh Fruit and Vegetable Program (FFVP). In addition, federal laws require school districts to implement wellness policies with goals for physical activity and nutrition, as well as implementing menu modifications for special nutritional needs.

Activities

- In accordance with the Healthy, Hunger-Free Kids Act of 2010, the school nurse can take an active role in implementing their school's wellness policy by becoming involved in developing, executing, evaluating, and advocating by notifying parents and students about the content of the local wellness policy.
- School nurses can also encourage good health and nutrition by conducting outreach, distributing school nutrition information, and participating in nutrition events such as School Breakfast Week, and School Lunch Week.

School Nurse Role

- The school nurse is an important partner of school nutrition programs as they can refer families to their school's nutrition program, communicate menu items that may contain allergens, and collaborate to meet a student's special nutrition needs. For example, a student with diabetes will likely base his/her insulin dosage on the intake of carbohydrates. The school nutrition office can provide menu product information, which includes carbohydrate content.
- It is recommended to know each school's nutrition office process for special nutrition needs for students with disabilities, and health concerns. School nurses can expect school nutrition to provide recipes and ingredient lists for foods served, special needs meals prepared and served with care to avoid cross-contact, and partnership for wellness policies to ensure healthy school environments.

Laws & Regulations

- [Child Nutrition Act of 1966](#)
- [Healthy Hunger-Free Kids Act of 2010](#)
- [Local School Wellness Policy](#)

Resources

[Delaware Department of Education Nutrition Programs](#)
[Delaware School Nutrition Association](#)
[USDA School Meals - Child Nutrition Programs](#)
[USDA Team Nutrition](#)

*Prepared by Aimee Beam, RD, Education Associate, Child Nutrition Programs, Delaware Department of Education.
June 2016*

Oral Health Services

Overview

A healthy smile should last a lifetime! Tooth decay is the most common childhood disease in the U.S., nearly five times more common than asthma. Yet, oral health problems can almost always be prevented. It is estimated that 90% of school age children suffer from dental caries or other dental problems. Dental disease can negatively impact a child's development and self-esteem. If left untreated, tooth decay can cause school absences and even affect a child's ability to learn and concentrate at school. Not only can dental caries be extremely painful, but treatment can be very costly for parents. Therefore, it is important that each student receives an oral examination and evaluation each year by a dentist. Some schools employ dental hygienists, but in most instances the school nurse participates in the dental health education and makes appropriate referrals. A current list of Delaware Dental Providers and those accepting Medicaid is available online (see resources below).

The Delaware Division of Public Health (DPH) has many resources to assist the school nurse and classroom teacher in the delivery of education and dental services through the Healthy Smile, Healthy You and the Sealant Program. Copies of materials can be obtained by emailing dhss_dph_dental@state.de.us or by calling 302-744-4554. The objectives of these programs are to assist the student in assuming responsibility for dental hygiene and to include dental health activities in the health education programs in the schools.

School Nurse Role

- Emphasize early and regular periodic dental examination
- Assist families in accessing and establishing a dental home
- Make referrals to the DPH dental services, if needed
- Participate in health education regarding dental hygiene and oral health
- Encourage limiting sugary foods and drinks, including sticky foods such as raisins and fruit rollups
- Encourage use of mouth guards in contact sports
- Discourage use of all tobacco products

Resources

[Children's Health Insurance Coverage Programs in Delaware](#)

[Delaware Dentists accepting Medicaid and S-CHIP](#)

[Delaware Division of Public Health Dental Clinics for Medicaid Eligible Children](#)

[Delaware Oral Health Program](#)

[Dental Resource Guide](#), First Smile Delaware

[First Smile Delaware Campaign](#)

[Whole School, Whole Community, Whole Child Oral Health Tool Kit](#)

Created by Barbara Antlitz and Dr. Greg McClure; Oral Health Services, Division of Public Health. June 2016

Healthy People 2020

Healthy People 2020 is a national initiative that sets and tracks a health promotion and disease prevention agenda for our population. Each state has a coordinator and has submitted data that is tracked for improvements in each target area. Dr. Paul Silverman, Division of Public Health, is the Delaware contact person. The [Delaware Health Tracker](#) is a helpful tool that can be accessed online. Much of the information is useful to school nurses in order to better understand the school community health risks and assets. There are measures about maternal and child health, adolescent health and environmental health. All of these are critical components of school nurse activities. It is often stated that “what gets measured gets done”. Healthy People 2020 puts its focus on prevention of disease and promotion of health for our communities and provides a report card to track progress and challenges.

Another national initiative of which Delaware is a part of is Kids Count. This initiative measures the status of the health of Delaware citizens and its families and children. Kids Count produces an annual report that compares several indicators to the other states and the nation as a whole.

Role of School Nurse

- Access health data for comparison within Delaware and surrounding areas
- Use data to assist in promoting health and or disease prevention.

Resources

[Healthy People](#)

[Healthy People 2020 - Progress Tracker- Delaware](#)

[Kids Count in Delaware](#)

Riley-Lawless, K. (2013). Demographics of Children and Adolescents. In J. Selekman *School Nursing: A Comprehensive Text* (2nd ed.), pp. 316-334. Philadelphia: F. A. Davis.

Risk Reduction

There are many factors and issues that affect a students' ability to learn. Children need personalized support, safe environments, and good health to be successful. There are many risks that our children face in their homes and communities, and from their personal choices. This section addresses several current risk areas for our students and provides an overview of Delaware programs and resources to meet their needs. Prevention is the best option but, often the school nurse will learn of the student's risk situation when intervention is needed to ensure safety and health.

School Nursing Practice Areas

- Child Abuse and Neglect
- Domestic Violence
- Dropouts
- HIV/STI and Teen Pregnancy Prevention
- Homeless Students
- LGBTQ Students
- Pregnant and Parenting Teens/ Safe Arms for Babies
- School Climate and Bullying
- School Crisis and Emergency Preparedness Plans
- Social and Emotional Health
- Students in Foster Care
- Students in Military Families

Child Abuse and Neglect

Overview

School nurses and any school employee, or person who in good faith suspect child abuse or neglect, are mandated by law ([16 Del. C § 904](#)) to report it immediately. This includes whenever there is reasonable cause to know or to suspect that a child has been subjected to abuse or neglect, or if there has been observation of a child being subjected to circumstances or conditions which would reasonably result in abuse or neglect. Keep in mind that it is not the responsibility of the reporter to prove that the child has been abused or neglected. Once a suspicion exists, the nurse (or staff member) should not engage the child in any interviewing or questioning. It is the responsibility of the Division of Family Services (DFS), Department of Services for Children, Youth and Families (DSCYF) to investigate the case, determine if abuse or neglect has occurred or if the child is at risk of being abused or neglected, and make a decision whether follow-up services are needed. In accordance with 16 Del. C, § 903 and 904, an oral report should be made to the Report Line at the Toll Free 24-Hour Report Line 1-800-292-9582. The phones are answered 24 hours a day, 365 days a year by DFS staff. Within 72 hours after the oral report, a completed [Child Abuse/Neglect Mandatory Reporting Form](#) should be mailed (to address on form). Care should be taken to only record facts and physical findings. School staff should not photograph a child's injuries. Only DFS or the police should take photographs as they have specialized training to do so. Additionally, schools should not notify parents that they made a report. All information is to remain strictly confidential. All educational employees must complete the required training, provided by the school, on child abuse.

School Nurse Role

The National Association of School Nurses has a Position Statement on [Child Maltreatment, Care of Victims: The School Nurse Role](#). "Prevention, early identification, prompt intervention, and treatment are critical to every aspect of the child's well-being".

In Delaware when you call in a report, be prepared to provide the following information, if known. A lack of information does not mean that DFS will not accept the report, but more information will assist DFS in making a decision about the urgency of the needed response.

- Name, age (date of birth if possible), gender of the child and other family members and the names of the parents/caretakers if available
- Address, phone numbers, and/or directions to the family's home or location of the child
- Description of the suspected abuse or neglect
- Current condition of the child (e.g., whether medical treatment appears necessary)
- Any other pertinent information which may assist DFS in investigating abuse or neglect

When making a report you will not have to give your name (anonymous report); however, if you do give your name it will allow the caseworker to call you for further information about the family and you will have documentation that you have followed the mandatory reporting law. By Delaware statute, there is no liability for making a report. It is DFS policy to never divulge the name of the reporter without the reporter's consent or, as required federally, to cooperate with investigatory entities such as law enforcement or the Department of Justice.

Once a report is received, the Report Line worker will review the facts of the case with a supervisor. In most instances, you will be informed at the conclusion of making the report that if you do not receive a call back, the report was accepted for investigation after supervisory review. If a decision is made not to investigate, you will be contacted by Report Line staff. If you have additional information or believe strongly that the case should be investigated, you should ask to speak to the Report Line Supervisor for further discussion.

Collaboration

Case Collaboration on Active DFS Cases: The public school districts and DFS encourage the sharing of information to facilitate the investigation, protect children, prevent further child abuse and neglect, and provide family-focused services. Before information can be shared, a signed State of Delaware Interagency Consent to Release Information must be obtained by either agency from the parents/custodians. To expedite the exchange of information, either agency may fax the signed consent form.

- A. No Identified DFS Caseworker
When the school has received confirmation that a case will remain open for treatment services, but the DFS caseworker's name is not known, a school staff person may contact the Report Line to request that the assigned caseworker contact them to share information about the case.
- B. Identified DFS Caseworker
When the school has received confirmation or otherwise knows that a case will remain open for treatment services and the caseworker's name is known, a school staff person should contact the caseworker directly to share information.

Memorandum of Understanding (MOU) between The Department of Education, Local Education Agencies and the Department of Services for Children, Youth and Their Families – Division of Family Services, Division of Prevention and Behavioral Health Services, and Division of Youth Rehabilitative Services: The MOU exists to describe specific reporting procedures, protocol for interaction between agencies, criteria for sharing of information, and problem resolution. It additionally designates liaisons for each agency. Some requirements under the MOU are:

- B. Liaisons
 - 1. Public school districts and charters will designate a representative from each school building to interface with the DFS School Liaison.
 - 2. DFS will designate School Liaisons from county operations management staff to interface with each public school district.
 - 3. The role of the Liaisons will be to:
 - a. ensure adherence to the MOU procedures;
 - b. develop and maintain a positive interagency relationship;
 - c. mediate conflict resolution;
 - d. identify training needs and encourage and assist in the development of cross-training efforts; and
 - e. meet semi-annually as a group (statewide School and DFS Liaisons) to discuss operations issues relative to the MOU and other pertinent issues.
- C. Annual review of the MOU

Laws & Regulations

- [Child Abuse and Neglect Definitions, Title 10, Chapter 9, Subchapter 1](#)

- [Title 11, Chapter 4, Subsection 468](#) (Delaware General Assembly website)
- [Title 16, Chapter 9, Subchapter I. Reports and Investigations of Abuse and Neglect; Child Protection Accountability Commission](#) (Delaware General Assembly website)
- [Title 16, Chapter 9, Subchapter II, Subsections 921 -929](#) (Delaware General Assembly website)

Resources

Division of Family Services (Department of Services for Children, Youth, and Their Families)

- Child Abuse Report Line: 1-800-292-9582.
This line is toll free and available 24 hours.
- [Mandatory Child Abuse and Neglect Reporting Form](#). Please note – a call to the Report Line must be made before submitting this form.
- [Child Abuse and Neglect Reporting](#)
- [DSCYF/School District Program Collaboration Matrix](#)
- Learn the Signs of Child Abuse
[Signs of Child Abuse](#)
[Behavioral and Physical Signs of Possible Sexual Abuse](#)
[Myths about Child Sexual Abuse](#)
[How Do I Report Child Abuse & Neglect?](#)
- [Parent Handbook / Manyèl pou paran / Manual de los Padres](#)
Description: This handbook was designed with parents in mind. It is intended to provide an overview of our services and should answer many common questions. Your caseworker can explain and provide answers to questions you may have which do not appear in this handbook.
 - [English version](#)
 - [Creole version](#)
 - [French version](#)
 - [Mandarin version](#)
 - [Spanish version](#)
- [State of Delaware Domestic Violence Advocate Pilot Project 2002-2004: An Overview and Evaluation](#)
- [The Professionals' Guide to Reporting Child Abuse and Neglect](#)

National Association of School Nurses. [Child Maltreatment, Care of Victims of: The School Nurse's Role. Child Protection Registry Information](#)

School Health Alert. (2016). Child Maltreatment. In *2016 School Nurse Resource Manual*, pp. 441-444. Nashville, TN: School Health Alert.

See the Signs – Make the Call
Report Child Abuse: 1-800-292-9582

Review by: Linda Shannon, Program Manager, Division of Family Services, Department of Services for Children, Youth and Their Families. June 2016

Indicators of Child Abuse and Neglect

Type of CA/N	Physical Indicators	Behavioral Indicators
Physical Abuse	<p>Unexplained bruises and welts:</p> <ul style="list-style-type: none"> on face, lips, mouth on torso, back, buttocks, thighs in various stages of healing clustered, forming regular patterns reflecting shape of article used to inflict (electric cord, belt buckle) on several different surface areas regularly appear after absence, weekend or vacation <p>Unexplained burns:</p> <ul style="list-style-type: none"> cigar, cigarette burns, especially on soles, palms, back or buttocks immersion burns (have sharp line of demarcation without drip or splash marks) patterned like electric burner, iron, etc. rope burns on arms, legs, neck or torso <p>Unexplained fractures:</p> <ul style="list-style-type: none"> to skull, nose, facial structure in various stages of healing multiple or spiral fractures <p>Unexplained lacerations or abrasions:</p> <ul style="list-style-type: none"> to mouth, lips, gums, eyes to external genitalia <p>Unexplained bite marks</p>	<p>Wary of adult contacts</p> <p>Apprehensive when other children cry</p> <p>Behavioral extremes:</p> <ul style="list-style-type: none"> aggressiveness, or withdrawal poor concentration/distractibility change in school performance <p>Frightened of parents</p> <p>Afraid to go home</p> <p>Reports injury by parents</p> <p>Symptoms of PTSD</p>
Physical Neglect	<p>Consistent hunger, poor hygiene, inappropriate dress</p> <p>Consistent lack of supervision, especially in dangerous activities or long periods</p> <p>Unattended physical problems or medical needs</p> <p>Abandonment</p>	<p>Begging, stealing food</p> <p>Extended stays at school (early arrival and late departure)</p> <p>Constant fatigue, listlessness or falling asleep in class</p> <p>Alcohol or drug abuse</p> <p>Delinquency (e.g. thefts)</p> <p>States there is no caretaker</p>
Sexual Abuse	<p>Difficulty in walking or sitting</p> <p>Torn, stained or bloody underclothing</p> <p>Pain, itching or discharge in genital area</p> <p>Bruises or bleeding in external genitalia, oral, vaginal, anal injuries</p> <p>STIs, especially in pre-teens</p> <p>Pregnancy</p>	<p>Unwilling to change for gym or participate in physical education class</p> <p>Withdrawal, fantasy or infantile behavior</p> <p>Bizarre, sophisticated, or unusual sexual behavior or knowledge</p> <p>Poor peer relationships</p> <p>Delinquent or run away</p> <p>Reports sexual assault by caretaker</p>
Emotional Maltreatment	<p>Speech disorders</p> <p>Lags in physical development</p> <p>Failure-to-thrive</p>	<p>Habit disorders (sucking, biting, rocking, etc.)</p> <p>Conduct disorders (social withdrawal, destructive, etc.)</p> <p>Neurotic traits (sleep disorders, inhibition of play)</p> <p>Psychoneurotic reactions (hysteria, obsession, compulsion, phobias, hypochondria)</p> <p>Behavior extremes:</p> <ul style="list-style-type: none"> compliant, pensive aggressive, demanding increased verbal abuse or physically aggressive with others <p>Overly adaptive behavior:</p> <ul style="list-style-type: none"> inappropriately adult inappropriately infant <p>Developmental lags (mental, emotional)</p> <p>Attempted suicide</p>

Provided by DSCYF, DFS. Reviewed 2016

Domestic Violence

Overview

Domestic Violence is any abusive act between family, members, ex-spouses, intimate cohabitants, former intimate cohabitants, dating couples and former dating couples in which one party seeks to gain/maintain power and control over the other partner. Couples or former couples can be of the same or opposite sex. Domestic violence can be physical, sexual, emotional, economic or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure or wound someone.

There are two categories of Domestic Violence.

Intimate Partner Violence: includes current and former spouses, current and former dating couples with or without a child in common and dating couples.

Non-Intimate Partner Violence: violence between individuals who are not intimate partners but have a familial relationship, such as, mother/adult son or brother/sister.

An important resource for Health Care Providers in Delaware is the Domestic Violence Coordinating Council (DVCC). This state agency was legislatively created in 1933 to improve response to domestic violence. A committee made up of health care providers, domestic violence advocates and affiliated professionals worked together to create [The Domestic Violence Resource Manual for Healthcare Professionals](#). The manual helps providers recognize domestic violence; feel comfortable screening for domestic violence and provides resources for domestic violence victims. It provides screening tips, documentation tools and additional resources. The Medical Manual is available on-line at <http://dvcc.delaware.gov/medhealthinfo.shtml>

Understanding Domestic Violence

Domestic Violence is a serious social problem that affects the health and well-being of millions of people each year. According to Amnesty International “violence against women is one of the most pervasive human rights abuses.” Though the true scope of domestic violence is nearly impossible to measure, various statistics can help define the issue. It is estimated that about 1.3 million women and 835,000 men experience domestic violence annually. Domestic violence occurs in both heterosexual and same-sex relationships and crosses all social, economic, race and ethnicity boundaries.

Symptoms Associated with Domestic Violence: Domestic violence is a major public health problem resulting in injuries and other short and long term health consequences including mental illness and complications of pregnancy. It is a chronic life-threatening condition that is treatable. Although a victim of domestic violence can present with no symptoms, domestic violence has been linked to a variety of symptoms and physical findings. Associated symptoms may include but are not limited to:

Physical Symptoms: Chronic pain, headaches, atypical chest pain, abdominal pain, sleep and appetite disturbances, fatigue, difficulty concentrating, STDs, Frequent UTIs, miscarriage/vaginal bleeding

Physical Injuries: injuries during pregnancy, placental abruption, multiple sites of injury, injuries in various stages of healing, any bite mark, sexual assault, repeated or chronic injuries, injuries that are inconsistent with history, injuries consistent with strangulation

Behavioral indicators: evasive/frightened/anxious, seems reluctant to leave, “doctor shops”, frequent visits, reluctant to answer questions, suicidal ideations/attempts

Children and Domestic Violence - Domestic violence is a learned behavior. It is learned through observation, experience/reinforcement in the family, communities (schools, peer groups, etc.) and culture. It is not caused by genetics, illness, alcohol, drugs, stress or the behavior of the victim in the relationship. More than 3 million children witness domestic violence in their homes every year.

Seeing or hearing violence among family members hurts children in many ways. In general, children can experience a sense of danger, chaos, confusion, anxiety, isolation, fear, tension and/or hopelessness. They do not have to be hit to feel the pain of violence. Children who witness domestic violence are a special risk for emotional and developmental problems and more likely to perpetuate violence in their adolescent and adult relationships.

Teen Dating Violence - Teen dating violence is domestic violence. Few of us are used to asking teenagers about their dating practices; however, there is growing evidence that teens are abused by their boyfriends and girlfriends at rates comparable to those of long term adult relationships. Statistics show that one in three teenagers have experienced violence in a dating relationship.

Victims of teen dating violence are more likely to do poorly in school and report binge drinking, suicide attempts and physical fighting. Victims and perpetrators are also more likely to carry the patterns of violence into adult relationships.

Warning signs may include:

- Their boyfriend/girlfriend calls them names or puts them down
- Their boyfriend/girlfriend acts extremely jealous
- The teen often cancels plans at the last minute
- The teen frequently apologizes for their boyfriend/girlfriend
- The teen has recently given up things that used to be important to them

In addition to the domestic violence hotlines, teens can receive age appropriate information and services via www.loveisrespect.org or www.safeandrespectful.org.

Resources

The Domestic Violence Hotline numbers are perhaps the single most important resource. All hotline numbers are confidential and available 24/7. Hotlines are staffed by trained professionals who will assist in safety planning and refer to available resources. Hotline providers are also happy to provide information and support to those working with suspected victims of domestic violence. Services are available to victims who do not speak English and/or who are hearing impaired (for Delaware Relay Service, dial 711).

[Domestic Violence Coordinating Council](#): 302-255-0405

[Resources for Victims of Crime](#) (includes 24 hour emergency hotlines)

<u>New Castle County</u>	<u>Kent</u>	<u>Sussex</u>
Domestic Violence - 302-762-6110	Domestic Violence - 302-678-3886	Domestic Violence - 302-422-8058
Rape Crisis - 302-773-8570	Bi-Lingual Hotline - 302-745-9874	Rape Crisis - 1-800262-9800
Bi-Lingual Hotline - 302-762-6110		Bi-Lingual Hotline - 302-762-6110
TTY - 1-800-232-5460		

The county programs can provide:

- Safety planning
- Court Assistance
- Police Assistance
- Group/Individual Counseling
- Transitional housing
- Shelters
- Case management
- Legal representation
- Financial assistance
- Career training and assistance

Reviewed and revised by Aimee Voshell String, Project Coordinator, Domestic Violence Council. June 2016

Overview

A study cited by the National Dropout Prevention Center/Network identified numerous reasons why students drop out of school. School related reasons include missing too many days, poor grades, dislike school, couldn't keep up, couldn't get along with teachers/peers, didn't feel safe, didn't belong and discipline. Non-school related reasons included pregnancy, need to support or care for family, marriage and employment responsibilities.

A student dropping out of school is usually the final result of a much longer process. It is important to recognize that this is not just a high school issue, but rather a cumulative process of disengagement from school that can begin as early as elementary school. Students begin to disengage from school when they fail to become involved in either the academic or social aspects of school. The following is a list of potential warning signs that might mean a student is at higher risk for dropping out:

- They don't feel challenged in school.
- They don't feel high educational expectations from either their family or school.
- They believe their parents are too controlling and they want to rebel.
- They have trouble with schoolwork or feel like they are not as smart as other students.
- They have drug, alcohol, or mental-health problems.
- They regularly miss school or are frequently tardy.
- They struggle with problems at home, including physical or verbal abuse.
- They feel like they don't fit in or have friends at school.
- Their peers or siblings have dropped out of school.
- They have poor learning conditions at school—such as overcrowding, high levels of violence, and excessive absenteeism.

Activities

- School engagement and dropout prevention initiatives are determined at the school level. School nurses can be valuable members of these committees.

School Nurse Role

School nurses play an important role in identifying students who show early warning indicators that could lead to a student dropping out. As stated previously, these indicators can surface as early as elementary school and anytime thereafter. The nurse's unique access to students who may be presenting with at-risk behaviors puts them in a position to raise awareness among other resources in the school. While the nurse isn't expected to "treat" the students with regards to dropout concerns, the nurse should be familiar with the school's policies or procedures for working with these students. The school nurse also has a heightened opportunity and responsibility when a child's health status is related to the reasons for dropping out, e.g. chronic absenteeism. It will be important to refer the student to the appropriate resources within the building.

Laws & Regulations

- Compulsory Education ([14 Del Code, 27, § 2702](#))
- [Age of Majority](#) (a student cannot dropout without parental permission until age 18)

Resources

[2014 – 2015 Delaware Dropout Summary Statistics](#)

[Communities in Schools \(Delaware\)](#)

[Delaware Dropout Statistics by Year](#)

[Del. Tech Adult Basic Education Program \(GED\)](#)

[James H. Groves Adult Education](#)

Reviewed and revised by Jennifer Davis, Education Associate, Student Services and Special Populations, Delaware Department of Education. June 2016

HIV/STI and Teen Pregnancy Prevention

Overview

Exemplary Sexual Health Education (ESHE) is defined as “a systematic, evidence-informed approach to sexual health education that includes the use of grade-specific, evidence-based interventions, but also emphasizes sequential learning across elementary, middle, and high school grade levels. ESHE provides adolescents the essential knowledge and critical skills needed to avoid HIV infection, other STD, and unintended pregnancy. ESHE is delivered by well-qualified and trained teachers, uses strategies that are relevant and engaging, and consists of elements that are medically accurate, developmentally and culturally appropriate, and consistent with the scientific research on effective sexual health education” (Center for Disease Control and Prevention, 2016)

The Adolescent Health Program helps districts and schools deliver ESHE, emphasizing HIV and other STD prevention, within the national health standards. Establishing healthy behaviors during childhood and adolescence is easier and more effective than trying to change unhealthy behaviors during adulthood. Schools can influence students’ risk for HIV infection and other STD through a variety of ways, including sexual health education, provision of or referral to physical and mental health services, and establishment of a safe and supportive environment that provides social and emotional support to young people, particularly those at high risk for HIV- and STD-related behaviors.

In addition to evidence-based prevention programs, teens need access to youth-friendly clinical services. Parents and other trusted adults also play an important role in helping teens make healthy choices about relationship, sex and prevention.

School Nurse Role

- Collaborate with Health Education staff with the development and implementation of grade-specific and evidence-based sexual health curriculum as appropriate.
- Collaborate with School Based Health Centers as appropriate.
- Individual Counseling and referrals to youth-friendly services.

Laws & Regulations

[Affidavit of Establishment of Power to Consent to Medical Treatment of Minors](#)

[Consent to Health Care of Minors](#)

Delaware Department of Education, [Health and Safety Regulations](#)

Delaware Department of Education, Regulation 851 [K to 12 Comprehensive Health Education Program](#)

Delaware Department of Education, Regulation 901 [Education of Homeless Children and Youth](#)

Delaware Department of Education, Regulation 930 [Supportive Instruction \(Homebound\)](#)

[Minors — Treatment, Consent, and Liability for Payment for Care](#)

Resources

[Delaware Comprehensive Health Education K-12](#)

[Delaware Health Education](#)

National Association of School Nurses [NASN]. (2015). [Position Statement – Pregnant and Parenting Students, The Role of the School Nurse](#).

[National Health Education Standards K-12](#)

[National Sexuality Education Standards](#)

School Health Alert. (2016)., HIV. In *2016 School Nurse Resource Manual*, pp. 208-212. Nashville, TN: School Health Alert.

Prepared by Patricia Ayers, Education Specialist, HIV/STI/Teen Pregnancy Prevention, Delaware Department of Education. June 2016

Homeless Students

Overview

Students that are homeless, are afforded educational rights under the federal McKinney-Vento Homeless Education Assistance Act. These rights seek to address barriers to “enrolling, attending, and succeeding in school.”

The McKinney-Vento Definition of Homeless

Subtitle VII-B of the McKinney-Vento Homeless Assistance Act (per Title IX, Part A of the Elementary and Secondary Education Act, as amended by the Every Student Succeeds Act) defines homeless as follows:

The term "homeless children and youths"--

(A) means individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1)); and

(B) includes--

(i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals;

(ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C));

(iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i)

School Nurse Role

- Work closely with district/charter/school homeless liaison ([List provided online](#))
- Note: The McKinney-Vento definition of homelessness differs from the definition used in the Tuberculosis Risk Questionnaires provided later in this chapter.

Enrollment of Homeless Students - “School nurses are typically assigned by districts to monitor and assure that students meet the regulatory requirements for school entry. Additionally, they are responsible for reducing the risk of the entire school to communicable disease. Because of this, they often have questions regarding how the school entry requirements relate to the McKinney-Vento statute” (*DDOE School Nursing Partners Newsletter*, March 2003). Homeless Students may lack the required (by regulation) medical documentation of immunizations, tuberculosis (TB) screening, a current physical and lead screening (age-dependent) for enrollment in school.

The following are points to be considered when working with homeless students:

- McKinney-Vento requires the school to immediately enroll students in class and assist the family in meeting all school enrollment requirements.
 - In the case of a child without a shot record, the school needs to assist the family in locating the record. The child should not be denied school entry during this time. In the event the record is never found, the school can follow the Lost Records section of the regulation if it is believed that the record was lost.
 - In the case of a child missing an immunization or a required booster, the school must assist the child in getting the vaccination. This may mean arranging for a doctor's visit, providing transportation, etc. It may be less interruptive to the family to address this on the day that the child enrolls and prior to getting to the classroom; however, if this cannot be arranged immediately the child should not miss class time while waiting for an appointment.
- Any child or staff member exhibiting signs of active communicable disease must be excluded from participating in school activities.
 - In the case of TB, a child may have multiple risk factors for TB and need to have a Mantoux skin test; however, unless the child has symptoms of disease (ex. night sweats, pallor, coughing, fever, etc.) he/she should not be excluded from school. (Refer to Tuberculosis Screening in this chapter under Screenings/Referral/Follow-up.)

Laws & Regulations

- Department of Education Regulation #901, [Education of Homeless Children and Youth](#)
- McKinney – Vento Act, <https://www2.ed.gov/programs/homeless/guidance.pdf>

Resources

[A Toolkit for Meeting the Educational Needs of Runaway or Homeless Youth](#)

Delaware Department of Education – [Homeless Liaison Resources](#)

Delaware Department of Education, Homeless Coordinator: John Hulse, Education Associate,
John.Hulse@doe.k12.de.us

[Local \(Delaware\) Homeless Education Liaison](#)

School Health Alert. (2016). Homelessness. In *2016 School Nurse Resource Manual*, pp. 449-451. Nashville, TN: School Health Alert.

Reviewed and revised: Jennifer Davis, Student Services & Special Populations, Delaware Department of Education. June 2016

LGBTQ Students

Overview

“All students - regardless of their sexual orientation, gender identity, or gender expression - are entitled to a safe, supportive and inclusive school environment with equal opportunities for achievement and participation”. (National Association of School Nurses [NASN], 2015).

School Nurse Role

- Collaborate with health education staff on the development and implementation of grade-specific and evidence-based inclusive health education and curriculum as appropriate
- Collaborate with School Based Health Centers as appropriate
- Provide culturally congruent care in a safe, private and confidential setting
- Provide Individual referrals to youth-friendly healthcare professionals knowledgeable about the healthcare needs of LGBTQ youth
- Provide support and resources for families that are available to help them to support their children
- Encourage a welcoming inclusive environment with safe spaces in the school
- Encourage the use of gender neutral school forms, dress codes, changing space and bathrooms
- Use the students' preferred names and pronouns

Resources

Delaware Department of Education [LGBTQ](#)

Delaware Department of Education [LGBTQ Education](#)

Delaware Department of Education [Safe and Supportive Environment](#)

National Association of School Nurses [NASN]. October 19, 2016. [LGBTQ Students: The Role of the School Nurse](#)

School Health Alert. (2016). Lesbian, Gay, Bisexual and Transgender Youth. In *2016 School Nurse Resource Manual*, pp. 452-456. Nashville, TN: School Health Alert.

Prepared by Patricia Ayers, Education Specialist, HIV/STI/Teen Pregnancy Prevention, Delaware Department of Education. June 2016

Pregnancy & Parenting Teens

Overview

The birthrate for teens (ages 15-19) was a historic low of 9% in 2013 (CDC, 2016). “Teens seem to be less sexually active, and more of those who are sexually active seem to be using birth control than in previous years” (CDC, 2016). However, disparities continue with teen birth rates “twice as high for Hispanic and non-Hispanic black teens compared with non-Hispanic white teens” and “geographic and socioeconomic disparities remain irrespective of race/ethnicity” (CDC, 2016).

Teen pregnancy can have negative health, economic, and social consequences for mothers and their children (CDC, 2016). There are many ways schools and school nurses can support students to make healthy decisions and avoid pregnancy during adolescence.

Activities

- Safe Arms for Babies.
- See Health Education covered previously in this chapter.

School Nurse Role

- Collaborate with Health Education staff with the development and implementation of grade-specific and evidence-based sexual health curriculum as appropriate
- Collaborate with School Based Health Centers as appropriate
- Individual referrals to youth-friendly services
- Help to coordinate homebound instruction as appropriate

Laws & Regulations

- Delaware Department of Education [Regulation #930 Supportive Instruction \(Homebound\)](#)

References & Resources

Centers for Disease Control and Prevention [CDC]. (2016). Reduced disparities in birth rates among teens aged 15-19 years – United States, 2006 – 2007 and 2013 – 2014. *Morbidity and Mortality Weekly Report*, 65 (16), 409 – 414. Retrieved from <http://www.cdc.gov/teenpregnancy/about/reduced-disparities-birth-rates.htm> on September 13, 2016.

(CDC). (2015). [Reproductive Health: Teen Pregnancy](#).

National Association of School Nurses [NASN]. (2015). [Position Statement – Pregnant and Parenting Students - The Role of the School Nurse](#).

School Health Alert. (2016). Teen Pregnancy / Teen Pregnancy Prevention. In *2016 School Nurse Resource Manual*, pp. 461-465. Nashville, TN: School Health Alert.

Prepared by Patricia Ayers, Education Specialist, HIV/STI/Teen Pregnancy Prevention, Delaware Department of Education. June 2016

Safe Arms for Babies

Safe Arms for Babies is a law that allows a parent to go to any Delaware hospital emergency department and leave their newborn (14 days old or younger) with any emergency department staff or volunteer. This law provides immunity from criminal prosecution provided the baby is alive, unharmed and brought into a hospital emergency department. For more information, please visit the Delaware Division of Public Health (DPH) website, [Safe Arms for Babies](#).

Toll-free 24-hour hotline: 1-800-262-9800

What happens to the person surrendering the baby?

The person surrendering the baby will not be asked for identification, will not be asked who they are, will not have their identity revealed and will not be contacted. The employee or volunteer of the hospital will make a reasonable attempt to provide the person surrendering the baby with the identification number of the baby, a mail-back medical questionnaire and information about the Safe Arms for Babies law that includes a list of phone numbers for public and private agencies that provide counseling and adoption services.

What happens if a baby is brought to a hospital emergency department?

If an infant is surrendered under the law, the hospital will place a numbered identification bracelet on the baby as an aid in linking the person and the medical questionnaire to the baby. The baby will receive a medical screening examination and any necessary medical care. The hospital will take temporary emergency protective custody of the baby and immediately notify the Division of Family Services and the State Police that a baby has been surrendered under the law. The Division of Family Services will request ex parte custody of the baby from Family Court and the State Police will submit an inquiry to the Delaware Missing Children Information Clearinghouse. The baby will be placed with a family willing to adopt the child if parental rights are terminated.

Can the birth parent(s) be reunited with their baby?

If a parent changes their mind and wants their baby back, they can call the Division of Family Services hotline at 1-800-292-9582 and say they wish to be reunited with their baby. The Division of Family Services shall seek to terminate parental rights unless the parent seeks reunification within 30 days of the date of surrender. It is important to note that the identification number given the baby at the time of surrender is an identification aid only and does not permit the person possessing the identification number to take custody of the baby on demand. Once the baby has been surrendered to the hospital, the baby will not be returned by the hospital until the Division of Family Services and Family Court determines that the baby can be cared for safely.

Who can I call for more information?

To speak with someone directly 24-hours a day about the Safe Arms for Babies, call the toll-free 24-hour hotline, 1-800-262-9800.

Information taken from DPH website, [Safe Arms for Babies](#).

School Climate

Overview

The Center for Disease Control and Prevention (CDC) describes a healthy school environment as “the physical and aesthetic surroundings and the psychosocial climate and culture of the school. Factors that influence the physical environment include the school building and the area surrounding it, any biological or chemical agents that are detrimental to health, and physical conditions such as temperature, noise, and lighting. The psychological environment includes the physical, emotional, and social conditions that affect the well-being of students and staff” (CDC, 2015).

The goal of School Climate and Discipline programs in Delaware is to promote necessary components of a healthy school climate: to support learning and contribute to students’ health by minimizing distractions and physical, psychological, and social hazards; to create a climate in which students and school staff do their best work; to expect that all students can succeed; and to implement supporting policies. This goal is accomplished by having in place collaborative relationships, an effective evaluation process, technical assistance and resources to ensure that schools are designed to provide a safe, healthy, and supportive environment that fosters learning.

School climate relates to the [Whole School, Whole Community, Whole Child](#) (WSCC) model. Strategies to improve the school climate by teaching conflict resolution and social skills can also be multi-tiered and include curriculum with teaching and modeling positive social interactions. Schools that implement programs such as Positive Behavior Support (PBS) incorporate proactive strategies at the building, class, and individual level. Schools whom adopt PBS establish a safe school climate that promotes academic, social, and emotional development. Other strategies and tools include the [Delaware School Climate Survey](#), an evaluation measure given to parents, school staff, and students to examine the needs and effectiveness of efforts to improve school climate. Using such an evaluation measure, allows all parties involved in the school to give input about the practices and environment of the school and will in turn, help foster a positive school climate. A positive school climate can also include anti-bullying strategies and drop-out prevention that can be implemented at any age level.

Resources

Center for Disease Control and Prevention (CDC). (2015). Components of the whole school, whole community, whole child (WSCC). Healthy School. Retrieved from <http://www.ascd.org/programs/learning-and-health/wsc-model.aspx> on September 13, 2016.

[DDOE School Climate and Discipline](#)

[Delaware Positive Behavior Support](#)

[Memorandum of Understanding to Reduce Truancy](#)

National Association of School Nurses [NASN]. (2013). [Position Statement – School Violence, Role of the School Nurse in Prevention](#).

National Association of School Nurses [NASN]. (2015). [Position Statement – Use of Restraints, Seclusion and Corporal Punishment in the School Setting.](#)

[National Drop-out Prevention Center/Network](#)

[Positive Behavior Support](#)

Review by: John Sadowski, DDOE, School Climate & Discipline, June 2016

School Crisis Plans/Emergency Preparedness

Overview

It is imperative that School Nurses are included in school emergency planning and disaster preparedness to ensure every student has the same opportunity for effective management and stabilization of an emergency which occurs within the school community. The goals of emergency planning are to mitigate/prevent, prepare, respond, and recover. A School Nurse's role is equally important in all four phases. In 2012, Delaware Legislators passed the Omnibus School Safety Act (OSSA) which directed the Delaware Department of Safety and Homeland Security (DSHS) to create and oversee a standardized set of Comprehensive School Safety Plans (CSSP) for all districts and charters to utilize in school emergency planning and disaster preparedness. These plans are compliant with the National Incident Management System (NIMS) as required by a presidential directive. In addition to the CSSP, the National Association of School Nurses (NASN) recognizes that students who have special health care needs are at greater risk for a medical emergency and these students should have an individualized Emergency Care Plan.

Activities

- As part of Delaware's CSSP, each public and charter school is to conduct two intruder/lock down drills per year as well as an annual tabletop exercise. The tabletop exercise topic should vary from year to year and could address a health related emergency such as a pandemic flu. In addition, each school is to manage its plans and exercises through the Emergency Response Information Portal (ERIP). Drills and tabletops are to be conducted with local emergency responders.
- Emergency Preparedness checklist should be completed annually by the school emergency preparedness team. The checklist can be found in ERIP.
- National Incident Management System (NIMS) and Incident Command System (ICS) are required emergency management systems. Trainings can be conducted through on-line modules. In addition, the Delaware Emergency Management Agency (DEMA) periodically sponsors free trainings related to these systems and overall crisis management for school-based incidents.
- Periodic updates to plans in ERIP are required to keep plans current and accurate.

Special Consideration

- Consider who will be your likely first responders in a medical emergency and communicate with those individuals on a regular basis and particularly during emergency preparedness drills and tabletop exercises
- Partnerships outside of the school community including:
 - National Association of School Nurses (NASN)
 - Local law enforcement and volunteer EMS staff
 - Delaware Department of Safety and Homeland Security CSSP staff
 - Delaware Division of Public Health
 - American Red Cross

- Local hospital and medical systems
- Receive training in the Incident Command System (ICS) with other school team members. Practice the ICS during non-emergency school related events and emergency drills
- Know your specific non-health related role in emergency situations where medical care is not required as part of the emergency response (i.e. reunification process)

School Nurse Role

The overarching actions and responsibilities of a school nurse as it relates to school crisis plans and emergency preparedness include:

- Providing leadership in the development of the school's all-hazards approach to emergency preparedness and response
- Providing medical care to students, staff, and/or visitors in relation to health-related emergencies caused by injury, illness, or large scale casualty incidents such as chemical exposure, weather-related incidents, or violent acts. Large casualty incidents should be managed in accordance with the National Response Framework (NRF) which enables all response partners to provide a unified response
- Prevention/Mitigation by participating in ongoing assessment to identify all possible hazards to reduce the potential of an emergency occurring
- Preparedness by participating in school/community/first responder planning groups including participation in planning drills and exercises as well as individualized planning for students/staff with specialized health needs. In addition, managing emergency equipment and supplies such as first aid kits and AED devices
- Responding with appropriate initial emergency medical care, training of first aid response teams and implementing student/family reunification efforts
- Recovery efforts by providing planning and longer-term health maintenance of affected students/staff and participation in debriefing meetings following an actual emergency event or exercise.

Laws & Regulations

- [Delaware Omnibus School Safety Act](#)
- [Homeland Security Presidential Directive 8 \(HSPD 8\)](#)

Resources

American Red Cross

- [Get Help](#)
- [The Pillowcase Project](#) (preparedness education for grades 3-5)

Delaware Comprehensive School Safety Program (CSSP)

- [ERIP Login page](#) (will require access approval by principal or district office) -

Delaware Emergency Management Agency (DEMA)

Delaware Health and Social Services School Preparedness Page

Disaster Preparedness

[Federal Emergency Management Agency \(FEMA\)](#)

- [Children and Disasters](#)
- [Incident Command System \(ICS\)](#)

School Health Alert. (2016). Disaster Preparedness. In *2016 School Nurse Resource Manual*, pp. 417-420. Nashville, TN: School Health Alert.

[National Incident Management System \(NIMS\)](#)

[Emergency Preparedness and Response in the School Setting: The Role of the School Nurse](#) (National Association of School Nurses)

Prepared by John Sadowski, Education & Associate, School Climate and Discipline, Delaware Department of Education. June 2016

Social and Emotional Health

Overview

Social-emotional development and academic achievement represent a continuum of development that is needed for all children to grow up healthy and succeed in school and life. Children's excitement for learning, self-concept, relationship with peers and adults, capacity to cooperate and manage themselves are components that lead to academic success.

Schools have the responsibility to support the intentional development of positive child-adult relationships and provide environments that allow all children to succeed. Intensive interventions are paramount for vulnerable children—those with language, economic, and other hardships that place obstacles to social development and academic success.

Activities and Related Documents

- Division of Prevention and Behavioral Health Services
- Mental Health Emergencies

School Nurse Role

"Mental health is as critical to academic success as physical well-being. School nurses play a vital role in the school community by promoting positive mental health development in students through school/community-based programs and curricula. As members of interdisciplinary teams, school nurses play a vital role in supporting early assessment, planning, intervention, and follow-up of children in need of mental health services. In addition, school nurses serve as advocates, facilitators and counselors of mental health services both within the school environment and in the community" (National Association of School Nurses, 2013).

Resources

NASN (2013). Mental Health of Students. *Position Statement*. Retrieved on September 21, 2016 from <https://schoolnursenet.nasn.org/blogs/nasn-profile/2017/03/13/mental-health-of-students>.

School Health Alert. (2016). Depression. In *2016 School Nurse Resource Manual*, pp. 112-116. Nashville, TN: School Health Alert.

School Health Alert. (2016). Suicide Ideation/Threats. In *2016 School Nurse Resource Manual*, pp. 457-460. Nashville, TN: School Health Alert.

Division of Prevention and Behavioral Health Services (DPBHS)

Department of Services for Children, Youth and Their Families

WHO IS DPBHS?

The Division of Prevention and Behavioral Health Services (DPBHS) is part of the Delaware Department of Services for Children, Youth, and Their Families (DSCYF).

WHO DOES DPBHS SERVE?

DPBHS provides voluntary mental health and substance abuse treatment services to children up to age 18 who have mental health or substance abuse problems and their families. Services are available for children without insurance or those with Medicaid who require more than 30 hours of outpatient treatment services.

WHAT SERVICES CAN DPBHS PROVIDE?

- Crisis Services
- Case Management
- Outpatient Services
- Wrap Services
- Day Hospital Services
- Day Treatment Services
- Residential Treatment Services
- Hospital Treatment Services

Licensed mental health professionals manage these services.

WHAT CAN FAMILIES EXPECT WHEN CONTACTING DPBHS?

- A staff person is available to guide them through the treatment process and to answer questions and concerns;
- The whole family is part of making the decisions about treatment;
- Information about the child and family will be confidential;
- Services will be voluntary; the family can choose whether or not to use them.

Resources

[Prevention and Behavioral Health Service, Delaware Department of Services for Children Youth and Their Families](#)

*Reviewed and revised: Jennifer Davis, Student Services & Special Populations, Delaware Department of Education.
June 2016*

MENTAL HEALTH EMERGENCIES

Division of Prevention and Behavioral Health Services (DPBHS)

DPBHS will respond to all child mental health or emotional emergencies, which would cause him/her to hurt him/herself or someone else.

Crisis Priority Response (CPR) is available 24 hours per day, 7 days per week

Mobile Crisis Service (CPR) -- 1-800-HELP (4357) statewide

Mental Health Emergencies

An emergency means that the child has a mental health or emotional problem which could cause him or her to hurt him/herself or someone else right now.

Call Crisis Services are available 24 hours per day,

7 days per week: 1-800-969-HELP (4357)

Crisis Text Line – Text DE to 741741 – A free, 24/7 text line for people in crisis

Non-Emergencies

If the family has private insurance or Medicaid and does not need emergency services, they can call the member services number on the back of the insurance card.

If there is a concern about a child's mental health, but it is not urgent, have the family call their Managed Care Organization (MCO).

If they do not have an insurance card with a telephone number or are not sure how to get help, call:

- DPBHS Intake 302-633-2571 (Monday-Friday, 8:00 a.m. - 4:30 p.m.), or
- Toll free 1-800-722-7710 (24 hours)

For non-emergencies, call the following outpatient service providers in your community.*

Mental Health specialization: **(MH)** Substance Abuse specialization: **(SA)**.

New Castle County	Kent County	Sussex County
Aquila (SA) : 302-999-1106 (Wilmington)	Catholic Charities (MH) : 302-674-4016 (Dover)	Aquila (SA) : 302-856-9746(Georgetown)
Catholic Charities (MH) : 302-655-9624 (Wilmington)	Delaware Guidance (MH) : 302-678-3020 (Dover)	Catholic Charities (MH) : 302-856-9578 (Georgetown)
Child Guidance Resource Centers 302-279-1010 (Middletown)	Open Door (SA) : 302-731-1504 (Dover)	Delaware Guidance (MH) : 302-645-5338 (Lewes, Georgetown)
Crossroads 302-652-1405 (Wilmington)	People's Place (MH & SA) : 302-422-8026 (Smyrna)	People's Place (MH & SA) : 302-422-8026 (Milford, Seaford, Millsboro)
Delaware Guidance (MH) : 302-652-3948 (Wilmington) 302-455-9333 (Newark)	SODAT (SA) : 302-656-4044 (Dover)	SODAT: 302-656-4044 (Seaford)
Jewish Family Services of Delaware (MH): 302-478-9411 (Wilmington)		
Latin American Community Center: 302-295-2160		
Open Door (SA) : 302-731-1504 (Newark & Claymont)		
SODAT (SA) : 302-656-4044 (Wilmington)		

*A more current list may be sent electronically by contacting Intake Department at DPBHS at 302-633-2571, or

DSCYF_Intake_Generale@state.de.us

Students in Foster Care

Overview

“Foster care is the temporary care for a child that has been removed from his/her home due to abuse, neglect, or dependency. The goal for most children in foster care is to be returned to their natural parents when circumstances that led to foster placement are resolved” (Delaware Department of Services for Children, Youth and their Families [DSCYF], 2016). The U.S. Department of Health and Human Services, Administration for Children and Families reports that in Delaware there were 635 children in foster care on September 30, 2014. That number has been declining over the previous nine years from a high in Fiscal Year 2007 of 1,157 (U.S. Department of Health and Human Services, 2015)

Children in foster care often have an increase in health problems both physical and emotional, and in some instances may have had lack of adequate and timely health care. Foster youth are more likely to experience barriers that lead to poor outcomes, including low academic standings, grade retention, and lower graduation rates. (U.S. Department of Education, 2016.) School nurses may be in a unique position to advocate for the children’s needs to be met. Foster children present challenges for school nurses that may be related to change of placements, inadequate caregivers, and incomplete health records. The school nurse plans interventions to meet the children’s needs and is often the link between the school, the social service agency, and foster families.

In Delaware there is close collaboration between DSCYF and schools. DSCYF provides a list of children, who are in foster care, to the Department of Education so that this information is entered into students’ electronic school records. There is a partnership between the Department of children, Youth and Their Families and Nemours/Al duPont Hospital for Children to assure that all children in foster care have a medical home.

On June 23, 2016 The U.S. Department of Education and the U.S. Department of Health and Human Services released guidance to states, school districts and social service agencies on new provisions in the Every Student Succeeds Act (ESSA) for supporting children in foster care. Implementation of this will occur over the next year. School nurses should be involved.

Activity

- Knowing Who to Notify (Summary Sheet follows)

Role of the School Nurse

- Be part of school teams that identify and intervene for high risk children, including children in foster care
- Get notified as early as possible by school administration of children that move into or out of foster care
- Be aware of unique needs of children in foster care
- Reach out to children in foster care to offer support

- Communicate and collaborate with social service case manager and foster parents to follow-up on health issues and concerns

References & Resources

Delaware Department of Services for Children, Youth and their Families [DSCYF]. (2016). *Foster Care: General Information*. Retrieved on September 16, 2016 from <http://kids.delaware.gov/fs/fostercare.shtml>.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2015). *Numbers of Children in Foster Care on September 30th, by State FY 2005-FY 2014*. Retrieved on September 16, 2016 from http://www.acf.hhs.gov/sites/default/files/cb/children_in_care_2014.pdf.

Schneiderman, Janet. (2004). The health of children in foster care. *Journal of School Nursing*, 20(6): 343-51. December, 2004.

Szilagyi, M. A., Rosen, D. S., Rubin, D., Zlotnik, S., Council on Foster Care, Adoption, and Kinship Care, Committee on Adolescence, & Council on Early Childhood. (2015). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics*, 136(4). Retrieved on September 16, 2016 from <http://pediatrics.aappublications.org/content/136/4/e1142>.

U.S. Department of Education. (2016). *Non-Regulatory Guidance: Ensuring Educational Stability for Children in Foster Care*. Retrieved on September 16, 2106 from <http://www2.ed.gov/policy/elsec/leg/essa/edhhsfostercarenonregulatorguide.pdf>.

AT A GLANCE SCHOOL SUMMARY SHEET:

WHO TO NOTIFY REGARDING STUDENTS IN FOSTER CARE

When children enter foster care, there are often multiple adults involved in their lives. It is helpful to know who does what and why. **If you are unsure of whom to contact, always start with the Division of Family Services (DFS) case worker.**

WHO'S WHO:

- **Division of Family Services (DFS) case worker:** DFS has custody of the child and must sign for **almost all** documents related to the student's education, enrollment, health, and wellness services. However, for school enrollment purposes, the case worker may also supply a foster parent with a letter authorizing the foster parent to enroll the child in school.

Contract social worker: DFS contracts out with other agencies to provide social work services to children and foster families. The contract case worker generally supports the foster family's needs in caring for the child in foster care. DFS should notify the school of the contract social worker who should also be informed of any education issues. However, if the school is not provided with the contract social worker's contact information, it is DFS' responsibility to contact the social worker.

- **Division of Prevention and Behavioral Health (PBH) case worker:** Some students receive a case manager for mental health services. At times, the PBH case worker or the child's therapist may meet with the child in school or attend school meetings.
- **Division of Youth Rehabilitative Services (YRS) case worker:** Some students receive a case manager for juvenile probation. The YRS case worker may meet with the child in school or attend school meetings.
- **Foster parent:** The foster parent is primarily responsible for the child's needs while a child is placed in foster care. The foster parent should be the first phone call for illness, school discipline, and emergencies. The foster parent should also be invited to attend parent-teacher conferences, special education meetings, or any other education related issues or activities. Foster parents may have a copy of the child's Individualized Education Program (IEP) but any other access to other special education records would require the written permission of the parent/ESP (unless the foster parent is also the ESP).
- **Guardian Ad Litem: Court Appointed Special Advocate (CASA)/ Attorney Guardian ad Litem (AGAL):** There are two types of guardians *ad litem* in Delaware—Court Appointed Special Advocates (CASAs) and attorneys. The CASA is a volunteer appointed by the court to represent the best interests of a child in foster care. The CASA is supervised by the CASA Program in Family Court. An Attorney Guardian Ad Litem (AGAL) is a volunteer attorney supervised through the Office of the Child Advocate to represent the child's best interests. Depending on the case, the child will be appointed either a CASA or an AGAL.

- For more information on these programs, visit the following websites:
 - Office of the Child Advocate: <http://courts.delaware.gov/childadvocate/>

- CASA: <http://courts.delaware.gov/family/casa/about.stm>
 - DFS has the responsibility to invite the CASA/AGAL to any meetings. However, if the school has contact information for this person, it is helpful to invite and include the advocate to any education related meetings or decisions.
- **An Educational Surrogate Parent (ESP):** This is a person appointed by the Department of Education (DOE) to represent a child who receives, or may be in need of, special education services when a parent is not able to assume parental special education rights.
 - An ESP is considered a “parent” under the Individuals with Disabilities Education Act (IDEA) and has the same rights as a “parent” in the special education process. Examples of rights include: providing consent for educational evaluations, providing consent for special education services, agreeing/disagreeing with special education services and signing the IEP as a “parent.” The ESP works collaboratively with the school team on the identification, evaluation, educational placement, and provision of special education and related services for a child.
 - If you believe that a child is in need of an ESP or you are unsure whether you have current ESP information, please contact:

**Educational Surrogate Parent Program, at the Parent Information Center:
(302) 494-4798 or www.picofdel.org**

- When an ESP has been appointed, special education parental rights and procedural safeguards must be followed.
- **Parent:** Even when a student is in DFS custody, the parent must consent to education needs, special education evaluations, and services (unless there is an educational surrogate parent or the court determines otherwise). The parent should be notified of discipline issues, school progress, enrollment, and related issues *unless* the parent no longer has legal rights to the child because of a termination of parental rights or a court order prohibiting the parent from participating.

*Note, the individual serving as the special education IDEA parent (may be the parent or an educational surrogate parent depending on the circumstances) must sign any documents relating to a child’s special education evaluation and services.

AT A GLANCE SCHOOL SUMMARY SHEET:

WHO TO NOTIFY REGARDING STUDENTS IN FOSTER CARE

ILLNESS/ INJURY

- Call the foster parent for immediate pick up.
- If no answer, call the DFS case worker or contract social worker.
- For any medical consent necessary, contact the DFS case worker.

MENTAL HEALTH CRISIS

- Call the child's therapist and/or DFS.
- Call the PBH Crisis Hotline at 1-800-969-4357.

ENROLLMENT/BEST INTEREST MEETING

- DFS case worker is the first point of contact.
- The youth voice should be included, either through direct participation or through a representative to express the youth's wishes.
- All written notices should go to the DFS case worker and the foster parent.
- DFS will arrange for other participants, such as the parent, CASA/AGAL, PBH case worker, or foster parent to attend a Best Interest Meeting.
- The Educational Surrogate Parent, if serving as the parent for IDEA (special education) purposes, may be invited where applicable.
- The decision is made by the Best Interest Meeting team. However, the opinion of the child and the DFS case worker (or parent—if involved) should be considered.

DISCIPLINE

- For immediate response, call the foster parent to pick up the student.
- Call the DFS case worker to notify of discipline or suspension.
- Notify the parent, if he or she retains educational rights to schedule a discipline meeting.
- Out of an abundance of caution, it is helpful to send all written notices to the DFS case worker, parent, foster parent, and ESP (if appointed).
- DFS will notify the CASA/AGAL.
- For a student receiving special education, the parent or Educational Surrogate Parent (ESP), who is serving as the parent for IDEA (special education) purposes, should be notified as well.

FIELD TRIP

- A Foster Parent, DFS Social worker/contract social worker, or parent may sign for a field trip.

ALL SPECIAL EDUCATION ISSUES

- Notify the parent or ESP of all issues related to identification, evaluation, educational placement and provision of special education and related services for a child. The parent or appointed ESP must sign all documents related to the child's special education needs even when the child is in DFS custody.
- Notify DFS as well.

***In all cases where an ESP has been appointed, special education parental rights and procedural safeguards must be followed. This includes but is not limited to requesting/providing consent for educational evaluations, providing consent for special education services, any discussions/decisions regarding special education services, placement, accommodations or modifications, and agreeing/disagreeing with special education services, signing the IEP as a "parent."*

Students in Military Families

Overview

“A military connected youth means any student having an immediate family member, including a parent, step-parent, sibling or any other person residing in the same household who is on active duty, serving in the reserve component or recently retired from a branch of the United States armed forces” (Delaware Department of Education, 2016). Currently there are approximately 2,000,000 military connected youth in America and over 80% of them are attending PK-12 public schools.

Useful Military Terminology

- **Branch of Service** (in order of largest to smallest number of personnel)
 - **Army** – Active Component, Reserve & Army National Guard
 - **Air Force** – Active Component, Reserve & Air Guard
 - **Navy** – Active Component and Reserve Component only
 - **Marine Corps** - Active Component and Reserve Component only
 - **Coast Guard** - Active Component and Reserve Component only
- **Active Duty** – Full-time (24/7, 365 days/year)
- **Reserve** – Part-time military, Reservists train 2 weeks + 1 weekend/month each year.
- **National Guard** – Two branches of the Armed Services (Army National Guard & Air National Guard) maintain a civilian reserve component, originally established to support international peace-keeping missions and respond to domestic crises.
- **Mobilization and Deployment** – Mobilization begins when a service member receives notice of orders to active duty, and prepares to transition from Reserve/Guard status to Active Component status. Active duty status begins with travel to the home station and is followed by mobilization to a location either in the U.S. or overseas. Deployment follows next.
- **Deployment Cycle** – For the family, the deployment cycle begins when the service member receives notice of impending deployment and ends between 3 and 6 months following the service member’s homecoming. This entire cycle is approximately 18 months long, depending on the service member’s branch of service.

Challenges Facing the Military Family

- Nationally, 2 million children have lived through a parent’s deployment
- 800,000 children have lived through two or more deployments
- As the total number of months of deployment increases, the child and family level of functioning declines with adolescent girls and older adolescents (ages 15-17) experiencing more stress than children of any other age.
- Children are at greater risk of maltreatment, primarily neglect, during deployment due to the caretaking parent’s heightened stress.
- Children who are temperamentally anxious and shy are more likely to require coping support during the time of the parent’s deployment than children of other temperaments.
- Children of veterans with PTSD are at higher risk for depression and anxiety than non-combat veterans; they can also develop PTSD as a result.

Activities

- Starting with the 2016-2017 school year all districts and charter schools are required to annually identify enrolled students who are “military connected youth”. Alignment and updates will be forthcoming for subsequent school year data collection.
- Delaware School Liaison Specialist
 - The School Liaison Specialist coordinates communication, resources, partnerships and programs to support the unique needs and experiences of military students. Additionally, the Liaison is available to provide training to schools and assist with implementing and supporting groups/programs for students in schools.
 - Delaware Contact Information:
 - Sonya Dyer (302-677-6383) or sonya.dyer.1@us.af.mil

School Nurse Role

Since there are military connected youth in every school district in the country, it is highly likely that a school nurse will work with these students during their career. School nurses can help link military connected youth to specialized support. It is important to identify and support children coping with the unique, significant challenge of a caregiver’s military deployment. The school nurse is a readily available resource for school-aged military children, their parents and the other professionals in the school. Often times, the school nurse will be a warm, familiar adult that children and adults will open up to about the stress of a parent’s deployment. School nurses also have the ability to collaborate with the student’s teachers and encourage parents to reach out to their local support network.

Laws & Regulations

- [Delaware Department of Education, Regulation 932](#)
- Military Connected Youth
- [Military Interstate Children’s Compact Commission](#) (Delaware is a member of the Interstate Compact)
 - [Rules](#)

References & Resources

Delaware Department of Education. (2016). [Regulation 932 Military –Connected Youth Free Tutoring](#)
[Military Child Education Coalition](#)
[Military Homefront](#)
[Military One Source](#)
[Resiliency Programs for Military Families](#)
[School Nurse Toolkit To Increase Awareness & Support to Military Children](#)
Staying Strong: [School Nurse Care Toolkit To Increase Awareness & Support to Military Children](#)

Reviewed and revised: Jennifer Davis, Student Services & Special Populations, Delaware Department of Education. June 2016

Substance Abuse

Overview

National data shows promising trends in adolescent drug use. The 2016 Monitoring the Future report indicated a decrease in the use of alcohol, cigarettes, many illicit drugs, synthetic drugs, and misuse of prescription drugs (National Institute on Drug Abuse [NIDA], 2016). Marijuana showed no increase, however there was a “continued decrease in perceived harm of marijuana use” and increase rate of electronic cigarette use (NIDA, 2016). The 2016 Delaware High School Youth Risk Behavior Survey saw a decrease in alcohol use and inhalants (Centers for Disease Control and Disease Prevention [CDC], 2016). However, 31.4% reports they “currently drank alcohol” that was “usually obtained . . . by someone giving it to them”, 23.3% “currently” use marijuana, 12.6% “took prescription drugs without a doctor’s prescription”, and 4.4% have tried cocaine (CDC, 2016).

Amongst Delawareans of all ages, heroin and death are at epidemic levels. In 2014, Delaware “expanded the use of naloxone” by community members and law enforcement departments (Delaware Department of Health and Human Services [DHSS], 2015). Additionally, the Department of Education (DOE) collaboration with the Division of Public Health to provide medical Standing Orders to public school nurses to administer naloxone to any individual showing signs of opioid overdose. Information on identifying and caring for a student who appears to be under the influence of drugs or alcohol, is provided in the Chapter 2 [Care Coordination](#), under Direct Care for Acute Illness & Injury.

Substance abuse education is a required component of Delaware Health Education Regulation 851, [K – 12 Comprehensive Health Education Program](#). The school nurse may provide direct instruction, for example with the current prescription drug abuse prevention program, or by assisting the health educator to identify resources. Delaware Regulation 612, [Possession, Use or Distribution of Drugs or Alcohol](#), established requirements for ensuring a safe, drug-free school environment.

Activities

- Naloxone availability in schools serving high school students
- Assessing students who appear to be under the influence (refer to Chapter 2 [Care Coordination](#))

Role of the School Nurse

- Be part of school teams that identify and intervene for student at-risk for substance abuse
- Provide assessments and referrals
- Communicate and collaborate with school colleagues, e.g., school counselor

Laws & Regulations

- Delaware Department of Education. Regulation 612, [Possession, Use or Distribution of Drugs or Alcohol](#),
- Delaware Department of Education. Regulation 851, [K – 12 Comprehensive Health Education Program](#).
- Delaware Department of Education. Regulation 877, [Tobacco](#)

References & Resources

Centers for Disease Control and Disease Prevention [CDC]. (2016). *Delaware 2015 and 2013 Results*. Retrieved on September 19, 2016 from <https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=DE>.

Delaware Department of Education. (2016). *Office of Safe and Drug Free Schools*. Retrieved on September 19, 2016 from <http://www.doe.k12.de.us/Page/1189>.

Delaware Department of Health and Human Services. (2015). *DHSS Press Release, August 26, 2015*. Retrieved on September 19, 2016 from <http://dhss.delaware.gov/dhss/pressreleases/2015/donationofnaloxone-082615.html>.

National Institute on Drug Abuse [NIDA]. (2016). *DrugFacts: High School and Youth Trends*. Retrieved on September 19, 2016 from <https://www.drugabuse.gov/publications/drugfacts/high-school-youth-trends>.

School Health Alert. (2016). Substance Abuse. In *2016 School Nurse Resource Manual*, pp. 360-365. Nashville, TN: School Health Alert.

U. S. Department of Health and Social Services. (2016). *Substance Abuse*. Retrieved on September 19, 2016 from <http://www.hhs.gov/ash/oah/adolescent-health-topics/substance-abuse/home.html>.

Screenings/Referral/Follow-up

[Regulation 815](#), Health Examinations and Screenings, requires Delaware public schools to provide routine screenings to all students. The current requirements are for vision, hearing, posture/gait, lead, and tuberculosis (TB). The school nurse must receive training in these screenings prior to conducting them with students to ensure proper technique, use of appropriate equipment, and criteria for referrals. Lead tests are conducted by a healthcare provider at entry into Pre-K or K. TB screenings by the healthcare provider or school nurse occur at any school entry. Vision and hearing screenings must be completed by January 15th; however, schools are urged to complete as early in the school year as possible. Delayed identification can be detrimental to the student's ability to succeed in school. Additional screenings may be provided, if they are approved by the school and the school nurse has competence in performing them, e.g. BMI.

School Nurse Role

A successful screening program begins with the school nurse's skills. The next important component is the ability to work well with the school administration, teachers, and parents. The school nurse should inform the administration of the screening requirements and solicit their support in scheduling and follow-up so that screening can be conducted early in the school year and efficiently. Student scheduling will influence the times available for screening. Staff can assist in suggesting times that will be least disruptive to instruction time. Finally parents and students should be made aware that screening will occur, what will take place during a routine assessment, and how they will be contacted if there is need for a referral. A sample letter for communicating with parents follows on the next page and can be customized for the school.

Working with pre-school, younger, and English Second Language (ESL) students can be a challenge to screening. The school nurse should:

- Meet students prior to the screening, if possible. This can occur by visiting a class and explaining what will happen during screening and showing them the equipment that will be used.
- Ask teacher to assist with familiarizing the students with what they will need to do, e.g. review the LEA symbols, raise their hand when they hear a beep, show the equipment, etc.
- Take a few minutes to build a rapport when the student arrives for screening.
- Make the screening fun – “We are going to play a game!”
- Use toys, light, and objects that do not make a sound. You want the student to respond to the screening stimuli, not the objects.
- Schedule screening so that there is little or no activity in the room to distract the student.

Some students may not be able to be screened in the school setting with routine equipment. Conferring with the teacher or parent (or having one of them present) during testing, may be able to resolve the child's inattentiveness, lack of cooperation, limited communication skills, or physical inability to hold the equipment as needed. A student's inability to perform the test should not be recorded as “failed”, but as “untestable”. For these students, specialized equipment that passively screens hearing or vision is recommended. Otherwise,

the student should be referred to their primary healthcare provider for a comprehensive screening or appropriate referral to a specialist.

School Nursing Practice Areas

- Hearing Screening
- Lead Screening
- Postural and Gait Screening
- Tuberculosis Screening
- Vision Screening

SAMPLE Pre-Screening Information Letter for Parents

[School Letterhead]

To: Parent(s)/Guardian(s)

Hearing, vision, and postural/gait screenings will be conducted by school nurses to students, as required by Delaware state regulations.

Why is screening important?

Hearing - The ability to communicate effectively impacts the well-being of a child, in terms of education, physical and social development. Early identification and intervention of hearing loss is critical in supporting speech/language development and full participation in the learning process. Even mild hearing losses may be educationally and medically significant.

Vision - Vision problems are common amongst school aged children and adolescents. If vision problems are not detected and treated early, they can lead to permanent vision loss and learning difficulties. When a child has an undiagnosed vision problem, it makes it much harder for them to succeed in school, sports, social situations, and in life.

Postural & Gait- For more than 30 years, Delaware students in grades 5 through 9 have been screened annually to detect orthopedic problems such as scoliosis. Scoliosis is a curvature of the spine. This thirty-second screening may result in early detection and treatment, consequently avoiding surgical correction.

How will the results be shared?

- If your child passes the screening, you will **not** be notified by your school nurse. You are welcome to contact the nurse to learn the screening findings.
- If your child does not pass the screening, the school nurse will contact you to share the results and may make a recommendation for further evaluation by a specialist.

School screening provides only a snapshot of how your child performs on the day the screening was administered and is not a substitute for a complete exam.

If you have any questions about the school screening programs, please contact the school nurse.

School Nurse

Phone/Fax/Email

Hearing Screening

Overview

The ability to communicate effectively impacts the well-being of a child, in terms of education, physical and social development. Early identification and intervention of hearing loss is critical in supporting speech/language development and full participation in the learning process. Even mild hearing losses may be educationally and medically significant.

Activities

- Screening
- Referral
- Follow-up

School Nurse Role

The role of the Delaware school nurse is to provide routine hearing screening and follow-up per [Regulation 815](#), Health Examinations and Screenings. The following procedures should be followed.

Procedures

Preparation

1. Obtain class rosters to use as a worksheet and to record results of screening, if results are not directly entered in a computer program.
2. Notify parents (school newsletter, note, other), students and faculty of upcoming screening.
3. Schedule screenings to assure completion by January 15.
4. Consider the impact of allergy and cold seasons when scheduling.
5. Review equipment and manufacturer's directions.
6. Testing area should be:
 - Quiet and free from ambient noises such as fans, typewriters, blowers, flushing toilets, ringing phones, band rehearsals, gymnasiums, or playgrounds. Experience has shown that rooms treated with acoustical tile, heavy drapes covering windows, carpeting, and solid core doors help to eliminate extraneous noise.
 - Of sufficient size to accommodate the evaluator and the student. In some cases it is helpful to have space that permits the seating of 2 to 4 additional students so that they may observe the test procedure.
 - Supplied with an electrical outlet (110V AC).
7. Set up a table sufficient in size to accommodate the audiometer and provide the evaluator with ample writing space. Seating for the tester and the student should be of appropriate size.
8. Assemble necessary forms: class roster for recording results, parent/guardian letter, and referral form.
9. Children with hearing aids or a medical diagnosis of hearing loss do not require further screening.

External Exam

Hearing screening affords the opportunity to observe for the following and make appropriate referrals:

- Hair/scalp/skin conditions
- Piercings, which may be un-healed or may interfere with alignment of headphones during procedure
- Drainage or cerumen from ear

Acuity Screening

1. Equipment needed

- Pure tone audiometer, calibrated annually to current American National Standards Institute (ANSI) standards.
- Some students with significant limitations may be incapable of screening via the traditional audiometric screening as described in this section. For these students, the school may elect to purchase specialized equipment to facilitate a screening. The School Nurse should receive appropriate training in the use of the equipment as a screening tool and follow recommended guidelines for appropriate screening frequencies, decibels, referral criteria, etc.

2. Recommended procedure

- 1) Turn on audiometer. Some manufacturers recommend allowing older machines to warm up for 15-20 minutes. Leave the machine on for the entire screening period.
- 2) Always test the audiometer before using it. (Test it on yourself.)
- 3) Arrange the chairs so the student cannot view the equipment or the recording sheet.
- 4) Give directions to the student on an appropriate response to hearing the tone.
- 5) Place earphones on the student's head, being sure to line up the microphone with the student's ear canal. Typically, the red earphone goes on the right ear. It may be necessary to remove earrings, headbands, hair from behind the ear and glasses to get a snug fit.
- 6) Screening should be performed only at the following frequencies: 1000, 2000, and 4000 Hertz (Hz).
- 7) Intensity level of screenings will be 20 decibels (dB) at each frequency. (NOTE: If there appears to be a fair amount of extraneous noise, screening intensity level can be raised to 25 dB for each frequency.) Press the tone for 2-4 seconds. Vary the interval between tones.
- 8) Only a lightly damp cloth should be used to clean the rubber earphones, unless recommended otherwise by the manufacturer. Do not put liquid on the microphones which are located in the center of each earphone. Alcohol is not recommended as it may dry the material.

3. Screening Failure Criteria

- Failure to respond at the recommended screening level at any frequency in either ear constitutes failure.
- All failures should be re-screened within the same session. This should be accomplished by removing and repositioning the earphones and carefully re-instructing the student.
 - An otoscopic exam should be done for any student who fails the initial and repeat screenings. Immediate referral is indicated for signs of otitis, cerumen build-up or foreign body.
- Any student who fails the initial screening should have a repeat screening done within two (2) weeks.
- Any student failing the repeat screening will be referred for appropriate follow-up and re-screened the following year.

Common Mistakes Screeners Make

- Not being organized
- Failure to check student's health record before screening to note whether already wears hearing aid or has medical diagnosis of hearing loss
- Not knowing how to use the testing equipment
- Not testing equipment before use
- Not using a quiet/private area for screenings
- Not making sure equipment fits correctly
- Not having child turned away/back to equipment for hearing
- Not holding hearing tone for sufficient length of time
- Screening only at 20dB when the room is noisy

- Failure to view ear with otoscope following failed hearing screening to rule out cerumen, foreign body, or infections
- Not following up on referrals
- Thinking that assessment equals intervention

Follow-up

- 1) Record test results and the equipment used on the School Health Record.
- 2) Referral
 - Students under professional care need not be referred, but should be followed to encourage continuity of appropriate treatment.
 - Notify parent/guardian that the student has failed the hearing screening and may have a hearing loss (See Hearing Referral Letter that follows.) They should be advised that they might elect to receive a diagnostic audiological and otological (ear examination by an ENT physician) through their family physician, community ENT physician, or the Division of Public Health.
- 3) Should the parent/guardian elect services through the Division of Public Health:
 - Contact the family physician to obtain permission to refer student to the clinic. Treatment services are not involved in this referral.

New Castle County: Referrals for Audiologic and Otologic Services should be forwarded to Christiana Care ENT Clinic at the following location: Wilmington hospital, Speech and Hearing Department, 501 West 14th Street, Wilmington, DE 19801 (428-2286).

Kent County: Refer for audiology or A & O services to: Williams State Service Center, Hearing Services, Route 13 and River Road, Dover, DE 19901 (739-5376).

Sussex County: Refer for audiology or A & O services to: Sussex County Health Unit, Hearing Services, 544 South Bedford Street, Georgetown, DE 19947 (856-5213).

- 4) Discuss suspected or known deviations with the appropriate school personnel.
- 5) Nurses are urged to follow-up the hearing of students receiving private care within a reasonable period of time or to check with the student or family on what care was given so as to insure adequate follow-up of the suspected hearing loss. It is recommended to document the date and results if possible of the last hearing screening by the private healthcare provider.

Resources

Bobo, N., Kimel, L., & Bleza, S. (2013). Promoting Health at School. In Selekmán (ED.) *School Nursing: A Comprehensive Text* (2nd ed.), pp. 454 – 456, 461 – 462. Philadelphia: F. A. Davis.

Hearing Referral Letter

SAMPLE

DATE: _____

Dear Parent/Guardian:

Your son/daughter _____ recently failed a hearing screening and may have a hearing problem. You may already be aware of this possible problem and are taking steps to correct it. If not, a medical examination is recommended. Please contact me to discuss the suspected problem.

Many hearing losses today may be corrected before they become serious. While some individuals have a temporary hearing loss during a cold or other infection, it is important that the cause of such a temporary loss be determined and treated to protect the individual's future hearing.

Nurse

School

EXAMINING PHYSICIAN
(Please complete and return to the school nurse.)

Name _____ School _____ Grade _____

Diagnosis _____

Prescribed Treatment _____

Additional Medical Recommendations:

Prognosis: Stationary _____ Will improve _____ Progressive _____ Intermittent _____

Educational Recommendations:

Do you advise any of the following educational recommendations for the student?

Speech reading _____ Auditory Training _____ Use of hearing aid or amplifier _____

Date of Examination: _____ Examiner _____ M.D. _____

Date of Return Visit: _____

NOTE: Please complete and return to the school nurse. Thank you.

Address _____

Fax _____

Height & Weight Screening

Overview

A student's height and weight can provide important information on his/her physical fitness. Using the height and weight, it is possible to identify students who are at risk for obesity, have delayed maturation, or have other growth conditions.

Delaware schools are not required to perform BMIs; however, [Regulation 503, Instructional Program Requirements](#), requires that "local school districts and charter schools shall annually assess the physical fitness of each student in grades 4 and 7, and in grade 9 or 10. The physical fitness assessment tool used by the districts and charter schools shall be one designated by the Delaware Department of Education (DDOE)" (DDOE, 2016). Currently, physical educators use the Fitnessgram for the required assessment. The school nurse may participate in the screening by conducting height and weight. Additionally, Delaware requires health examinations at school entry and at Grade 9 (DDOE, [Regulation 805](#)), and annually for participation in interscholastic sports (DDOE, [Regulation 1008](#)). Height and weight screening should be conducted at that time and continued screening should be a part of the medical home visit.

"Body Mass Index (BMI) is a person's weight in kilograms divided by the square of height in meters. A high BMI can be an indicator of high body fatness. BMI can be used to screen for weight categories that may lead to health problems but it is not diagnostic of the body fatness or health of an individual" (Centers for Disease Control and Prevention [CDC], 2015b). The CDC provides [tools for calculating and interpreting](#) BMI results, based on age (CDC, 2015b). "For children and teens, BMI is not a diagnostic tool and is used to screen for potential weight and health-related issues. For example, a child may have a high BMI for their age and sex, but to determine if excess fat is a problem, a health care provider would need to perform further assessments. These assessments might include skinfold thickness measurements, evaluations of diet, physical activity, family history, and other appropriate health screenings" (CDC, 2015b).

School Nurse Role

- Ensure the nurse is skilled at taking height and weight. Minor errors of even fractions of inches or pounds will create an unreliable BMI.
- Work with the physical educator regarding responsibilities for BMI as a part of the physical assessment. The school nurse, not the physical educator, should conduct height and weight.
- Maintain confidentiality of student information and provide for confidential screenings.
- Determine if BMI assessment is needed relative to student needs.

Process

The following process is based on CDC's [BMI Measurement in Schools](#) and *School Nursing: A Comprehensive Text* (2nd ed.). CDC refers to its guidelines as "**Safeguard 2.** [to]ensure that staff members who measure height and weight have the appropriate expertise and training to obtain accurate and reliable results and minimize the potential for stigmatization" (CDC, 2015a). Prior to any screening, the nurse should determine how the information will be used and shared, and if appropriate resources are available for referrals. Because this is not a required screening, nurse should consult with his/her administration and notify parent prior to the screening. It is recommended that screenings are conducted during a time of the year when students are wearing light weight clothing or as part of the posture/gait screening.

Height

1. Identify a place where student privacy is ensured for the screening.
2. Use a wall-mounted stadiometer or tool for height measurement, not a spring-loaded scale with arm extension.
3. Ask the student to remove shoes, hair ornaments, and other things that would potentially increase a height measurement. If necessary, unbraid hair that interferes with the measurement.
4. Ask, or position, the student to with feet flat and against the wall (not molding). Arms should hang loosely at the side and the student should look straight ahead with the line of vision parallel to the floor. Ideally, four points should touch the wall, e.g. head, shoulders, buttocks, heels.
5. The measurement tool's arm extension, or headpiece, should rest flat and snugly on top of the head and form a right angle with the wall.
6. The nurse must read the measurement with his/her line of vision parallel to the floor and at the height of the headpiece.
7. Record the height to the nearest 1/8th inch (for example, 48.2 inches).
8. Repeat the measurement to ensure accuracy. This should include repositioning the child and the equipment. If the first two measurements differ, two more should be taken until there is an agreement in two back-to-back measurements.
9. Record the final (consistent) measurement in the student's electronic health record.
10. Accurately record the height to the nearest 1/8th inch or 0.1 centimeter.

Weight

1. Identify a place where student privacy is ensured for the screening.
2. Use a digital scale, not a spring-loaded scale) that rests flat on the floor and not carpeting.
3. Ask the student to remove shoes, bulky clothing, hair ornaments, anything in their pockets, and other things that would potentially increase a weight measurement.
4. Ask, or position, the student to stand in the middle of the scale with arms hanging loosely at the side.
5. Record the weight to the ¼ pound (for example, 55.5 pounds).
6. Repeat the measurement to ensure accuracy. This should include repositioning the child and the equipment. If the first two measurements differ, two more should be taken until there is an agreement in two back-to-back measurements.
7. Record the final (consistent) measurement in the student's electronic health record.

BMI

1. Use CDC [tools for calculating and interpreting](#) BMI results. This includes a calculator and the inclusion of a child's age.
2. Record the final (consistent) measurement in the student's electronic health record.

Laws & Regulations

- Delaware Department of Education. [Regulation 1008, DIAA Junior High and Middle School Interscholastic Athletics](#).
- Delaware Department of Education. [Regulation 503, Instructional Program Requirements](#).
- Delaware Department of Education. [Regulation 805, Health Examinations & Screenings](#).

References & Resources

Centers for Disease Control and Prevention. (2015a). *Body Mass Index (BMI) Measurement in Schools – Safeguard 2*. Retrieved on September 20, 2016 from https://www.cdc.gov/healthyschools/obesity/bmi/bmi_measurement_schools_safeguard2.htm.

Centers for Disease Control and Prevention. (2015b). *Healthy Weight: Body Mass Index (BMI)*. Retrieved on September 20, 2016 from <https://www.cdc.gov/healthyweight/assessing/bmi/>.

Centers for Disease Control and Prevention. (2015c). *Measuring Height and Weight Accurately at Home*. Retrieved on September 20, 2016 from https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/measuring_children.html.

Bobo, N., Kimel, L., & Bleza, S. (2013). Promoting Health at School. In J. Selekman, *School Nursing: A Comprehensive Text* (2nd ed.), pp. 454-456, 463-464. Philadelphia: F.A. Davis

Lead Screening

Overview

Lead has existed since antiquity and occurs naturally in the environment. Egyptians used lead in mascara and the United States later used it in paint, plumbing and gasoline. Paint containing lead was banned in the late 1970's; however, the military continued to use it. Lead poisoning is a silent disease with subtle, if any, signs and symptoms, but very damaging because it affects soft tissues of the body (ex. brain, kidneys, bone, etc.) and can be passed through the placenta to a fetus. Lead poisoning effects concentration and the ability of children to learn. High blood levels have been associated to lower IQs. Lead poisoning can be obtained by inhalation or water, but the most common mode is hand-to-mouth. More than 80% of houses built prior to 1950-55 have lead, even if well maintained. In 1995, legislation was passed requiring lead exposure. Its goal is the foundation of today's program: to assure all Delaware children have reduced exposure to lead and receive early identification.

While lead poisoning is more likely to occur in early childhood, older children and adults can also be exposed and affected. In 2005 the CDC issued *Recommendations for Lead Poisoning in Newly Arrived Refugee Children*. The report noted: "Although blood lead levels (BLLs) in children aged 1 to 5 years are decreasing in the United States, the prevalence of elevated BLLs among newly resettled refugee children is substantially higher than children born in the United States." The complete *Recommendations for Lead Poisoning in Newly Arrived Refugee Children* are available online at www.cdc.gov/nceh/lead. In Delaware, Medicaid will cover testing costs for newly arrived refugee children. Possible exposure, signs and symptoms include:

Exposure:

Breathing air or dust with lead

- Dust from lead-based paint
- Work-site where lead paint is used
- Certain hobbies (stained glass, home renovation, removing lead paint, making lead fishing weights, etc.)

Ingesting contaminated food/water

Non-western cosmetics

Health-care products with lead that are not produced in the U.S.

Folk remedies with lead

Improperly glazed pottery, ceramic dishes or leaded-crystal glassware

Lead piping for plumbing

Signs/Symptoms associated with lead poisoning:

Poor concentration

Anemia

Weakness in fingers, wrists or ankles

Decreased reaction time

Mental retardation

Decreased physical growth

Activities

- Delaware Lead Screening Program

The [Childhood Lead Poisoning Prevention Act](#) is a Delaware statute that requires all healthcare providers to order screening for children at or around 12 months of age. “Child care facilities, public and private nursery schools, preschools and kindergartens shall require screening for lead poisoning for admission or continued enrollment.” The Delaware Department of Public Health requires this screening to be a blood lead test.

School Nurse Role

Schools are responsible for informing parents of the lead screening mandate at the time of registration for PreK or Kindergarten. Documentation that a blood lead test was completed must be on file and in the student electronic health record. Results of the test are not required although encouraged. School nurses should work with families of children with known high blood levels to assure follow-up and appropriate treatment. Families failing to provide documentation should be notified early in the school year. Per the statute, children without documentation will be excluded from school after 60 days of the date of enrollment. Religious exemptions are acceptable. A sample affidavit follows.

In 1995, legislation was passed requiring lead exposure. Its goal is the foundation of today’s program: to assure all Delaware children have reduced exposure to lead and receive early identification.

Resources

[Centers for Disease Control and Prevention - Lead](#)

School Health Alert. (2016). Lead Poisoning. In *2016 School Nurse Resource Manual*, pp. 232-234. Nashville, TN: School Health Alert.

Affidavit of Religious Belief for Lead Exemption

S A M P L E

The Childhood Lead Poisoning Prevention Act states *“for every child born on or after March 1, 1995, and who has reached the age of 12 months, child care facilities and public and private nursery schools, preschools and kindergartens shall require screening for lead poisoning for admission or continued enrollment; except in the case of enrollment in kindergarten, such testing may be done within 60 calendar days of the date of enrollment. A statement shall be provided from the child's primary health care provider that the child has been screened for lead poisoning or in lieu thereof a certificate signed by the parent or guardian stating that the screening is contrary to that person's religious beliefs.”*

The following Affidavit is provided as a template, but another form can be used. Notarization is not required.

STATE OF DELAWARE

_____ COUNTY

(I) (We) (am) (are) the (parent[s]) (legal guardian[s]) (Relative Caregiver[s]) of

Name of Child

(I) (We) hereby (swear) (affirm) that (I) (we) subscribe to a belief in a relation to a Supreme Being involving duties superior to those arising from any human relation.

(I) (We) further (swear) (affirm) that our belief is sincere and meaningful and occupies a place in (my) (our) life parallel to that filled by the orthodox belief in God.

This belief is not a political, sociological or philosophical view of a merely personal moral code.

This belief causes (me) (us) to request an exemption from the lead screening for

Name of Child

Signature of Parent(s) or Guardian(s)

Postural & Gait Screening

Overview

Early identification of any condition, including orthopedic deviations, is critical in ensuring prompt intervention and possible alleviation of the condition. Delaware schools have provided orthopedic screening since the 1960s through a program initiated by A.I. DuPont Hospital for Children. Today's programs begin with the school nurse screening for postural and gait abnormalities in grades 5-9, as required by [Regulation 815](#). This screening is referred to as "Phase I". Referrals are made directly to the child's primary healthcare provider or to "Phase II". In Phase II, a physical therapist (PT) from A.I DuPont comes on-site to the school to screen students referred from Phase I by the nurse. There are no fees for this service.

Activities

- Screening
- Referral
- Follow-up

School Nurse Role

School nurses are responsible for the Phase I screening referrals to Phase II or the child's primary healthcare provider. The school nurse works closely with families to inform them of the screening and to support any necessary follow-up.

Procedures

Preparation for Phase I

- 1) Only school nurses with training in posture & gait screening should conduct the assessments. Screening may not be delegated to other school staff or volunteers.
- 2) Obtain class roster to use as work sheet and to record results of screening.
- 3) Notify parents, students and faculty of upcoming screening. Include information on rationale for screening and procedure.
- 4) Males and females should be screened separately. Boys should be dressed in typical school attire.
- 5) Arrange for a private area for screening of each student.
- 6) Review the requirements from the Nurse Practice Act relative to the [Treatment or examination of minors](#)
 - For all routine assessments when no one else is present: If another adult (school employee over the age of 18 and of the same sex of the child being examined, if practicable) is not present when the nurse examines a child, the nurse should only examine (including visualization and palpation) areas of the body which are visible with the child wearing the clothes he/she wore to school, or, except for breasts, genitalia or rectum, are made visible by moving, without removing, any article of clothing.
- 7) Make arrangements to complete screenings by December 15. Report referral numbers to Lead Nurse as soon Phase I is completed.

Procedure for Phase I

Examination should be done in this sequence:

- 1) Student walks toward examiner, look for:
 - a. Symmetry of the body

- b. Abnormality of gait (limp, waddle, feet turn in or out excessively, walks on toes)
- 2) With student standing in front of examiner who is seated, look for:
 - a. Limitation of neck motion
 - b. Limitation of arm motion
 - c. Shoulder level
 - d. Eye level
 - e. Pelvic tilt
 - f. Short leg
 - g. Leg and foot abnormalities interfering with gait/comfort
- 3) With student standing sideways to examiner, look for:
 - a. Abnormalities of anterior posterior (AP) posture
- 4) With student standing with back to the examiner who is seated, look for:
 - a. Curvature of the spine or other abnormalities
 - 1. Back straight
 - 2. Back bent in Adam's Forward Bend Test position
- 5) Student walks away from examiner and gait is checked again
 - a. In addition to the above, look for such things as allergies, suspicious moles, skin conditions, flat feet, and scarring. Refer to primary healthcare provider for further evaluation.
 - b. Pain is a cardinal sign for immediate referral to student's primary healthcare provider.

Common Mistakes Screeners Make

- Not being organized
- Not having a quiet-private area for screenings
- Scheduling males/females at the same time
- Failing to check student's health record before screening to note if student is followed for an orthopedic condition or is already scheduled for a re-examination in Phase II from a previous year (If already scheduled for a re-examination in Phase II, the student does not need to be seen in Phase I again.)
- Letting student wear shoes
- During the Adam's Forward Bend Test:
 - Overlooking the thoracic area
 - Not looking directly at lumbar spine
 - Forgetting to assure that the student's knees are straight
 - Allowing the student to bend over too fast, or too far, or with one knee bent
- Referring a student with a dominant side (shoulder) slightly lower than the other side (This is normal as long as all other aspects of exam are normal.)
- Failing to alert parents of Phase I and/or Phase II
- Not following up on referrals
- Thinking that assessment equals intervention

Follow-up for Phase I

1. Record Phase I findings in the student's electronic School Health Record. It should be recorded as "pass" or "fail". If there is a failure, further information should be added in the comments relative to findings.
2. Indicator for immediate and direct referral to primary healthcare provider: pain, acute or chronic.
3. Indicators for referral to Phase II
 - a. Scoliosis
 1. Positive Adam's Forward Bend Test, OR
 2. Asymmetry in two or more areas of the visual assessment, OR

3. Positive family history of scoliosis and demonstrates asymmetry in visual assessment
- b. Gait
 1. Abnormal gait, e.g., limp, excessive turning in of the feet, or walks on toes
4. If a suspected deviation is detected, complete one copy of *Postural/Gait Screening - Phase II Referral Form*. (Form follows in this section.)
5. Notify the Lead School Nurse by December 15 of the number of students to be checked in Phase II.
6. Notify parent of referral to Phase II right away. (Sample letter, *Postural/Gait Screening Letter reporting Phase I Referral Findings*, follows.)
 - a. If parent/guardian elects to seek private medical care in lieu of Phase II:
 1. Obtain name of physician and send one copy of the Phase II Referral Form with a cover letter.
 2. Check with the student or family within a reasonable time on what care was given to insure adequate follow-up.
 3. Have parent/guardian sign authorization to release information for private physician, DuPont Hospital for children, and Shriners Hospital referrals.

Phase II

- A. The Lead School Nurse will arrange for Phase II through the Department of Education (DOE), School Health Service Program Manager who creates the screening schedule.
 - B. Phase II is performed by Physical Therapists (PTs) provided by A.I. DuPont Hospital for Children. The PTs come on-site to examine students referred from Phase I.
 - C. The school nurse will receive notification from DOE indicating the date and times of screenings. Students should be ready for screening upon the therapist's arrival. Also, the school nurse should have completed the Phase II referral sheets for each student prior to the arrival of the PT.
 - D. If indicated, the PT will provide a letter of referral to the student at the time of the exam.
 - E. If the PT made a referral, follow up with the parent/guardian. (Sample letter, *Postural/Gait Screening Letter reporting Phase II Referral Findings*, follows.)
- Note: Some families may have to check with their primary care physician before contacting the DuPont Hospital for Children or Shriners Hospital.

Resources

Bobo, N., Kimel, L., & Bleza, S. (2013). Promoting Health at School. In J. Selekman, *School Nursing: A Comprehensive Text*, 2nd ed., pp. 454-456, 462-463. Philadelphia: F.A. Davis

Postural/Gait Screening - Phase II Referral Form

This form is a permanent part of the student's health record. The Physical Therapist will need a copy of this form completed for each referral and will reuse the student's original form each year for Phase II Screening.

Phase I

Screening

To be completed by the School Nurse

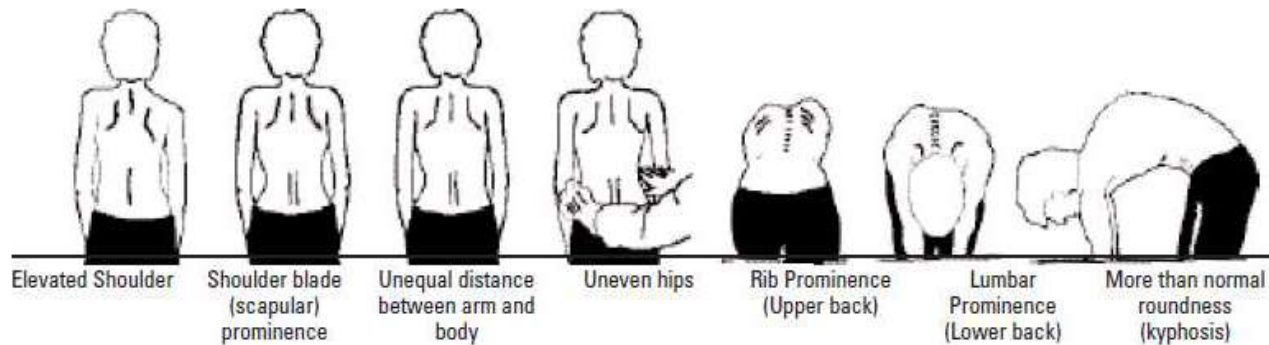
Student Name: _____

Sex: ☐ Female ☐ Male

School: _____

DOB: ____/____/____

School Nurse Examiner: _____



	Phase I Screening ¹ –School	
	Left (describe prn)	Right (describe prn)
* Adam's Forward Bend Test		
* Shoulder Elevated		
* Rounded Shoulders		
* Shoulder Blade Prominence		
* Unequal Distance between Arm and Body		
* Uneven Hips		
* Rib Prominence		
* Lumbar Prominence		
Chest		
Kyphosis Increased		
Irregular Gait – limp, feet turned in, other		
Upper/Lower Extremities Abnormality – contracture, reduced ROM, other		
Musculature – weakness, poor muscle tone, other		

* These are postural asymmetries. To proceed to Phase II, student should demonstrate two or more postural asymmetries OR a positive Adam's Forward Bend Test.

¹ Refer student to primary healthcare provider immediately for pain

Scoliosis Family history

☐ Mother ☐ Father ☐ Sibling ☐ Other: _____

Phase II Screening

To be completed by the Physical Therapist

For Females: Age of onset of Menses

Age ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ Other: _____

Date: _____

Age ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ Other : _____

Grade: ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Angle of Trunk Rotation: _____

Findings: _____

Recommendation: ☐ Refer ☐ Re-Check ☐ No future check needed

Examiner: ☐ Dawson ☐ Novick ☐ Turner-Bare

Date: _____

Age ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ Other : _____

Grade: ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Angle of Trunk Rotation: _____

Findings: _____

Recommendation: ☐ Refer ☐ Re-Check ☐ No future check needed

Examiner: ☐ Dawson ☐ Novick ☐ Turner-Bare

Date: _____

Age ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ Other : _____

Grade: ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Angle of Trunk Rotation: _____

Findings: _____

Recommendation: ☐ Refer ☐ Re-Check ☐ No future check needed

Examiner: ☐ Dawson ☐ Novick ☐ Turner-Bare

Date: _____

Age ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ Other : _____

Grade: ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Angle of Trunk Rotation: _____

Findings: _____

Recommendation: ☐ Refer ☐ Re-Check ☐ No future check needed

Examiner: ☐ Dawson ☐ Novick ☐ Turner-Bare

Postural/Gait Screening Letter reporting Phase I Findings

DATE: _____

Dear Parent/Guardian:

A recent postural/gait screening test at school indicates that _____ may have a postural or gait irregularity which could affect him/her during these growing years.

The physical therapist will be at this school on _____ to perform Phase II of the postural/gait screening. He/she will examine your child to determine if a referral to the doctor is needed. Please make every attempt to have your child at school on time this day. If there is a family history of a postural or gait irregularity, for example scoliosis, please let me know so that I can share it with the physical therapist.

After this exam, you will be notified if the physical therapist feels that your child needs to have an additional exam by his/her doctor.

Please call the school nurse with any questions.

School Nurse

Phone

Postural/Gait Screening Letter Reporting Phase II Referral Findings

To be mailed to Parent/Guardian after Phase II

DATE: _____

Dear Parent/Guardian:

Recently your child, _____ (child's name) was seen by the physical therapist in the Phase II screening for Postural & Gait. At that time the physical therapist provided your child with a letter of referral to your family healthcare provider. That letter is attached.

If you have not already scheduled an appointment with your provider, please do so as soon as possible. Some posture and gait conditions can change quickly and should be evaluated right away. If you need any assistance with the referral, please feel free to contact me.

Please have your healthcare provider complete the information at the bottom and let me know if there is any assistance the school can provide. Also, I will update your child's school health record.

Thank you for your attention to this matter.

School Nurse

Phone Number

Date of Exam: _____

DIAGNOSIS:

☐ No treatment recommended

☐ Treatment recommended: _____

Follow-up Office Visit:

☐ N/A

Printed Name (MD or DO)

☐ Date: _____

Signature

Phone Number & Email Address

Tuberculosis (TB)

Overview

Tuberculosis is a bacterial infection that can be active in the lungs, joints or other organs of the body. Students, school staff, and school volunteers must be assessed for exposure to tuberculosis or active disease. The School Health Tuberculosis Control Program is defined in Department of Education [Regulation #805](#). Practices regarding school entry, travel, populations at risk, school staff and personnel, and volunteers are included in the regulation and in the following pages of the manual.

Prior to enrollment in a Delaware Public School, tuberculosis status must be documented by the use of Tuberculosis Risk Assessment, Tuberculosis skin test (Mantoux), or other testing including blood test, x-ray or sputum culture. Tuberculosis testing must have been administered within the past 12 months prior to school entry. Staff is required to have testing done at the time of employment. Volunteers, too, must provide documentation of screening.

Tuberculosis testing and results must be documented in the student's Electronic Health Record (EHR). Additional forms and information related to the School Tuberculosis Control Program are provided on the following pages. They have been provided and/or reviewed by the Division of Public Health.

Activities

- Reviewing or providing screening, via health history, of students at school entry.
- Reading of TB results, e.g., Mantoux skin test, as needed.
- Consultation to school administration on employee and volunteer requirements.
- Follow-up, further assessment, and exclusion, as appropriate

School Nurse Role

Students

- Collect TB results provided by healthcare providers
- At school entry conduct questionnaire assessment if child has no TB screening on record, but is up-to-date with immunizations and has a current physical
- Assess student for active TB if referred for history of TB exposure using the form, *Tuberculosis (TB) Pediatric Symptom Screening Tool for Active TB*, which follows in this manual
- Refer students with positive response to assessment
- Record in students EHR the TB screening results and follow-up

Employees & Volunteers

- Provide consultation and referrals, as requested and appropriate. Their questions are on following pages

Resources

School Health Alert. (2016). Tuberculosis. In *2016 School Nurse Resource Manual*, pp.381-384. Nashville, TN: School Health Alert.

Delaware Department of Health & Social Services, Division of Public Health. (n.d.). [Tuberculosis Information](#).

Links

[Tuberculosis \(TB\) Risk Assessment Questionnaire for Students](#)

[Confidential Tuberculosis \(TB\) Health Questionnaire for School Employees](#)

[Tuberculosis \(TB\) Pediatric Symptom Screening Tool for Active TB](#)

[Confidential Tuberculosis \(TB\) Health Questionnaire for Volunteers in Public Schools](#)

Vision Screening

Overview

The primary goal of school vision screening is early identification and referral of students with vision problems that may affect the student's quality of life and educational outcomes. The school nurse is responsible for utilizing evidence-based practice for the screening process and conducting follow-up for students who require referral to eye care professionals. School nurse caseloads and capacity vary throughout the state. For pre-school students, screening once is the recommended standard by American Association for Pediatric Ophthalmology & Strabismus (AAPOS), while annual screening is considered best practice by some researchers (Cotter, Cyert, Miller, & Quinn, 2014). Screening is especially important for pre-school students if there are any academic or behavioral concerns. Screening beyond the required intervals (as seen in grid below) and screening using other techniques or equipment may be conducted by the school nurse if he/she is competent in the procedures and has the approval of his/her administration. It is recommended that the required screening for all new enterers, at any age, be conducted within 30 days of enrollment if there is no evidence of previous screening. Vision screening includes tests for binocular vision, distance vision, near vision, depth perception, and color vision.

Frequency of Visual Function Screening by Grade Level

	<i>Assessment of External Eye Structures</i>	<i>Binocular Vision Cover/uncover Stereoaucuity**</i>	<i>Distance Vision</i>	<i>Near Vision*</i>	<i>Color Vision**</i>
Preschoolers	X	X	X		X***
Kindergarteners	X	X***	X		X***
Grade 2	X	X***	X		X***
Grade 4, 7, and 9 (or 10)	X		X		
Referral for Special Services, e.g. IEP, RTI	X	X	X		X**
New Enterers	X	X	X		X**

* Near Vision is required only if there are indications of difficulty near acuity.

** Stereoaucuity and Color Vision is only required once and should take place at the first school screening.

*** Binocular Vision and Color Vision screening should be repeated for students in kindergarten and Grade 2 IF they failed previous color or binocular vision screening. The rationale for repeating the screening is that often younger children fail the screening because of their inability to appropriately respond to the screening and not because of an inability to see colors or fixate on an object.

Screening for distance vision should be done at each required time. Screening for binocular vision and color vision is required ONCE in a student's school life - UNLESS there is suspicion of developing visual problem. It is also recommended to repeat the color screening for students in Grade 2, if they had a previous failure, as they may have had previous difficulties with testing due to their developmental age and not their vision.

Students who are clearly unable to pass the screening, should be referred immediately. Rescreening by the nurse should take place for any student who was difficult to screen or had inconsistent results. All referrals should take place within 30 days of the initial screen. Ideally the referral will result in a timely appointment with an eye care professional. Note: It may take up to six weeks for the parent to get an appointment; therefore prompt referrals by the school nurse are critical.

If a student has received a diagnosis of an eye condition, e.g. strabismus or color blindness, the school nurse should not continue to screen for this condition. The exception would be acuity screening.

Pre-School Screening

Healthy People 2020 goals include to:

- “Increase the proportion of preschool children aged 5 years and under who receive vision screening.”
- “Reduce blindness and visual impairment in children and adolescents aged 17 years and under.”

Approximately 2% to 4% of preschool-age children have amblyopia, which is an alteration in the visual neural pathway in the developing brain that can lead to permanent vision loss in the affected eye (United States Preventive Services Task Force, 2011). Early detection and treatment is necessary to prevent possible permanent vision loss. Therefore, it is important that preschool-age vision screening is performed and includes screening for risk factors for amblyopia, including strabismus, significant refractive error, and other associated risk factors.

Teacher and or parent input can be helpful for those students who are struggling academically. The *Parent /Teacher Vision Checklist*, which follows in this manual, is a sample checklist, that can be used to assess problems with the eyes not, just vision acuity.

Since most young children have no idea how they are supposed to see and will not report vision problems, it is important to perform an assessment on the preschoolers that includes appearance, behavior, and complaints. Many of the sign/symptoms of vision/eye problems may not be observable during the screening procedure; therefore, it is helpful to include the parent/teacher input in the screening. Behaviors, which are consistent and not one time occurrences, to consider include:

- Poor eye contact
- Looking out of corner of eye
- Squinting
- Holds object close to face to see
- Frequent rubbing or blinking of eyes
- Frowning during near work
- Covers or closes one eye to view something
- Tilts/turns head to one side to view something
- Thrusts head forward to see distant objects

Activities

- Screening
- Referral
- Follow-up

School Nurse Role

- Delaware [Regulation 815](#), requires periodic vision screening of students attending a public school at kindergarten and in grades 2, 4, 7, and 9 or 10. Additionally, screening is required for:
 - those who are new (at any age) to the school system, including all students enrolled in preschool
 - those who are referred for vision difficulty by a teacher, administrator, or parent
 - those who are being considered for special education placement
 - those taking a driver's education class (within one year prior to driving experience)

Process

Preparation

1. Scheduling
 - 1) Inform parents/guardians and school staff of upcoming screenings, e.g., school newsletter or website, note, email.
 - 2) Remind parents/guardians to have students bring corrective eyewear (eyeglasses or contact lenses) to school on day of screening, e.g., "homework assignment" to bring glasses to school.
 - 3) Schedule screenings to assure completion by January 15.
2. Setting up for Screening
 - 1) Position computer for easy data entry during screening. Otherwise, obtain class rosters to use as a worksheet and to record results of screening. Direct recording into the computer is recommended.
 - 2) If necessary, arrange for location in school building to perform screening and assistance with health office coverage.
 - 3) Check to make sure all needed equipment is available and suitable for use. (Do not use acuity wall charts that are dusty, stained, bent, or yellowed.)
 - 4) Prepare Vision Referral Letters (see sample form that follows) that can be filled out and given to the student at the time of screening.
 - 5) An overview of the required screenings areas is on the chart, Delaware Vision Screening for School Nurses 2015, that follows.
3. Health History
 - Some students may have a predisposition to vision problems. These include:
 - Students with siblings who have diagnosed refractive error
 - Students with a parent who wore glasses before age 6
 - Students with a family history of strabismus and/or amblyopia
 - Students of Asian & Middle Eastern heritage (increased distance acuity problems)
 - Students in pre-teen & early teen years (increased incidence of distance acuity problems)
 - Students with neurodevelopmental disorders, e.g. hearing impairment, cerebral palsy, Down Syndrome, cognitive impairment, autism spectrum disorder, speech delays
 - Students with systemic diseases (such as diabetes and sickle cell)
 - Premature birth at less than 32 weeks gestation
 - Students who take medication that is known to cause eye disorders
 - The school nurse should determine if there are symptoms, which may be indicative of a eye problem:
 - Blurred vision
 - Double vision, e.g. states seeing two of something
 - Eye pain

- Eye itching
- Frequent headaches
- Light sensitivity
- Information from parents and teachers can be obtained through use of the Parent/Teacher Vision Checklist that follows.

Screening Considerations

- 1) During the screening process, be attentive for students who may have an indication of a possible vision condition.
 - Frequent eye rubbing, blinking, or tearing
 - Squinting
 - Tilting head or covering one eye
 - Moving closer to board or holding text closer to face
 - Reports of blurred vision
 - Headaches
 - Light sensitivities

Note: “Difficulty reading” may be an indicator of a vision condition; however, AAPOS recommends evaluation by a reading specialist prior to referral to a vision specialist.
- 2) Vision screening procedures include assessment of: external eye, distance acuity, near acuity (if indicated), binocular vision, and color vision. Assessment of the external eye and distance acuity should be performed on every student at every vision screening.
- 3) Instrument Based Screening
 - Photoscreeners and auto-refractors are instruments that can screen simultaneously for binocular, distance, and near vision. They indicate if a referral is needed. They do not provide a specific measurement of visual acuity, nor do they assess the external eye structures or color vision.
 - If using this equipment, the school nurse should ensure that his/her screening skills and technique with the equipment is accurate.
 - While these instruments are expensive, they can be an asset to screening pre-school and kindergarten students, and those with limited ability to participate in lengthy screening or follow directions. Some districts have had this equipment donated through a community service club.
 - These instruments are improving quickly. The school nurse should review current literature, with regard to accuracy, prior to purchasing equipment. The type of instrument(s) used for screening and the results from screening with this equipment should be documented as *pass* or *fail* for each of the assessments performed.
 - If a referral is made, the name of the instrument(s) should be reported on the Vision Referral Letter. Additionally, if available, the printout from the screener with the results should be attached to the referral form.

Assessment of External Eye Structures

The school nurse should assess for signs/symptoms which could indicate a vision problem and should be referred for immediate evaluation from the primary healthcare provider:

- Abnormal color of iris or shape of pupils
- Asymmetry of eyes or pupil size
- Cloudy or hazy appearance to cornea
- Crusty eyelashes
- Discoloration of sclera

- Drainage (any) from eyes
- Drooping of eyelid(s)
- Growth on lid or eye
- Redness and/or swelling of eyes, eyelids, or conjunctiva

Visual Acuity Assessment

1. If corrective lenses (eyeglasses or contact lenses) have been previously prescribed for the student, perform all testing with student wearing corrective lenses. If the student no longer has recommended corrective eyewear, proceed with screening. Document in student record, and on the Vision Referral Letter if referred, whether corrective eyewear was either worn or unavailable during screening.
2. For students requiring all vision function tests, always begin with binocular vision, then proceed with distance vision and color vision (in that order).
3. Distance Vision Acuity
 - a. Equipment Needed
 - (1) Wall-mounted or Self-Illuminating Acuity Chart (5 foot, 10-foot or 20 foot distance)
 - All newer charts use the 10 ft. distance.
 - Chart should be chosen with age-appropriate optotypes (letters or symbols).
 - Preschool, Kindergarten, ESL students – recommend LEA Symbols or HOTV symbols. Other charts are not recommended.
 - School-age, Adolescents – use Sloan Letters chart. Other charts are not recommended.
 - (2) Occluder
 - For preschool – kindergarten: Adhesive patch or opaque tape, specialized occluder glasses are also acceptable
 - For students over 5: Hand held occluders may be used, but must be sanitized between students. Individual plastic cups may also be used to occlude the non-tested eye.

Note: Stereoscope machines (such as Titmus Vision Tester, Stereo Optical's Optec, and Keystone's Telebinocular) are not recommended. They have been reported to have minimal specificity, that is, increased incidence of false positive results (Proctor, 2009).

- a. Procedure
 - (1) Perform screening in quiet room, with adequate lighting (natural or fluorescent)
 - (2) Attach acuity chart to wall at eye level of students being screened.
 - (3) Clearly mark the floor where the student will stand or sit during screening. Use the appropriate distance designated by the acuity chart.
 - (4) Have students stand with heels on the line. If the student will be seated in a chair, place rear legs of chair on the line.
 - (5) Do not allow the student to lean torso or head forward toward the chart during screening.
 - (6) Screen vision in each eye individually. Screening may be done right eye first or left eye first BUT the same technique is to be used for all students being screened to increase the reliability of the outcomes.
 - (7) When working with preschoolers or kindergartners, practice naming the optotypes before screening.
 - (a) If using the LEA Symbols acuity chart, clarify the name of the shapes. (For example, the apple shape may be identified as a heart, but that is acceptable if consistent. Vision screening should assess vision, not language.) The LEA

Symbols acuity chart has hand-held cards that students can hold up to identify the optotypes on each line of the chart.

- (b) If using Sloan Letters chart, make sure the student can correctly identify the letters.
- (c) Have the student place occluder over eye NOT being tested, but instruct them to keep both eyes open. Also observe any attempts by student to peek or squint.
 - (i) If possible, having a person, other than the student or the nurse, hold the occluder is the preferable technique.
- (d) Always start with the top line to ensure success. The student should identify the first optotype on each line down the chart until one is misidentified. The screener should then move up to the next line and ask the student to read the full line and then move down the chart, in full lines, until the student cannot identify correctly the majority (typically 3 of 5) optotypes.
 - (i) If the line has an even number of optotypes, a majority is needed to pass, e.g., 3 out of 4.
- (e) Progress through each line to enable identification of a 2 or more line difference in acuity between the eyes, which can cause amblyopia if undiagnosed or treated.
- (f) When screening the opposite eye, repeat the same procedure described above. You may want to start on the opposite line and move right to left to prevent memorization.

Note: Each eye should be screened individually.

- (8) Students are permitted a second attempt if they are unsuccessful on their initial attempt.
- (9) Record:
 - (a) The smallest line that the student can read successfully, i.e., the majority of optotypes, for each eye
 - (b) The equipment used
- c. Criteria for PASSING (APPOS)
 - (1) 3-5 years old: 20/40 (10/20) or better in each eye
 - (2) > 5 year olds and & older: 20/32 (10/16) or better in each eye
 - (3) If there is a 2 or more line difference between eyes, even if both eyes meet passing criteria, rescreening is recommended. If the line difference is present during the rescreening, a referral is needed.
- d. Referral & Follow-up
 - (1) The vision screening process is incomplete without appropriate referral and follow-up.
 - (2) If a student does not pass screening, a written referral to the parents/guardian should be sent promptly after the screening. If rescreening is planned, both the second screening and the referral letter sent to the parent should be completed within 30 days of the initial screening.
 - (3) Ideally, a referral letter should be handed to the student immediately upon completion of the screening. A follow-up letter or call should take place within 30 days of the initial screening. The referral letter should:
 - invite parents to contact the nurse with any questions;
 - advise parents to contact the nurse for information on availability of resources for families who do not have health insurance with vision coverage; and

- include a form to be completed and signed by the eye care professional, which that includes results of their eye examination and recommendations for treatment, to be returned to the school nurse.
 - (a) Teachers working with a student, who is referred to an eye care professional, should be made aware of potential students' needs (e.g. preferential seating).
 - (b) If there is no response from the parent/guardian regarding the referral form within 30 days, the nurse should make phone contact inquiring as to status of the referral. If this contact is unsuccessful, the nurse should notify the appropriate administrator and work with the appropriate interdisciplinary school team.
4. Near Vision Acuity
- NOTE: Near vision screening is ONLY recommended for students who show or have reported difficulty with seeing objects at a near range. It is recommended that a student who is having difficulty reading, should first be evaluated by a reading specialist.
- a. Equipment Needed
 - (1) The Sloan Letters chart or LEA Symbols chart/cards are recommended for Near Vision Screening
 - (2) Occluders (same as Distance Vision Acuity)
 - b. Procedure
 - (1) Follow the same sequence of screening as in distance screening.
 - (2) Review the letters or symbols with the student.
 - (3) Hold the chart 14" – 16" away from the student's eyes or per the manufacturer's instructions. The charts have a cord to hold up to the eye to give an accurate measure of the distance between the chart and the eyes.
 - (4) Begin screening with the same eye that was screened first during distance vision screening.
 - (5) Have the student place the occluder over the eye not being tested.
 - (6) Always start with the top line to ensure success. The student should identify the first optotype on each line down the chart until one is misidentified. The screener should then move up to the next line and ask the student to read the full line and then move down the chart, in full lines, until the student could not identify correctly the majority (typically 3 of 5) optotypes.
 - (a) If the line has an even number of optotypes, a majority is needed, e.g., 3 out of 4.
 - (7) Progress through each line to enable identification of a 2 or more line difference in acuity between the eyes, which can cause amblyopia if undiagnosed or treated.
 - (8) When screening the opposite eye, repeat the same procedure described above. You may want to start on the opposite line and move right to left to prevent memorization. Note: Each eye should be screened individually.
 - (9) Students are permitted a second attempt if they are unsuccessful on their initial attempt.
 - (10) Record in EHR:
 - (a) The smallest line that the student can read successfully, i.e., the majority of optotypes, for each eye
 - (b) The equipment used
 - c. Criteria for PASSING (is the same as for distance screening)
 - (1) 3-5 year olds: 20/40 (10/20) or better in each eye
 - (2) >5 years old: 20/32 (10/16) or better in each eye

- (3) If there is a 2 or more line difference between eyes, even if both eyes meet passing criteria, rescreening is recommended. If the line difference is present during the rescreening, a referral is needed.

d. Referral & Follow-up

- (1) The vision screening process is incomplete without appropriate referral and follow-up.
- (2) Refer to the guidelines for Referral & Follow-up under Distance Vision Acuity Screening.

5. Binocular Vision

A critical component of school vision screening in children is the assessment of both eyes functioning as a pair. When vision in one eye is decreased due to problems in ocular alignment, amblyopia may develop. If undiagnosed and not treated before the age of 6 to 9 years, amblyopia may result in permanent vision loss in the affected eye. The earlier the treatment for amblyopia is initiated, the better the outcome.

Binocular vision is assessed using an ocular alignment test.

a. Ocular Alignment Test

Cover-Uncover Test is recommended, with “near point” and “far point” assessment.

(1) Equipment Needed

- (a) Handheld occluder (the “Cover”)
- (b) Focal object for “near point” distance (such as tongue blade with picture or finger puppet)
- (c) Focal object for “far point” distance (picture or object mounted on wall)

(2) Procedure

- (a) Position student in a chair, facing you, at about 2 feet distance.
- (b) Hold the near point focal object in your non-dominant hand, close to your nose. Ask student to focus attention on the object. Instruct student to maintain focus on the object.
 - (i) Younger children should be reminded to fixate on the object. Identifying details on the object is helpful.
 - (ii) Consider having several different targets available and rotate as needed to keep a young student’s attention and fixation.
- (c) Holding the occluder in your dominant hand, with handle down, place it to the side of the student’s face near one eye. Then move the occluder over that eye (without touching the eye). Keep the eye covered for 1 to 2 seconds, and then uncover the eye by moving the occluder to the side of the face. Repeat the “cover-uncover” process several times.
- (d) Carefully observe the uncovered eye for movement when the other eye is occluded. If any movement is detected, note the direction of the movement (i.e., toward the nose, toward the ear, or movement up or down).
- (e) Repeat the process, occluding the opposite eye, and observe for movement in the uncovered eye.
- (f) Ocular alignment is considered intact if there is NO movement of either eye as the occluder is moved from one eye to the other.
- (g) Ask the student to focus on the “far point” focal object that is located at a point over your shoulder.
- (h) Repeat the above procedure, noting any movement in the uncovered eyes.

(3) Criteria for PASSING

- (a) The student passes if no movement is observed.
- (b) Record the results as “pass” or “fail”.

(4) Referral & Follow-up

- (a) The vision screening process is incomplete without appropriate referral and follow-up.
- (b) Refer to the guidelines for Referral & Follow-up under Distance Vision Acuity Screening.

NOTE: If the student was referred for vision screening based upon student performance and the student passes the Cover-Uncover Test, the Alternate Cover-Uncover Test should be conducted. The only difference between the two tests is that the occluder covers the first eye for 2 seconds, switches quickly to the second eye for 2 seconds, and then quickly occludes the first eye again. This technique is used for all aspects of the Cover-Uncover Test described above.

b. Stereoacuity (depth perception) Test

Stereopsis, (depth perception) is measured by a Stereoacuity Test. Stereopsis is affected by alignment of the eyes and visual acuity. As a child matures, depth perception continues to develop and by age 6 a child should have full stereopsis.

(1) Equipment Needed

- (a) Stereoacuity Test
 - (i) The PASS Test 2 (recommended for Pre-K and Kindergarten)
 - (ii) Butterfly Test (recommended for school-age)
- (b) Polarized glasses
- (c) Adequate lighting

(2) Procedure for both Tests

- (a) If the student wears corrective lens, perform the screen with the student wearing the lens.
- (b) Position student in a chair at a table or desk
- (c) Place the polarized glasses on the student's face (Glasses are fragile and excessive handling by student can result in breakage).
 - i. Polarized glasses are placed over the prescription lens.
- (d) Screen according to manufacturer's directions for the stereoacuity test being used.

(3) PASS Test 2 (Preschool Assessment of Stereopsis with a Smile 2)

- (a) Position Card A with the Happy Face and blank card approximately 16 inches from eyes.
- (b) The student will be asked to look at the Happy Face on the card and asked to identify the Face
 - i. For students ages 3 and 4, after the student identifies the Happy Face, choose the blank card and card B. After mixing the blank card and Card B, show both cards to the student and ask what he/she sees. Repeat 4 – 5 times to insure accuracy. The student will pass if the student correctly identifies the Happy Face on Card B.
 - ii. For students, ages 5 and older, follow the same sequence but after the student correctly identifies Card B, proceed to Card C. Repeat 4 - 5 times to insure accuracy. The student passes if the student correctly identifies the Happy Face on Cards B & C with the polarized glasses in place.
- (c) Criteria for Passing
 - Students, age 3 or 4: "Pass" if the student, with the polarized glasses in place, correctly identifies the Happy Face on Card B on 4 out of 5 attempts.
 - Students, age 5 or older: The student must correctly identify the Happy Face on Card B and Card C.

(3) Butterfly Test

- (a) Position open booklet approximately 16 inches from eyes.
- (b) Ask the student to identify the image and trace it with his/her finger. (It may take a short time for student to adjust to stereo vision, be patient and encourage student).
- (c) If student is unable to see the image, ask the student to identify the “L” and “R” at the bottom of the page. If unable to perform this task, he/she is untestable.
- (d) Next ask the student to look at the opposite page where the rows are labeled A and B. Beginning with row A, ask the student to point to the symbol or animal that appears to lift off the page. You may need to point to each symbol and ask “Is this on the page or above the page?” Proceed to Row B and repeat procedure.
- (e) Criteria for Passing
 - Pass if the student successfully outlines the butterfly in front of the butterfly without touching the butterfly.
 - Pass if the student correctly identifies the “floating” symbol/animal in rows A or B.
 - Record the student’s response as “pass” or “fail”.

Color Vision Assessment

Although color vision disorders are not considered to be a serious problem by eye care professionals, these problems are not correctable and can significantly affect the student’s academic success and quality of life. The American with Disabilities Act (ADA) requires that the school provide accommodation for students with color disorders. A 504 plan may be needed for any student in need of such assistance.

1) Equipment Needed

- a. Pseudoisochromatic plates
 - H-R-R (Hardy-Rand-Rittler) Plates (recommended)
 - Good-Lite 16 plate Book
- b. Cotton-tipped applicators or artist’s paintbrush
- c. Adequate lighting (critically important)
 - Test near window that allows considerable natural light
 - Test under fully operating (not flickering) fluorescent lights

2) Procedure

- (1) Place plates on table with book closed.
- (2) Seat student comfortably at table, next to yourself.
- (3) Provide student with cotton-tipped applicator or paintbrush. (Note: Touching pseudoisochromatic plates with fingers leaves residue of skin oil, which alters color of plates over time. Instruct the student not to touch the plates or the tips of applicator or paintbrush with their hands. Older students who already know numbers and shapes, can identify the patterns by name rather than by tracing.)
- (4) Begin screening using the first 4 plates, which are considered practice plates. The student performs this screening with both eyes, not with each eye individually.
- (5) Ask the student to trace the shape he/she sees, using the applicator or paintbrush. If these shapes are numbers, the student may identify the name of the number verbally.
- (6) Proceed to next 6 plates, known as screening plates. Have the student repeat procedure of tracing or naming shapes seen on each plate. There is no time limit for student to discern images (within reason). If unsuccessful, student may have second attempt to trace or name correctly.
- (7) Rescreen any student who does not pass initial screening within 6-12 months before communicating possibility of color vision deficiency with parents or teachers, particularly with preschoolers, kindergarteners, and ESL students.

- (8) There are an additional 14 pseudoisochromatic plates that follow the 6 screening plates. These are used to determine the type and severity of the color vision defect identified through the screening process.
- 3) Criteria for Passing
 - (1) If the student successfully identifies the shapes on the 6 screening plates, the student passes the screening and no further plates need to be used.
 - (2) Record the student's response as "pass" or "fail".
- 4) Referral & Follow-up
 - (1) Parents and the teacher should be notified of failure to pass color vision screening.
 - a. If a student in Pre-K, K, or Grade 1 fails the screening, he/she should be re-screened at the next screening interval as younger children may have difficulty with the procedure.
 - (2) Information on the implications of color blindness should be shared with them. Resources are listed under:
 - o [Teachers Tips](#)
 - o [Home Tips](#)
 - (3) Girls should be referred for further evaluation as this is very rarely seen in females. Color vision defects are found in some (very rare) retinal dystrophies in females and occasionally, again rarely, in acute neurologic diseases like optic nerve swelling, or optic neuritis.
 - (4) Both girls and boys should be referred if they have a history of passing a color vision screening and then fail a subsequent test.

Vision Screening Referral & Follow-up

1. The vision screening process is incomplete without appropriate referral and follow-up.
2. If a student does not pass any one vision screening test (visual acuity, binocular vision and/or stereo acuity), a written referral to the parents/guardian should be sent promptly after the screening. If rescreening is planned, both the second screening and the referral should be completed within 30 days of the initial screening.
3. Ideally a letter should be handed to the student immediately upon completion of the screening. A follow-up letter or call should take place within 30 days of the initial screening. The referral letter should:
 - a. inform parent/guardian of the screening failure and refer for examination by an eye care professional;
 - b. invite parents to contact the nurse with any questions;
 - c. advise parents to contact the nurse for information on availability of resources for families who do not have health insurance with vision coverage; and
 - d. Include a form with the screening results and an area on the form to be completed and signed by the eye care professional that includes results of their eye examination and recommendations for treatment, to be returned to the school nurse.A sample letter, *Vision Referral Letter*, follows in this section.
4. Teachers working with a student who, is referred to an eye care professional, should be made aware of potential students' needs and any recommendations, e.g., preferential seating.
5. If there is no response from the parent/guardian regarding the referral form within 30 days, the nurse should make phone contact inquiring as to status of the referral.
 - a. If this contact is unsuccessful, the nurse should notify the appropriate administrator and work with the appropriate interdisciplinary school team.

Vision Screening Guide for School Nurses		
EXAM	FINDINGS	DOCUMENTS
External Exam	No abnormalities	"External Exam normal"
Distance Acuity	<ul style="list-style-type: none"> - Age 3-5: 20/40 or better in each eye - Age >5: 20/32 or better in each eye - Each eye has no more than one line difference in acuity reading 	20/line read, e.g., 20/100 Or 10/line read if using 10' chart
Near Acuity	- Same as Distance Acuity	Same as Distance Acuity
Binocularity: Cover Uncover Test	No eye movement	- "Pass" or "Fail"
Binocularity: Stereopsis (Butterfly)	<ul style="list-style-type: none"> - Outlines the butterfly in front without touching - Identifies floating symbol 	<ul style="list-style-type: none"> - "Pass" or "Fail" - Test used
Binocularity: Stereopsis (Pass 2 and 3)	<ul style="list-style-type: none"> - Age 3-4: identifies Happy Face on Card B for 4 out of 5 attempts - Age >5: identifies Happy Face on Card B and Card C 	<ul style="list-style-type: none"> - "Pass" or "Fail" - Test used
Color Vision	Identifies number or shape in every plat	"Pass" or "Fail"

Resources & References

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Parent/Teacher Vision Checklist

This tool is to help identify children who may have a problem with their eyes. Please check the appropriate items and return to the school nurse.

Name: _____ **Date:** _____

Appearance

- ___ Eyes turn in or out or eyes are crossed
- ___ Crusty or red eyelids
- ___ Different size pupils or eyes
- ___ Swelling of eyelids
- ___ Conjunctivitis (pink eye)
- ___ Drooping lids
- ___ Excessive tearing
- ___ Eyes appear hazy or clouded
- ___ Other: _____

Behavior – Teacher Observation

- ___ Tilts head, covers or closes one eye for critical seeing
- ___ Thrusts head forwards, squints or frowns
- ___ Holds printed materials in an unusual position
- ___ Other: _____

Complaints – Child's Statements

- ___ Eyes hurt or blur while reading/near work
- ___ Headaches, dizziness, or nausea following close work
- ___ Words move or jump about when reading/near work
- ___ Double vision
- ___ Unable to see the board
- ___ Eyes itching, burning or a "scratchy" feeling
- ___ Difficulty seeing near objects (may report a "blur")
- ___ Other: _____

Please include any additional comments/concerns about academic progress.

Vision Referral Letter

SAMPLE
<District/School Name or Letterhead>

Date _____

Dear Parent/Guardian:

Recent vision screening test at school indicates that _____ may have some vision
(student and grade)
difficulty. A comprehensive eye examination is recommended. Please take this form with you at the time of
examination.

(School Nurse)

(School Contact information)

REASON FOR REFERRAL

Vision Test Results _____ Screening Tool(s) used*: _____

Blinking Blurred Vision Frequent headaches after reading

Squinting Watering Eyes Other _____

Remarks _____

* If an automated screening was used, attach printout from the machine.

EYE EXAMINER'S REPORT TO SCHOOL

Diagnosis: _____

- ☐ No Treatment Indicated
- ☐ Treatment Recommended
 - ☐ Glasses Prescribed
 - ☐ To be worn at all times
 - ☐ To be worn at all times except during physical education
 - ☐ To be worn for far vision activities, e.g., driving, looking at the board
 - ☐ To be worn for near vision activities, e.g. computer work, reading, writing Other: _____

Vision to be expected with correction: R 20/ L 20/

Classroom/School Recommendations:

Recommended Date for Re-examination: _____

We would appreciate any additional information which may be pertinent to this student's school adjustment.

Date _____

Name of Eye Examiner (MD, DO, or OD)

Phone/Email _____

Signature of Eye Examiner

NOTE: Please complete and return to the school nurse. Thank you.

DELAWARE VISION SCREENING OVERVIEW FOR SCHOOL NURSES 2015

Test order: **1. Binocular** **2. Stereoacuity** **3. Distance Acuity** **4. Color**

Test	Who to Test	Pass Result
BINOCULAR VISION		
Cover-Uncover <ul style="list-style-type: none"> Near Point 2 Feet Away Far Point Object over your shoulder 	<ul style="list-style-type: none"> All New Enterers PRE-K Kindergarten Grade 2 Those considered for Special Education At least once in student's school life <p><u>Note:</u> If student wears glasses, test <i>without</i> glasses.</p>	No movement of either eye
STEREOACUITY		
Depth Perception <ul style="list-style-type: none"> PASS Test 2 (Pre-K, kindergarten) Butterfly Stereoacuity Test (school-age) 	<ul style="list-style-type: none"> All New Enterers PRE-K Kindergarten, if prior failure Grade 2, if prior failure Those considered for Special Education At least once in student's school life <p><u>Note:</u> If student wears glasses, test with polarized glasses <i>over</i> the prescription glasses.</p>	<p>With polarized glasses:</p> <p><u>PASS Test 2</u> Pre-K: Correctly identifies Card B Grade K and older: Correctly identified Card B & C</p> <p><u>Stereo Butterfly Test</u> Pre-K: Correctly outlines butterfly without touching plate and identifies "floating" symbol in A and B Grade K and older: Correctly outlines butterfly without touching plate and identifies "floating" symbol in A & B</p>
DISTANCE		
Acuity <ul style="list-style-type: none"> LEA symbols or HOTV symbols Chart (Pre-K, kindergarten, and ESL) Sloan letters Chart (school-age) 	<ul style="list-style-type: none"> All New Enterers PRE-K Kindergarten Grades 2, 4, 7, 9 (or 10) Those considered for Special Education At least once in student's school life <p><u>Note:</u> If student wears glasses, test with glasses.</p>	<p><u>Age 3-5: 20/40 (10/20)</u> <u>Ages 5 or older: 20/32 (10/16)</u></p> <p><u>All ages:</u> More than 2 line difference between</p> <p><u>Note:</u> Record the smallest line the student successfully reads more than ½ of the optotypes</p>
COLOR VISION		
Pseudo-isochromatic plates Using Q-tip on plates	<ul style="list-style-type: none"> All New Enterers, if not previously screened PRE-K Kindergarten, if prior failure Grade 2, if prior failure Those considered for Special Education At least once in student's school life 	<p>Correctly identifies all plates No referral needed for boys Refer failure for girl. Notify Parent/Guardian and Teacher if unable to complete test correctly.</p>
NEAR VISION – Only recommended for students who show or have reported difficulty seeing objects at a near range		
Near Vision Chart <ul style="list-style-type: none"> Sloan Chart – K – Adolescence LEA Symbols Chart – Pre-K, K, & ESL 	<p>This is not a routine test. It is only recommended for students who show or have reported difficulty seeing objects at a near range</p>	<p><u>Pre-K & K</u> 20/40 (10/20) <u>K – Adolescence</u> 20/32 (10/16) <u>All ages</u> More than 2 line difference between</p> <p><u>Note:</u> Record the smallest line the student successfully reads more than ½ of the optotypes</p>
ESL = English as Second Language K = Kindergarten PRE-K = Pre-Kindergarten		

Revisions

- 01/13/2017 Page – 19 Immigration vaccine requirements
- 01/13/2017 Page – 22 Polio exemption for students
- 05/18/2017 All Updated all NASN links
- 10/10/2017 Page – 65 Added Crisis Text Line
- 01/10/2018 Page – 43 Required Training
- 04/13/2018 Pages - 97,98,100 Updated Forms
- 04/24/2019 Page – 81 Removed and added recommendation
- 06/14/2019 Page – 54 Updated McKinney-Vento Definition of Homeless
- 08/26/2019 Pages- 96,97, 99 Updated TB travel question
- 12/17/2019 Page 97 Deleted actual forms and added hyperlink to forms

