OFFICE OF SCHOOL HEALTH
NURSE ROLE OVERVIEW

Michael R. Bloomberg, Mayor

Dennis M. Walcott,
Chancellor

Department of Education

Thomas A. Farley, M.D., M.P.H.,
Commissioner

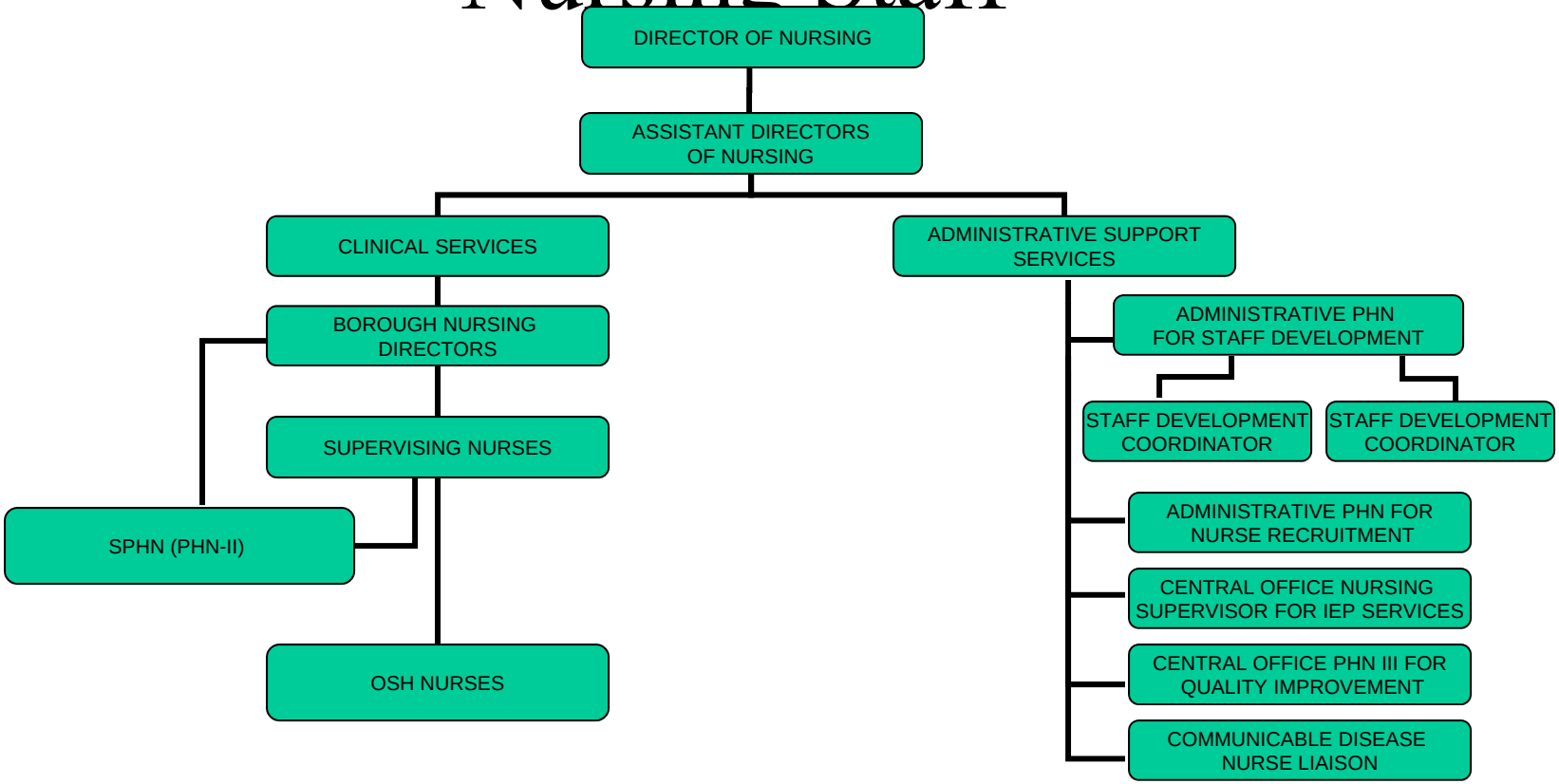
Department of Health and Mental Hygiene

Revised January 2011

SCHOOL HEALTH
OUR MISSION

- The Office of School Health provides public health services for New York City's 1.4 million school children.
- The Office of School Health promotes the physical, emotional, social and environmental health of every child enrolled in the City's approximately 1,800 public and nonpublic schools.
- School Health Nurses provide preventive health teaching, health education, case management, and direct services.

OSH Organizational Chart
Nursing Staff



SCHOOL HEALTH DRESS CODE

- As representatives of the Office of School Health, it is important that the image we project is one of professionalism.
- Please dress professionally.
- Always wear your ID tag so that it's visible.
- Never wear scrubs, blue jeans spandex or stirrup pants.

RN Registration

In compliance with a recommendation from the Bureau of Human Resources, Office of School Health nurses should keep a photocopy of their current RN registration certificate on their person.

Part 59.8 (c) of the Regulations of the Commissioner of Education states:

…Where practice is carried on in other than individual offices, each licensee shall have a current registration certificate available for inspection at all times.

Copies of RN registration certificates are maintained centrally in compliance with this regulation. However, since the OSH nurses are uniquely situated throughout the 5 boroughs of New York City, it is imperative that we ensure nurses are able to produce a copy of current RN registration certificate upon request in situations where it may be warranted.

OFFICE OF SCHOOL HEALTH NURSE ROLE

JOB GOALS:

- Under the supervision of the Supervising Nurse and PHN II the OSH Nurse:
  - Functions as a health care provider
  - Acts as a member of the health team
  - Uses the nursing process to assess, plan, implement and evaluate the health needs of students.

OFFICE OF SCHOOL HEALTH NURSE ROLE

- Responsible for case identification & for promoting an optimal level of wellness for students.

DUTIES & RESPONSIBILITIES:

These include but will not be limited to:

- Coordinates the activities of the health staff in each school to ensure that every student has a documented new admission examination, a current School Health Record and to see that other mandated services are provided.
- Engages in case-finding, referral and case management activities in conjunction with the school health team and the community providers.

OFFICE OF SCHOOL HEALTH NURSE ROLE

- Implements the OSH standardized tracking system for the follow-up of student referrals. Monitors compliance with health care plans at appropriate intervals.
- Directs health staff in managing the delivery of first aid.
- Follows the OSH communicable disease control procedures, informs and advises administration and/or parents regarding school exclusion & readmission. Implements steps recommended to prevent further outbreak.
- Collaborates with school personnel in the development and implementation of case management plans to meet the health needs of students.

OFFICE OF SCHOOL HEALTH NURSE ROLE

- Develops individualized health care plans with specific goals, objectives and interventions for the student with special health needs and/or chronic health problems.
- Advocates for the student and family in matters pertaining to health assessment and need. Serves as a liaison between the medical provider, community groups, the school, and the staff regarding student health concerns.
- Assesses environmental conditions that may prove hazardous to student health and makes recommendations to appropriate administrators.

OFFICE OF SCHOOL HEALTH NURSE ROLE

- Reports suspected physical abuse, sexual abuse and neglect of children as mandated by law.
- Conducts teacher-nurse conferences to identify student health problems and provides an opportunity to clarify or reinforce specific recommendations requested by health providers.
- Responsible for planning and monitoring physician and MD medical sessions in schools.
- Serves as resource person to school and community regarding health issues.

OFFICE OF SCHOOL HEALTH NURSE ROLE

- Provides information to families on health practices including nutrition. Conducts outreach activities for Medicaid-eligible children and families to access Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) program.
- Provides on-going health education programs to student, parents and school staff.
- Provides in-service training to health staff on current health issues.
- Prepares monthly reports to be used by nursing supervisors for program evaluation and on-going needs assessment.

REPORTING FOR DUTY

- Report to your school's Administration Office first.
- Introduce yourself to the Principal and Office Staff.
- Get the keys to Medical Room and Medicine Cabinet from Administration.

Covering Nurse Folder

- Each Medical Room will have a Covering Nurse Folder with the name of the Contract Liaison and Supervising Nurse/PHN II

Covering Nurse Folder

Included in the Covering Nurse Folder are:

- School Information Sheet
- School Contact Numbers
- Chronic Diagnosis List
- Organizational Sheet
- Regional Contact Information
- HFA Maintenance Form
- Preparation Guide for Covering Nurse
- Password for computer Contact Supervising Nurse

COVERING NURSE FOLDER

DISTRICT_____**SCHOOL**_____

Important

Covering Nurse upon arrival at school ,please call

1) Contract Liaison _____Phone:_____

2) Supervising Nurse/Supervising Public Health Nurse:_____

Phone _____

*If unable to reach Contract Liaison or Supervisor please call Borough Nursing Director:*_____

Included in Covering Nurse Folder :

- School Information Sheet
- School Contact Numbers
- Organization Sheet
- Regional Contact Information
- Chronic diagnosis list
- HFA Maintenance Form
- Password for Computer Contact Supervising Nurse

SCHOOL INFORMATION SHEET

School _____ **OSH Daily Presence (Name/Title)** _____

District 75 Nurse, Name _____ **Room #**_____**Phone Ext**_____

School Enrollment _____ **Grades**_____

Does school have Pre K? _____**Y/N** **District 75** _____**Y/N**

Trailers _____**Y/N** **Mini building** _____**Y/N** **Annex sites** _____**Y/N**

Location of:
Medical Room Key _____ **Medicine Cabinet Key** _____

Double Lock Medicine Cabinet Key_____ **File Cabinet Key**_____

Refrigerator Key_____**Bathroom Key**_____

DOE Staff within school that have copy of Keys _____

MAF Medication Log Book Location (be specific) _____

Chronic Diagnosis List_____**Biographical**_____**Cross Reference** _____

Fanny Pack _____ **(CPR Mask, Epi-Pen, Gloves)**

Emergency Bag_____ **Daily Log Book** _____

Stock Albuterol Location _____ **Epi pen Location**_____

DOH Telephone and Plug in site_____ **Emergency Cards** _____

Thermometer & Shields_____ **Splxgs & Stethoscope**_____

Student Lunch Period on Bulletin Board

Time of OSH Nurse/Advisor lunch break_____

DOE designee to cover while nurse is at lunch_____

MAF/504 Coordinator: Please state Name/Title and date they were oriented to the MAF's
_____

Anything else unusual: _____
***Copy to Supervising Nurse**
Form completed by_____**Date** _____

Preparation Guide for Covering Nurses

When reporting to a new school assignment nurse will complete the following:

- Report to school's administration office
- Introduction to principal and office staff
- Obtain keys for medical room, medication cabinet, narcotic cabinet, file cabinet and storage cabinet (if applicable)
- Call contract liaison within 20 minutes of arrival to medical room
- Locate red fanny bag (contains Epipen, Epipen Jr., CPR face mask and gloves)
- Locate emergency supply bag
- Locate and review covering nurse folder
- Locate and review medication binder (identify students receiving daily medication and treatment services)
- Locate referral forms, reporting forms and blank MAFS
- Open medication cabinet:
    1. check medications for concordance with MAF and expiration dates
    2. locate stock Ventolin Inhaler
    3. complete Control Substance Count Sheet (as appropriate)
    4. locate thermometer, stethoscope and safety retractable lancets (if needed)

Walk ins:

- Document all visits in walk in log and ASHR or 103S
- Notify parent of medical room visit (telephone call and 12S or SH 10)
- Issue referrals as needed (E12S, O12S etc.)
- Initiate case management as needed
- Follow up for prior visits as needed (i.e. 911 calls)

MAFs/Nursing Services:

- Contact OSH nursing supervisor upon receipt of new MAF and prior to administration of medication
- Review MAF with OSH nursing supervisor for approval
- Follow directions of OSH nursing supervisor regarding faxing and processing MAF
- Always auscultate student's lungs before and after administering rescue inhaler

Communication/Call OSH supervisor if:

- Unable to locate keys, supplies, discrepancy in medication count etc.
- An emergency occurs
- Work day must be extended due to emergency
- Communicable disease, food borne illness, blood and body fluid exposures occur
- Guidance/direction/ clarification is needed regarding OSH policy and protocol

*Contract agency work day is 7 hours in public schools and 6 hours in non public schools. Nurses must not leave school/yard premises during assignment. An addition to the scheduled workday must have OSH supervisory approval.

Revised January 2011

Medical Room Standardization

Keys:

- Medical Room key maintained in General Office at night (known by supervisor)
- Medication keys secured in Medical Room (keys should be labeled)
- Keys kept in possession while in the school building
- Principal maintains copy of keys

Medical Room Standardization

Medication Binder and Log Book:

- Maintain in locked file cabinet or in top medication drawer at night (labeled)

Memo Folder:

- Contains all OSH memos and important papers and maintained in desk drawer or file cabinet

Medical Room Standardization

Coverage Nurse Folder:

- Contains Chronic Diagnosis List, Biographical List, Organizational Sheet, School Information Sheet, School contact numbers, Regional contact information, HFA Maintenance Form and Preparation Guide for Covering Nurse

Emergency Bag:

- Is easily accessible during the day and locked in cabinet after school hours

Medical Room Standardization

Red Fanny Bag:

- Contains Epipen 0.3 mg., Epipen 0.15 mg, CPR mask and gloves
- Red Fanny Bag should be in your possession during the school day

Medication Cabinet:

- All medications stored in a plastic bag with student's name and class
- Medication expiration dates can be noted on Medication Administration Record
- Thermometer stored in upper section of Medication Cabinet
- OSH supplied Safety Retractable Lancets maintained in Medication Cabinet

Medical Room Standardization

File Cabinet/Storage Cabinet:

- Maintain labeled Epipen trainer (Epipen trainer resembles medication and must be stored in a separate location
- Neatly organize forms and label drawers and shelves
- At least one of each form should be kept on file

Forms posted on Bulletin Board:

- Table of Organization, Lunch schedule
- School Emergency Plan
- Supervisor/BND contact information, Contact Liaison information
- Communicable Disease Reporting Form
- Diabetes Manual
- HFA Placard
- Preparation Guide for Covering Nurse Placard
- Disinfection and Cleaning Schedule for Office of School Health

Posters in Medical Room: Cover your cough, Hand Hygiene, Triage

Emergency Response

The school nurse will respond to emergencies within the school:

- Always wear/carry red fanny bag when in the school building to be prepared to respond to an emergency
- Red fanny bag contains CPR mask, gloves and Epipen
- OSH staff may also carry emergency bag when responding to an emergency

Automated External Defibrillator (AED)

NYS Education Law Section 917, enacted in May 2002, requires:

- At least one AED installed in each public school mounted at the main entrance
- Other AEDs may be placed strategically as needed i.e. outside the cafeteria or gym
- Each school must have school staff members certified in AED/CPR to respond to emergencies

Automated External Defibrillator (AED)

- When a medical emergency is identified a Code Blue is called and 911 is initiated. The trained school staff will pick up the AED and respond. The school nurse will also respond if available
- If the school nurse is the first to respond to a life threatening emergency, he/she will initiate the Code Blue and instruct someone to call 911 and get the AED

YOUR WORK SCHEDULE

- For **DOHMH Nurses**, they have a fixed schedule that covers the regular school day. They may flex from the schedule by up to 30 minutes, provided that the principal is notified in advance and that the nurse is still present when school begins and when the regular school day ends. Work hours are either 6 or 7 hours per day based on the job offer accepted.
- **Schedules are:** *based upon needs of the school; include one hour unpaid lunch.*

YOUR WORK SCHEDULE

- For **DOE Nurses**, they have work hours that follow the school schedule. Work hours are 6 hours and 55 minutes per day.
- They have a ½ hour lunch that is not duty free and must remain in the school building during their lunch time in case of emergency.

YOUR WORK SCHEDULE: WHAT IF????

- A student has a medical emergency at the end of the school day.
  - Attend to that emergency.
  - You will be paid for your time.
  - Let your Supervising Nurse (SN) or Borough Nursing Director (BND) and the principal know so that your time can be approved.
- If you have a personal emergency, notify your SN and follow his/her instructions. Do **not** leave the school without your SN's or BND's permission.

THE CITY OF NEW YORK

Office of School Health

Michael R. Bloomberg
Mayor

Joel I. Klein
Chancellor
Department of Education

Thomas R. Frieden, M.D., M.P.H.
Commissioner
Department of Health and Mental Hygiene

Dear Principal,

September 23, 2005

In order to assure that school nurses can provide services to students in a setting that assures both safety and privacy, the Office of School Health has developed standards for school medical rooms. The current standards are shown below.

STANDARDS FOR MEDICAL ROOMS IN NYC SCHOOLS – September 2005

Minimum Requirements

1) Sink with hot and cold running water
2) Adequately sized room (in general, at least 200 square feet)
3) No through traffic
4) Floor to ceiling walls
5) Internet access and adequate electrical power for computer (public schools)

Key Attributes

1) Internal bathroom (or bathroom within a few steps of the health room)
2) Separate (off corridor) waiting space for students
3) Adequate heating, air conditioning, lighting and ventilation
4) Telephone line and adequate electrical outlets
5) Internet access (non-public schools)
6) Permanent location. Any temporary location must meet minimum requirements

If the Regional Nursing Director feels that the current health room in your school does not meet minimum standards, she will speak to you or your designee. At times, it may be helpful to have the Regional Health Director participate in these discussions. Our experience is that, with a proper explanation of the need, principals have been able to provide a suitable space.

If, after the issues have been thoroughly discussed, it is not possible to identify a suitable room, the Regional Nurse Director, after consultation with the central School Health Nursing Director, may reassign the school nurse.

If you have questions or concerns about this policy, feel free to speak to Carole Marchese, R.N., Director of Nursing, or to me. Thank you very much for you help in dealing with this issue.

Roger Platt, M.D.

MEDICAL ROOM WALK-INs

- All students should present a pass (a Teacher Referral Slip, Form 194s) from his/her teacher to enter the Medical Room.
- In the Public School (Elementary, Middle, Intermediate and Junior High): Utilize the Automated Student Health Record(ASHR).
- In the High School & Non Public School : Enter the student's name, date and time of arrival in the Office of School Health Daily Log.

TEACHER'S REFERRAL SLIP

OFFICE OF SCHOOL HEALTH

NAME OF STUDENT	GRADE/CLASS	ROOM	TIME LEFT CLASS

REASON FOR REFERRAL

DATE	TEACHER

TIME LEFT MEDICAL ROOM ❑ AM ❑ PM

DISPOSITION:

- ☐ May return to class.
- ☐ Please allow student to wait in the main office.
- ☐ Please allow student to eat breakfast/early lunch (circle one).
- ☐ Please have student return at _____AM/PM for follow-up.
- ☐ Student should go home. Please have student gather belongings and wait in classroom until parent/guardian arrives.
- ☐ Please allow student to go to principal's/dean's office.

Other _____

_____

_____

_____

_____

DATE	NAME and TITLE

194S (Rev. 8/05)

The City of New York

The City of New York – Department of Health and Mental Hygiene
Office of School Health
Walk-In – Unplanned Visits to Medical Room

DOE Region:	CSD:
School:	

*Legend of (Disposition) 1. Returned to Class
2. Parent Contact to Home or MD
3. Calls to EMS

Signature/Title	Initials

Date	TIME		NAME		DOB	Class	Complaint	Action	FORM		Comments	Initials
	In	Out	Last	First					Issued	Disp.*		

SH 92 (Rev. 6/05)

MEDICAL ROOM WALK-INs *contd*.

- Assess the student's condition.
- Public School (Elementary, Middle, Intermediate and Junior High): utilize ASHR and enter findings on Teacher Referral Slip (194S)
- High School & Non Public School: Enter your findings in the log, on the Teacher Referral Slip (194s)

MEDICAL ROOM WALK-Ins *contd.*

- For situations requiring extensive documentation, such as documenting CPR chronology, the 103S should be used

- . You will find the individual medical record (103S) for each student in the locked file cabinet.

MEDICAL ROOM WALK-Ins *contd.*

It is not appropriate within the practice of School Nursing for a nurse to:

- undress a student
- expose a student's genitals
- Examine a student's genitals

Contact your Office of School Health supervisor with any questions/concerns

SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE

LAST NAME FIRST NAME MIDDLE NAME SEX BIRTHDATE

NUMBER AND STREET	ZIP CODE	BORO	FL./APT.	TELEPHONE NO.	GRADE/CLASS	SCHOOL/BORO

NAME OF PARENT OR GUARDIAN
LAST FIRST RELATIONSHIP TO CHILD

SIBLINGS IN FAMILY (Keep current) No. Older: No. Younger: No. Persons in Home:

MEDICAL HISTORY — Explain all items checked and give recommendations under: Health Problems" below

FAMILY ILLNESSES — SIGNIFICANT (SPECIFY) IF PARENTS OR SIBLINGS ARE DEAD, GIVE CAUSES AND DATES, (Keep current)

CHILD'S HISTORY — BIRTH DEVELOPMENTAL

IMMUNIZATION STATUS:
IMMUNIZATION COMPLETE: (DIPTHERIA (DT, TD), POLIOMYELITIS) (MEASLES, RUBELLA, MUMPS) YES ☐ NO ☐
IF IMMUNIZATION INCOMPLETE: REFERRED ____________ DATE: ____________

CHILD'S HISTORY — CHECK AND GIVE DATES IF KNOWN

- ☐ Chicken Pox
- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Allergies (specify)
- ☐ Frequent colds or sore throats
- ☐ Ear Infections
- ☐ Trouble hearing
- ☐ Intestinal Parasites
- ☐ Bronchitis or Asthma
- ☐ Convulsions
- ☐ Rheumatic fever
- ☐ Heart trouble
- ☐ Orthopedic problem
- ☐ Tuberculosis
- ☐ Eye or vision problem
- ☐ Speech problem
- ☐ Urinary Track Infection
- ☐ Serious Illnesses (specify & give dates)
- ☐ Serious accidents (specify & give dates)
- ☐ Operations (specify & give dates)
- ☐ Other problems or handicapping conditions (specify)
- ☐ Is child now under regular medical care, name of doctor, hospital or clinic
- ☐ Address:

Is child now taking any regular medication? Specify:

CURRENT HISTORY AND EXAMINATION					
DATE					
PARENT PRESENT					
A. EATING HABITS					
B. SLEEPING HABITS					
C. TOILET HABITS					
D. BEHAVIOR					
E. OTHER HISTORY					
1. PHYSICAL APPEARANCE					
G. Good A. Ave. B. Below Par					
2. SKIN					
3. EARS					
4. EYES					
5. MOUTH and TEETH					
6. NOSE and THROAT					
7. HEART					
8. LUNGS					
9. ABDOMEN					
10. HERNIA and GENITALS					
11. POSTURE and EXTREMITIES					
12. OTHER					

NOTES BY SCHOOL DOCTOR AND NURSE
At beginning of note, code activity, sign all notes

DATE	

103-S (Rev. 9/03) **Check (✓) all abnormalities, explain all items checked and give recommendations under "Notes"**

HEALTH PROBLEMS DURING SCHOOL CAREER

DOCTOR'S OR PNA'S ACTIVITY (Red Ink)

NA New Admission SHA Selective Health Assessment SR Spec. Referral
DPPC Professional Person Conference DSC Student Conference

NURSING ACTIVITY (Blue/Black Ink)

NDI Daily Inspection NFU Follow Up NP Parent Conference
HV Home Visit TNC Teacher Conference
NPPC Professional Person Conference HPE Health & Physical Education

DATE	ACTIVITY CODE	PARENT PRESENT	HEALTH PROBLEMS; SIGNIFICANT FINDINGS; ACTION TAKEN; AND SIGNATURE	RECOMMENDED ACTION	ACTION COMPLETED

NOTE: When student is transferred forward this record to new school
SCHOOL MEDICAL RECORD
(To be kept in medical room)

103-S (Rev. 9/03) **DEPARTMENT OF HEALTH AND MENTAL HYGIENE – THE CITY OF NEW YORK**

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Cumulative Health Record

104S (Rev. 8/03)

LAST NAME (Print)	FIRST NAME	MIDDLE NAME	DATE OF BIRTH Month	Day	Year
			I.D. #		

IMMUNIZATION HISTORY

EXEMPT: (DOCUMENTATION MUST BE ATTACHED) RELIGIOUS _____ MEDICAL _____

DPT or DT or TD _____ Date _____ Date _____ Date _____ Date _____ Date

POLIO _____ Date _____ Date _____ Date _____ Date _____ Date

MMR _____ Date MEASLES * _____ Date MUMPS* _____ Date RUBELLA* _____ Date

MMR _____ Date MEASLES * _____ Date MUMPS* _____ Date RUBELLA* _____ Date

HIB _____ Date (Pre-K attendees only)

OTHERS _____ (Type and Date) _____ (Type and Date) _____ (Type and Date)

Signature of Preparer _____ Date** _____

*WHEN APPROPRIATE MEDICAL DOCUMENTATION INDICATES THAT THE STUDENT HAD THE DISEASE, ATTACH COPY OF DOCUMENTATION.

**ALL INFORMATION ENTERED SUBSEQUENT TO THIS DATE MUST BE INITIALED.

implant

Mantoux PPD _____ Date read ❑ Negative _____ mm ❑ Positive _____ mm Chest x-ray _____ Date

PHYSICAL EXAMINATIONS

New Admission Physical Completed _____ Date

Additional Physical Exams _____

_____

_____

Chronic Health Problems or restrictive conditions reported: _____

_____

Also see "Entries By Health Professionals" (Page 4)

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TEACHER OBSERVATIONS

104S (Rev. 8/03)

School													
Boro													
Grade / Class													
School Year													
Tires easily													
Restless													
Excessive Absences													
Recurrent Colds													
Frequent Earaches													
Nose Bleeds													
Squints													
Speech Problems													
Coordination Problems													
Excessive Use of Lavatory													
Seizures													

ADDITIONAL COMMENTS BY SCHOOL PERSONNEL

Date	Include signature and title for all entries

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HEALTH SCREENINGS

104S (Rev. 8/03)

LAST NAME (Print)	FIRST NAME	MIDDLE NAME	DATE OF BIRTH Month	Day	Year
			I.D. #		

Grade / Class													
School Year													
Height													
Weight													
VISION	B												
Far glasses	R												
Far glasses	L												
Far w/o glasses	B												
Far w/o glasses	R												
Far w/o glasses	L												
Near glasses	B												
Near glasses	R												
Near glasses	L												
Near w/o glasses	B												
Near w/o glasses	R												
Near w/o glasses	L												
Fusion P / F													
Color P / F													
HEARING Sweep P / F													
Threshold P / F													
DENTAL Note Returned													
BLOOD Hematocrit / Hgb													
Lead													

P = Pass F = Fail

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104S (Rev. 8/03)

ENTRIES BY HEALTH PROFESSIONALS (NURSE, PHYSICIAN, HRC, PHA, PA, OTHER)

Date	Include signature and title for all entries

RECOMMENDATIONS FOR WALK-INs: POSSIBLE OUTCOMES

- The student returns to class.
- The student is excluded from school because of presenting the possibility of a communicable disease.
- The student is referred for follow-up care with appropriate referrals and notifications.
- Always notify parent/guardian with the SH-10 form &/or 12S form and by phone. Get the student's current contact information from the Pupil Accounting Secretary.

12S

OFFICE OF SCHOOL HEALTH
DEPARTMENT OF HEALTH AND MENTAL HYGIENE – THE CITY OF NEW YORK

Issued at:

Date: _____

Grade/Class: _____

OSIS #: _____

Student Name: _____ Date of Birth: _____
Last *First*

❑ Dear Parent:
It is advisable to consult your physician regarding the following:

_____

_____

_____

If this form is not completed and returned, your child may be assessed by our school health doctor as authorized by the NYC Health Code. If you do not wish your child to be placed on the physician's schedule, please contact the nurse at _____ (phone).

❑ Dear Doctor:
Will you please give your opinion and recommendations on the lower portion of this form. A description of your findings will be appreciated. If you find it necessary to refer this child for further study, please note and indicate where referred.

_____ _____
Name Title

PLEASE RETURN TO SCHOOL MEDICAL ROOM

TREATMENT AGENCY REPORT

Findings :

Diagnosis:

Treatment Plan:

*** RECOMMENDATIONS FOR SCHOOL**

❑ NORMAL ACTIVITY
❑ Special Health Accommodations
- ❑ Bus Transportation
  Duration _____
- ❑ No Competitive Games
- ❑ Adaptive Physical Education
- ❑ Elevator Pass (if available)
- ❑ Other _____

* Additional information may be required from the provider.

Child is under treatment: Yes ❑ No ❑. I wish to see child again on _____

If referred to another physician or clinic, please indicate where referred: _____

Hospital/ER ❑
Clinic ❑
Managed Care ❑
Private Practice ❑

Date _____ _____
Please Print Name & Title

Address _____ Tel. No. _____

THIS REPORT IS TO BE RETURNED TO THE NURSE BY PARENT OR STUDENT
THE DEPARTMENT OF HEALTH WILL BE GLAD TO COOPERATE IN CARRYING OUT YOUR RECOMMENDATIONS

12S (Rev. 3/09)

SH 10

OFFICE OF SCHOOL HEALTH

School: _____ Date: _____

Dear Parent/Guardian of: _____ Class: _____ DOB: _____

Subject: **Medical Room Visit** OSIS: _____

Your child was seen in the medical room today for:

____Abrasion
____Ache/Pain
____Allergy Symptoms
  ____Eyes: itchy/red/teary
  ____Nose: itchy/runny/stuffy/sneezing
  ____Throat: scratchy/itchy
____Bite
____Cut
____Cough/Cold
____Earache: right/left
____Eye: right/left
____Other (specify)_____
____Fever: ____F
____Headache/Dizziness
____Nausea/Vomiting
____Nosebleed
____Pain
____Rash
____Skin: itchy/dry/irritation
____Sore Throat
____Stomachache
____Tiredness/Fatigue
____Toothache
____Trauma
____Vision Problem: right/left

Treatment Given:

____Ice Pack
____Band-Aid
____Cold Compress
____Meal/Snack
____Pressure to stop bleeding
____Area cleaned with soap & water
____Fluids: Water/Juice

Recommendations:

____Please see your doctor/dentist for an evaluation
____Keep at home until temperature is normal for 24 hours
____Keep at home until eyes are free of discharge
____Keep at home until vomiting has stopped for 24 hours
____Update your emergency card for parental contact **(we were unable to reach you)**
____Submit **New Admission Physical Exam** Form (211s)

Please contact your Health Care Provider for evaluation:

____If your child complains of headache, dizziness, nausea, and/or sleepiness
____If area of complaint becomes swollen and/or very painful
____If pain and/or condition continues

Additional Comments: _____

_____

_____

SEEN BY: _____ **TEL. #:** _____
(Name and Title)

SH 10 (Rev. 8/05)

Head Injury Form

NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Thomas A. Farley, MD, MPH
Commissioner

NEW YORK CITY DEPARTMENT OF
EDUCATION
Cathleen P. Black
Chancellor

OFFICE OF
SCHOOL HEALTH

Date: _____

Dear Parent/Guardian,

*Your child*_____ *may have injured his/her head today. There is no evidence of a serious head injury, such as confusion or loss of consciousness, at this time. However, symptoms of a serious head injury may be delayed.*

There is no specific treatment needed for a mild head injury. It is recommended that your child rest quietly for the next few hours and abstain from strenuous activity for the next 24 hours. It is normal to have a headache after a head injury. However, if the headache becomes worse or it is very difficult to wake your child up, contact your physician immediately or go to the emergency room.

Please observe your child for the symptoms listed below over the next 24 hours. These symptoms may indicate a serious head injury. Contact a physician immediately or go to the emergency room if any of these symptoms develop.

The following symptoms were observed at the time of or immediately after the injury:

_____

Thank you,

_____ _____ _____
Signature *Title* *Phone Number*

HEAD INJURY SYMPTOMS

1. **SEVERE HEADACHE**
2. **EXCESSIVE DROWSINESS**
3. **NAUSEA AND/OR VOMITING**
4. **DOUBLE VISION, BLURRED VISION OR PUPILS (dark area in center of colored part of each eye) OF DIFFERENT SIZES**
5. **LOSS OF MUSCLE COORDINATION: FALLING DOWN, STAGGERING**
6. **ANY UNUSUAL BEHAVIOR: CONFUSION, BREATHING IRREGULARLY OR DIZZINESS**
7. **BLEEDING OR DISCHARGE FROM THE EAR, NOSE OR MOUTH**
8. **CONVULSION**

MEDICAL ROOM WALK-INs: NOTIFYING THE PARENT/GUARDIAN

- If you provided treatment to a child, **do not leave school** without notifying the parent/guardian on the SH-10/12S form and by phone.
- **Seek direction** from your Supervising Nurse or Borough Nursing Director whenever you feel uncertain about the proper course of action to be taken.

Documentation of Student Visit

- Document visit in ASHR or walk in log and 103s
- Document referrals issued
- Initiate and document case management as needed
- Follow up for prior visits as needed (i.e. 911 calls from the previous day)

WALK-INs: WHAT IF????

If a student has a dire medical emergency:

- You or a Principal or his/her designee can call EMS (911).
- If a Principal disagrees with your clinical judgment, **call 911 yourself and notify your Supervising Nurse, PHN II or Borough Nursing Director (BND) immediately.**
- **Only** school personnel (**not the school nurse**) can escort the student offsite.
- **Under no circumstances** should you escort a student outside the school.

HEALTH SERVICES:
MEDICATION & PROCEDURES

School Nurses may perform any of the following prescribed skilled nursing services, i.e.:

1. Administration of oral medication.
2. Administration of medication through an inhaler or nebulizer
3. Application of ear, eye or nose drops.
4. Application of topical creams or ointments to the skin for a chronic condition.
5. Injections (SC and IM), generally insulin, glucagon, and epi-pens.

HEALTH SERVICES:
MEDICATION & PROCEDURES
continued

6. Blood glucose monitoring.
7. Medical management of an insulin pump.
8. Rectal medications.
9. Tracheostomy care/suctioning.
10. Nasogastric tube care and feedings.
11. Gastrostomy feeding
12. Check urine dipstick (usually for ketones).
13. Catheterization (urinary).

HEALTH SERVICES:
MEDICATION & PROCEDURES
continued

14. Central Venous Line (limited to assessment and dressing)
15. Oral/Pharyngeal Suctioning
16. Oxygen Administration
17. Ostomy Care
18. Chest Clapping
19. Percussion
20. Postural Drainage
21. Dressing Change

HEALTH SERVICES:
MEDICATION & PROCEDURES

- In the Schools with ASHR, utilize ASHR Daily Medication/Medication Profile . In the High School & Non Public School look in locked Medicine or File Cabinet, to find the Daily Medication Binder for your school.

Health Services: Medication and Procedures cont.

- All schools maintain a Daily Medication Binder.
  The binder is divided into three sections:
  - Section I: Standing Orders and Protocols related to Medication/Treatment Services
    - ▪Standing Order for Use of Epipen in a School Setting
    - ▪OSH Diabetes Protocol for Safety Sharps: Safety Retractable Lancets and Insulin Pen Safety Needles Updated May 2010
    - ▪Stock Ventolin Policy and Procedure
    - ▪NYS Education Department Memo: Training Unlicensed Individuals in the Injection of Glucagon in Emergency Situations (NYSED Memo, March 2004)
    - ▪Verbal Order Protocol/Verbal Order Form
    - ▪Disposal of Medication in Office of School Health Setting (2-9-09)

Health Services: Medication and Procedures *cont.*

- Section II: Special Health Services – Daily
  For ASHR schools- ASHR Daily Medication Report
  For non-ASHR schools- Daily Medication/Treatment Summary
- Section III: Special Health Services -- PRN
  For ASHR schools-Student's Medication Profile Summary Report
  For non-ASHR schools-PRN Medication/Treatment Summary

- For ASHR schools, treatments should be listed on Daily and/or PRN Medication/Treatment Summary.

The City of New York Department of Health and Mental Hygiene
Office of School Health

Student Daily Medication for School

School Year 2006 - 2007

User:

July 31, 2007 2:59pm

Time	Medication/Dose	Student ID	Student name	Gender	DOB	Grade	Rm#
	Insulin - 0 NONE			M	03/17/2001	0K	125
12:00 pm	Dextroamphetamine - 10			M	06/05/1997	04	414
12:00 pm	Dextroamphetamine - 10			M	06/05/1997	04	414
01:00 pm	DDAVP - 0.1 mg			F	03/22/1997	04	103
Q 4	Xopenex - 0.63 mg			M	01/25/2000	01	208
Q 4	Artificial Tears - 1 gtts			M	10/30/1996	05	103

Total Students: 5

The City of New York Department of Health and Mental Hygiene
Office of School Health

Student Medication Profile for School :

School Year 2006 - 2007

User: August 1, 2007 9:16am

Student ID	Student name(Last, First)	Gender	DOB	Grade	Medication Ordered
		F	02/26/1999	02	-Albuterol (PRN :)
		F	04/08/2001	0K	-Albuterol (PRN : Q 4)
		M	09/04/1996	05	-EpiPen (PRN :) -Benadryl (PRN :)
		M	09/24/2001	0K	-STD Albuterol (PRN : Q 4)
		M	10/14/1997	04	-STD Albuterol (PRN : Q 4)
		M	03/13/1996	05	-STD Albuterol (PRN : Q 4)
		M	06/18/1999	02	-Xopenex (PRN : Q 8) -Albuterol (PRN : Q 4)
		M	02/07/1997	04	-Albuterol (PRN : Before Exercise) -STD Albuterol (PRN : Q 4)
		M	11/14/1996	05	-Xopenex (PRN : Q 4)
		M	07/20/1996	05	-STD Albuterol (PRN : Q 4)
		F	03/14/1996	05	-STD Albuterol (PRN : Q 4)
		F	11/27/1997	04	-STD Albuterol (PRN : Q 4)
		M	08/29/2001	0K	-EpiPen Jr (PRN :) -Maxair (PRN : Q 4) -Benadryl (PRN : Q 4) -Xopenex (PRN :)
		F	08/02/1996	05	-Pre-Gym Albuterol (PRN : Before Exercise) -Albuterol (PRN : Q 4)
		F	12/16/1997	04	-Albuterol (PRN :)

Total Students: 15

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NEW YORK CITY DEPARTMENT OF
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Chancellor

OFFICE OF
SCHOOL HEALTH

OFFICE OF SCHOOL HEALTH
Non – Public School Summary List for Daily Medications / Treatments

SCHOOL: _____ SCHOOL YEAR: _____

NURSE/PHADVISOR: _____

NURSING SUPERVISOR: _____ PHONE NUMBER: _____

MEDICATION KEY LOCATION: _____ BB: _____

TIME	STUDENT NAME	DOB	CLASS/ RM	MEDICATION/TREATMENT	COMMENTS/ ALERTS	SC/SA

SH 100 (Rev. 1/2011)

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OFFICE OF
SCHOOL HEALTH

OFFICE OF SCHOOL HEALTH
Non – Public School Summary List for PRN Medications / Treatments

SCHOOL: _____ SCHOOL YEAR: _____

NURSE/PHADVISOR: _____

NURSING SUPERVISOR: _____ PHONE NUMBER: _____

MEDICATION KEY LOCATION: _____ BB: _____

TIME	STUDENT NAME	DOB	CLASS/ RM	MEDICATION/TREATMENT	COMMENTS/ ALERTS	SC/SA

HEALTH SERVICES:
MEDICATIONS & PROCEDURES

This "Special Health Services – Daily" list tells you

1. How many children require nursing services that day.
2. When each child is expected to come to the medical room that day.
3. Medication should be administered within 30 minutes of the designated time.
4. **DO NOT** administer medication outside this one hour window. If you do, you will be in violation of physician's orders.

HEALTH SERVICES:
MEDICATIONS & PROCEDURES

- Attached to the specific Health Services and Section 504 Accommodations Form are the request/authorization forms for nursing services such as:
  - Medication Administration Form
  - Provision for Medically Prescribed Treatment (Non-Medication) for skilled nursing services
  - Diabetes Medication Administration Form (DMAF)
  - Request for Accommodation Form

HEALTH SERVICES:
MEDICATION & PROCEDURES

- When assigned to a High School or **N**on **P**ublic **S**chool: for every student on the School Summary for Daily Medication and School Summary for PRN Medication lists, you will find individual orders in the Daily Medication Binder.
- When assigned to a **P**ublic **S**chool: in most cases, pre-printed orders via ASHR**(**Automated School Health Record) will be found in the Daily Medication Binder.
- The properly signed **Health Services and Section 504 Accommodations Form** is your permission to execute the orders for the student named on that form.

HEALTH SERVICES:
MEDICATIONS & PROCEDURES

Also attached to the Health Services and Section 504 Accommodations Form for each student requiring Daily or PRN Medication & Procedures are:

- The Daily Medication Log for each student.
- Receipt of Medication/Equipment form for each student.
- Controlled Substance Count Sheet, if required.
- Asthma Action Plan, if appropriate.
- Diabetes Documentation Form, if appropriate
- HFA Monitoring Form, if appropriate

Medication Administration Record

Office of School Health

Students Name: _____ DOB:_____ Gender:_____ Grade/Class: _____
Medication & Dosage_____ Frequency & Time: _____ OSIS# : _____
_____ _____ Expiration date_____
Prescriber's Name:_____ _____ Phone # : _____ School: _____
Parent's Name:_____ Phone # : _____ School Year: _____

Int.	Name / Title	Int.	Name / Title	Int.	Name / Title

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Comment
Sept	AM																																
	PM																																
Oct.	AM																																
	PM																																
Nov.	AM																																
	PM																																
Dec.	AM																																
	PM																																
Jan.	AM																																
	PM																																
Feb.	AM																																
	PM																																
Mar.	AM																																
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Apr.	AM																																
	PM																																
May	AM																																
	PM																																
June	AM																																
	PM																																
July	AM																																
	PM																																
Aug.	AM																																
	PM																																

SH 96 (8/09) **Codes**: X – Weekend • N- Not Available • W- Dose Withheld • H – Holiday • F- Field Trip • O- No Show • A- Absent • D- Early Dismissal • R- Refused

Office of School Health

Treatment Administration Record

Students Name: _____ DOB:_____ Gender:_____ Grade/Class: _____
Treatment _____ Frequency & Time: _____ OSIS# : _____
_____ _____
Prescriber's Name:_____ _____ Phone # : _____ School: _____
Parent's Name:_____ Phone # : _____ School Year: _____

Int.	Name / Title	Int.	Name / Title	Int.	Name / Title

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Comment
Sept	AM																																
	PM																																
Oct.	AM																																
	PM																																
Nov.	AM																																
	PM																																
Dec.	AM																																
	PM																																
Jan.	AM																																
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Feb.	AM																																
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Apr.	AM																																
	PM																																
May	AM																																
	PM																																
June	AM																																
	PM																																
July	AM																																
	PM																																
Aug.	AM																																
	PM																																

SH 96 (8/09) **Codes**: X – Weekend • N- Not Available • W- Dose Withheld • H – Holiday • F- Field Trip • O- No Show • A- Absent • D- Early Dismissal • R- Refused

Receipt of Medication/ Equipment Form

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Chancellor

OFFICE OF SCHOOL HEALTH

OSH – Receipt of Medication / Equipment Form

Name: _____ **DOB:** _____

Date	Medication/Equipment	Number of Tablets	Nurse Signature	Parent / Guardian Signature

Revised January 2011

Controlled Substance Count Sheet

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OSH – CONTROL SUBSTANCE COUNT SHEET

Student Name: _____ **DOB:** _____

Name of Medication: _____ **Dosage:** _____ **Route:** ___ **Frequency:** _____

Date & Time	Amount on Hand	Amount Used	Amount Remaining	Staff Signature	Witness

*Control Substance count should be completed daily
January 2011

Asthma Action Plan

Asthma Action Plan

[To be completed by Health Care Provider]

Updated On: _____

Name _____ Date of Birth _____

Address _____ Emergency Contact/Phone _____

Health Care Provider Name _____ Phone _____ Fax _____

Asthma Severity: ❑Mild Intermittent ❑Mild Persistent ❑Moderate Persistent ❑Severe Persistent

Asthma Triggers: ❑Colds ❑Exercise ❑Animals ❑Dust ❑Smoke ❑Food ❑Weather ❑Other

Every Day Medicines

Child feels good:
- Breathing is good
- No cough or wheeze
- Can work / play
- Sleeps all night

Peak flow in this area:
_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

20 minutes before exercise use this medicine:

If Not Feeling Well

Take Every Day Medicines and Add these Rescue Medicines

Child has *any* of these:
- Cough
- Wheeze
- Tight chest

Peak flow in this area:
_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Call doctor if these medicines are used more than two days a week.

If Feeling Very Sick Get help from Doctor NOW!

Take These Medicines

Child has *any* of these:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't walk of talk well
- Ribs show

Peak flow below:
_____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

SEEK EMERGENCY CARE or CALL 911 NOW if: Lips are bluish, Getting worse fast, Hard to breathe, Can't talk or cry because of hard breathing or has passed out

Health Care Provider Signature _____ Date _____

Patient Signature _____ Date _____

NYC Health
New York City Department of Health and Mental Hygiene
Michael R. Bloomberg, *Mayor*
Thomas.R Frieden, M.D., M.P.H., *Commissioner*
Website: nyc.gov/health

New York City Childhood Asthma Initiative
Adapted from Finger Lakes Asthma Action Plan and NHLBI
01/03

WHITE - PATIENT COPY
YELLOW - SCHOOL/DAY CARE COPY
PINK - PROVIDER COPY

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OFFICE OF SCHOOL HEALTH

Name: _____ OSIS # Or DOB: _____
Grade/Class: _____ School: _____ Region: _____
Date Begin: _____ Date End:
Prescriber's Name: _____ Tel. #: _____
Parent's Name: _____ Tel. #: _____
Emergency Contact: _____ Tel. #: _____

Name of Insulin: _____
☐ No Insulin
☐ Syringe
☐ Insulin Pen
☐ Insulin Pump with:
☐ Automatic Dosing Calculator
☐ Dose calculated manually

Print Name/Title	Initials

Date	Actual Time & Indicate if lunch, gym, prn or snack	Blood Glucose	Carbohydrate Grams Meal/Snack	Carbohydrate Coverage (Food Bolus)	Correction Bolus	Total Insulin Bolus Calculated Manually	Dose delivered by Automatic Dosing Pump (if applicable)	Injection Site for Syringe or Pen	Ketones if BG ≥___	Treatment For Low BG i.e. Glucagon, Glucose tabs	Comments	Initials

HFA Maintenance Form

Student's Name____ Class___________________________

CIRCLE THE INHALER THAT APPLIES.

Prime with	**Priming Frequency**	**Expiration Date**	**Washing and Drying instructions Mouthpiece**
4 sprays	Before 1st use Prime before use if not used within 2 weeks. **If dropped, must be reprimed.**	*12 months after aluminum packet is opened or if unopened, the date on package, whichever date is sooner. **Date Opened:______________________** **Date on Canister:___________________**	Minimum Once a week. **Wash mouthpiece - only if used.** Flush warm running water from both ends for 30sec. **No Soap**. Shake off excess water. **Do not dry with towel.** Air dry overnight. **Visually inspect aperture to ensure no medication is present**
4 sprays	Before 1st use Prime before use if not used within 2 weeks.	Date on canister	
4 sprays	Before 1st use Prime before use if not used within 3 days.	Date on canister	
3 sprays	Before 1st use. Prime before use if not used within 2 weeks.	Date on canister	

If reason for spraying is to administer medication, please also document in ASHR/Medication Administration Record

Indicate Reason for spray- MedAdmin. - MA Priming - P Cleaning - C	**# sprays used.**	**Remaining sprays. Place number of sprays left in canister.**	**Date/Time**	**Indicate Reason for spray- MedAdmin. - MA Priming - P Cleaning - C**	**# sprays used.**	**Remaining sprays.**	**Date/Time**	**Indicate Reason for spray- MedAdmin. - MA Priming - P Cleaning - C**	**# sprays used**	**Remaining sprays**
xxxxxxxxxxxxxx	xxxxx									

Stock Ventolin HFA Maintenance Form

If reason for spraying is to administer medication, please also document in ASHR/Medication Administration Record

Prime with	**Priming Frequency**	**Expiration Date**	**Washing and Drying instructions Mouthpiece**
4 sprays	Before 1st use Prime before use if not used within 2 weeks. **If dropped, must be reprimed.**	*12 months after aluminum packet is opened or if unopened, the date on package, whichever date is sooner. **Date Opened:________________________** **Date on Canister:____________________**	Minimum Once a week. <u>**Wash mouthpiece - only if used.**</u> Flush warm running water from both ends for 30sec. **No Soap**. Shake off excess water. **Do not dry with towel.** Air dry overnight. **Visually inspect aperture to ensure no medication is present**

Indicate Reason for spray- MedAdmin. - MA Priming - P Cleaning - C	**# sprays used.**	**Remaining sprays. Place number of sprays left in canister.**	**Date/Time**	**Indicate Reason for spray- MedAdmin. - MA Priming - P Cleaning - C**	**# sprays used.**	**Remaining sprays.**	**Date/Time**	**Indicate Reason for spray- MedAdmin. - MA Priming - P Cleaning - C**	**# sprays used**	**Remaining sprays**
xxxxxxxxxxxxx	**xxxxx**									

HEALTH SERVICES:
MEDICATIONS & PROCEDURES

- Effective school year 2008-2009, OSH will accept medical orders from New York, New Jersey and Connecticut providers as authorized under the NYS Nurse Practice Act. This act prohibits OSH nurses from accepting medical orders from medical providers outside the tri-state region.
- OSH can accept orders from Certified Nurse Practitioners under the Nurse Practice Act
- As of October 2, 2009, OSH nurses can accept MAFs completed by Physician Assistants that are not co-signed by a physician.

HEALTH SERVICES:
Verbal Orders

- OSH permits school nurses to accept verbal orders from licensed providers if an MAF/DMAF already exists for the student
- Verbal orders are not acceptable for new or different medication or a change of medication route that already exists on the MAF
- Written documentation (Verbal Order Addendum Form) via fax must be provided within 48 of the verbal order and attached to the MAF/DMAF

HEALTH SERVICES:
Disposal of Medications

OSH staff must strongly encourage parents to pick up expired medications and all medications at the end of the school year.

If parents do not pick up unused medication or expired medication, OSH staff will document the medication has been abandoned in ASHR/Medication Binder

HEALTH SERVICES:
Disposal of Medications

Medication Disposal:

- Medication involving sharps should be disposed of in Red Container supplied by OSH or Office of Occupational Safety and Health (DOE)
- Oral medication should be placed in a container and mixed with water or salt to enhance destruction of the medication. The container should be sealed with tape. Care should be taken to ensure students do not have access to trash

HEALTH SERVICES:
MEDICATIONS & PROCEDURES

- The is parent/guardian or designated adult is requested to bring medicine/equipment to school.
- The parent is also requested to provide a recent picture of student.
- **You must fill out the RECEIPT OF MEDICATION/EQUIPMENT FORM together with the parent/guardian for each student.**
- When you receive the medication or equipment, you must count out the number of tablets – or equipment – in the presence of the parent.
- In the last column on the Receipt of Medication form, marked "Signature", **you and the parent/guardian must each sign your names in that box.**

HEALTH SERVICES:
MEDICATIONS & PROCEDURES

- Check the "Special Health Services—Daily" List against the individual orders in the Daily Medication Binder.
- Check the Medicine Cabinet to locate each child's medication.
- Check the label of the medication for accuracy. Check expiration date.
- If you see a four- or five-day supply, contact the parent/guardian that they need to order more medication and to bring it to school.

GLUCOSE MONITORING REQUIRES SAFETY LANCETS

- On the Daily Special Health Services or PRN Health Services list, review the children who need glucose monitoring.
- The OSH requires the use of safety retractable lancets when you monitor children's glucose in schools. (see OSH Diabetes Protocol for Safety Sharps: Safety Retractable Lancets and Insulin Pen Safety Needles Updated May 2010).
- If a parent has not provided prescription labeled safety lancets for a child requiring glucose monitoring on your Daily or PRN Health Services lists, use the OSH supplied Safety Retractable Lancets maintained in the medicine cabinet.

GLUCOSE MONITORING REQUIRES SAFETY LANCETS

- The stock box of Office of School Health provided safety lancets is for glucose monitoring **only** for those students without a prescribed supply.
- The Safety Retractable Lancets can be ordered from McKesson.
- Follow the illustrated directions on the safety lancet box.
- A Dear Provider and Dear Parent letter are available for distribution.
- If you need guidance, contact your SN or BND to assist you in the proper technique for using retractable safety lancets.

GLUCOSE MONITORING REQUIRES SAFETY LANCETS

- You must perform glucose monitoring for all students on the Daily or PRN lists who are too young to self-administer this procedure.
- You should observe every student noted on these lists as self-administering glucose monitoring. In some instances, the student may self-test in areas other than the medical room. Maintain infection control practices.
- If a student who is noted as self-administering has signs and/or symptoms of hypo- or hyper-glycemia, you must perform the glucose monitoring procedure on him/her **with safety lancets.**

Insulin Pen Safety Needles

- OSH requires the use of insulin pen safety needles for the purpose of administering insulin with an insulin pen to students in schools
- When D-MAF prescribes insulin by pen in school the “Dear Provider” letter will be forwarded to provider to request insulin pen safety needles

Insulin Pen Safety Needles

- Nurses should order the Novofine Autocover 30g Insulin Pen Safety Needle through Office of School Health until insulin pen safety needles are provided by parent if an insulin pen is prescribed and provided for use. The Novofine Autocover 30g Insulin Pen Safety Needle can be ordered from McKesson.
- OSH staff will use insulin pen safety needles for those children who because of age or other factors are unable to self administer
- Parent should make every effort to provide insulin pen safety needles where applicable

Insulin Pen Safety Needles

- Children unable to provide insulin pen safety needles will be allowed to use their own insulin pen needle provided by parents as long as the child can demonstrate to the OSH staff person in the school that they are able to do so in a safe and responsible manner

Insulin Pen Safety Needles

- In the event that a student who was previously able to self-administer becomes unable to do so, the OSH staff person will attach the Novefine Autocover safety needle to the student's insulin pen to administer the prescribed insulin
- Nurses should document requests for safety needles
- Nurses must note when insulin pen safety needles are received for students with Diabetes

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Commissioner

NEW YORK CITY DEPARTMENT OF EDUCATION
Catherine Black
Chancellor

OFFICE OF
SCHOOL HEALTH

January 2011

Dear Provider:

The Office of School Health (OSH) is pleased to accommodate your request for diabetes management for your patient as received on the Diabetes Medication Administration Form.

We would like to remind you that because of safety concerns and in order to comply with OSHA and PESH regulations, students are encouraged to use safety sharps devices for prescribed insulin administration during school. These are most appropriate for a school setting because they are self-contained and allow for safer disposal.

We urge you to make every effort to order safety retractable lancets (SRLs) and safety shields for insulin pens.

OSH has supplied SRLs for blood glucose monitoring in medical rooms in the past and plans to continue this service. Additionally, we will make provisions to supply the Novofine Autocover insulin pen safety needles to OSH serviced medical rooms in cases where the insulin pen is prescribed for school use. This action is necessary because of the unacceptable risk of needle sticks to others with a conventional insulin pen. With proper usage, the Novofine Autocover reduces the risk of a needlestick.

Students who are able to self-inject insulin via the insulin pen and detach needle will be encouraged to do so with their own devices. However, if the school nurse has concerns about a student's ability to responsibly carry out this action, she or he will assist using the Novofine Autocover to administer the insulin as ordered.

Thank you for allowing us to participate in the medical management of your patient during school hours. If you have any questions, please feel free to contact the Office of School Health at 212-676-2500 or 212-442-2400.

Sincerely,

Cheryl Lawrence, MD
Medical Director
Office of School Health

HEALTH SERVICES: ADMINISTERING/OBSERVING

- When you are administering or observing a self-directed student, **ENSURE THE SIX RIGHTS:**
- **Right Person**
- **Right Medication**
- **Right Dosage**
- **Right Time**
- **Right Route**
- **Right Documentation**

HEALTH SERVICES: ADMINISTERING/OBSERVING

The identity of the student must be confirmed prior to administering medication/treatments:

- Parent is requested to provide a recent photograph of the student to be placed on the medication administration record
- Nurse will ask student to state his or her full name

HEALTH SERVICES: ADMINISTERING/OBSERVING

continued

With the Six Rights, make sure you know:

- The **intended effects** of the medication or procedure.
- The possible **side effects** of the medication.
- Any specific **precautions** involved with the medication or procedure.
- **Interactions** with other medications.

HEALTH SERVICES: ADMINISTERING/OBSERVING

continued

- In each medical room, you will find a Nursing Drug Handbook and Nursing Procedures book that serves as a resource.
- If you have any questions about daily or PRN medication and procedures, contact your Supervising Nurse, PHN II or the Borough Nursing Director (BND).
- **PLEASE REMEMBER THAT THE OFFICE OF SCHOOL HEALTH SN, BND, MD and PHN II ARE YOUR <u>ONLY</u> SOURCE FOR PROFESSIONAL GUIDANCE.**

Managing Asthma in Schools (MAS)

- MAS is a comprehensive approach to assist students with asthma obtain an appropriate management plan
- Each medical room should have a MAS binder including protocols, tools and resources
- MAS Quick Reference Guide outlines the components of MAS

Goals of MAS

- Optimize learning opportunities for children with asthma by minimizing absences
- Maximize participation in school activities
- Reduce unscheduled visits to the medical room

MAS Protocol for Students with Poorly Controlled Asthma In School Administration of ICS

Why administer ICS in school?

Adherence to daily medications to control asthma can be a major challenge to families. In school administration of ICS can be a temporary solution for a child whose asthma is not well controlled. After experiencing several months of improved control, families may be better able and more motivated to take on this responsibility at home.

MAS Protocol for Students with Poorly Controlled Asthma In School Administration of ICS

- **How to determine if student is eligible for ICS school administration:**
  - If student is receiving ICS at home, monitor for improvement for 3 - 4 weeks.
  - If no improvement after recommended home administration, recommend school administration of ICS to parent and PCP.
- Follow OSH procedures: MAF must be received from PCP and signed by parent prior to in-school administration.

MAS Protocol for Students with Poorly Controlled Asthma In School Administration of ICS

- If student's asthma is still poorly controlled, continue to consult with OSH MD.
- ICS Administration in school is meant to be a temporary intervention

CFC vs. HFA Inhalers

- The medication is the same in CFC and HFA inhalers, the **propellant** is different
- CFC = Chlorofluorocarbons

  -feels cold

  -medication delivered in a sharp burst
- HFA = Hydrofluoralkanes

  -feels warm

  -medication delivered in a slow mist

HFA Rescue Inhalers

- There are 4 brands of HFA Rescue MDIs: Ventolin, ProAir, Proventil, and Xopenex
- There is no generic available at present
- There are new priming, cleaning and drying requirements for HFA MDIs
- The counter starts at 204
- The float test is not permissible
- The amount of sprays (including priming sprays) used must be counted for all MDIs except Ventolin, which has a dose counter

Transition from CFC to HFA Inhalers

- After December 31, 2008 CFC Albuterol inhaler production is not permitted in the United States
- All manufacturers have stopped making Albuterol CFC MDIs and increased production of HFA MDIs
- Although the FDA has stopped the production of CFC MDIs, they can still be supplied by students
- Currently, you may have a Stock Albuterol CFC Inhaler, which can be used until it expires
- Beginning September 9, 2009 schools were provided with a stock Ventolin HFA MDI.

Spacers

- The OSH recommends the use of a spacer with all MDIs

1. Optichamber: previously supplied by OSH, may be used

   -Clear

   -Wash with soap before use then wash as needed, completely dissemble when washing

2. Aerochamber Z STAT Plus: currently supplied by OSH

   -Opaque

   -Wash weekly if used– remove back end only

   -Rinse both parts in warm water with liquid soap

   -Rinse in clean water

   -Let air dry

NEW HFA INHALER INSTRUCTIONS

1. All 3 steps must be completed for the new HFA inhaler to function properly.
2. Inhaler may cease to deliver medication if not properly cleaned.
3. Never submerge the canister in water. The "float test" must not be used with the HFA inhaler. Water can cause the new HFA canister to malfunction.

	Step 1: Priming Instructions		Step 2: Washing 1x a week	Step 3: Drying
	Upon Opening Package....	*If not in use after.....*	(ONLY mouthpiece not canister) (Do Not use soap)	
Ventolin	Test 4 sprays in the air	2 weeks – 4 test sprays in the air *if dropped must be reprimed	Flush warm running water from the top through the mouthpiece for 30 seconds Plus** Invert mouthpiece then repeat	Shake off excess water. Dry overnight then reassemble inhaler If buildup still visible then repeat step 2 & step 3.
Proventil	Test 4 sprays in the air	2 weeks – 4 test sprays in the air	Flush warm running water from the top through the mouthpiece for 30 seconds	Shake off excess water. Dry overnight then reassemble inhaler
Xopenex	Test 4 sprays in the air	3 days – 4 test sprays in the air	Same	Same
ProAir	Test 3 sprays in the air	2 weeks – 3 test sprays in the air	Same	Same

Spacer Maintenance

Aerochamber	**Wash spacer weekly if used**	**Remove back end only. Do not Tamper with valve.**	**Rinse both parts in warm water with liquid soap**	**Rinse in clean water**	**Let air dry. Do not rub with any material**	**Replace back end**
Optichamber	**Completely dissemble**	**Wash with soap and warm water before use**	**Wash as needed**	**Let air dry. Do not rub with any material**	**Reassemble**	

Differences/Similarities of CFC & HFA

	CFC	HFA
Differences	1. Feels cold 2. Medication delivered in sharp burst	1. Feels warm 2. Medication delivered in a soft mist
Similarities	1. Similar Size 2. Same medication dose	

8/14/09

HEALTH SERVICES: STOCK VENTOLIN POLICY AND PROTOCOL

- Purpose: Reduce the number of students with asthma who must be sent home with asthma flares due to lack of access to rescue medications during the school day.

HEALTH SERVICES: STOCK VENTOLIN POLICY AND PROTOCOL

- Nurses will review that parents have initialed the back of the MAF next to the " I hereby certify that I have consulted with my health care provider and that I authorize the Office of School Health to administer stock Ventolin HFA in the event that my child's prescription medication is unavailable" portion of the "Consent Authorization and Release" section.

HEALTH SERVICES: STOCK VENTOLIN POLICY AND PROTOCOL

- School nurses and doctors may administer the stock Albuterol or Ventolin metered dose inhaler with spacer, while the public health advisor may provide the stock Albuterol or Ventolin and spacer to the self directed student, in the event a student with an MAF has run out of their prescription and has an asthma flare in school prior to their parent or guardian supplying their medication.

HEALTH SERVICES: STOCK VENTOLIN POLICY AND PROTOCOL

- One stock Ventolin HFA metered dose inhaler and spacer will be supplied to each elementary, intermediate, and high school with a school nurse or advisor. Given the valve design of MDI's, "common canister use" has been demonstrated to be safe. One stock Albuterol canister may be used to administer treatments to multiple students. Additionally, each student with an MAF order will be provided with their own spacer.

HEALTH SERVICES:
STOCK VENTOLIN POLICY AND PROTOCOL

Ventolin Inhaler Maintenance Instructions:

a. **DO NOT OPEN VENTOLIN PACKAGE UNTIL READY TO USE. The Ventolin HFA expires twelve months after package is opened. There is also an expiration date on the canister. Document both the date opened and the expiration date on canister on Stock Ventolin HFA Maintenace Form. Whichever date comes first is the date to dispose of the medication.**

b. **Never submerge medication canister in water**

HEALTH SERVICES:
STOCK VENTOLIN POLICY AND PROTOCOL

Reordering Instructions:

- You must submit your request for a replacement Ventolin MDI when the dose counter states 50 doses are remaining. For Ventolin MDIs that are about to expire, you must reorder at least one month proir to the expiration date.
- Reorder form for Ventolin HFA, Spacer and Epipen will be submitted to Regional Office
- Nursing Supervisor needs to be informed when you receive the replacement Ventolin in your school

HEALTH SERVICES:
EPI-PEN STANDING ORDER

- OSH supplies Epipen stocks to:
- Every elementary medical room with 1 of each Epi-pen adult and 1 Epi-pen junior for children under 66 lbs. (as appropriate for the school population).
- JHS receives 1 Epipen adult only.
- Epipen is stored in the Red Fanny Bag, which the nurse wears while on duty.
- You have a standing order to administer the Epi-pen/Epi-pen Jr. in the event of anaphylaxis. Standing order is filed in Daily Medication Binder.

HEALTH SERVICES: ADMINISTER EPI-PEN FOR ANAPHYLAXIS

- Anaphylaxis is a potentially life-threatening medical condition occurring in allergic individuals after exposure to specific allergens such as medications, foods or insect bites or stings.
- Anaphylaxis is a collection of symptoms affecting multiple systems in the body.
- Onset of symptoms can vary from minutes to hours. The majority of reactions occur within one hour and can progress rapidly.

HEALTH SERVICES:
ADMINISTER EPI-PEN FOR ANAPHYLAXIS

Symptoms of anaphylaxis include:

Hives, itching, difficulty swallowing, coughing, difficulty breathing, nausea, abdominal pain, change in mental status, drop in blood pressure or shock.

HEALTH SERVICES: ADMINISTER EPI-PEN FOR ANAPHYLAXIS

- **The Epi-pen is an auto-injector single-use dose of Epinephrine, the treatment of choice for anaphylaxis.**
- **In 2010 Dey Pharmaceuticals replaced the original Epipen device with a device containing a needle safety shield**
- **In September 2010, Greenstone launched a generic auto-injector Epipen without a needle safety shield. Students may provide the device manufactured by Greenhouse**

HEALTH SERVICES: ADMINISTER EPI-PEN FOR ANAPHYLAXIS

- **The effects of the Epi-pen injection wear off after 10-20 minutes.**
- **Immediately after administering the Epi-pen or Epi-pen junior, call 911.**
- **Notify principal and have parents contacted.**

Health Services:
Administer Epi-pen For Anaphylaxis
contd.

- Carefully place the used auto injector into the storage tube and give the used unit to the EMS (Emergency Medical Services) personnel upon their arrival.
- Under no circumstances should you leave the school to accompany anyone in the ambulance.

HEALTH SERVICES: ADMINISTER EPI-PEN FOR ANAPHYLAXIS

- Contact your Supervising Nurse/ Borough Nursing Director (BND) to notify them informing them of the incident and that you have used an Epi-pen
- Submit the Re-order Form for Ventolin HFA/ Spacer and Epi-pen to Regional Office for a replacement
- Document the Epi-pen/Epi-pen jr. administration in ASHR or the daily log and on the child's 103S, noting your name as the person administering the Epi-pen/Epi-pen jr. as well as the manufacturer and lot number of the epinephrine
- You will receive instruction from your SN/BND regarding the completion and submission of a 911 Documentation Form

NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Thomas A. Farley, MD, MPH
Commissioner

NEW YORK CITY DEPARTMENT OF
EDUCATION
Cathleen P. Black
Chancellor

OFFICE OF
SCHOOL HEALTH

Dear Provider:

We recently received an order from you for Twinject. Office of School Health staff does not administer this medication because it requires manipulation of an exposed sharp for the second dose of epinephrine.

We ask you to prescribe an epinephrine pen that is not a sharps hazard for students and staff. Until we receive a new order from you, we will administer the first dose with Twinject. If a second dose of epinephrine is needed, the same dose will be given using EpiPen.

Thank you for your assistance with this matter.

Cheryl Lawrence, M.D.
Medical Director
Office of School Health.

1/26/11

HEALTH SERVICES: STORAGE of EPI-PEN

- The parent/guardian is responsible for providing an Epi-pen for the student and for replacing the Epi-pen when it has expired or becomes discolored
- Parents should be encouraged to provide two Epi-pens
- Appropriate measures should be taken to ensure that the Epi-pen is available at all times including when a student is away from the school building

HEALTH SERVICES: STORAGE of EPI-PEN

- The Epi-pen should remain accessible to trained staff even if the nurse is not present
- Epipen should remain with teacher trained to administer and transferred to other trained personnel when student changes classes
- Allergy Response Plan is developed for individual student
- Principal should ensure a report of who has been trained to administer the Epi-pen and the location of the Epi-pen is included in the online safety plan
- If a locked drawer is not available in the student's classroom, a locked box should be provided

Health Services:
Chancellor's Regulation A.715

- Chancellor's Regulation A.715 require that at least two non-nursing school staff personnel be trained to administer an Epipen when a nurse is not available, in any school where there is a student who has an MAF on file for the administration of an Epipen.

Health Services;
Chancellor's Regulations A.715

Nurses Role:

- Identify students with an order for Epipen/Epipen Jr.
- Collaborate with principal and parents to develop a School Allergy Response Plan.
- Consult with principal to identify staff to be trained to administer Epipen.
- Consult with SN/BND to schedule Epipen training.
- Use the guidelines and power point presentation provided by the Office of School Health to train unlicensed DOE personnel

School Allergy Response Plan

- Student's Name:_____
- DOB:_____
- Teacher/Class:_____ School_____ photo here
- ALLERGY TO:_____
- ++++++++++
- **High risk** for severe reaction (eg. hx asthma) ___yes ___no
- _____
- *****GENERAL SIGNS OF SEVERE ALLERGIC REACTION*****
- Systems: Symptoms:
- Mouth: itching and swelling of lips, tongue or mouth
- Throat*: itching and/or a sense of tightness in throat, hoarseness, and hacking cough
- Skin: hives, itchy rash, and/or swelling of face or extremities
- Gut: nausea, abdominal cramps, vomiting and/or diarrhea
- Lung*: shortness of breath, repetitive coughing and/or wheezing
- Heart*: "thready pulse", "passing out"
- Note: the severity of symptoms can change quickly.
- *These symptoms can potentially progress to a life-threatening situation.

School Allergy Response Plan

- **If exposure to allergen is suspected and/or symptoms are:**
- **_____**
- **1. Give _____IMMEDIATELY!**
- **(medication/dose/route)**
- **2. Then call 911/EMS (ask for advanced life support) following school procedures for 911**.
- **3. Call parent/Guardian _____or emergency contacts.**
-
- **4. Call Dr. _____at _____.**
- **DO NOT HESITATE TO CALL 911!**
- Trained School Staff:
- 1._____ Title _____Room_____
- 2._____ Title _____Room_____
- 3._____ Title _____Room_____
- Emergency Contacts (other than parent/guardian):
- 1. _____ Phone:_____ Relationship:_____
- 2. _____ Phone:_____ Relationship:_____
- Nurse signature_____ Date_____
- Parent/guardian signature _____Date_____

School Allergy Response Plan

- (*Adapted from the Food Allergy and Anaphylaxis Network)*
- Specific training on the Allergy Response Plan (including administration of epi-pen in an emergency if nurse is unavailable) to be given by school nurse to these school staff:
- _____
  _____
- _____
  _____
- _____
  _____

Glucagon Administration and Public Health Advisors

- Public Health Advisors are trained to administer Glucagon for a student with a Glucagon order in an emergency if the nurse is not present
- Public Health Advisors will complete the Knowledge and Return Demonstration form for Glucagon Administration during annual Staff Development

Glucagon Administration and Public Health Advisors

- If there is a student with a Glucagon order in the Public Health Advisor's assigned school, the nurse/PHN II will complete the Emergency Severe Low Blood Sugar Care Plan and review with Public Health Advisor
- The school nurse/ PHN II will provide education/reinforcement for Public Health Advisor as needed

EMERGENCY SEVERE LOW BLOOD SUGAR CARE PLAN

FOR NON-MEDICAL SCHOOL STAFF TRAINED TO GIVE GLUCAGON

School Year: _____

Student Photo

If student is UNCONSCIOUS, UNRESPONSIVE, SEIZING, OR UNABLE TO SWALLOW, Assume student has SEVERE LOW BLOW SUGAR.

FOLLOW THESE STEPS:

1. Tell someone to **Call 911**-alert operator that a student with diabetes is **UNCONSCIOUS, UNRESPONSIVE, SEIZING, OR UNABLE TO SWALLOW.**
2. Contact School Nurse **IMMEDIATELY.**
3. If school nurse is **NOT AVAILABLE**, Give glucagon **IMMEDIATELY.**
4. Remove needle and apply slight pressure to injection site.
5. Place used syringe and needle in the plastic Glucagon Emergency Kit case.
6. Ask someone to notify Parent/Guardian/ or EMERGENCY Contact.
7. Turn student on left side in case he/she vomits.
8. Stay with student until EMS arrives. Principal must assign a staff member other than the nurse to go to the emergency room with the student if the parent/guardian is not present.

Student _____ Grade _____ DOB _____

Parent/Guardian 1 _____ Relationship _____

Home # _____ Work # _____ Cell # _____

Parent/Guardian 2 _____ Relationship _____

Home # _____ Work # _____ Cell # _____

Emergency Contact _____ Relationship _____

Home # _____ Work # _____ Cell # _____

Doctor _____ Work # _____

Preferred Hospital in an Emergency _____

Glucagon Dose _____ (usually .5 mg for under 40 lbs and 1 mg for over 40 lbs)

Name of Student _____

Symptoms of Your Child's Low Blood Sugar

Please circle the symptoms your child experiences when his/her blood sugar is low.

Others: _____

_____

_____

_____

1. _____ **Date** _____

2. _____ **Date** _____

3. _____ **Date** _____

4. _____ **Date** _____

5. _____ **Date** _____

* **Please note:** If Principal requests Glucagon training for non-licensed DOE staff, each case must be reviewed and approved by Office of School Central Office Nursing Staff.

☐ **Copy given to Parent/Guardian** ☐ **Copy sent to Doctor**

Prevention and Treatment of Severe Hypoglycemia
Training for Public Health Advisors
2010 Annual Staff Development

Knowledge and Demonstration of Glucagon Administration

Name of Public Health Advisor _____Date_____

KNOWLEDGE SETS	YES/NO	COMMENTS
Understands the legal rights of the students and non-medical staff		
Recognizes symptoms of mild and moderate hypoglycemia (low blood sugar)		
Identifies treatment for mild and moderate hypoglycemia		
Knows where the treatment supplies are stored		
States purpose of Glucagon and when it is to be used -if student is **UNCONSCIOUS, UNRESPONSIVE, SEIZING, OR UNABLE TO SWALLOW**		
Verbalizes where to give Glucagon- upper arm or thigh		
Understands must give student specific Glucagon		
Describes the side effects of Glucagon		
SKILL SETS – ADMINISTERING GLUCAGON		
Knows to tell someone to call 911 IMMEDIATELY for severe low blood sugar		
Removes cap off vial		
Removes cover off needle		
Injects liquid into vial		
Gently shakes vial to dissolve Glucagon		
Withdraws Glucagon solution back into syringe and **removes** needle from vial		
Demonstrates proper injection technique (clean site, inject at 90^{o}, apply pressure)		
Place used needle and syringe in the plastic Glucagon Emergency Kit case – does not recap		
Knows to position student on left side in case he/she vomits		
Remains with student until EMS arrives		

Trainer name_____ Trainer Signature_____
PH Advisor_____ Public Health Advisor signature_____

Prevention and Treatment of Severe Hypoglycemia
2010-2011 Knowledge and Skills Review for Glucagon Administration

Directions: Supervisor/PHN II/School Nurse will review knowledge and skills for Glucagon Administration with Public Health Advisor when Emergency Severe Low Blood Sugar Care Plan is completed and as needed during school year.

Name of Public Health Advisor _____Date_____

KNOWLEDGE SETS	Date	Knowledge and Skills Review	Date	Knowledge and Skills Review	Date	Knowledge and Skills Review
Understands the legal rights of the students and non-medical staff						
Recognizes symptoms of mild and moderate hypoglycemia (low blood sugar)						
Identifies treatment for mild and moderate hypoglycemia						
Knows where the treatment supplies are stored						
States purpose of Glucagon and when it is to be used -if student is **UNCONSCIOUS, UNRESPONSIVE, SEIZING, OR UNABLE TO SWALLOW**						
Verbalizes where to give Glucagon- upper arm or thigh						
Understands must give student specific Glucagon						
Describes the side effects of Glucagon						
SKILL SETS – ADMINISTERING GLUCAGON						
Knows to tell someone to call 911 IMMEDIATELY for severe low blood sugar						
Removes cap off vial						
Removes cover off needle						
Injects liquid into vial						
Gently shakes vial to dissolve Glucagon						
Withdraws Glucagon solution back into syringe and **removes** needle from vial						
Demonstrates proper injection technique (clean site, inject at 90^{o}, apply pressure)						
Place used needle and syringe in the plastic Glucagon Emergency Kit case – does not recap						
Knows to position student on left side in case he/she vomits						
Remains with student until EMS arrives						

Trainer name_____ Trainer Signature_____
PH Advisor_____ Public Health Advisor signature_____

HEALTH SERVICES: SCHOOL EVACUATIONS

- For instances where a principal announces a school evacuation, contact your Supervising Nurse (SN)/ Borough Nursing Director (BND) to notify them of the incident and provide an update on the school's course of action .
- Before leaving the school, make sure to bring with you the red fanny bag, emergency bag, medications of students with 504/IEP services and daily medication binder containing the medication orders.
- Work with the principal by making her aware of your whereabouts so that you can be easily reached by students with medication orders and those needing medical assistance.

Process for Reportable Incidents

- A Reportable occurrence is an unusual or unexpected event that is not consistent with the routine operation of the medical room or the routine care of the patient/student.
- Categories of Reportable Incidents:

  -Occurrences resulting in injury or accidents

  -Occurrences resulting in medication errors/adverse reactions

  -Occurrences involving security issues

Process for Reportable Incidents (cont.)

-Occurrences resulting from percutaneous exposure to bloodborne pathogens/needle sticks

-Occurrences involving accidents/illnesses/incidents arising from environmental/physical factors/facilities.

Process for Reportable Incidents (cont.)

- Blank Reportable Incident Forms will be maintained in the Medical Room. Forms (RM1) are included in the Forms Kit.
- Each school will be provided with three (3) stamped, preaddressed envelopes to the Regional Office. Request Regional Office to replace the envelopes when needed.
- On the date of the reportable incident, the nurse will complete and sign the Reportable Incident Form, notify the supervisor of the incident and mail the form ASAP to the Regional Office in the envelopes provided to the attention of the SN/BND.
- The form must receive timely review and processing.

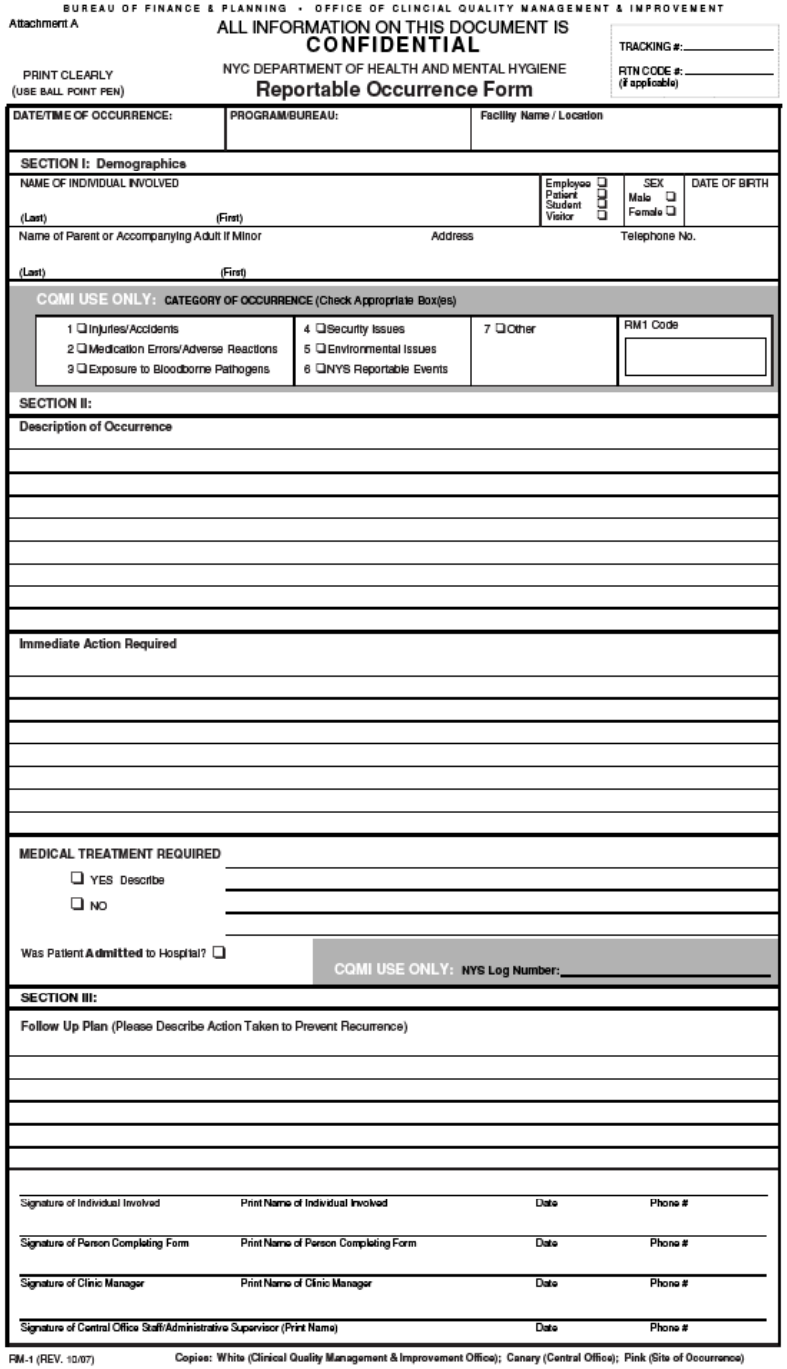
Process for Reportable Incidents (cont.)

- On the following Tuesday, the Regional Office staff will hand the SN/BND the Reportable Incident Form with the time sheets. The SN/BND will review the form and indicate any additional action needed. The SN/BND will sign the Reportable Incident Form and return it to the Regional Office staff with the time cards.
- On the following day (Wednesday) the Reportable Incident Form will be delivered to CO with the time cards by the Regional MVO.

Process for Reportable Incidents (cont.)

- The final reviewer at Central Office will forward the report to OCQMI for review and further determinations. The report should be received in OCQMI within fourteen (14) days of the reportable incident.

Reportable Occurrence Form



BUREAU OF FINANCE & PLANNING • OFFICE OF CLINCIAL QUALITY MANAGEMENT & IMPROVEMENT

Attachment A

ALL INFORMATION ON THIS DOCUMENT IS **CONFIDENTIAL**

TRACKING #: _____

RTN CODE #: _____ (if applicable)

PRINT CLEARLY (USE BALL POINT PEN)

NYC DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Reportable Occurrence Form

DATE/TIME OF OCCURRENCE:	PROGRAM/BUREAU:	Facility Name / Location

SECTION I: Demographics

NAME OF INDIVIDUAL INVOLVED (Last) (First)	Employee ❑ Patient ❑ Student ❑ Visitor ❑	SEX Male ❑ Female ❑	DATE OF BIRTH

Name of Parent or Accompanying Adult if Minor (Last) (First) — Address — Telephone No.

CQMI USE ONLY: CATEGORY OF OCCURRENCE (Check Appropriate Box(es))

1 ❑ Injuries/Accidents	4 ❑ Security Issues	7 ❑ Other	RM1 Code
2 ❑ Medication Errors/Adverse Reactions	5 ❑ Environmental Issues		
3 ❑ Exposure to Bloodborne Pathogens	6 ❑ NYS Reportable Events		

SECTION II:

Description of Occurrence

Immediate Action Required

MEDICAL TREATMENT REQUIRED

❑ YES Describe

❑ NO

Was Patient **Admitted** to Hospital? ❑

CQMI USE ONLY: NYS Log Number: _____

SECTION III:

Follow Up Plan (Please Describe Action Taken to Prevent Recurrence)

Signature of Individual Involved	Print Name of Individual Involved	Date	Phone #
Signature of Person Completing Form	Print Name of Person Completing Form	Date	Phone #
Signature of Clinic Manager	Print Name of Clinic Manager	Date	Phone #
Signature of Central Office Staff/Administrative Supervisor (Print Name)		Date	Phone #

RM-1 (REV. 10/07) Copies: White (Clinical Quality Management & Improvement Office); Canary (Central Office); Pink (Site of Occurrence)

911 Documentation Form

911 Documentation

Date /Time of Event:	School:	District:
Name of Reporter	Title:	

Student Name:	Sex: Male ☐ Female ☐	Date of Birth:	OSIS #:

Event (Check Appropriate Box)

1 ☐ Injuries/Accidents ☐ Fractures ☐ Amputations 2 ☐ Head Injury	3 ☐ Asthma ☐Pending MAF ☐New Case 4 ☐ Diabetes	5 ☐ Epi- Pen Usage: ☐ Stock ☐ Students	6 ☐ Seizure 7 ☐ Psych/Behavioral	8 ☐ Other

Description of Event/ Signs and Symptoms:

Immediate Action Required:

Number of times student has been seen in medical room for similar/ related signs and symptoms in past month_____

What were actions taken _____

Number of times 911 previously called for student exhibiting similar signs and symptoms _____

Was a new case management opened? ☐ Yes ☐ No Case management already opened? ☐ Yes ☐ No

Personal Protective Equipment Used: ☐ Gloves ☐ Gown ☐ Face Mask/ Face shield

Admitted to Hospital: ☐ Yes ☐ No

Hospital Name:

Follow Up:_____

Referrals: ☐ Guidance Counselor ☐ Social Worker ☐ Principal ☐ Dr's Session

Form Completed by: Date:

Signature of Supervising Nurse /BND Reviewer: Date:

Date faxed to Central Office:

Staff will submit completed form to Supervising Nurse within a week

Supervising Nurse will Fax to Office of School Health, Attention: Ada Santiago @ 212-442-1815

Revised July 2010

MEDICATION ERRORS

- A medication error includes any failure to administer a medication as prescribed for a particular student
- This includes failure to administer the prescribed medication to the correct student, at the correct time, in the correct dose or through the correct route

MEDICATION ERRORS

- Call your SN/BND *immediately* if there is an error in administering medication to a child.
- Notify parent and secure student's safety
- Notify licensed prescriber
- Your SN/BND will instruct you to document the error on the Reportable Incident Form (RM-1).

REPORTING
CHILD ABUSE/NEGLECT

- NYS Law (Social Services Law 413) requires that any health care professional who suspects that a child under eighteen (18) years of age is being endangered or maltreated by parent or other person legally responsible for care must report the suspicion to the NYS Central Registry.
- OSH Nurses are mandated reporters

REPORTING
CHILD ABUSE/NEGLECT

- You are not required to possess certainty before a report is made, only a reasonable suspicion.
- Immediately discuss with your nursing supervisor or PHN II
- After consultation with supervisor, discuss particulars of suspected abuse/neglect case with principal or designee

REPORTING
CHILD ABUSE/NEGLECT

- The Social Service Law requires only one report from an institution
- As a mandated reporter, if the principal does not agree with you, he/she may not prevent you from making a report
- File an oral report with the State Central Registry (SCR) at 1-800-635-1522

REPORTING
CHILD ABUSE/NEGLECT

- If student is in need of immediate medical care, call 911 and notify Administration for Children's Services (ACS) of the action
- If a child verbalizes he/she does not feel safe to go home, the police should be called
- Notify your nursing supervisor of report
- Supervisor will notify Supervising Medical Doctor (SMD) or Medical Director

REPORTING
CHILD ABUSE/NEGLECT

Administration for Children's Services requires a written report to be submitted within 48 hours of the oral report (Form 2221-A)

- The school nurse will complete 2221-A by the close of the workday
- The NS/BND must review the report and forward to Central Office within 48 hours of the event
- The 2221-A report will be reviewed by Central Office and forwarded to the local ACS office

REPORTING
CHILD ABUSE/NEGLECT

Follow up:

- Reporter should obtain the case number and consult with the case worker about recommendations for the student and family. You can call the Application Unit at the borough office for the case workers name
- The objective it to obtain assistance for the child and family
- The reporter should remain in communication with ACS until the case is resolved

REPORTING
CHILD ABUSE/NEGLECT

Documentation:

- Information is confidential and should be confined to an objective description of the physical findings
- Using the initials SCAN (suspected child abuse and neglect) indicates that a phone call was made to the central registry and form 2221A was submitted
- Document the case number

2221-A

LDSS-2221A (Rev. 9/2007) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
REPORT OF SUSPECTED CHILD ABUSE OR MALTREATMENT

Report Date	Case ID	Call ID
Time : ☐ AM ☐ PM	Local Case #	Local Dist/Agency

SUBJECTS OF REPORT

List all children in household, adults responsible and alleged subjects. Line #	Last Name	First Name	Aliases	Sex (M, F, Unk)	Birthday or Age Mo/Day/ Yr	Race Code	Ethnicity (Ck Only If Hispanic/Latino)	Relation Code	Role Code	Lang. Code
1.							☐			
2.							☐			
3.							☐			
4.							☐			
5.							☐			
6.							☐			
7.							☐			

☐ MORE

List Addresses and Telephone Numbers (Using Line Numbers From Above)	(Area Code) Telephone No.

BASIS OF SUSPICIONS

Alleged suspicions of abuse or maltreatment. Give child(ren)'s line number(s). If all children, write "ALL".

___ DOA/Fatality	___ Child's Drug/Alcohol Use	___ Swelling/Dislocation/Sprains
___ Fractures	___ Poisoning/Noxious Substances	___ Educational Neglect
___ Internal Injuries (e.g., Subdural Hematoma)	___ Choking/Twisting/Shaking	___ Emotional Neglect
___ Lacerations/Bruises/Welts	___ Lack of Medical Care	___ Inadequate Food/Clothing/Shelter
___ Burns/Scalding	___ Malnutrition/Failure to Thrive	___ Lack of Supervision
___ Excessive Corporal Punishment	___ Sexual Abuse	___ Abandonment
___ Inappropriate Isolation/Restraint (Institutional Abuse Only)	___ Inadequate Guardianship	___ Parent's Drug/Alcohol Misuse
___ Inappropriate Custodial Conduct (Institutional Abuse Only)	___ Other (specify) ___	

State reasons for suspicion, including the nature and extent of each child's injuries, abuse or maltreatment, past and present, and any evidence or suspicions of "Parental" behavior contributing to the problem.

(If known, give time/date of alleged incident)
MO
DAY
YR
Time : ☐ AM ☐ PM

☐ Additional sheet attached with more explanation.

The Mandated Reporter Requests Finding of Investigation ☐ YES ☐ NO

SOURCE(S) OF REPORT

CONFIDENTIAL		*CONFIDENTIAL*	
NAME	(Area Code) TELEPHONE	NAME	(Area Code) TELEPHONE
ADDRESS		ADDRESS	
AGENCY/INSTITUTION		AGENCY/INSTITUTION	

RELATIONSHIP

___ Med. Exam/Coroner ___ Physician ___ Hosp. Staff ___ Law Enforcement ___ Neighbor ___ Relative ___ Instit. Staff
___ Social Services ___ Public Health ___ Mental Health ___ School Staff ___ Other (Specify)

For Use By Physicians Only	Medical Diagnosis on Child	Signature of Physician who examined/treated child X	(Area Code) Telephone No.
	Hospitalization Required: ☐ None	☐ Under 1 week ☐ 1-2 weeks	☐ Over 2 weeks

Actions Taken Or About To Be Taken				
	☐ Medical Exam	☐ X-Ray	☐ Removal/Keeping	☐ Not. Med Exam/Coroner
	☐ Photographs	☐ Hospitalization	☐ Returning Home	☐ Notified DA

Signature of Person Making This Report: X	Title	Date Submitted Mo. Day Yr.

REPORTING COMMUNICABLE DISEASES

- All communicable diseases and conditions that are a threat to public health **must be reported to your Supervising Nurse (SN) or the Borough Nursing Director IMMEDIATELY.**
- Your SN/BND is responsible for notifying the Supervising Medical Doctor (SMD) and the School Health Central Office.

REPORTING COMMUNICABLE DISEASES

Common reportable events are:

- Hepatitis
- Meningitis
- Vaccine Preventable Diseases
- Suspected Tuberculosis
- Food-related illness
- Blood Exposures: Incidents involving broken skin such as needle sticks or human bites.

OFFICE OF SCHOOL HEALTH
GUIDELINES FOR MANAGEMENT OF CONFIRMED COMMUNICABLE DISEASE OCCURENCES IN SCHOOLS

Disease	Mode of Transmission (1)	Exclusion Policy	OSH Rsponse	Comments
Conjunctivitis (pink-eye)	Direct contact with secretions from eyes, nose, and mouth	Exclude during the acute stage if discharge and swelling present. While not all patients will need antibiotics, those who do may return to school after 24 hrs of treatment	Consider letter / DOH fact sheet for a cluster of 3 or more cases in a classroom or group setting.	Treatments differ for bacterial, viral, or allergic conjunctivitis
Hand-foot-mouth disease (Coxsackie virus)	Fecal - oral or contact with mouth, nose, or open skin lesions	Until fever is gone and child is well enough to participate in normal activities - lesions or rash may still be present	Consider letter / DOH fact sheet for a cluster of 3 or more cases in a classroom or group setting.	
Hepatitis A	Fecal - oral	Exclude for 1 week after onset of illness and jaundice disappears (Contagious period lasts from 2 weeks before until 1 week after onset of symptoms)	Coordinate contact investigation and prophylaxis information to close contacts with BCD.	14 day window for post-exposure treatment of selected groups
Hepatitis B or C	Blood and body fluid exposure	None	Immediate consultation with Health Professional if blood exposure occurs	
Herpes simplex virus (cold sores)	Direct contact with infected oral secretions or lesions	None	None	
Impetigo or other skin infections	Direct contact with discharge from lesions	If lesion can't be securely bandaged and remain dry. Until 24 hrs after treatment begins	Consider letter / DOH fact sheet for a cluster of 3 or more cases in a classroom or group setting.	
Infectious mononucleosis	Direct contact with fluids from mouth or nose	Until child feels well enough to return to normal activities	Consider letter / DOH fact sheet	The virus is shed in respiratory fluids for many months after illness; well-appearing individuals may shed virus intermittently
Lice	Direct contact	"No Lice" policy; exclude only for live lice, not nits	Letter and fact sheet to affected individual. Consider letter / DOH fact sheet to classroom as needed	
Meningitis	Depends on specific cause Bacterial: direct contact with secretions/droplets from nose and throat	Until condition improved/treated	Coordinate with DOHMH BCD. Consider parent letter and factsheet	N. meningitidis or H. influenzae type B - contact investigation and prophylaxis to close contacts as per BCD

OFFICE OF SCHOOL HEALTH
GUIDELINES FOR MANAGEMENT OF CONFIRMED COMMUNICABLE DISEASE OCCURENCES IN SCHOOLS

Disease	Mode of Transmission (1)	Exclusion Policy	OSH Rsponse	Comments
Molluscum contagiosum	Direct contact	None	Consider letter / DOH fact sheet for a cluster of 3 or more cases in a classroom or group setting.	
Parvovirus (fifth disease)	Contact with respiratory droplets	None	Letter and fact sheet to be issued for first documented case to school population and re-issued after 20 days of first case if necessary.	High risk groups: pregnant women, sickle cell disease, HIV
Ringworm	Direct contact with lesions or fomites *	Ringworm of body: none as long as lesion can be covered. Avoid activities that involve body contact until lesions are no longer present	Consider letter / DOH fact sheet	Ringworm of the scalp: Until 24 hours after treatment begins; personal items (combs, brushes, hats, etc.) should not be shared
Scabies	Direct contact or fomites	Until the day after first treatment is completed	Consider letter / DOH fact sheet	
Strep - scarlet fever	Contact with respiratory droplets	Until 24 hrs after treatment begins	Consider letter / DOH fact sheet for a cluster of 3 or more cases in a classroom or group setting.	OSH central notifies BCD of clusters
Strep throat	Contact with respiratory droplets	Until 24 hrs after treatment begins	Consider letter / DOH fact sheet for a cluster of 3 or more cases in a classroom or group setting.	OSH central notifies BCD of clusters
Tuberculosis	Airborne	Until child's physician or DOHMH states that child is noninfectious	Coordinate with DOHMH BTBC	Coordination for close contact identification and testing by BTBC
Typhoid / Paratyphoid	Fecal - oral	Until cleared by DOH	Coordinate with BCD	
Gastroenteritis	Fecal-oral	Generally 24 hrs from last episode of diarrhea. If due to Norwalk virus then 3 days from last episode of diarrhea.	Conduct group hand hygiene classes as needed	
Pinworm	Fecal -oral / clothing	None	Conduct group hand hygiene classes as needed	

OFFICE OF SCHOOL HEALTH
GUIDELINES FOR MANAGEMENT OF CONFIRMED COMMUNICABLE DISEASE OCCURENCES IN SCHOOLS

Disease	Mode of Transmission (1)	Exclusion Policy	OSH Rsponse	Comments
[1]**Modes of transmission:**				
Contact with respiratory droplets - Infected droplets of respiratory secretions are propelled into the air by an infected person (by coughing, sneezing, spitting, etc.)				
A susceptible person may become infected by inhaling or having contact with the infected droplets.				
Airborne - Very small particles filled with germs are suspended in the air for extended periods of time and can infect individuals.				
Particles of this size are usually generated by coughing, but not by sneezing and spitting.				
Direct contact - The infected area of one person must physically touch another person in order for the infection to spread.				
Many infections that spread by direct contact may be spread indirectly through fomites.				
Fecal-oral - Infections carried in the gastrointestinal tract (stomach and intestines) are shed in the feces (stool), and spread when another person ingests (eats)				
those infected feces (often through food contamination).				
[1] **Fomites:** Objects which are capable of carrying germs from one individual to another (eating utensils, cups, clothing, washcloths, etc.)				

Abbreviations

BCD	Bureau of Communicable Diseases
BOI	Bureau of Immunizations
BTBC	Bureau of Tuberculosis Control

OFFICE OF SCHOOL HEALTH
GUIDELINES FOR MANAGEMENT OF CONFIRMED VACCINE-PREVENTABLE COMMUNICABLE DISEASE OCCURRENCES IN SCHOOLS

Disease	Mode of Transmission (1)	Exclusion Policy	OSH Rsponse	Comments
Varicella (Chicken Pox)	Airborne / respiratory droplets and direct contact w/blister fluid	Until all lesions are crusted. Non-immunized individuals to be excluded from day 8 through day 21 after exposure.	Coordinate with DOHMH BOI. Issue parent letters and fact sheet for first case identified via principal. Nurse does not need to wait for doctor confirmation.	Vaccine available for pre or post-exposure prevention. Unimmunized individuals to be excluded during the period when disease may develop. Non-immune/unimmunized should consider post-exposure prophylaxis. ¶
Diphtheria	Contact with fluids from nose, mouth or skin lesions	Exclude sick person and contacts until treatment completed	Contact tracing and treatment as per BOI.	Unimmunized individuals will be excluded during incubation period
Rubella (German measles)	Contact with respiratory droplets	Until 7 days after rash onset	Coordinate with DOHMH BOI.	Unimmunized individuals will be excluded during incubation period
Measles (Rubeola)	Airborne / contact with respiratory droplets	Until 5 days after rash onset	Coordinate with DOHMH BOI.	Vaccine available for pre or post-exposure prevention. Unimmunized individuals to be excluded during the period when disease may develop. Non-immune/unimmunized should consider post-exposure prophylaxis. ¶
Mumps	Airborne / respiratory droplets	Until 5 days after onset of swollen glands or until all swelling has disappeared	Coordinate with DOHMH BOI.	Vaccine available for pre or post-exposure prevention. Unimmunized individuals to be excluded during the period when disease may develop.
Polio	Fecal - oral and respiratory		Coordinate with DOHMH BOI.	
Shingles	Direct contact (may cause chicken pox in susceptible persons - those not previously infected or vaccinated)	If lesions can not be covered to prevent contact than exclude until all lesions are crusted.	Consider letter and fact sheet if lesions are exposed.	Non-varicella immune individuals may develop chicken pox. See Varicella exclusion policy above.
Invasive Haemophilus influenzae (Hib)	Respiratory droplets and direct contacts with respiratory secretions		Coordinate with DOHMH BOI.	Nursery school and childcare contacts should receive prophylactic antibiotics if 2 cases of invasive Hib disease occur within 60 days of eachother¶

OFFICE OF SCHOOL HEALTH
GUIDELINES FOR MANAGEMENT OF CONFIRMED VACCINE-PREVENTABLE COMMUNICABLE DISEASE OCCURRENCES IN SCHOOLS

Disease	Mode of Transmission (1)	Exclusion Policy	OSH Rsponse	Comments
Pertussis (Whooping cough)	Respiratory droplets and direct contacts with respiratory secretions	21 days after start of cough or after completion of 5 days of appropriate antibiotic treatment	Coordinate with BOI	Unimmunized individuals will be excluded during incubation period. For close contacts post-exposure prophylaxis is recommended regardless of immunization status.

[1]**Modes of transmission:**

Contact with respiratory droplets - Infected droplets of respiratory secretions are propelled into the air by an infected person (by coughing, sneezing, spitting, etc.) *A susceptible person may become infected by inhaling or having contact with the infected droplets.*

Airborne - Very small particles filled with germs are suspended in the air for extended periods of time and can infect individuals. Particles of this size are usually generated by coughing, but not by sneezing and spitting.

Direct contact - The infected area of one person must physically touch another person in order for the infection to spread. Many infections that spread by direct contact may be spread indirectly through fomites.

Fecal-oral - Infections carried in the gastrointestinal tract (stomach and intestines) are shed in the feces (stool), and spread when another person ingests (eats) those infected feces (often through food contamination).

¶= Contact BOI for questions of appropriate post exposure prophylaxis

Abbreviations

BCD	Bureau of Communicable Diseases
BOI	Bureau of Immunizations
BTBC	Bureau of Tuberculosis Control

REPORTING COMMUNICABLE DISEASES

Scarlet Fever

- **Scarlet Fever confirmed by an MD note is not reported to DOHMH Bureau of Communicable Diseases (BCD).**

- When three or more confirmed cases (a cluster) in a class or group setting occur within 4-5 days, the SN/ School Health Staff should call Office of School Health @ 212-442-1695.

REPORTING COMMUNICABLE DISEASES

Fifth Disease

- Once a documented case is reported, a letter and fact sheet should be issued to the entire school population. Please contact the nursing supervisor/BND for direction. Each individual case should be faxed to **@ 212-442-1815,** attention: Ada Santiago, R.N., School Health Central Office.

OFFICE of SCHOOL HEALTH
REPORTING FORM
FOR FIFTH DISEASE

DATE: ____/____/____ REGION: _____ DISTRICT: _____

SCHOOL: _____ PRINCIPALS NAME: _____ TEL #: (____)_____-_____

REPORTER: _____ TEL #: (____)_____-_____
NAME TITLE

OSIS #: _____

STUDENTS NAME: _____ _____
LAST NAME FIRST NAME

DATE of BIRTH: ____/____/____ SEX: Male Female GRADE/CLASS _____

ADDRESS: _____

BOROUGH: MANHATTAN BKLYN RICHMOND
BRONX QUEENS ZIP
__/__/__/__/__

PARENT/GUARDIAN NAME: _____

HOME TEL #: (____)_____-_____

DATE of ONSET: _____/_____/_____

LAST DAY IN SCHOOL: _____/_____/_____

DATE of DIAGNOSIS: _____/_____/_____

MD INFORMATION CONFIRMING DIAGNOSIS:

DR's NAME: _____ TEL #: (____)_____-_____

ADDRESS: _____

HOSPITAL: _____

First Case: Yes No **Case #:** _____ **Total Number** of cases in school: _____

Was letter and fact sheet for Parents/School staff given to Principal? Yes _____ No _____

Date Issued: _____/_____/_____

7/9/04 A.S.

REPORTING COMMUNICABLE DISEASES

Chicken Pox

- The **only** disease that doesn't require a Doctor's note for confirmation to send out a letter and fact sheet.
- If you receive information that a student has chicken pox, contact the SN/BND for direction.
- Schools with ASHR will complete the Varicella Reporting Form in the student's ASHR record. The information will be forwarded to Bureau of Immunization and to Ada Santiago at central office.
- Schools without ASHR will complete form and fax each individual case on a Varicella Reporting Form to the **Bureau of Immunization to 212-676-2300.**
- Schools without ASHR will also fax a copy of that form for each initial case per class **to 212-442-1815, attention Ada Santiago, R.N., School Health Central Office.**

Office of School Health
Varicella Reporting Form

Date: _____

Name: _____

Address: _____

_____

Date of Birth: _____

Gender: _____

Parent/Guardian: _____

Telephone #: Home _____
Work _____

Diagnosis: ***Chickenpox***

Confirmed with MD note: Yes___ No_____

Doctor's Name: _____

Doctor's Telephone: _____

Onset of Illness: _____

Last Day in School: _____

Date Returned to School: _____

Date of Varicella Vaccine:
Dose #1_____
Dose #2_____
_____Not Vaccinated

Reporter: _____

Phone #: _____

District: _____

School: _____

Address: _____

_____

Principal: _____

Telephone #: _____

Grade: _____ Class: _____

Students in School: _____

Students in Class: _____

Was student hospitalized: Yes_____ No ____ If yes, what hospital? _____

Does anyone else in the home have chickenpox? Yes_____ No _____ Who? _____

Was a letter and fact sheet for parents given to the Principal? Yes_____ No _____
Date Copy Sent to Supervising Nurse Office: _____

***All reports are to be faxed to NYC DOHMH Bureau of Immunization attention Charles Asumeng at (212) 676-2300.** If you need to speak with Charles please call 212-676-2288.
Fax the report of the initial case that occurs in the class to NYCDOHMH Office of School Health,
Attention: Ada Santiago at (212) 44 2-1815

08/28/07

Varicella (Chicken Pox)
Zero Monthly Report

- Report verifying there were **zero** Varicella cases identified in the school during the previous month.
- Schools with ASHR will complete Varicella Zero Monthly Report in ASHR. The report can be accessed under reports in the school tab of ASHR. Information will automatically be forwarded to Bureau of Immunization and Ada Santiago, Communicable Disease Liaison, at Central Office.
- Schools without ASHR will complete report and fax on the second Wednesday of each month to Maggie Doll at 212-676-2274

New York City Department of Health and Mental Hygiene
Bureau of Immunization, Surveillance Unit

Varicella Monthly Summary Report

Reports may be faxed or e-mailed. Reports should be sent by the second Wednesday of each month, for the previous month.

TO: **Maggie Doll**

Fax: **212-676-2274**

Email: **mdoll@health.nyc.gov**

Reporter Name: _____

School Name & Number: _____

_____

Report for: _____ **(month/year)**

Please check one of the following:

☐ **There have been ZERO varicella (chickenpox) cases identified in this school in the previous calendar month**

☐ **There have been 1 or more varicella (chickenpox) cases identified in this school in the previous calendar month**
(Please also submit a *Varicella Reporting Form* for each varicella case)

Signature: _____

VARICELLA/ CHICKEN POX FLOW CHART

Initial Varicella (Chicken Pox) Report

- Dr's note or
- Verbal confirmation from Parent/ Guardian

All Varicella (Chicken Pox) Reports are to be entered into ASHR (under menu options, choose Varicella Reporting Form)

If ASHR is not available then report is faxed to Bureau of Immunization: 212-676–2274 (Attn: Maggie Doll)

When first case of chicken pox is identified in the class, a letter and fact sheet are to be issued to the class
Office of School Health will receive the report of the initial case that occurs in the class once entered into ASHR

If ASHR is not available fax to:

- Ada Santiago - 212 – 442-1815

↓

Varicella / Chicken Pox Monthly Summary Report

- Varicella Monthly Summary Report that must be completed in ASHR for the Bureau of Immunization by the second Wednesday of each month if you have not reported any Varicella (Chicken Pox) cases within the month.
  If varicella cases were reported, ASHR will automatically generate a Varicella Monthly Summary Report and forward to Bureau of Immunizations.
- If ASHR is not available then Varicella Monthly Summary Report must be faxed to 212- 676-2274 (Attn: Maggie Doll)

OFFICE of SCHOOL HEALTH
REPORTING FORM
FOR FIFTH DISEASE

DATE: _____/_____/_____ REGION: _____ DISTRICT: _____

SCHOOL: _____ PRINCIPALS NAME: _____ TEL #: (_____) _____-_____

REPORTER: _____ TEL #: (_____) _____ - _____
NAME TITLE

OSIS #: _____

STUDENTS NAME: _____ _____
LAST NAME FIRST NAME

DATE of BIRTH: _____/_____/_____ SEX: ☐ Male ☐ Female GRADE/CLASS _____

ADDRESS: _____

BOROUGH: ☐ MANHATTAN ☐ BKLYN ☐ RICHMOND

☐ BRONX ☐ QUEENS ZIP ___/___/___/___/___

PARENT/GUARDIAN NAME: _____

HOME TEL #: (_____) _____ - _____

DATE of ONSET: _____/_____/_____

LAST DAY IN SCHOOL: _____/_____/_____

DATE of DIAGNOSIS: _____/_____/_____

MD INFORMATION CONFIRMING DIAGNOSIS:

DR's NAME: _____ TEL #: (_____) _____ - _____

ADDRESS: _____

HOSPITAL: _____

First Case: ☐ Yes ☐ No **Case #:** _____ **Total Number** of cases in school: _____

Was letter and fact sheet for Parents/School staff given to Principal? Yes _____ No _____

Date Issued: _____/_____/_____

Each individual case to be faxed to NYCDOHMH Office of School Health, Attention: Ada Santiago at (212) 442-1815.
8/07 A.S.

Reporting Communicable Diseases

Action to be taken by Office of School Health staff.

The City Health Information (CHI) dated March 09 which lists diseases and conditions that must be reported to the NYC Department of Health, should be posted in every medical room.

Diseases and conditions listed in the CHI should be reported to the Supervising Nurse (SN) or the Senior Public Health Nurse immediately.

The SN/SPHN will notify the Supervising Medical Doctor (SMD) and the Office of School Health at (212) 442-1695 to report the following diseases:

- Hepatitis
- Meningitis
- Vaccine Preventable Diseases
- Suspected Tuberculosis
- Food Related illness.
- Blood Exposures: Incidents involving broken skin ex: Needle sticks, or human bites with history of a known communicable disease.

Fifth Disease: Once a documented case is reported, a letter and fact sheet should be issued to the entire school population. Each individual case should be faxed to NYCDOHMH Office of School Health, A.Santiago **@ 212- 442-1815.** If a 2nd case is reported 20 days after the initial case, a 2nd letter and fact sheet should be issued.

Scarlet Fever: O.S.H. is called only when there is a cluster of three or more confirmed cases in a class or group setting that occur within 4-5 days, SN/School Health staff should call **Office of School Health @ 212-442-1695.**

Varicella/Chicken Pox: Currently the only disease for which you don't need a Drs note for confirmation, to be able to send out a letter and fact sheet. Each individual case must be entered into ASHR**.** Letter and fact sheet to be issued to class once the first case is reported in each class.
If it is a Non Public or you do not have access to ASHR, Office of School Health should receive the report of the initial case that occurs in each class addressed to: Ada Santiago – Faxed @ 212- 442- 1815. Bureau of immunization Surveillance Unit: Varicella Monthly report should be entered into ASHR by the second Wednesday of each month or faxed to Maggie Doll @ 212-676-2274 if you do not have access to ASHR.

The following information is needed when reporting a communicable disease to central office:

- The students name, address, date of birth, grade, parents name, and home telephone number.
- School number, address, Principals name and telephone number
- Last day in school
- The onset of illness date
- Suspected diagnosis
- The name of Hospital/Doctor and telephone number
- Admission date/date seen

Staff should always consult with the supervisory staff about medical conditions that are of concern to the school.

Reporting Communicable Diseases

MRSA

Methicillin Resistant Staphylococcus Aureus

MRSA is a strain of the staphylococcus bacteria that can cause infection in different parts of the body. It is resistant to many antibiotics. Most MRSA infections are not serious, some can be life threatening.

Reporting Communicable Diseases

MRSA

- Complete the Risk Assessment Document to determine if the student poses an additional risk to others.
- Report a cluster (3 cases) of MRSA to Ada Santiago, OSH Infection Control Nurse at 212-442-1695. Fax a copy of the lab cultures and antibiotic sensitivity report and risk assessment to Ada Santiago at 212-442 1815

School Health Risk Assessment Form for MRSA In Students

School Health Risk Assessment Form for MRSA Infection in Students

This form is to determine if school children with confirmed MRSA infections are at high risk for transmission.

REPORTING INFORMATION Date:___/___/_____

School Nurse/Physician Last Name _____ First Name_____

School name: _____

School address:_____

Borough: _____District: _____ Zip: _____ Tel#:_____

DEMOGRAPHICS AND INFECTION DETAILS *(filled out before calling provider/parent)*

Patient Last Name _____Patient First Name_____

DOB: ____/____/____or Age: _____ Grade _____

(1) Is this first confirmed case in this school? ☐ Yes [Skip to RISK ASSESSMENT] ☐ **No***, fill out below:

Number of confirmed MRSA cases: _____ Last case's Confirmation date:___/____/___

RISK ASSESSMENT *(Call healthcare provider or parent to obtain the information below):*

Person being interviewed:

Last Name _____ First Name_____Tel#:_____

This person is: ☐ Patient ☐ Parent/Guardian ☐ Healthcare provider ☐ other, specify _____

(2) Describe (or ask) infection location: _____

(3) Has the wound been covered by a bandage at all times? ☐ Yes ☐ No* ☐ Unknown

(4) Can pus from the wound be contained by a bandage now? ☐ Yes ☐ No* ☐ N/A ☐ Unknown*

(5) Does patient participate in any organized contact sports such as football, wrestling?

☐ Yes ☐ No [if no skip to (3)] ☐ Does not know+ ☐ Unable to contact parent/guardian+

+If speaking to Healthcare provider, and he/she does not know, contact parent/guardian. If parent/guardian was not reached, also check "Unable to contact parent/guardian".

(6) If yes, which sport(s)? ☐ **football*** ☐ **wrestling*** ☐ **basketball***

☐ Others, specify all: 1)_____, 2) _____, 3) _____

Coach Last Name _____ First Name_____Tel#:_____

(7) Does the patient have any developmental disabilities or are there other circumstances that may increase his/her chances of having skin-to-skin contact with others?

☐ No (end interview) ☐ Yes*, Explain _____

IF ANY STARRED ITEMS (*) ARE CHECKED, CONTACT ADA SANTIAGO IMMEDIATELY.

Last Update 11/24/2010

Seasonal Flu (H1N1)

- On April 23, 2009 Ms. Pappas, the nurse at St. Francis Prep identified an increased number of students with fever visiting the medical room
- At that time there was an unusually severe respiratory illness in Mexico
- Several students traveled to Mexico during that time
- The incidence of influenza like illness (ILI) increased significantly throughout Queens and spread to other boroughs

Seasonal Flu (H1N1)

- School nurses played a vital role in identifying, monitoring, reporting and educating students, staff and family during the flu outbreak
- Nurses should continue to be alert for any unusual patterns of illness within the school and report situations of concern

REPORTING COMMUNICABLE DISEASES

MUST HAVES

You **must have all of this information** whenever you report a communicable disease or any threat to public health:

1. Student's name and address and parent/guardian contact information.
2. Last day this student attended school.
3. The date of the onset of the illness.
4. Suspected diagnosis.
5. The name of the Hospital/Doctor and telephone number.
6. Admission date or date seen by physician.

REPORTING COMMUNICABLE DISEASES

When in doubt,

please consult your

Supervising Nurse, PHN II

or the

Borough Nursing Director (BND)

REPORTING FOOD-BORNE ILLNESSES

- When 3 or more children present signs and symptoms such as vomiting, nausea, cramps or fever in the lunch room or come to the medical room within an hour of eating there, you should **suspect food-borne illness**.
- **To rule out viral illnesses**, check in the Office of School Health Daily Log for the previous10 days to establish a pattern.

REPORTING FOOD-BORNE ILLNESSES

- Interview the children with signs and symptoms to determine when, where and what each child ate and drank.
- Assess the severity of the symptoms and determine appropriate action.
  - Should these children remain in school?
  - Should they be taken to a hospital emergency room?

REPORTING FOOD-BORNE ILLNESSES

Suspected food-borne illnesses require the same procedures as all medical room walk-ins:

1. Always notify the parent/guardian by phone and complete the 12S form, which is used to notify parents and/or providers for follow-up.

REPORTING FOOD-BORNE ILLNESSES

2. Enter the student's name, date and time of arrival in the Medical Room in the Office of School Health Daily Log or ASHR.
3. Enter your findings on ASHR or 103S for each student you assess.

REPORTING FOOD-BORNE ILLNESSES

- Notify the SN/BND of the event.

- You will be asked to report your findings on the "Reporting Notification Form for Suspected Food-Borne Illnesses" and fax the form immediately to 212-788-4299 to Faina Stavinsky, the Food-Related Illness Coordinator.
- Faina Stavinsky can be reached at 212-442-3372.

DOH CASE NO._____

REPORTING NOTIFICATION FORM FOR SUSPECTED FOODBORNE ILLNESSES

DATE OF OCCURRENCE_____SCHOOL_____ADDRESS_____

NURSE/ PHA/DSN'S NAME AND TITLE_____TELEPHONE NUMBER_____

NUMBER OF STUDENTS ILL_____TOTAL NUMBER OF STUDENTS IN SCHOOL_____NUMBER OF FACULTY ILL_____TOTAL NUMBER OF FACULTY_____

NUMBER OF MEAL PERIODS AND TIMES OF EACH_____ GRADES SERVED DURING EACH OF THE MEAL PERIODS_____

IS BREAKFAST ALSO SERVED AT THIS SCHOOL?_____ IF SO, AT WHAT TIME?_____

DID THE SCHOOL/CLASS PARTICIPATE IN ANY SPECIAL EVENTS WITHIN THE PAST 72 HOURS? _____ IF SO, DESCRIBE:_____

NUMBER OF CLASSES PER GRADE_____

HAS THE PRINCIPAL BEEN REMINDED TO SAVE THE SUSPECT FOOD ITEMS?

PATIENT'S NAMES	AGE/ GRADE	SEX	SYMPTOMS*						FOODS EATEN DURING SCHOOL DAY-INCLUDE LUNCH AND BREAKFAST	TIME OF MEALS	ONSET TIME OF SYMPTOMS	DR OR ER VISIT? NAME AND ADDRESS OF DOCTOR/ HOSPITAL	DIAGNOSIS
			N	V	D	C	F	O					

N=NAUSEA V=VOMIT D=DIARRHEA C=CRAMPS F=FEVER O=OTHER

BRIEF HISTORY OF OUTBREAK/ADDITIONAL INFORMATION:

INITIAL CALL TO NYCDOH AT 212-442-3372 BY:_____DATE/TIME_____

FAXED TO DOH (212-442-3378) BY: _____DATE/TIME_____

FORM COMPLETED BY_____

REPORTING FOOD-BORNE ILLNESSES

- Notify lunch room staff that you have faxed DOHMH to notify them to conduct an environmental investigation.
- Work with the Department of Education (DOE) lunch room staff to save samples of all food and drink for inspection and analysis by the DOHMH environmental investigators.

REPORTING FOOD-BORNE ILLNESSES

- The day after a suspected food-borne illness event occurred:
  - Note the doctor's findings and recommend-ations on ASHR or each child's 103S. (The teacher will send the child with a doctor's note to the Medical Room.)
  - If any students involved are absent, contact the parent and note the reason and physician's findings on ASHR or each absent child's 103S.

No Head Lice Policy

- **Students with head lice will be excluded when the head lice are identified along with parent identification.**
- Students with head lice will not be allowed to re-enter until they are lice free. They will be re-examined by the principal's designee (**NOT** the school nurse) upon returning to school.
- Students who have been cleared of lice will be re-examined in 14 calendar days (or closest school day if the 14th day falls on a weekend or holiday) by principal's designee.

No Head Lice Policy

- Students found to have head lice on re-examination will once again be excluded until they are lice free.
- **Students with nits and no evidence of head lice will NOT be excluded from school.**
- **No school-wide surveillance will be conducted for nits (studies have shown them to be ineffective).**

No Head Lice Policy

How school nurses can help:

- Train personnel designated by the principal on how to properly identify live head lice.
- Provide consultation on cases that do not resolve after two treatments.

  -Confirm that parents are following treatment recommendations appropriately.

  -Initiate case management as needed
- Provide health education to staff and parents as needed.

BEDBUG PROTOCOL

- Any bedbug specimen should be processed by the prinicipal's designee. All OSH nurses are not to accept, process or mail presumed bedbug specimen. The principal will designate the school personnel who will take responsibility for these tasks. The principal will distribute the bedbug parent notification letters as needed.

BEDBUG PROTOCOL

- OSH nurses will only be responsible for initiating case management on students with confirmed cases of bedbugs. The Office of School Health will continue to provide the bedbug education meetings to the staff and parents as needed.

BLOOD EXPOSURE

- Whenever school children are involved in incidents with exposure to blood with the potential for exposure to blood-borne pathogens, contact your Supervising Nurse (SN)/Borough Nursing Director (BND) for guidance on risk evaluation, management options and appropriate treatment and follow-up.
- If staff are involved in blood exposure incidents, they should be managed and evaluated according to the Employee Health policy of their agencies.

BLOOD EXPOSURE: TYPES OF INJURIES

Types of injuries that occur in schools with the potential for significant exposure are:

1. Human bites where the biter breaks the skin of another person, resulting in a significant amount of bleeding.
2. Injuries where a person is bleeding or secreting bodily fluids contaminated with blood, and another person's open wound or mucous membrane is exposed to the blood or bodily fluids.

BLOOD EXPOSURE: TYPES OF INJURIES

3. Fights where one person punches another in the mouth resulting in a bleeding cut to the skin of the puncher.
4. Injuries where a sharp object has pierced the skin of one person and subsequently pierces the skin of another.
5. An injury where a person's blood splatters into the mouth, nose or eye of another person.

BLOOD EXPOSURE: TYPES OF INJURIES

6. Any injury resulting in broken skin at risk for contamination with germs present at the source of the trauma (needle, weapon, teeth, mouth, etc.)
7. A skin-penetrating injury from a sharp object whose contamination status is unknown.

BLOOD EXPOSURE: MANAGEMENT & REPORTING

Immediate Wound Management

- **Strictly observe Universal Precautions**
- **Provide First Aid**
  - Thoroughly clean wound with soap and water
  - Flush wound under fast running water
  - Apply pressure to stop bleeding
  - Cover wound lightly with a clean, dry dressing

BLOOD EXPOSURE: MANAGEMENT & REPORTING

- Contact your Supervising Nurse (SN)/ Borough Nursing Director (BND) immediately to discuss the incident.
- You will need to know the risk of exposure, which is determined by:
  - Presence of blood in direct contact with an injury with depth or a permeable skin surface, providing a portal of entry

    and

  - Consideration of the health status of the individuals involved and their immunization status (Tetanus:total # doses received; date and type of last dose. Hep B: # doses received). ***Review the 103S, ASHR, 104S,and the Health & Accommodations Form.***

Data Collection Form for Human Bites and Blood Exposures

Report Date: _____ Report Time: _____ AM/PM
Reporter: _____ Reporter phone #: _____
School: _____ District: _____
Exposure Date: _____ Exposure Time: _____ AM/PM
Exposure type: ___ Bite ___ Sharp object ___ Sexual ___ Other

---

NAME: _____
OSIS#: _____
DOB: _____ Sex: M F
Phone: _____
Guardian: _____
Grade: _____ Class: _____
Status: ___ Student ___ BOE
___ DOH ___ Visitor

Site of injury: __ skin __ mouth (biter)
__ mucous membrane __ N/A

Depth: __ Muc Memb __ Penetrating
__ Superficial __ No Contact/barrier

Quantity of blood at site of injury:
__ Active bleeding __ Visible blood
__ Unable to evaluate __ No visible blood __ N/A

Body site of injury (N/A to biter/sticker):
___ Head/face ___ Head/scalp
___ Trunk/front ___ Trunk/back
___ Neck ___ UE ___ LE

NAME: _____
OSIS#: _____
DOB: _____ Sex: M F
Phone: _____
Guardian: _____
Grade: _____ Class: _____
Status: ___ Student ___ BOE
___ DOH ___ Visitor

Site of injury: __ skin __ mouth (biter)
__ mucous membrane __ N/A

Depth: __ Muc Memb __ Penetrating
__ Superficial __ No Contact/barrier

Quantity of blood at site of injury:
__ Active bleeding __ Visible blood
__ Unable to evaluate __ No visible blood __ N/A

Body site of injury (N/A to biter/sticker):
___ Head/face ___ Head/scalp
___ Trunk/front ___ Trunk/back
___ Neck ___ UE ___ LE

Name: _____

Hep B complete? Y N U
Tetanus UTD? Y N U
in past 5 years? Y N U

Well child Y N U
Medical history: __ Asthma
__ ADHD __ Seizures __ MR
__ Dev delay __ Other: _____

HIV: ___ Definite, documented pos
___ Increased (bld prod/STD/IVDA)
___ No risk/No known risk
___ Possible (family positive)
___ Probable (anti-retroviral Rx)
___ Suspected (OI/OI prophylaxis)

HB: ___ Definite, documented pos
___ Increased (bld prod/HD/STD/IVDA)
___ No risk/No known risk
___ Possible (liver disease, family pos)

HC: ___ Definite, documented pos
___ Increased (bld prod/HD/STD/IVDA)
___ No risk/ No known risk
___ Possible (liver disease, family pos)

Name: _____

Hep B complete? Y N U
Tetanus UTD? Y N U
in past 5 years? Y N U

Well child Y N U
Medical history: __ Asthma
__ ADHD __ Seizures __ MR
__ Dev delay __ Other: _____

HIV: ___ Definite, documented pos
___ Increased (bld prod/STD/IVDA)
___ No risk/No known risk
___ Possible (family positive)
___ Probable (anti-retroviral Rx)
___ Suspected (OI/OI prophylaxis)

HB: ___ Definite, documented pos
___ Increased (bld prod/HD/STD/IVDA)
___ No risk/ No known risk
___ Possible (liver disease, family pos)

HC: ___ Definite, documented pos
___ Increased (bld prod/HD/STD/IVDA)
___ No risk/ no known risk
___ Possible (liver disease, family pos)

Circumstances:

VISION SCREENING: AMBLYOPIA DETECTION & FOLLOW-UP

- The Office of School Health Vision Screening Teams screen kindergarteners, first graders, new entrants and special referrals for possible vision difficulties.
- The Vision Follow-Up Unit calls the parents of children with very serious problems, such as possible amblyopia, to urge professional evaluation and treatment.
- Amblyopia is an eye condition in which one eye is weaker than the other. Without early treatment (by age 7 or 8), the weaker eye can lose vision altogether.

VISION SCREENING: FOLLOW-UP

- The Vision Team asks parents to return all doctor's forms to the Vision Follow-Up Unit. Often, however, a parent brings a form to the school nurse.
- If you receive a vision report from a parent, please do the following:
  - Fax the white copy to (212) 442-4757. Please make sure the doctor's identifying information is included in the faxed copy. Vision follow up team will enter completed E12s forms into ASHR.
  - Know your Vision follow-up person. Communication prevents duplication of effort and/or students' falling through the cracks.

Please return top copy (completed) to Vision and Hearing, 2 Lafayette St., Box 23, 22nd Fl., New York, NY 10007

NYC DEPARTMENT OF HEALTH AND MENTAL HYGIENE — NYC DEPARTMENT OF EDUCATION

EYE REPORT AND RECOMMENDATIONS

(Please Print On Hard Surface)

CHILD'S NAME: Last, First	SEX: ☐ Male ☐ Female	OSIS #	DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP
SCHOOL	BOROUGH/DISTRICT		GRADE/CLASSROOM
PARENT/GUARDIAN	TELEPHONE #		

E12 History

	Yes	No	Unknown	
Newly identified case (1ST E12S)	☐	☐	☐	Date of issue: _____
Follow up for previous issue of E12S not returned	☐	☐	☐	By: _____
Annual follow up for case with completed E12S	☐	☐	☐	Title: _____

TO THE PARENT: Your child did not pass one or more parts of the vision test. Please take your child to an eye doctor for an examination.

Screening Results: *(To be filled out by DOHMH only.)*

Date of screening: _____ Team code: _____

FAR			NEAR	
Without Glasses	With Glasses		Without Glasses	With Glasses
20/	20/	Right	20/	20/
20/	20/	Left	20/	20/
20/	20/	Both	20/	20/

Right Eye (+1.50): Pass ☐ Fail ☐ Fusion: Pass ☐ Fail ☐

Left Eye (+1.50): Pass ☐ Fail ☐ Color Test: Pass ☐ Fail ☐

TO THE DOCTOR: Please fill out all data fields below to permit proper educational planning for this child.

DOCTOR'S EXAMINATION: *(To be filled out by medical staff only.)*

Date of examination: _____ Next visit: _____

Is any ocular pathology or any field limitation present? ☐ Yes ☐ No

If yes, describe: _____

	Uncorrected		Corrected	
	Distance	Near	Distance	Near
Right				
Left				
Both				

Prescription given:

	Sphere	Cylinder	Axis	Add
Right				
Left				

Diagnosis: _____

Special vision services recommended? ☐ Yes ☐ No If yes, specify: _____

Color deficiency confirmed by doctor? ☐ Yes ☐ No

Your recommendations:

Are glasses to be worn? ☐ Yes ☐ No Indicate extent of use: ☐ For near ☐ For far ☐ Constant

New prescription? ☐ Yes ☐ No

Eyeglasses dispensed today? ☐ Yes ☐ No

Patch prescribed? ☐ Yes ☐ No Which eye to be covered? ☐ Left ☐ Right

Where worn? ☐ In school ☐ After school ☐ Both

Hours per day? _____

Other treatment: _____

School accommodations:

Seating accommodation requested? ☐ Yes ☐ No

Indicate the position: ☐ Front center ☐ Front left ☐ Front right

Other accommodation: _____

Exclude from contact sports? ☐ Yes ☐ No If yes, until ☐ Temporary date: _____ ☐ Permanently

Wear protective goggles in gym/sports? ☐ Yes ☐ No

Doctor's Name: _____ (First) _____ (Last) Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: (_____) _____ License #: _____

For office use only Vendor: _____

E12S DOHMH/DOE (Rev. 1/06) COPIES: White (Vision and Hearing Program); Canary (Medical Room); Pink (Parent)

Educational Vision Services

The New York City Public Schools provide specialized educational services for students who are blind or visually impaired. Students are eligible if their best-corrected vision in the better eye is 20/70 or lower, or if they have specified visual impairments, such as macular degeneration, retinopathy of prematurity, optic atrophy, high myopia or albinism. Services are designed to give students access to the general curriculum, and to participate in general or special education classes at the highest possible level of independence. Available services include:

- Braille
- Large print reading materials
- Training with low vision devices
- Specialized adaptive computer technology
- Instruction in other skills to attain literacy in:
  - reading
  - writing
  - mathematics
  - sciences
  - computers
- Instruction in orientation and mobility for independence in travel
- Bus transportation, if needed.

For further information contact:

Educational Vision Services
400 First Avenue, 7th Floor
New York, NY 10010
Phone: (917) 256-4259
Fax: (917) 256-4230

FORMS:
DOCUMENTING YOUR CARE

- Forms provide accurate documentation of the nursing care you give each child during your school assignment.
- Forms assist parents/guardians in caring for their children.
- Forms assist providers delivering follow-up care and monitoring.

FORMS
You Need to Know

Medical Record/Clinical Information Forms

- **103S:** Individual student medical record kept in the locked cabinet in the Medical Room. **All interactions with the child (not documented in ASHR) – except normal listed Daily & PRN medications & procedures – are noted on this form.**
- **CH 205:** Comprehensive Medical Form for New Admission Examinations. The CH205 form is attached to the individual student medical record, the 103S.

SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE

LAST NAME	FIRST NAME	MIDDLE NAME	SEX	BIRTHDATE

NUMBER AND STREET	ZIP CODE	BORO	FL./APT.	TELEPHONE NO.	GRADE/CLASS	SCHOOL/BORO

NAME OF PARENT OR GUARDIAN LAST | FIRST | RELATIONSHIP TO CHILD

SIBLINGS IN FAMILY (Keep current) No. Older: No. Younger: No. Persons in Home:

MEDICAL HISTORY — Explain all items checked and give recommendations under: Health Problems" below

FAMILY ILLNESSES — SIGNIFICANT (SPECIFY) IF PARENTS OR SIBLINGS ARE DEAD, GIVE CAUSES AND DATES, (Keep current)

CHILD'S HISTORY — BIRTH DEVELOPMENTAL

IMMUNIZATION STATUS:
IMMUNIZATION COMPLETE: (DIPTHERIA (DT, TD), POLIOMYELITIS) (MEASLES, RUBELLA, MUMPS) YES ☐ NO ☐
IF IMMUNIZATION INCOMPLETE: REFERRED ______ DATE: ______

CHILD'S HISTORY — CHECK AND GIVE DATES IF KNOWN

- ☐ Chicken Pox
- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Allergies (specify)
- ☐ Frequent colds or sore throats
- ☐ Ear Infections
- ☐ Trouble hearing
- ☐ Intestinal Parasites
- ☐ Bronchitis or Asthma
- ☐ Convulsions
- ☐ Rheumatic fever
- ☐ Heart trouble
- ☐ Orthopedic problem
- ☐ Tuberculosis
- ☐ Eye or vision problem
- ☐ Speech problem
- ☐ Urinary Track Infection
- ☐ Serious Illnesses (specify & give dates)
- ☐ Serious accidents (specify & give dates)
- ☐ Operations (specify & give dates)
- ☐ Other problems or handicapping conditions (specify)
- ☐ Is child now under regular medical care, name of doctor, hospital or clinic
- ☐ Address:

Is child now taking any regular medication? Specify:

CURRENT HISTORY AND EXAMINATION

DATE					
PARENT PRESENT					
A. EATING HABITS					
B. SLEEPING HABITS					
C. TOILET HABITS					
D. BEHAVIOR					
E. OTHER HISTORY					
1. PHYSICAL APPEARANCE					
G. Good A. Ave. B. Below Par					
2. SKIN					
3. EARS					
4. EYES					
5. MOUTH and TEETH					
6. NOSE and THROAT					
7. HEART					
8. LUNGS					
9. ABDOMEN					
10. HERNIA and GENITALS					
11. POSTURE and EXTREMITIES					
12. OTHER					

NOTES BY SCHOOL DOCTOR AND NURSE
At beginning of note, code activity, sign all notes

DATE	

103-S (Rev. 9/03) **Check (✓) all abnormalities, explain all items checked and give recommendations under "Notes"**

HEALTH PROBLEMS DURING SCHOOL CAREER

DOCTOR'S OR PNA'S ACTIVITY (Red Ink)

NA New Admission SHA Selective Health Assessment SR Spec. Referral
DPPC Professional Person Conference DSC Student Conference

NURSING ACTIVITY (Blue/Black Ink)

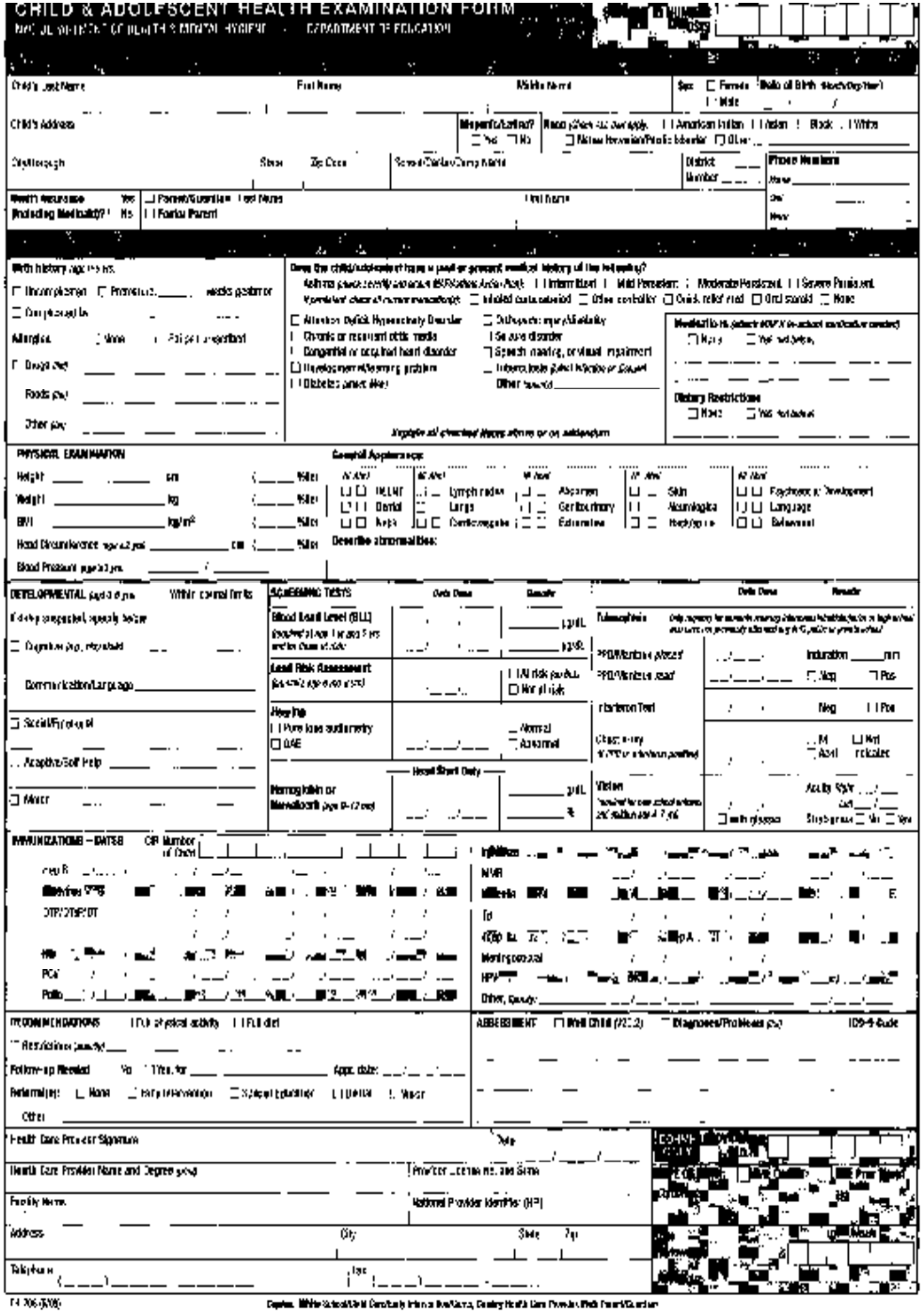
NDI Daily Inspection NFU Follow Up NP Parent Conference
HV Home Visit TNC Teacher Conference
NPPC Professional Person Conference HPE Health & Physical Education

DATE	ACTIVITY CODE	PARENT PRESENT	HEALTH PROBLEMS; SIGNIFICANT FINDINGS; ACTION TAKEN; AND SIGNATURE	RECOMMENDED ACTION	ACTION COMPLETED

NOTE: When student is transferred forward this record to new school
SCHOOL MEDICAL RECORD
(To be kept in medical room)

103-S (Rev. 9/03) **DEPARTMENT OF HEALTH AND MENTAL HYGIENE – THE CITY OF NEW YORK**

CH205



CHILD & ADOLESCENT HEALTH EXAMINATION FORM

PHYSICAL EXAMINATION

DEVELOPMENTAL

SCREENING TESTS

IMMUNIZATIONS – DATES

RECOMMENDATIONS

ASSESSMENT

FORMS
You Need to Know

Health Services and Section 504 Accommodation Forms allow students with special needs to receive the necessary services to ensure their participation in the educational setting.

1. **Medication Administration Form** for requests involving the in-school administration of medication for students.
2. **Provision of Medically Prescribed Treatment (Non-Medication)** for special procedures such as bladder catheterization, postural drainage, tracheal suctioning, gastrostomy tube feeding, etc.

NYC
Department of
Education

Guidelines For the Provision of Health Services and/or Section 504 Accommodations For Students in New York City Public Schools
2010-2011

To All Parents, Physicians, and Health Care Providers:

The New York City Department of Education and the New York City Department of Health and Mental Hygiene's Office of School Health work collaboratively to make certain that all students with special needs are provided services to ensure their full participation in the educational setting. To this end, parents and providers must use the enclosed forms for all requests for in school direct health services and/or accommodations under Section 504 of the Rehabilitation Act of 1973. **These forms must be returned to the child's school for processing.** A new request and authorization form will be required for each school year if the child continues to require the requested services in school. The following guidelines should be followed in order to facilitate the review of the completed forms and to provide clinically appropriate services:

- The physician/health care provider completing the form should be the one who will be actively managing the condition for which services are requested.
- A valid New York State, New Jersey or Connecticut license number must be provided. If a physician-in-training without a license number completes the form, it must be counter-signed by a supervisor (e.g., attending physician) and include the supervisor's license number.
- The order should be specific, legible and clearly written so that it is completely understandable to the nurse and can be carried out in a clinically responsible way.
- Only those services that must be performed during school hours should be requested, (e.g., if medication can be given at home before or after school hours, it should not be requested in school).
- Homeopathic medications will not be administered.
- Please note that medication is typically stored in a locked cabinet in a designated room (i.e., medical room) unless the student is authorized by you to carry medication in school.
- Parents, physicians, school staff and students must work together to encourage each child to be as self-sufficient as possible. If the child is able to self-administer the medication, the parent should initial the appropriate area on the back of the medication form. Most students at the intermediate and high school level should be self-directed in taking medications, (i.e., identify the following: that the medication is the correct one; what the medication is for; that the correct dosage or amount is being administered; when the medication is needed during the school day; describe what will happen if it is not taken). Those students are then permitted to carry and self-administer only those medications that are necessary during the school day without supervision; however, **students are never permitted to carry controlled substances.**

Parents, remember to attach a small photograph of your child to the upper left corner of the Medication Administration Form (MAF) for proper identification.

There are four types of request and authorization forms:

- Medication Administration Form (MAF) - should be completed only for requests involving administration of medication for students. For cases of asthma, providers may attach an Asthma Action Plan with the MAF. Use of nebulizers on school trips can be cumbersome, please consider prescribing an inhaler and spacer whenever possible.
- Provision of Medically Prescribed Treatment (Non-Medication) - should be completed when requesting special procedures such as bladder catheterization, postural drainage, tracheal suctioning, gastrostomy tube feeding, etc. This form may be used for all skilled nursing treatments.
- Diabetes Medication Administration Form: should be completed for students with Diabetes who require any of the following: glucose monitoring, insulin and/or glucagon administration.
- Request for Section 504 Accommodation(s) - should be used when requesting special services such as a barrier-free building, elevator use, testing modification, etc. This form should **NOT** be used for Related Services such as occupational therapy, physical therapy, speech and language therapy, counseling, etc. which is properly addressed and provided by a student's Individualized Education Program (IEP).

Please contact the student's school if you have any questions. Thank you for your assistance.

NOTE: Parent signature required on reverse side of this form. Current photograph of student MUST be attached to upper left corner of this form.

MEDICATION ADMINISTRATION FORM

Authorization for Administration of Medication to Students for School Year 2010–2011

Student's Name (Last, First, Middle)		Male ☐ Female ☐	Date of Birth	I.D. Number
DOE District	School (PS, IS, etc. and Name)	Grade	Class	Borough
School Address				Zip Code

Health Care Practitioner Order

1. Diagnosis ASTHMA ☐ Yes ☐ No

SEVERITY:

☐ Intermittent ☐ Moderate Persistent*
☐ Mild Persistent* ☐ Severe Persistent*
☐ Exercise Induced

*National guidelines recommend inhaled corticosteroids for children with persistent asthma.

INDICATE HOME MEDS IN BOTTOM LEFT BOX.

Check Medication and Order Type	*Instructions for lack of improvement or adverse reaction*	*Choose all that are appropriate*
Stock supply only available for Ventolin HFA. *(see back)* ☐ Ventolin HFA (may be provided by school for shared usage). ☐ Other HFA _____ (to be provided by parent). **ORDER TYPE** ☐ Standard order. 2 puffs q 4 hrs. via MDI and spacer prn cough, wheeze, tightness in chest, difficulty breathing or shortness of breath. May repeat in 15 mins x 2 if no improvement (3 total). ☐ Pre exercise. 2 puffs via MDI with spacer 15-30 minutes before exercise. ☐ URI or recent asthma flare (within 3 days). 2 puffs @ noon via MDI inhaler and spacer for 3-5 days.	If improved, but not enough to return to class, call parent. If significant respiratory distress persists, call 911 and notify parent and PMD. May provide additional puffs as needed until EMS arrives.	☐ Student may carry medication and may self-administer. *(PARENT MUST INITIAL REVERSE SIDE).* ☐ Store medication in medical room and student to self-administer under observation. ☐ Store medication in medical room and nurse to administer.

2. Diagnosis _____

Medication/Preparation/Concentration

Dose/Route

☐ Diagnosis substantially controlled with medication.
☐ Diagnosis not substantially controlled with medication.

☐ Standing daily dose. Specify time(s): _____

AND/OR

☐ prn _____
specific signs, symptoms or situations

Time interval: q ____hours as needed

Any repeats if no improvement? ☐ Yes, in _____ hr/mins, max _____ times

Conditions under which medication should not be given:

☐ Student may carry medication (includes epi pen and MDI) and may self-administer. *(PARENT MUST INITIAL REVERSE SIDE).*
NOT FOR CONTROLLED SUBSTANCES.
☐ Store medication in medical room and student to self-administer under observation.
☐ Store medication in medical room and nurse to administer.

3. Diagnosis _____

Medication/Preparation/Concentration

Dose/Route

☐ Diagnosis substantially controlled with medication.
☐ Diagnosis not substantially controlled with medication.

☐ Standing daily dose. Specify time(s): _____

AND/OR

☐ prn _____
specific signs, symptoms or situations

Time interval: q ____hours as needed

Any repeats if no improvement? ☐ Yes, in _____ hr/mins, max _____ times

Conditions under which medication should not be given:

☐ Student may carry medication (includes epi pen and MDI) and may self-administer. *(PARENT MUST INITIAL REVERSE SIDE).*
NOT FOR CONTROLLED SUBSTANCES.
☐ Store medication in medical room and student to self-administer under observation.
☐ Store medication in medical room and nurse to administer.

List medication(s) student takes at home and at what time:

Health Care Practitioner (HCP) Name (PLEASE PRINT)	HCP Signature	
HCP/Clinic Address		
HCP/Clinic Tel. No.	HCP/Clinic Fax No.	NYS Registration No. **(Required)** / Date

FOR DOHMH USE: Revisions per DOHMH after consultation with prescribing provider

INCOMPLETE PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

MEDICATION ADMINISTRATION FORM (MAF): PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION
2010-2011

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary equipment to administer the medication, in accordance with the instructions of my child's physician. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I understand that if I provide an asthma inhaler, it must be supplied in its original and UNOPENED medication box. I further understand that I must immediately advise the principal and/or his/her designee(s) especially the school nurse of any change in the prescription or instructions stated above.
I understand that no student will be allowed to carry or self-administer controlled substances.

I understand that this Authorization is only valid until the earlier of: (1) **June 30, 2011** (This prescription may be extended through August if the student is attending a New York City Department of Education (the "Department") sponsored summer instruction program); or (2) such time that I deliver to the principal or his/her designee(s) and nurse a new prescription or instructions issued by my child's physician regarding the administration of the above prescribed medication. By submitting this MAF, I am requesting that my child be provided with specific health services by the Department and the New York City Department of Health and Mental Hygiene ("DOHMH") through the Office of School Health ("OSH"). I understand that part of these services may entail an assessment by an OSH physician as to how my child is responding to the prescribed medication. Full and complete instructions regarding the provision of the above-requested health service(s) are included in this MAF. I understand that the Department, DOHMH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that are provided in this MAF. I further understand that the Department, DOHMH and their agents are not responsible for any adverse reaction to this medication.

I recognize that this form is not an agreement by the Department or DOHMH to provide the services requested, but, rather, my request, consent and authorization for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize the Department, DOHMH and their employees and agents, to contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to my child.
SELF-ADMINISTRATION OF MEDICATION: Initial this paragraph for use of an Epi-Pen, asthma inhaler and other approved self-administered medications):

_____ I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further authorize my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, as well as for any and all consequences of my child's use of such medication in school. I further hereby authorize the Department, DOHMH, their agents and employees; including the principal, his/her designee(s), school nurse and my child's teacher(s), to administer such medication in accordance with the instructions of my child's physician should my child be temporarily incapable of self-administering such medication. I understand that the school nurse will confirm my child's ability to self carry and self administer in a responsible manner with the school. In addition, I agree to provide "back up" medication in a clearly labeled bottle to be kept in the medical room in the event my child does not have sufficient medication to self administer.

_____ I also authorize the principal, his/her designee(s) and school nurse to store and/or administer to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

_____ **I hereby certify that I have consulted with my child's health care provider and that I authorize the Office of School Health to administer stock Ventolin in the event that my child's asthma prescription medication is unavailable.**

Please Print Parent/Guardian's Name & Address Below:

_____
Parent/Guardian's Signature

_____
Date Signed

_____
Daytime Telephone No. **Home Telephone No.**

(DO NOT WRITE BELOW - FOR DOE AND DOHMH ONLY)

Student's Name:_____ OSIS No: _____

Received by: _____ _____ Reviewed by _____ _____
Name Date Name Date

Referred to School 504 Coordinator ☐ Yes ☐ No Self-Administers/Self-Carries: ☐ Yes ☐ No

Services provided by: ☐ Nurse ☐ DOHMH Public Health Adv. ☐ School Based Health Center ☐ DOE School Staff

Signature and Title_____ _____
(RN OR MD) (Date school notified and form forwarded to DOE Liaison)

10-11

FOR DOE/DOHMH USE:
☐ **504** ☐ **IEP** ☐ **OTHER**

REQUEST FOR PROVISION OF
MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)
2009-2010 SCHOOL YEAR

Student's Name: Last:_____ First: _____ Middle: _____

Male: _____ Female: _____ D.O.B:_____ I.D. #: _____

Borough: _____ District: _____ School: _____ Grade: _____ Class: _____

School Address: _____ Zip Code:_____

Part I: Physician's Statement/Order
(Attach prescription(s)/additional sheet(s) if necessary to provide requested information and medical authorization).

Clean Intermittent Catheterization	**Tracheostomy Care**	**Chest Clapping**
Central Venous Line	**Oral/Pharyngeal Suctioning**	**Percussion**
Gastrostomy Feeding	**Oxygen Administration**	**Postural Drainage**
Naso-Gastric Feeding	**Ostomy Care**	**Dressing Change**

Other_____

1. Diagnosis_____
2. Treatment required in school_____
3. Specific instructions for providing treatment_____
4. Frequency/time to be provided _____
5. Conditions under which treatment should not be provided _____
6. Date(s) when treatment should be initiated _____terminated _____
7. Possible side effects/adverse reactions to treatment _____
8. Specific instructions for non-medical school personnel in case of adverse reactions_____
9. Specific instructions for nurse (if one is assigned and present) in case of adverse reactions
10. Diagnosis is substantially controlled with provision of medically prescribed treatment Yes _____ No _____
11. Diagnosis is self- limited Yes _____ No _____

_____ _____
Physician's Name (Print) Physician's Signature

_____ _____ _____
Physician/Clinic's Address NYS Registration No. Date Signed

_____ _____
Zip Code Physician/Clinic's Telephone No. Physician/Clinic's Fax No.

FOR DOE/DOHMH USE: Revisions as per DOE/ DOHMH contact with prescribing physician
_____
_____
_____

09-10

PROVISION OF MEDICALLY PRESCRIBED TREATMENT:
PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION
2010-2011

I hereby authorize the provision of medically prescribed treatment in accordance with the attached instructions of my child's physician. I understand that I must furnish all necessary equipment and supplies and that I must immediately advise the principal and/or his/her designee(s) especially the school nurse of any change in the prescription or instructions stated above.

I understand that this Authorization is only valid until the earlier of: (1) **June 30, 2011**; (This prescription may be extended through August if the student is attending a New York City Department of Education (the "Department") sponsored summer instruction program; or (2) such time that I deliver to the principal and/or his/her designee (s) a new prescription or instructions issued by my child's physician regarding the provision of the above-prescribed treatment.

By submitting this Request for Provision of Medically Prescribed Treatment (Non-Medication) Form, I am requesting that my child be provided with specific health services by the Department and the New York City Department of Health and Mental Hygiene ("DOHMH") through the Office of School Health ("OSH"). Full and complete instructions regarding the provision of the above-requested health service(s) are included in this form. I understand that the Department, DOHMH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that are provided in this form. I understand that it is my responsibility to provide all equipment and supplies necessary for the provision of the above-requested medically prescribed non-medication treatment.

I recognize that this form is not an agreement by the Department or DOHMH to provide the services requested, but, rather, my request, consent and authorization for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize the Department or DOHMH and their employees and agents to contact, consult with and to obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment from any health care provider and/or pharmacist.

Please Print Parent/Guardian's Name & Address below:

_____ _____

Parent/Guardian's Signature

_____ _____

Date Signed

_____ _____

Daytime Telephone No./Home Telephone No.

DO NOT WRITE BELOW
(FOR DOE AND DOHMH ONLY)

Student's Name:_____ OSIS No: _____

Received by: _____ _____ Reviewed by: _____ _____
Name Date Name Date

Referred to School 504 Coordinator: ☐ Yes ☐ No

Services provided by: ☐ Nurse ☐ DOHMH Public Health Adv. ☐ School Based Health Center ☐ DOE School Staff

Self-Directs Treatment: ☐ Yes ☐ No

Signature and Title:_____
(RN OR SMD)

(Date school notified and form forwarded to DOE liaison)

10-11

FORMS
You Need to Know

3. The **Diabetes Medication Administration Form** contains the PCP's orders for blood glucose monitoring, insulin administration, snack orders, and emergency treatments. No additional MAF is needed for student with services for Diabetes
4. **Request for Accommodations under Section 504 of the Rehabilitation Act of 1973** for accommodations such as a barrier-free building, elevator use, testing modification, etc.

NYC OFFICE OF SCHOOL HEALTH – DIABETES MEDICATION ADMINISTRATION FORM

SCHOOL YEAR 2010-2011

Student Name			Sex ☐ Female ☐ Male	Date of Birth ___/___/____ Month Day Year
ID Number ___ ___ ___ ___ ___ ___ ___ ___ ___	DOE District ___ ___	School	Grade ___ ___	Class / Borough
School Address				Most Recent A1C Date ___/___/___ Result _____

EMERGENCY SITUATIONS

Severe Hypoglycemia

☐ **Give Glucagon AND CALL 911**

PRN for unconsciousness, unresponsiveness, seizure, or inability to swallow EVEN if the bG is unknown. Turn onto left side to prevent aspiration.

☐ 1 mg SC/IM

☐ ___ mg SC/IM

Risk for Diabetic Ketoacidosis (DKA)

☐ **Ketones:** Test ketones if hyperglycemic*, vomiting, or fever ≥100.5
If small or trace, give water. Re-test ketones and bG in _____ hours
If initial or retest ketones are moderate or large, give water and:
☐ Call parent and/or MD ☐ No Gym
☐ If vomiting, unable to take PO, and MD not available, CALL 911.
☐ Give insulin, if ordered below

Diagnosis ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Other:

Blood Glucose Monitoring and Insulin Orders

Student:

☐ May check bG without supervision ☐ May give insulin without supervision
☐ May check bG with supervision ☐ May give insulin with supervision
☐ Must have school personnel check bG ☐ Must have school nurse give insulin

	☐ Lunch	☐ Snack	☐ Gym	☐ PRN
Hypoglycemia	For bG< _____ mg/dL Give _____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in _____ minutes; If bG < _____, repeat carbs and re-check until bG > _____. THEN ☐ Give insulin, BEFORE Lunch ☐ Give insulin AFTER Lunch	For bG< _____ mg/dL Give _____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in _____ minutes; If bG < _____, repeat carbs and re-check until bG > _____. THEN ☐ Give insulin BEFORE Snack ☐ Give insulin AFTER Snack	For bG< _____ mg/dL Give _____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in _____ minutes; If bG < _____, repeat carbs and re-check until bG > _____. ☐ If initial bG < ____, No Gym ☐ Give Snack AFTER treatment THEN send student to Gym	For bG< _____ mg/dL Give _____ oz juice, or ____ glucose tabs, or ____ gm carbs Re-check in _____ minutes; If bG < _____, repeat carbs and re-check until bG > _____. ☐ Give Snack after treating Hypoglycemia
Between Hypo- and Hyperglycemia	☐ Give insulin BEFORE Lunch ☐ Give insulin AFTER Lunch	☐ Give insulin BEFORE Snack ☐ Give insulin AFTER Snack	☐ Give Snack BEFORE Gym ☐ Send to Gym	
Hyperglycemia* bG > _____	☐ Test ketones if bG > _____ mg/dL Treat as per Risk for DKA above ☐ Give insulin BEFORE Lunch ☐ Give insulin AFTER Lunch	☐ Test ketones if bG > _____ mg/dL Treat as per Risk for DKA above ☐ Give insulin BEFORE Snack ☐ Give insulin AFTER Snack	☐ Test ketones if bG > _____ mg/dL Treat as per Risk for DKA above For bG> _____ mg/dL No Gym For bG> _____ mg/dL AND at least ____ hours since last insulin, give insulin	☐ Test ketones if bG > _____ mg/dL Treat as per Risk for DKA above For bG> _____ mg/dL No Gym For bG> _____ mg/dL AND at least ____ hours since last insulin, give insulin
Carb Coverage Insulin Instructions	☐ Carb coverage ONLY ☐ Carb coverage PLUS Correction Dose when bG > Target bG	☐ Carb coverage ONLY ☐ Carb coverage PLUS Correction Dose when bG > Target bG		

INSULIN ORDERS (CHECK ONE BOX ONLY)

☐ Carb Coverage (plus Correction Dose if ordered above) ☐ Sliding Scale ☐ Carb Coverage plus Sliding Scale for Correction ☐ No Insulin at School Glucose Monitoring ONLY

☐ Syringe / Pen	Name of Insulin			☐ Insulin Pump (*Brand & Model*)			
Target (Single #) bG = _____ mg/dL	Sensitivity Factor (Correction) 1 unit will decrease bG by _____mg/dL	Insulin:Carb Ratio: (I:C)	For LUNCH 1:_____ gms	For SNACK 1:_____ gms	Basal Rate(s):	In School _____ units/hour	☐ Gym _____ %	Temporary basal rate for _____ hours	☐ Disconnect Pump for gym

Round DOWN the insulin dose to the closest 0.5 units for syringe/pen

$$\text{Carb Coverage} = \frac{\#\text{ gms carb in meal}}{\#\text{ gms carb in I:C}} = \_\_\_\_\_ \text{ units insulin} \qquad \text{Correction Dose} = \frac{\text{bG} - \text{Target bG}}{\text{Sensitivity Factor}} = \_\_\_\_\_ \text{ units insulin}$$

Example: Carb Coverage plus Correction Dose

Current bG = 250 Target bG=150 Sensitivity Factor = 100 Insulin:Carb ratio = 1:20 Lunch carbs = 60 gms

Carb Coverage: $\frac{60 \text{ gms carb}}{20} = 3$ units PLUS Correction Dose: $\frac{250-150}{100} = 1$ unit TOTAL DOSE: 3+1=4 units

For Pump:
☐ Follow Pump recommendation for bolus dose (If not using Pump recommendation, round DOWN the dose down to nearest 0.1 unit)
☐ For bG > _____ mg/dL that has not decreased ____ hours after correction consider pump failure. Notify parent.
☐ For suspected pump failure: DISCONNECT pump and give insulin by syringe or pen

SLIDING SCALE

Name of Insulin _____

Ranges do NOT overlap ranges (e.g. 150-200, 200-300, etc). If ranges overlap, the lower dose will be given.

☐ Pre lunch	bG Range	Insulin Units	☐ Other time	bG Range	Insulin Units

SNACK:
Time of day: _____
Type & Amount:
☐ Student may carry and self administer snacks

HOME MEDICATIONS
Insulin (*Dose, Frequency, and Dose*)
Oral Medications (*Dose, Frequency, and Dose*)

OTHER DIABETES ORDERS

Health Care Practitioner Name (*Please Print*)		Tel. No.	For DOHMH USE: Revisions per consult with Prescriber:
Health Care Practitioner Signature	Date ___/___/___	Fax No.	
Address		NYS Lic. No. (Required)	

SH-101 (Rev. 3/10)

MONITORING BLOOD SUGAR, MEDICATION AND DIETARY NEEDS:
PARENT/GUARDIAN'S CONSENTAND AUTHORIZATION
2010-2011

I hereby authorize: (1) the monitoring of my child's blood sugar, (2) the provision of medically prescribed treatment and/or (3) the treatment of hypoglycemic episodes on school premises, in accordance with the attached instructions of his/her physician. I understand that I must furnish all necessary snacks, equipment and supplies and that I must immediately advise the principal and/or his/her designee(s), especially the school nurse, of any change in the prescription or instructions stated above.

I understand that this Authorization is only valid until the earlier of: (1) June 30, 2011; (This prescription may be extended through August if the student is attending a New York City Department of Education (the" Department") sponsored summer instruction program); or (2) such time that I deliver to the principal, his/her designee(s) and school nurse a new prescription or instructions issued by my child's physician regarding the administration of the above-prescribed monitoring and treatment.

I recognize that the New York City Department of Education (the "Department"), its agents and the Department of Health and Mental Hygiene ("DOHMH") has a responsibility to ensure a safe environment in the medical room and anywhere else where my child may test his or her blood sugar. I will make every effort to provide the school with safety lancets and other safer needle devices for the purpose of glucose monitoring and insulin administration.

By submitting this Diabetes Medication Administration Form, I am requesting that my child be provided with specific health services by the Department and the New York City Department of Health and Mental Hygiene ("DOHMH") through the Office of School Health ("OSH").I understand that part of these services may entail an assessment by an OSH physician as to how my child is responding to the prescribed medication. Full and complete instructions regarding the provision of the above-requested health service(s) are included in this form. I understand that the Department, DOHMH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that are provided in this form. I further understand that the Department, DOHMH and their agents are not responsible for any adverse reaction to this medication.

I recognize that this form is not an agreement by the Department or DOHMH to provide the services requested, but, rather, my request, consent and authorization for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize the Department, DOHMH and their, employees, and agents, to contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist.

Please Print Parent/Guardian's Name & Address Below:

_____
Parent/Guardian's Signature

_____
Date Signed

_____
Daytime Telephone No./ Home Telephone No.

_____

_____

_____

DO NOT WRITE BELOW (FOR DOE AND DOHMH ONLY)

Student's Name:_____ OSIS No:_____

Received by: _____ _____ Reviewed by:_____ _____
Name Date Name Date

Referred to School 504 Coordinator: ☐ Yes ☐ No Self-Monitors: ☐ Yes ☐ No

Services provided by: ☐ Nurse ☐ DOHMH Public Health Adv. ☐ School Based Clinic ☐ DOE School Staff

Signature and Title:_____ _____
(RN OR SMD) (Date school notified and form forwarded to DOE liaison)

10-11

REQUEST FOR ACCOMMODATIONS UNDER SECTION 504 of the REHABILITATION ACT of 1973
2010-2011 SCHOOL YEAR

Student's Name: Last: _____ First: _____ Middle: _____

Male: _____ Female: _____ D.O.B: _____ I.D. #: _____

Borough: _____ District: _____ School: _____ Grade: _____ Class: _____

School Address: _____ Zip Code: _____

Physician's Statement for Requested 504 Accommodations (if applicable):

1. Describe the nature of the concern: _____

2. Medical Diagnosis/Disability: _____

3. Describe how the disability affects the student's educational performance: _____

4. List/describe the educational service(s) that are being requested: _____

Physician's Name (Print) Physician's Signature

Physician/Clinic's Address NYS Registration No. Date Signed

Zip Code Physician/Clinic's Telephone No. Physician/Clinic's Fax No.

Parent's Statement for Requested 504 Accommodations:

1. Describe the nature of the concern: _____

2. Describe how the disability affects the student's educational performance: _____

3. List/describe the 504 accommodations that are being requested: _____

To determine whether 504 accommodations are necessary, a 504 team will convene to review your request. If a 504 Accommodation Plan is necessary it will be completed by the school with your input. This plan must be reviewed annually.

By submitting this Request for 504 Accommodations, I am requesting that my child be provided with specific educational accommodation(s)) by the New York City Department of Education (the "Department"). I have provided the full and complete information regarding this request for educational accommodation(s) in this form. I understand that the Department, its agents, and its employees involved in the provision of the above-requested accommodation(s) are relying on the accuracy of the information that I have provided in this form to determine whether and to what extent my child will be provided with accommodations under Section 504.

Please Print Parent/Guardian's Name & Address Below:

Parent/Guardian's Signature

Date Signed

Daytime Telephone No.

10-11

REQUEST FOR ACCOMMODATIONS UNDER SECTION 504 OF THE REHABILITATION ACT OF 1973
2010- 2011

DO NOT WRITE BELOW
(FOR NYC DEPARTMENT OF EDUCATION USE ONLY)

Student's Name: _____ OSIS No: _____

Reviewed by: _____ _____
Name (Please Print) Title Date

Request for Educational Service(s)

Approved _____ Denied _____ Referred for Further Review _____

Reason Request Approved or Denied:

Referred to CSE _____ Sent to School 504 Coordinator

Date of Referral _____ Date of 504 Team Mtg. _____

_____ _____
Signature Date

10-11

FORMS
You Need to Know

Referral Forms

12S and SH 10: Complete these forms to notify parents and/or providers of the med room visit and the need for further evaluation and medical care for the student.

12S

OFFICE OF SCHOOL HEALTH
DEPARTMENT OF HEALTH AND MENTAL HYGIENE – THE CITY OF NEW YORK

Issued at:

Date: _____

Grade/Class: _____

OSIS #: _____

Student Name: _____ Date of Birth: _____
Last *First*

❑ Dear Parent:
It is advisable to consult your physician regarding the following:

_____

_____

_____

If this form is not completed and returned, your child may be assessed by our school health doctor as authorized by the NYC Health Code. If you do not wish your child to be placed on the physician's schedule, please contact the nurse at _____ (phone).

❑ Dear Doctor:
Will you please give your opinion and recommendations on the lower portion of this form. A description of your findings will be appreciated. If you find it necessary to refer this child for further study, please note and indicate where referred.

_____ _____
Name Title

PLEASE RETURN TO SCHOOL MEDICAL ROOM

TREATMENT AGENCY REPORT

Findings :

Diagnosis:

Treatment Plan:

*** RECOMMENDATIONS FOR SCHOOL**

❑ NORMAL ACTIVITY
❑ Special Health Accommodations
- ❑ Bus Transportation
  Duration _____
- ❑ No Competitive Games
- ❑ Adaptive Physical Education
- ❑ Elevator Pass (if available)
- ❑ Other _____

* Additional information may be required from the provider.

Child is under treatment: Yes ❑ No ❑. I wish to see child again on _____

If referred to another physician or clinic, please indicate where referred: _____

Hospital/ER ❑
Clinic ❑
Managed Care ❑
Private Practice ❑

Date _____ _____
Please Print Name & Title

Address _____ Tel. No. _____

THIS REPORT IS TO BE RETURNED TO THE NURSE BY PARENT OR STUDENT
THE DEPARTMENT OF HEALTH WILL BE GLAD TO COOPERATE IN CARRYING OUT YOUR RECOMMENDATIONS

12S (Rev. 8/09)

SH10

OFFICE OF SCHOOL HEALTH

School: _____ Date: _____

Dear Parent/Guardian of: _____ Class: _____ DOB: _____

Subject: **Medical Room Visit** OSIS: _____

Your child was seen in the medical room today for:

____Abrasion
____Ache/Pain
____Allergy Symptoms
  ____Eyes: itchy/red/teary
  ____Nose: itchy/runny/stuffy/sneezing
  ____Throat: scratchy/itchy
____Bite
____Cut
____Cough/Cold
____Earache: right/left
____Eye: right/left
____Other (specify)_____
____Fever: ____F
____Headache/Dizziness
____Nausea/Vomiting
____Nosebleed
____Pain
____Rash
____Skin: itchy/dry/irritation
____Sore Throat
____Stomachache
____Tiredness/Fatigue
____Toothache
____Trauma
____Vision Problem: right/left

Treatment Given:

____Ice Pack
____Band-Aid
____Cold Compress
____Meal/Snack
____Pressure to stop bleeding
____Area cleaned with soap & water
____Fluids: Water/Juice

Recommendations:

____Please see your doctor/dentist for an evaluation
____Keep at home until temperature is normal for 24 hours
____Keep at home until eyes are free of discharge
____Keep at home until vomiting has stopped for 24 hours
____Update your emergency card for parental contact **(we were unable to reach you)**
____Submit **New Admission Physical Exam** Form (211s)

Please contact your Health Care Provider for evaluation:

____If your child complains of headache, dizziness, nausea, and/or sleepiness
____If area of complaint becomes swollen and/or very painful
____If pain and/or condition continues

Additional Comments: _____

_____

_____

SEEN BY: _____ **TEL. #:** _____
(Name and Title)

SH 10 (Rev. 8/05)

FORMS
You Need to Know

Referral Forms

C12S: Cardiac Report and Recommendations

- Review the C12S
- If the student's activities are restricted by the physician, **you must**
  - **Notify** the child's classroom teacher and the gym teacher and document your notification in ASHR/103S
  - **Log** findings/recommendations on the child's 103S or ASHR and the date/time you notified the child's classroom and gym teachers
  - **Log** recommendations on the child's 104s

DEPT. OF HEALTH & MENTAL HYGIENE — THE CITY OF NEW YORK OFFICE OF SCHOOL HEALTH — DEPARTMENT OF EDUCATION

CARDIAC CONSULTATION AND RECOMMENDATIONS

NAME: LAST	FIRST	DATE OF BIRTH	❑ MALE ❑ FEMALE	OSIS NO.
PARENT/GUARDIAN	ADDRESS	BORO	APT.	ZIP	TELEPHONE NO.
SCHOOL NUMBER/NAME	ADDRESS	BORO	GRADE	CLASS

REASON FOR REFERRAL

SIGNATURE/TITLE: DATE: / /

TO BE COMPLETED BY PHYSICIAN

CARDIAC DIAGNOSIS

❑ No Heart Disease	❑ Congenital Heart Disease (specify)
❑ Innocent Murmur	❑ Aquired Heart Disease (specify)

❑ Other Existing Medical Conditions (specify)

❑ Cardiac Surgery ❑ Yes ❑ No Date and Procedure

1.

2.

Cardiac Examination:

Functional Classification: ❑ I ❑ II ❑ III ❑ IV Therapeutic Classification: ❑ A ❑ B ❑ C ❑ D ❑ E

Medications:

SBE Prophylaxis Recommended: ❑ Yes ❑ No Medication:

Cardiac Supervision Necessary: ❑ Yes ❑ No If Yes, Frequency of Appts.

SCHOOL PLACEMENT RECOMMENDATION	ACCOMMODATIONS REQUEST
❑ Regular School	❑ Bus Transportation
❑ Barrier Free School	❑ Elevator
❑ Home Instruction	❑ Extra Set of Books
❑ Hospital School (specify)	❑ Assistance with Ambulation
	❑ Other

PHYSICAL EDUCATION/GYM PLACEMENT RECOMMENDATION	
❑ Full Activity/Regular Gym/Contact Sports	❑ No Competitive Games/Contact Sports
❑ Adaptive Physical Education	❑ No Physical Education/No Gym
❑ Other (specify)	

PHYSICIAN'S NAME (Print)	ADDRESS	❑ Primary Care
SIGNATURE	TELEPHONE NO.	❑ Cardiologist

C12S (Rev. 8/05) (FRONT)

DEPT. OF HEALTH & MENTAL HYGIENE — THE CITY OF NEW YORK OFFICE OF SCHOOL HEALTH — DEPARTMENT OF EDUCATION

CARDIAC CONSULTATION AND RECOMMENDATIONS

INSTRUCTIONS

TO EXAMINING PHYSICIAN: Important – Please read carefully and complete all information requested on front of form.

An examination and a report are requested for all children with definite, potential or possible heart disease, whether or not any modification of physical activity in school is recommended. A new report on this form is requested twice a school year for those receiving home instruction, and at least once a year for all other children.

Your record of clinical findings, diagnosis, and recommendations will form the basis for planning the physical activities of the child in school. It is always to the advantage of the child to attend a regular class whenever he is able to do so. To facilitate the prompt transfer of a child back to school or to regular class in school, it will be helpful if a definite period of special placement is stipulated.

Changes in the physical activities of the school child in school are subject to the approval of the Department of Health which reserves the right to examine all children recommended for such changes.

FUNCTIONAL AND THERAPEUTIC CLASSIFICATIONS

(CHECK ON REVERSE SIDE APPROPRIATE NUMBER AND LETTER)

Functional Classification (Degree of Cardiac Disability)

Class I. Ordinary physical activity does not cause discomfort.

Class II. Ordinary physical activity causes slight discomfort.

Class III. Ordinary physical activity causes marked discomfort.

Class IV. Unable to carry on any physical activity without discomfort.

Therapeutic Classification (Recommendations for Physical Activity)

Class A. Physical activity need not be restricted.

Class B. Ordinary physical activity need not be restricted, but child should be advised against unusually severe or competitive efforts.

Class C. Ordinary physical activity should be moderately restricted and more strenuous habitual efforts should be discontinued.

Class D. Ordinary physical activity should be markedly restricted.

Class E. Should be at complete rest, confined to bed or chair.

TYPES OF EDUCATIONAL PLACEMENT AND ACTIVITIES WHICH MAY BE RECOMMENDED

The types of placement recognized by the Board of Education are listed by number below. Please indicate your recommendation by checking only one of the items on the reverse side under the heading "Examining Physician's Recommendations for Educational Placement and Activities."

C12S (Rev. 8/05) (REVERSE)

FORMS
You Need to Know

Referral Forms

E12S: Eye Report and Recommendations

- Review the E12S
- If the student's activities are restricted by the physician, **you must**
  - **Notify** the child's classroom teacher and the gym teacher and document notification in ASHR/103 S.
  - **Log** findings/recommendations on the child's 103S or ASHR and the date/time you notified the child's classroom and gym teachers
  - Log recommendations onto student's 104s.

E12S

Please return top copy (completed) to Vision and Hearing, 2 Lafayette St., Box 25, 22nd Fl., New York, NY 10007

NYC DEPARTMENT OF HEALTH AND MENTAL HYGIENE — NYC DEPARTMENT OF EDUCATION

EYE REPORT AND RECOMMENDATIONS

(Please Print On Hard Surface)

CHILD'S NAME: Last, First	SEX: ☐ Male ☐ Female	OSIS #	DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP
SCHOOL	BOROUGH/DISTRICT		GRADE/CLASSROOM
PARENT/GUARDIAN	TELEPHONE #		

E12 History	**Yes**	**No**	**Unknown**	
Newly identified case (1ST E12S)	☐	☐	☐	Date of issue: _____
Follow up for previous issue of E12S not returned	☐	☐	☐	By: _____
Annual follow up for case with completed E12S	☐	☐	☐	Title: _____

TO THE PARENT: Your child did not pass one or more parts of the vision test. Please take your child to an eye doctor for an examination

Screening Results: *(to be filled out by DOHMH only)*

Date of screening: _____ Team code: _____

FAR			NEAR	
Without Glasses	With Glasses		Without Glasses	With Glasses
20/	20/	Right	20/	20/
20/	20/	Left	20/	20/
20/	20/	Both	20/	20/

Right Eye (+1.50): Pass ☐ Fail ☐ Fusion: Pass ☐ Fail ☐

Left Eye (+1.50): Pass ☐ Fail ☐ Color Test: Pass ☐ Fail ☐

TO THE DOCTOR: Please fill out all data fields below to permit proper educational planning for this child.

DOCTOR'S EXAMINATION: *(to be filled out by medical staff only)*

Date of examination: _____ Next visit: _____

Is any ocular pathology or any field limitation present? ☐ Yes ☐ No

If yes, describe: _____

	Uncorrected		Corrected	
	Distance	Near	Distance	Near
Right				
Left				
Both				

Prescription given:

	Sphere	Cylinder	Axis	Add
Right				
Left				

Diagnosis: _____

Special vision services recommended? ☐ Yes ☐ No If yes, specify: _____

Color deficiency confirmed by doctor? ☐ Yes ☐ No

Your recommendations:

Are glasses to be worn? ☐ Yes ☐ No Indicate extent of use: ☐ For near ☐ For far ☐ Constant

New prescription? ☐ Yes ☐ No

Eyeglasses dispensed today? ☐ Yes ☐ No

Patch prescribed? ☐ Yes ☐ No Which eye to be covered? ☐ Left ☐ Right

Where worn? ☐ In school ☐ After school ☐ Both

Hours per day? _____

Other treatment: _____

School accommodations:

Seating accommodation requested? ☐ Yes ☐ No

Indicate the position: ☐ Front center ☐ Front left ☐ Front right

Other accommodation: _____

Exclude from contact sports? ☐ Yes ☐ No If yes, until ☐ Temporary date: _____ ☐ Permanently

Wear protective goggles in gym/sports? ☐ Yes ☐ No

Doctor's Name: _____ (First) _____ (Last) Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: (_____) _____ License #: _____

For office use only Vendor: _____

E12S DOHMH/DOE (Rev. 1/06) COPIES: White (Vision and Hearing Program), Canary (Medical Room), Pink (Parent)

Back of

E12S

Educational Vision Services

The New York City Public Schools provide specialized educational services for students who are blind or visually impaired. Students are eligible if their best-corrected vision in the better eye is 20/70 or lower, or if they have specified visual impairments, such as macular degeneration, retinopathy of prematurity, optic atrophy, high myopia or albinism. Services are designed to give students access to the general curriculum, and to participate in general or special education classes at the highest possible level of independence. Available services include:

- Braille
- Large print reading materials
- Training with low vision devices
- Specialized adaptive computer technology
- Instruction in other skills to attain literacy in:
  - reading
  - writing
  - mathematics
  - sciences
  - computers
- Instruction in orientation and mobility for independence in travel
- Bus transportation, if needed.

For further information contact:

Educational Vision Services
400 First Avenue, 7th Floor
New York, NY 10010
Phone: (917) 256-4259
Fax: (917) 256-4230

FORMS
You Need to Know

Referral Forms

O12S: Orthopedic Report and Recommendations

- Review the O12S
- If the student's activities are restricted by the physician, **you must**
  - **Notify** the child's classroom teacher and the gym teacher and document notification in ASHR /103 S.
  - **Log** findings/recommendations on the child's 103S or ASHR and the date/time you notified the child's classroom and gym teachers
  - **Log** recommendations on the child's 104s

TYPE OR USE BALL POINT PEN TO ENSURE CLEAR CARBON COPIES

ALL INFORMATION MUST BE COMPLETED

THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

ORTHOPEDIC REPORT AND RECOMMENDATIONS

NAME, LAST	FIRST	ADDRESS	APT. NO.	BORO	TEL. NO.
DATE OF BIRTH	❑ MALE ❑ FEMALE	NAME OF PARENT OR GUARDIAN	CLINIC NO.		MEDICAID NO.
HOSPITAL SCHOOL ❑ YES ❑ NO NAME OF HOSPITAL		SCHOOL (OR SCHOOL PREVIOUSLY ATTENDED)	ADDRESS	BORO	GRADE-CLASS

PRESENT EDUCATIONAL PLACEMENT AND ACTIVITIES

1. REGULAR CLASS	2. HEALTH CONSERVATION CLASS	3.	4.
Normal a. ❑ Activities b. ❑ No Comp. Games c. ❑ No Physical Training	Bus a. ❑ Transp. Without b. ❑ Bus. Transp.	HOME ❑ INSTRUCTION	❑ WITHDRAWN FROM SCHOOL ❑ NOT YET ATTENDING

INFORMATION AND QUESTIONS FROM SCHOOL HEALTH SERVICE TO EXAMINING PHYSICIAN:

TITLE

ALL INFORMATION MUST BE COMPLETED

DIAGNOSIS	DATE OF ONSETS OF ORTHOPEDIC DISABILITY	PARTS OF BODY INVOLVED
DATE OF LAST PHYSICAL EXAMINATION: MONTH DAY YEAR	HAS MEDICAL SUPERVISION OTHER THAN ORTHOPEDIC BEEN ARRANGED? ❑ YES ❑ NO ❑ WILL ARRANGE AT:	
RECENT SURGERY PERFORMED: ❑ YES ❑ NO DATE:	PROCEDURE:	
DEGREE OF DISABILITY ❑ COMPLETE ❑ SEVERE ❑ MODERATE ❑ MILD ❑ NONE	STATUS OF DISABILITY ❑ PROGRESSIVE ❑ STATIC ❑ IMPROVING ❑ MAXIMUM IMPROVEMENT	
IF APPLIANCE, CAST OR SPECIAL SHOE WORN? ❑ YES ❑ NO WHAT TYPE?	MAY APPLIANCE BE REMOVED? ❑ YES ❑ NO WHEN, AND HOW LONG?	
ITEMIZE POSITIVE FINDINGS? OTHER THAN ORTHOPEDIC:		
DOES CHILD RECEIVE PHYSICAL THERAPY? ❑ YES ❑ NO	PHYSICAL THERAPY GIVEN AT:	HOW OFTEN?
HAS REFERRAL FOR VOCATIONAL REHABILITATION BEEN MADE? ❑ YES ❑ NO WHERE?		
HOW FAR TO SCHOOL MAY CHILD WALK? _____ BLOCKS	SHOULD CHILD CLIMB STAIRS? ❑ NO ❑ AS NECESSARY ❑ LIMITED *(SPECIFY)*	
SPECIFY OTHER LIMITATIONS AND INSTRUCTIONS TO SCHOOL HEALTH SERVICE:		

RECOMMENDATION FOR EDUCATIONAL PLACEMENT AND ACTIVITIES (Select Number from Instructions on Reverse Side)

NUMBER (And Letter)	DURATION OF PLACEMENT
_____ M.D. SIGNATURE OF EXAMINING PHYSICIAN	NAME OF PHYSICIAN (PRINT OR TYPE)
ADDRESS OF EXAMINING PHYSICIAN	TELEPHONE NO. / DATE SIGNED
IF EXAMINED IN HOSPITAL OR CLINIC – GIVE NAME, ADDRESS, AND PHONE NUMBER OF SAME	CLINIC NUMBER / MEDICAID NUMBER

FOR USE OF THE DEPARTMENT OF HEALTH ONLY

REMARKS:	DATE	APPROVED: _____ M.D. SCHOOL PHYSICIAN
REMARKS:	DATE	APPROVED: _____ M.D. ORTHOPEDIC CONSULTANT

012S (Rev. 9/03)

THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

ORTHOPEDIC REPORT AND RECOMMENDATIONS

INSTRUCTIONS

TO EXAMINING PHYSICIAN: Important – Please Read Carefully

An examination and a report are requested for all children with any orthopedic abnormality whether or not any modification of physical activity in school is recommended. A new report on this form is requested twice a school year for those receiving home instruction, and at least once a year for those in special classes.

Your diagnosis and recommendation will form the basis for planning the physical activities of the child in school. It is always to the advantage of the child to attend a regular class whether he is able to do so. To facilitate the prompt transfer of a child back to school or to regular class in school, it will be helpful if a definite period of special placement is stipulated.

Changes in the physical activities of the school child in school are subject to the approval of the Department of Health which reserves the right to examine all children recommended for such changes.

TYPES OF EDUCATIONAL PLACEMENT AND ACTIVITIES WHICH MAY BE RECOMMENDED (SUBJECT TO THE APPROVAL OF THE DEPARTMENT OF HEALTH)

The eight types of placement recognized by the Board of Education are listed by number below. Please indicate your recommendation by selecting only one of the numbers, and noting it in the section of the reverse side under the heading "Recommendation for Educational Placement and Activities." Attention is called to the subdivisions under "1" and "6" (regular class) where it is necessary to indicate the letter as well as the number.

ELEMENTARY AND JUNIOR HIGH SCHOOL (No Elevators Available)	SENIOR HIGH SCHOOL
1. REGULAR CLASS a. Normal Activity b. Competitive Games Adjusted to Physical Limitation c. No Physical Activity d. Bus Transportation – Duration _____	**1. REGULAR CLASS** a. Normal Activity b. Competitive Games Adjusted to Physical Limitation c. No Physical Activity d. Bus Transportation – Duration _____ e. Elevator Pass f. Extra Set of Books *Child will be allowed conditioning exercises, marching, dancing, group games (no relay races), shuffle-board, volley ball, net games, swimming.
2. HEALTH CONSERVATION CLASS (For Children with Orthopedic Handicaps who need bus transportation)	**2. HEALTH CONSERVATION CLASS** (For Children with Orthopedic Handicaps who need bus transportation)
3. HEALTH CONSERVATION CLASS (SERIES 20) (For Children with severe orthopedic and neuromuscular handicaps)	**7. HEALTH CLASS**
4. HOME TEACHER (Restricted to children who should be at rest, bed, or chair	**8. HOME TEACHER** (Restricted to children who should be at rest, bed, or chair)
5. WITHDRAW FROM SCHOOL (Refers to children who are acutely ill)	**9. WITHDRAW FROM SCHOOL** (Refers to children who are acutely ill)

After completing the information requested on this form, please mail the first two copies to the school listed on the reverse side, (attention of School Physician). If school of child is unknown, mail to Orthopedic Consultant, Bureau for Families with Special Needs.

012S (Rev. 9/03)

FORMS:
URGENT ACTION

- Conduct a clinical review of **every form** you receive (such as the CH205, C12S, E12S, O12S)
- **If** the findings/recommendations restrict a child's activities then **you must**:
  - **Notify** the child's classroom teacher and the gym teacher and document the notification in ASHR / 103 S
  - **Log** findings/recommendations on the child's 103S or ASHR and the date/time you notified the child's classroom and gym teachers
  - **Log** recommendations on the child's 104s

Office of School Health Initiatives

OSH initiatives include:

- Managing Asthma in Schools (MAS)
- Healthy Options and Physical Activity in Schools (HOP)
- Connecting Adolescents to Comprehensive Health Care (CATCH)
- Screening the At Risk Student (STARS)

OSH School Based Collaborations

- OSH Nurses may be involved in the following School Based Collaborations:
  - School Health and Wellness Team
  - Nutrition Committee
  - Child Abuse and Prevention and Intervention Team Attendance Committee
  - Safety Committee
  - IEP (Individual Education Program) Team

Welcome to the School Health Team (You Are Never Alone)

- **Your Supervising Nurse, PHN II and Borough Nursing Director (BND) are your support team**

- **Contact them whenever you need clarification or assistance**

Test Your Knowledge of School Health

- Answer the following 25 true or false questions about your nursing assignment with School Health.

Test Your Knowledge of School Health

1. On reporting for duty, I can wear colorful scrubs to work. True _____ False____
2. One of my roles is to serve as a liaison between the medical provider, community groups, the school and the staff regarding student health concerns. True _____ False____
3. For Medical Room walk-ins, I only enter information in the Daily Log.
   True _____ False____
4. The student's individual paper School Health Record is known as the 103S. True _____ False____

Test Your Knowledge of School Health

5. I should always accompany a student in an ambulance. True _____ False____
6. The Daily Medication Binder contains lists indicating which students to expect for medication and procedures and what time to expect them.
   True _____ False____
7. I have a 3-hour window to administer medication to a student on the "Special Health Services – Daily" list. True _____ False____

Test Your Knowledge of School Health

8. A child can bring medication or equipment to me on his or her own.
   True _____ False____
9. Whenever I observe a self-directed student, I always follow the four rights.
   True _____ False____
10. If I have any questions about daily or PRN medication and procedures, I should ask the principal. True _____ False____
11. The SN/BND are my primary source for professional guidance. True _____ False____

Test Your Knowledge of School Health

12. All diseases and conditions that are threat to public health must be reported immediately to the SN or BND.
    True _____ False____
13. Food-related illnesses and blood exposures are 2 examples of public health threats that must be reported immediately to the SN/BND.
    True _____ False____
14. You do **not** need to report hepatitis or meningitis to your SN/BND. True _____ False____

Test Your Knowledge of School Health

15. The only disease that does **not** require a confirming doctor's note is Scarlet Fever.
    True _____ False____
16. There are 3 "must haves" whenever you report a communicable disease.
    True _____ False____
17. If school personnel refuse and your SN/ BND agrees that you must report a suspected abuse/neglect case, you should call the Central Registry yourself. True _____ False____

Test Your Knowledge of School Health

18. You can use any type of lancet for glucose monitoring that a parent provides.
    True _____ False____
19. In the event that a student who was previously able to administer Insulin via Insulin pen becomes unable to do so, to OSH nurse will attach the Novofine Autocover safety needle to the students insulin pen to administer the prescribed insulin. True _____ False____

Test Your Knowledge of School Health

20. To rule out viral illness from a suspected food-borne incident, check the daily log for the past 10 days. True _____ False____

21. DOE lunch staff will work with you to save samples of food and drink for DOHMH environmental investigators to inspect. True _____ False____

Test Your Knowledge of School Health

22. The 12S is used to notify parents/ providers the need for further evaluation and medical care for the student. True _____ False____

23. A student diagnosed with MRSA must be excluded until the infection site is healed. True _____ False____

24. The 103S is the child's individual paper school health record kept in the locked file cabinet in the medical room. True _____ False____

Test Your Knowledge of School Health

25. After your clinical review of any form that restricts a child's activities, notify the classroom and gym teachers and log the findings on ASHR or his/her 103S and indicate the restrictions on the student's 104s.

True _____ False____