OFFICE OF SCHOOL HEALTH
CONTRACT SCHOOL HEALTH NURSING
NURSE ROLE Part 1 of 3

William DE Blasio, Mayor

Richard A. Carranza

Chancellor

New York City Department of Education

Dave A Chokshi

Commissioner

New York City Department of Health and Mental Hygiene

https://www.youtube.com/watch?v=neV3EPgvZ3g

Office of School Health (OSH)

Office of School Health (OSH):

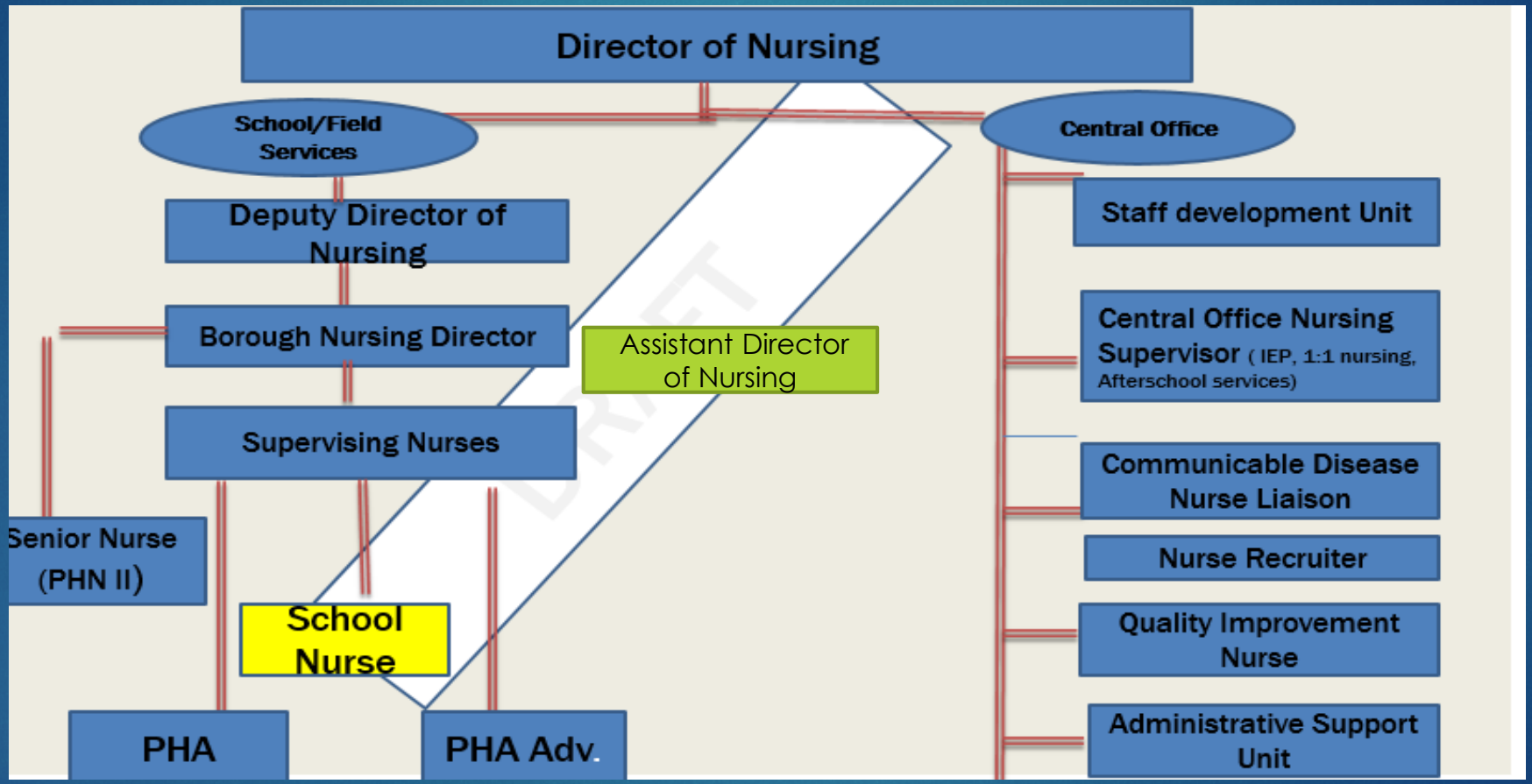
- A joint office of the NYC Department of Education (DOE) and the New York City Department of Health and Mental Hygiene (DOHMH).

Office of School Health provides:

- Public health services for New York City's 1.3 million students in approximately 1800 Public and Non-public Schools and Afterschool Programs

- Direct services, Case management and Health education

Office of School Health Organizational Chart



OSH INITIATIVES

- **Asthma** – Enhanced Asthma School Intervention (EASI) clinical pathways for assessment, treatment and emergency management of asthma symptoms.

  Inhaled Corticosteroids (ICS) - Flovent, an (ICS) can be supplied by OSH to improve asthma control.

- **Obesity** – Healthy Options and Physical Activity (**HOP**)

- **Mental Health** _ Screening the At Risk Students (**STARS**)- a suicidal prevention screening tool

- **Reproductive Health** – Connecting Adolescents to Comprehensive Health (**CATCH**) -High Schools Only

OSH/ Agency Clinical Staff

- Supervising Medical Physicians(SMD)- Supervise OSH Field Physicians
- Field Physicians – examine students, prescribe asthma medications, provide CATCH services in the HS program
- Borough Nursing Directors (BNDs)- manage OSH nursing services by borough
- Nursing Supervisors- DOE and DOHMH- (PHN ll /PHN III/ SN)
- Contract Agency Nursing Supervisors- educate, supervise contracted nurses

- Registered Nurses (RNs) –Direct care, case management
- Public Health Advisors (PHADV) – provide first aid, administer some emergency medications, chaperone MD exams, Observe supervised students with some medications
- Public Health Assistants (PHASST) – Provide First Aid, assist with MD exam preparations, record maintenance

Registered Nursing Requirements

- Contract Nurse requirements:
- Maintain current RN State registration
- Maintain current certification in Cardio-Pulmonary Resuscitation (CPR) and Automated External Defibrillators (AED's) for Adults, children and infants
- Have 1-2 years recent Registered Nurse experience (SY 20-21 **Only**)
- Complete the CDC "Heads Up" Concussion video for health professionals every 2 years and provide certificate to Agency
- Attend Blood borne Pathogens Training with Agencies

*CDC LINK Here

Obtain a National Provider Identification (NPI) Number

Professional Identification & Customer Service

- Wear your DOE/agency identification while on duty to identify you as the Registered Professional Nurse
- Wear professional attire, scrubs or jeans are not appropriate for OSH
- Maintain professional work relationships
- Communicate in a professional manner with students, parents and school staff
- Comply with the standard DOE policies for personal devices for communication
- Self-assess social media use for appropriateness

- Respect for all

Be alert, awake and available for duty

Registered Nurses On Duty

Nurses who service OSH must:

- **Carry copy of their NYS current registration certificate or state ID**
- **Carry DOE and or Agency Identification**
- **Part 59.8 (C) of the Regulations of the Commissioner of Education States:**
  - **…Where a practice is carried on in other than individual offices each licensee shall have a current registration certificate available for inspection at all times**

Contract Nurse Service Models

- **Long Term Contracts/Agreements- One nurse in 1 school for the year**
- **Short Term – Intermittent day to day or extended on request**
- **1:1 nurse-Provides prescribed care to that student only when mandated on students Individualized Education Programs (IEPs)** or 504 Accommodations and upon review of clinical needs. The student with 1:1 service requires 1:1 care to attend school**
- **Trip nurse- Accompanies student (s) on school trips on OSH request**

  Due to COVID-19, NYCDOE trips are postponed until further notice
- **Transportation Nurse (TN) -Accompanies a student in DOE authorized vehicle as per IEP and MAF review**

*****An Individualized Educational Program (IEP) is a written Federal mandate for DOE to provide services in the least restrictive environment (LRE)**

Nursing Hours

- Work hours are generally 6 hours and 55 minutes per day. Individual school hours may differ in each building.
- Contract Nurses are entitled to a ½ hour break/lunch on school premises
- **Staff must remain in the school building for the day and must remain available for care if needed**
- Inform the General Office Staff of your break time and location on the premises if a medical need arises

Nursing Hours

- Nurses on premises earlier or later than their assigned work hours are expected to respond to requests for nursing assistance
- Nurses must confirm additionally requested hours (after-school) with their agencies
- Notify OSH Supervising Nurse (SN) or Borough Nursing Director BND and the Contracting Agency of school emergencies or personal emergencies that may interrupt your tour of duty
- **Leaving the OSH assignment during duty without authorization may be considered abandonment and reportable to the state**

Identifying Students & Schools In OSH

Public School Identification:

- Public Schools identify NYC DOE by their **D**istrict, Borough and **N**umber (DBN)

Public School Students identifications :

- NYC DOE assigns individual “osis numbers” upon admission to NYC schools

Non-Public schools (NPS) and Private Schools

- NPS is identified by name and Geographical district location
- NPS students are identified by name + Date of Birth (DOB)

NYC DOE School Personnel

NYC Department of Education (DOE) personnel manage school/building services:

School Principals manage services of :

- Assistant Principals/Deans
- Teachers
- General Office Secretaries
- School Aides
- Paraprofessional
- Guidance Counselors
- Food Service Employees (supervised by Dieticians)
- School Custodian Teams

- OSH Nursing Teams collaborate with school administrations for some student services

Serviced Populations & Settings

- Universal Pre-K (UPK) 3/4-year-old – Can be stand alone or within an Elementary school
- Elementary Schools
- Middle (Junior High) Schools
- High Schools
- Charter Schools (District 84)
- D75 Programs – students with Individual educational plans (IEPs) – can be stand alone or co-located
- Non –Public Schools
- Schools sites with co-located schools – can be a combination of any above mentioned
- School Based Health Centers (SBHC) – may be within a school/ may or may not have an OSH nurse

Identifying Schools

Borough	Borough code	NYC DOE School Districts	DBN School identification examples
Manhattan	M	1,2,3,4,5,6	02M555/02M888 (co-located eg)
Bronx	X	7,8,9,10,11,12	12X222
Brooklyn	K	13,14,15,16,17,18,19,20,21,22,23	23K144
Queens	Q	24,25,26,27,28,29, 30	29Q893
Staten Island	R	31	31R999
Administrative Districts:		District 75 Citywide programs	75K555 75M222
Non-Public Schools and private schools identify by name		Charter Schools coded 84, all boroughs	84X333 84Q002

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Arrival At Your Assigned School

***** New-Must wear Face Coverings/masks upon entry and during work**

Be prepared to :

- Display appropriate ID as requested
- Greet the Office Staff and/ or Principal/School Administration as the assigned school nurse, trip nurse (trips postponed 20/21 until further notice) or 1:1 nurse
- Schools may requests nurses' signatures
- Obtain medical room keys from General Office

Nursing Preparation Guide

NYC | Department of Health and Mental Hygiene | Department of Education

Office of School Health

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 pack (contains Epipen, Epipen Jr., CPR face mask and gloves)
- Locate emergency supply bag and Yellow BRT Medication Carrying Kit
- 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:
  - Check medications for concordance with MAF and expiration dates
  - Locate stock Ventolin inhaler
  - Complete Control Substance Count Sheet (as appropriate)
  - Locate thermometer, stethoscope, and safety retractable lancets and insulin safety needles (if needed)

Walk-ins:

- Document all visits in walk-in log and ASHR or 1035
- Notify parent of medical room visit (telephone call and 125 or SH10)
- Issue referrals as needed (E125, O125 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
- Long-term contract agency nurses may approve MAFs and notify nursing supervisor
- 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
- If you need guidance with DMAF, diabetes management or unexpected diabetes events
- Call 911 and notify principal and OSH supervisor for emergencies including but not limited to:
  - A student with Diabetes with a blood glucose level elevating above target during the day and you are unable to contact PCP and/or parent
  - A blood glucose meter reading, "Hi" or "High" for a student with diabetes who may or maynot be symptomatic and you are unable to contact PCP and/or parent

*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.

Last revised 1/30/19

Contract Nurse Arrival in the Medical room

- Locate the OSH Covering Nurse Folder in the medical room for OSH and school contact information
- In D75 it may be a binder labeled as “Substitute Nurse Binder”
- ****Call the OSH liaison from medical room within 20 mins of arrival in the school**
- Locate the medication cabinet keys secured in the Medical Room
- Lock Medical Room if you have to step away for any reason and place signage
- Keep keys in nurse’s possession while in the school building
- Return keys to the secured location listed in the covering folder at the end of the day’s duty

Covering Nurse Folder

NYC | Department of Health and Mental Hygiene | Department of Education

Office of School Health

Covering Nurse Folder

Name of School: _____

ATS/DBN: _____

IMPORTANT - Upon arrival at school, Covering Nurse must call:

1. **Contract Liaison:** _____ **Phone:** _____
2. **OSH Supervising Nurse:** _____ **Phone:** _____

If unable to reach Contract Liaison or Supervisor, please call:

3. **Borough Nursing Director (BND):** _____ **Phone:** _____

Included in Covering Nurse Folder:

- School Information Sheet
- School Contact Numbers
- Organization Sheet
- Regional Contact information
- For Computer Password, please contact Supervising Nurse

NYC | Department of Health and Mental Hygiene | Department of Education

Office of School Health

SCHOOL CONTACT NUMBERS

School _____ ATSDBN _____

School Hours _____ After-school Program (Days/Hours) _____

Medical Room Phone _____ School Phone _____

Principal _____ General Office Phone _____

Pupil Accounting Secretary _____ Phone _____

504 (MAF) Coordinator _____ Room _____ Phone _____

School Health Aide _____ Room _____ Phone _____

School Safety Officer _____ Room _____ Phone _____

Guidance Counselor _____ Grade _____ Room _____ Phone _____

Guidance Counselor _____ Grade _____ Room _____ Phone _____

Social Worker _____ Room _____ Phone _____

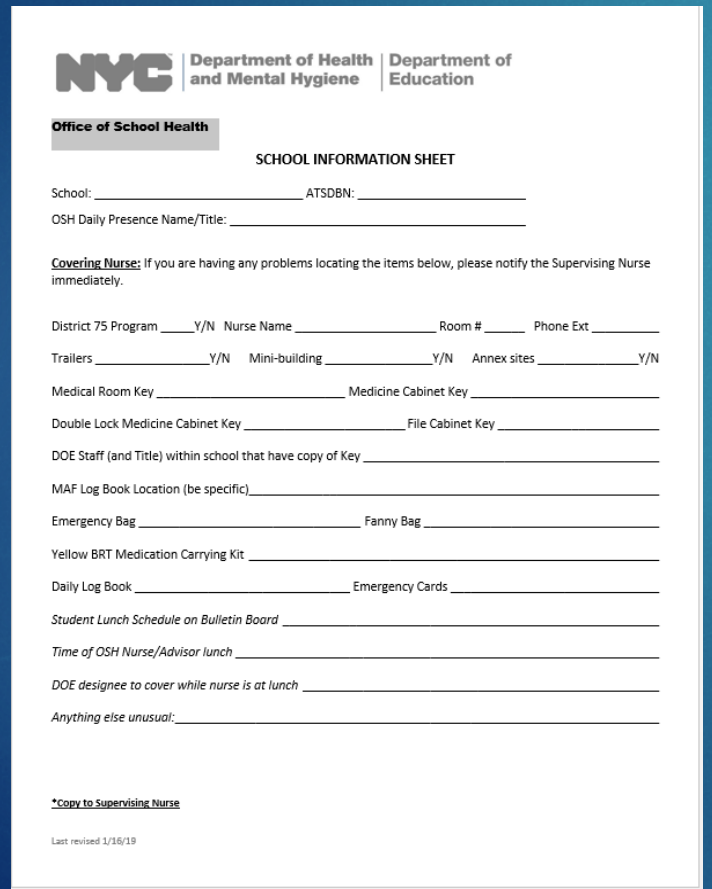
Custodial Office _____ Room _____ Phone _____

Cafeteria _____ Room _____ Phone _____

Last revised 1/16/19

Information of assigned school

School information sheet



NYC | Department of Health and Mental Hygiene | Department of Education

Office of School Health

SCHOOL INFORMATION SHEET

School: _____ ATSDBN: _____

OSH Daily Presence Name/Title: _____

Covering Nurse: If you are having any problems locating the items below, please notify the Supervising Nurse immediately.

District 75 Program ____Y/N Nurse Name _____ Room # _____ Phone Ext _____

Trailers _____Y/N Mini-building _____Y/N Annex sites _____Y/N

Medical Room Key _____ Medicine Cabinet Key _____

Double Lock Medicine Cabinet Key _____ File Cabinet Key _____

DOE Staff (and Title) within school that have copy of Key _____

MAF Log Book Location (be specific)_____

Emergency Bag _____ Fanny Bag _____

Yellow BRT Medication Carrying Kit _____

Daily Log Book _____ Emergency Cards _____

Student Lunch Schedule on Bulletin Board _____

Time of OSH Nurse/Advisor lunch _____

DOE designee to cover while nurse is at lunch _____

*Anything else unusual:*_____

***Copy to Supervising Nurse**

Last revised 1/16/19

Different school reports needed from Main office

Name of the List	Contact Information
Biographical List (Bio List)	Students' names and contacts
Cross Reference List	Students' names and school census
Class List	Students separated by class
Admissions List	Students admitted to the school- used by OSH medical room staff to create new school health records (103S)
Transfer List	incoming and transferring students- used by OSH medical room staff to prepare 103S to give to the office for the transfer
Discharge List	Discharge List-lists students officially discharged
The above lists are also used to schedule students for OSH Medical exam sessions	

Generated Reports in Public and Non –Public Schools

- DOE Public schools' lists are generated via electronic system Automate The Schools (ATS) by the main office

- These reports listed in the previous slide – should be available in medical room or can be requested from the main office:

  - Biographical List
  - Class List
  - Cross Reference List

Private Schools and Non-Public schools generate their student contact information lists - Know school's Emergency contact numbers and Plans

Office of School Health Medication and treatment administration for School coverage, student transport and 1:1 service

Medication & Treatment Policies

OSH Manages the processes for Health Services/Section 504 Accommodation such as:

- Medication administration
- Medically-prescribed treatments
- Glucose monitoring
- Insulin pump maintenance
- Other Section 504 and Individualized Education Program (IEP) services

- Families provide medications, except for some asthma medications stocked by OSH for shared usage in school
- Families provide medications for trips

- OSH accepts medical orders from NY,NJ and Connecticut providers as authorized under the NYS Nurse Practice Act. This act prohibits OSH nurses from accepting medical order from medical providers outside the tristate region
- OSH can accept orders from Certified Nurse Practitioners under the Nurse Practice Act
- As of October 22, 2009 OSH nurses can accept Medication Administration Forms (MAF's) completed by Physician Assistants (PA) that are not co-signed by a physician

Medication Administration Forms (MAFs) Packets

- Medication Administration Forms (MAFs) must be completed by a healthcare practitioner for nurses to perform or supervise prescribed medications or treatments
- Parents/guardians sign the MAF consents on back of MAFs – (asthma has a specific assessment and medication protocol- EASI)
- https://www.schools.nyc.gov/school-life/health-and-wellness/health-services
- Stock Epinephrine (Epi pen or Auvi Q) is the only medication that Registered Nurses servicing OSH can administer without a specific MAF for a student or an adult who is having s/s of anaphylaxis (reviewed Mod 2) while on duty.
- *Know Epi pen standing orders, also available in the NYC DOE Chancellor's Regulations
- https://www.schools.nyc.gov/about-us/policies/chancellors-regulations/volume-a-regulations/2

*(See the Asthma and Anaphylaxis Module2)

MAF Review and Implementation of Services

- Student's name, school, NYC osis or DOB
- Medication name, dose, frequency, route
- Type of treatment, specific frequency
- GT formula-frequency specifics
- **(BID /TID–MAF must specify times)
- Healthcare Provider 's and parent 's signature
- Note: OSH does not have a "standardized time" for BID/TID/QD

*Skill Levels, defined by NYS, are determined by the prescriber on the MAFs:

- Independent
- Supervised
- Nurse dependent

Families provide medications with pharmacy labels

Over-the-counter medications must be prescribed on the MAF for the nurse to administer or supervise and labeled by parent/pharmacist with student's name, DOB and osis #

Medication Binder Set-up, Review and Maintenance

Review the MAF binder for:

- Last school year's students with no current year MAF (see asthma policies) and follow up with calls, assessment if indicated on review of services, issue new MAFs
- Review medication in medical room and match with current school year 20-21 MAFs

Make a Medication administration and Treatment Binder if none exists

Daily medication/treatment orders
Pre-Exercise medication
PRN medication
Diabetes Medication Administration Forms (DMAFs)

Counts and records medications on count sheets, before medications are administered

- Review orders and equipment
- Notify Vendors and/or OSH count discrepancies or missing items

MAF and treatment policies and procedure

Medication and treatment Forms (MAFs) are renewed every school year
MAFs are issued every May-June

Sept-June and August if the student attends summer school
Each MAF is specific to the student's condition
Providers prescribes medications or treatments on the front of the applicable form
Parent sign back of the form to authorize service and contact to the PCP
Parent provide most specific medications, equipment and feedings prescribed

OSH REVIEWS FORMS PRIOR TO IMPLEMENTATION OF SERVICES CONTRACT NURSE REVIEW AND IMPLEMENT MAFS FOR ASTHMA STANDARD MEDICATION ORDERS

Seek guidance from OSH if a prior year' MAF was received for the current Sept-June school year

All PRESCRIBED TREATMENTS AND MEDICATIONs- need MAF orders to provide/supervise care

- Oral medication
- Inhaler or Nebulizer treatments
- Ear, eye or nose drops
- Topical creams or ointments
- Injections
- Oxygen Administration
- Blood Glucose Monitoring
- Insulin Pump management
- Ketone monitoring
- Intermittent urinary catheterization
- Tracheostomy care/suctioning
- Nasogastric tube care and feedings
- Gastrostomy feedings
- Central Venous Line Assessment -Limited to reinforcing dressing
- Percussion
- Postural Drainage
- Dressing Change
- Ostomy Care
- Rectal medications
- Pulse Oximetry

Medication Administration Forms (MAF)

All are available on line every school year which is September through June, August if Summer School

https://www.schoolhealthny.com/cms/lib/NY01832015/Centricity/Domain/85/MedicationManagement-DEC2017.pdf

- Asthma MAF
- Allergy/Anaphylaxis MAF
- General MAF
- Seizure MAF (New)
- Procedure/Treatment MAF
- Diabetes Medication Administration Form (DMAF) Part A and Part B

Guidelines for Parents/Health Care Practitioners

Guidelines for Parents

Department of Education

GUIDELINES FOR HEALTH SERVICES AND SECTION 504 ACCOMMODATIONS FOR STUDENTS IN NEW YORK CITY PUBLIC SCHOOLS
SCHOOL YEAR 2020-2021

To All Parents and Health Care Practitioners:

The NYC Department of Education (DOE) and the Office of School Health (OSH) work together to provide services to all students with special needs. These services allow students to fully participate in school. If your child needs health services and accommodations under Section 504 of the Rehabilitation Act, complete the form(s) in this packet. The NYC Department of Education **requires** a new approval for services each school year

There are three types of health services and accommodations forms:

1. **Medication Administration Forms (MAFs)** – This form is completed by your child's medical provider to receive medicine or treatment at school.
   - There are five separate MAFs: asthma; allergies; diabetes; seizures and general.
   - Please submit completed forms to the school nurse.
2. **Medically Prescribed Treatment (Non-Medication) Form** – This form is completed by your child's medical provider to request special procedures such as tube feeding catheterization, suctioning, etc. to be performed at school. This form may be used for all skilled nursing treatments.
   - Please submit completed forms to the school nurse.
3. **Request for Section 504 Accommodation(s)** – Complete this form to request special services such as a barrier-free building, elevator use, testing modification, etc.
   - Do **NOT** use this form for related services such as occupational therapy, physical therapy, speech and language therapy, counseling, etc. Related services should be provided through an Individualized Education Program (IEP).
   - There are two separate forms that must be completed: one for parents, and one for your child's medical provider
   - Please submit completed forms to your school's 504 Coordinator

Parents:

- Please take your child to his or her health care practitioner every year to complete these forms.
- **These forms should be submitted to your school nurse by June 1, 2020 for the new school year. Forms received after this date may delay processing.**
- If the school nurse is unavailable, you may be notified to come to school to give your child medicine.
- If you decide to use the school's stock medicine, you must send your child's epinephrine, asthma inhaler, and other approved self-administered medicines with your child on a school trip day and/or after school programs in order that he/she has it available. Stock medications are for use by OSH staff in school only.
- **Please make sure you sign the back of the form so that your child can receive these services in school**
- **Attach a small current photo to the upper left corner of the medication form(s). This helps the school to properly identify your child.**

Please reach out to the student's school nurse and/or the school's 504 Coordinator if you have any questions. Thank you for your assistance.

Health Care Practitioners: please see back of page.

Rev. April 2020

Guidelines for Health Care Practitioners

Department of Education

GUIDELINES FOR HEALTH SERVICES AND SECTION 504 ACCOMMODATIONS FOR STUDENTS IN NEW YORK CITY PUBLIC SCHOOLS
SCHOOL YEAR 2020-2021

Health Care Practitioner Instructions for Completion of the Request for Accommodations Form
Please follow these guidelines when completing the forms:

- Your patient may be treated by several health care practitioners. The health care practitioner completing the form should be the one treating the condition for which services are requested.
- This form must be completed by the student's licensed medical provider (MD, DO, NP, PA) who has treated the student and can provide clinical information concerning the medical diagnoses outlined as the basis for this request. Forms cannot be completed by the parent/guardian. Forms cannot be completed by a resident.

All requests for accommodations are based on medical necessity. Please ensure that your answers are complete and accurate. **All requests for medical accommodations will be reviewed by the Office of School Health (OSH) clinical staff, who will contact you if additional clarification is needed.** There is a school nurse present in most schools. Requests for 1:1 nursing will be reviewed on a case-by-case basis.

- Please clearly type or print all information on this form. **Illegible, incomplete, unsigned or undated forms cannot be processed and will be returned to the student's parent or guardian.**
- Provide the full name and current diagnoses of clinical relevance for the student.
- Describe the impact of the diagnoses/symptoms, medical issues, and/or behavioral issues that may affect the student during school hours or transport, including limitations and/or interventions required.
- Include any documentation and test results for any specialty services or referrals relevant to the accommodations requested.
- Only request services that are needed during school hours. Do not request medicine that can be given at home, before or after school hours.
- If a student requires medications or procedures to be performed, please complete and submit all relevant Medication Administration Forms (MAFs) and/or a Request for Medically Prescribed Treatment. The orders should be specific and clearly written. This allows the school nurse to carry it out in a clinically responsible way.
- Requests for alternative medicines will be reviewed on a case-by-case basis.
- Clearly print your name and include the valid New York State, New Jersey, or Connecticut license and NPI number.
- On the Medical Accommodations Request Form:
  - Please list the days and times that are best to contact you to provide further clarification of the request.
  - Please sign the attestation documenting that the information provided is accurate.
- Epinephrine may be stored in the classroom, in a common area, or transported with students as indicated in their Allergy Response Plan.

Student Skill Level: Students should be as self-sufficient as possible in school. Health Care Practitioners must determine whether the child is nurse-dependent, should be supervised, or is independent to take medicine or perform procedures

- **Nurse-Dependent Student:** nurse must administer. Medicine is typically stored in a locked cabinet in the medical room.
- **Supervised Student:** student self-administers, under adult supervision. The student should be able to identify their medicine, know the correct dose and when to take it, understand the purpose of their medicine, and be able to describe what will happen if it is not taken.
- **Independent Student:** student can self-carry/self-administer. For students who are independent, initial the section of the form that allows student to self-administer at school and during trips. **Students are never allowed to carry controlled substances.**
- ***If no skill level is selected, OSH clinical staff will designate the student as nurse-dependent by default, until further advised by the student's health care practitioner.***

Thank you for your cooperation.

Rev. April 2020

Attach student photo here

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM | Office of School Health | School Year **2020-2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

Student Last Name First Name Middle Initial | Date of Birth __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y) | ☐ Male ☐ Female

OSIS # __ __ __ __ __ __ __ __ __ DOE District __ __ Grade/Class _____

School ATSDBN/Name Address, and Borough:

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis
- ☐ Asthma
- ☐ Other:_____

Control *(see NAEPP Guidelines)*
- ☐ Well Controlled
- ☐ Not Controlled / Poorly Controlled
- ☐ Unknown

Severity *(see NAEPP Guidelines)*
- ☐ Intermittent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

History of near-death asthma requiring mechanical ventilation	☐ Y	☐ N	☐ U	
History of life-threatening asthma (loss of consciousness or hypoxic seizure)	☐ Y	☐ N	☐ U	
History of asthma-related PICU admissions (ever)	☐ Y	☐ N	☐ U	
Received oral steroids within past 12 months	☐ Y	☐ N	☐ U	____ times last : __ __ / __ __ / __ __
History of asthma-related ER visits within past 12 months	☐ Y	☐ N	☐ U	____ times
History of asthma-related hospitalizations within past 12 months	☐ Y	☐ N	☐ U	____ times
History of food allergy or eczema, specify: _____	☐ Y	☐ N	☐ U	

Student Skill Level *(Select the most appropriate option)*
- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers under adult supervision
- ☐ Independent Student: student is self-carry/self-administer
  I attest student demonstrated the ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.

Practitioner Initials

Quick Relief In-School Medication

☐ **Albuterol** [*Only generic Albuterol MDI is provided by school for shared usage*] *(plus individual spacer)*: ☐ Stock ☐ Parent Provided ☐ MDI w/ spacer ☐ DPI

Standard Order: Give 2 puffs q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath. Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE**.

If in Respiratory Distress: Call 911 and give 6 puffs; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** 2 puffs 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare:** 2 puffs @ noon for 5 school days.
Special Instructions:

☐ **Other:** Name: _____ Strength: _____
Dose: _____ Route: _____ Frequency: ___ hrs

Give ___ puffs/____AMP q ___ hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath. Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE**.

If in Respiratory Distress: Call 911 and give __ puffs/ ___AMP; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** __ puffs/___ AMP 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare:** ___ puffs/___ AMP @ noon for 5 school days
Special Instructions:

Controller Medications for In-School Administration

(Recommended for Persistent Asthma, per NAEPP Guidelines)

☐ **Fluticasone** [Only *Flovent® 110 mcg MDI is provided by school for shared usage*] ☐ Stock ☐ Parent Provided ☐ MDI w/ spacer ☐ DPI

Standing Daily Dose:___ puffs ONCE a day at ___ AM
Special Instructions:

☐ **Other ICS Standing Daily Dose:**
Name: _____ Strength: _____
Dose: _____ Route: _____ Frequency: ___ hrs

Home Medications *(Include over the counter)*

☐ Reliever _____ ☐ Controller _____ ☐ Other _____

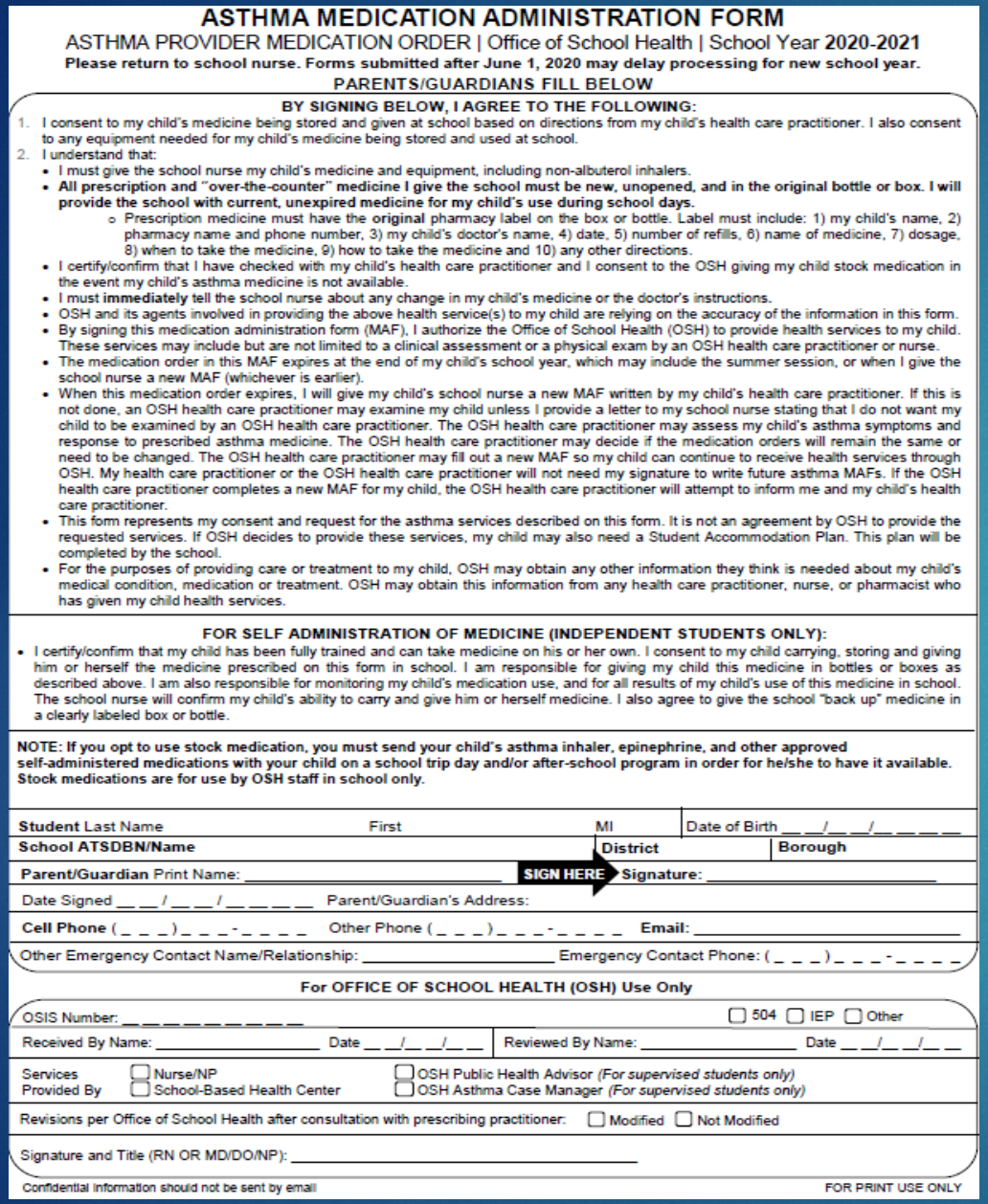
Health Care Practitioner (Please print name and circle one: MD, DO, NP, PA) Last First		Signature	Date __ __ / __ __ / __ __ __ __
Address	Tel. (_ _ _) _ _ _ - _ _ _ _	Fax (_ _ _) _ _ _ - _ _ _ _	NPI # _ _ _ _ _ _ _ _ _ _
Email Address	NYS License # **(Required)**	CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.	

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS. | REV 4/20

FORMS CANNOT BE COMPLETED BY A RESIDENT

PARENTS MUST SIGN PAGE 2 ➔

Asthma MAF



ASTHMA MEDICATION ADMINISTRATION FORM

ASTHMA PROVIDER MEDICATION ORDER | Office of School Health | School Year **2020-2021**

Please return to school nurse. Forms submitted after June 1, 2020 may delay processing for new school year.

PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
   - I must give the school nurse my child's medicine and equipment, including non-albuterol inhalers.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's doctor's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I certify/confirm that I have checked with my child's health care practitioner and I consent to the OSH giving my child stock medication in the event my child's asthma medicine is not available.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the doctor's instructions.
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), I authorize the Office of School Health (OSH) to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier).
   - When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. If this is not done, an OSH health care practitioner may examine my child unless I provide a letter to my school nurse stating that I do not want my child to be examined by an OSH health care practitioner. The OSH health care practitioner may assess my child's asthma symptoms and response to prescribed asthma medicine. The OSH health care practitioner may decide if the medication orders will remain the same or need to be changed. The OSH health care practitioner may fill out a new MAF so my child can continue to receive health services through OSH. My health care practitioner or the OSH health care practitioner will not need my signature to write future asthma MAFs. If the OSH health care practitioner completes a new MAF for my child, the OSH health care practitioner will attempt to inform me and my child's health care practitioner.
   - This form represents my consent and request for the asthma services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment to my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

FOR SELF ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.

NOTE: If you opt to use stock medication, you must send your child's asthma inhaler, epinephrine, and other approved self-administered medications with your child on a school trip day and/or after-school program in order for he/she to have it available. Stock medications are for use by OSH staff in school only.

Student Last Name _____ First _____ MI _____ Date of Birth __ __/__ __/__ __ __ __

School ATSDBN/Name _____ **District** _____ **Borough** _____

Parent/Guardian Print Name: _____ **SIGN HERE** **Signature:** _____

Date Signed __ __/__ __/__ __ __ __ Parent/Guardian's Address: _____

Cell Phone (_ _ _) _ _ _ - _ _ _ _ Other Phone (_ _ _) _ _ _ - _ _ _ _ **Email:** _____

Other Emergency Contact Name/Relationship: _____ Emergency Contact Phone: (_ _ _) _ _ _ - _ _ _ _

For OFFICE OF SCHOOL HEALTH (OSH) Use Only

OSIS Number: __ __ __ __ __ __ __ __ __ ☐ 504 ☐ IEP ☐ Other

Received By Name: _____ Date __ __/__ __/__ __ Reviewed By Name: _____ Date __ __/__ __/__ __

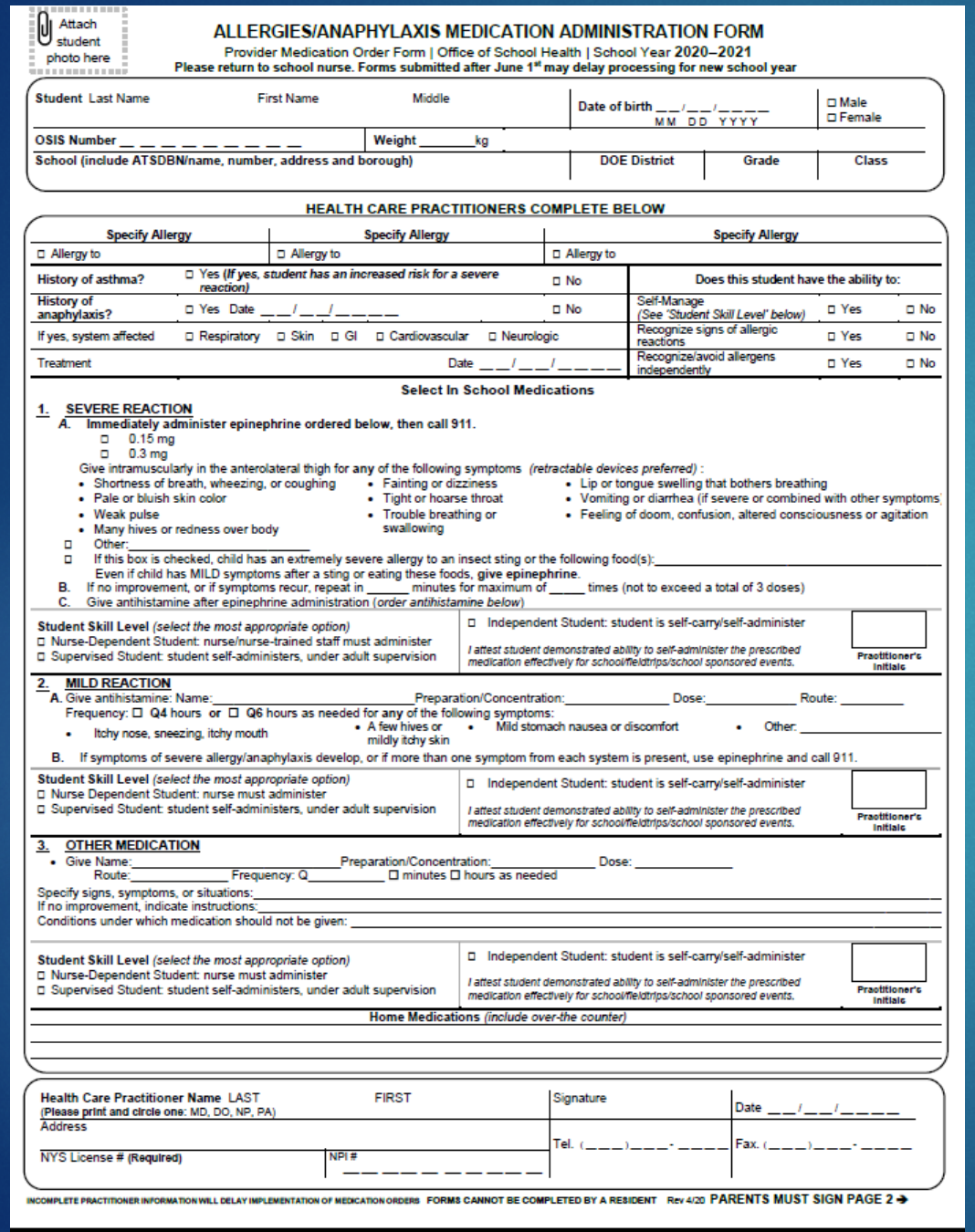
Services Provided By ☐ Nurse/NP ☐ School-Based Health Center ☐ OSH Public Health Advisor *(For supervised students only)* ☐ OSH Asthma Case Manager *(For supervised students only)*

Revisions per Office of School Health after consultation with prescribing practitioner: ☐ Modified ☐ Not Modified

Signature and Title (RN OR MD/DO/NP): _____

Confidential information should not be sent by email FOR PRINT USE ONLY

Asthma MAF- page 2 - Parental/Guardian Consent Page



Attach student photo here

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2020–2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year

Student Last Name | First Name | Middle | **Date of birth** __/__/____ MM DD YYYY | ☐ Male ☐ Female

OSIS Number _____ | **Weight** _____kg

School (include ATSDBN/name, number, address and borough) | **DOE District** | **Grade** | **Class**

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Specify Allergy	Specify Allergy	Specify Allergy
☐ Allergy to	☐ Allergy to	☐ Allergy to

			Does this student have the ability to:		
History of asthma?	☐ Yes (*If yes, student has an increased risk for a severe reaction*)	☐ No			
History of anaphylaxis?	☐ Yes Date __/__/____	☐ No	Self-Manage *(See 'Student Skill Level' below)*	☐ Yes	☐ No
If yes, system affected	☐ Respiratory ☐ Skin ☐ GI ☐ Cardiovascular ☐ Neurologic		Recognize signs of allergic reactions	☐ Yes	☐ No
Treatment	Date __/__/____		Recognize/avoid allergens independently	☐ Yes	☐ No

Select In School Medications

1. SEVERE REACTION

A. Immediately administer epinephrine ordered below, then call 911.

☐ 0.15 mg
☐ 0.3 mg

Give intramuscularly in the anterolateral thigh for **any** of the following symptoms *(retractable devices preferred)* :

- Shortness of breath, wheezing, or coughing
- Pale or bluish skin color
- Weak pulse
- Many hives or redness over body
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Lip or tongue swelling that bothers breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Feeling of doom, confusion, altered consciousness or agitation

☐ Other:_____

☐ If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):_____
Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

B. If no improvement, or if symptoms recur, repeat in _____ minutes for maximum of _____ times (not to exceed a total of 3 doses)

C. Give antihistamine after epinephrine administration *(order antihistamine below)*

Student Skill Level *(select the most appropriate option)*
☐ Nurse-Dependent Student: nurse/nurse-trained staff must administer
☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: student is self-carry/self-administer

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Practitioner's Initials

2. MILD REACTION

A. Give antihistamine: Name:_____ Preparation/Concentration:_____ Dose:_____ Route: _____
Frequency: ☐ **Q4** hours **or** ☐ **Q6** hours as needed for **any** of the following symptoms:

- Itchy nose, sneezing, itchy mouth
- A few hives or mildly itchy skin
- Mild stomach nausea or discomfort
- Other: _____

B. If symptoms of severe allergy/anaphylaxis develop, or if more than one symptom from each system is present, use epinephrine and call 911.

Student Skill Level *(select the most appropriate option)*
☐ Nurse Dependent Student: nurse must administer
☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: student is self-carry/self-administer

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

Practitioner's Initials

3. OTHER MEDICATION

- Give Name:_____ Preparation/Concentration:_____ Dose: _____
  Route:_____ Frequency: Q_____ ☐ minutes ☐ hours as needed

Specify signs, symptoms, or situations:_____
If no improvement, indicate instructions:_____
Conditions under which medication should not be given: _____

Student Skill Level *(select the most appropriate option)*
☐ Nurse-Dependent Student: nurse must administer
☐ Supervised Student: student self-administers, under adult supervision

☐ Independent Student: student is self-carry/self-administer

I attest student demonstrated ability to self-administer the prescribed medication effectively for school/fieldtrips/school sponsored events.

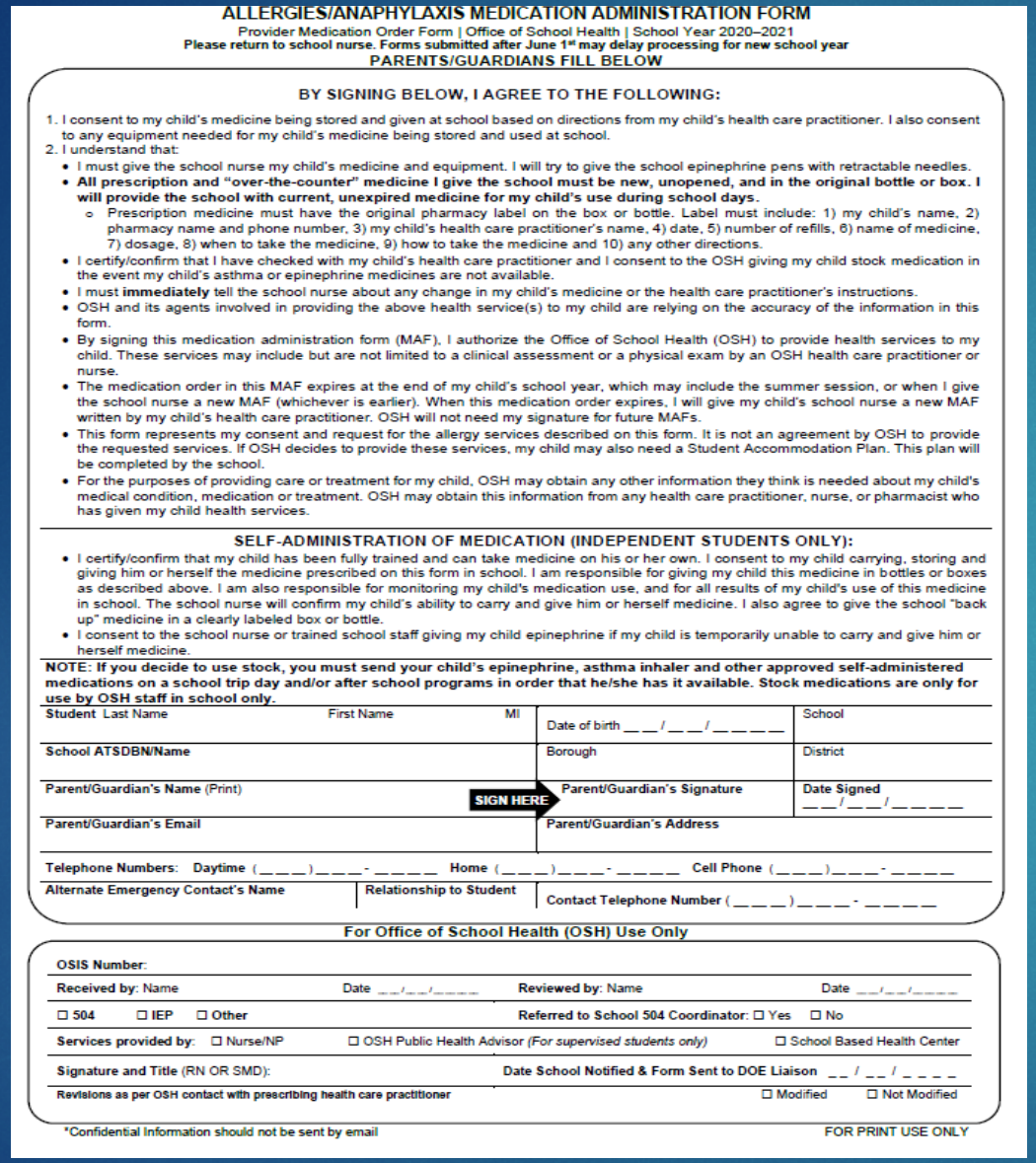
Practitioner's Initials

Home Medications *(include over-the counter)*

Health Care Practitioner Name LAST | FIRST | Signature | Date __/__/____
(Please print and circle one: MD, DO, NP, PA)
Address | Tel. (___)___-____ | Fax. (___)___-____
NYS License # **(Required)** | NPI #

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS **FORMS CANNOT BE COMPLETED BY A RESIDENT** Rev 4/20 **PARENTS MUST SIGN PAGE 2 ➔**

Allergy / Anaphylaxis MAF



ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year 2020–2021

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year

PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. I understand that:
   - I must give the school nurse my child's medicine and equipment. I will try to give the school epinephrine pens with retractable needles.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired medicine for my child's use during school days.**
     - Prescription medicine must have the original pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I certify/confirm that I have checked with my child's health care practitioner and I consent to the OSH giving my child stock medication in the event my child's asthma or epinephrine medicines are not available.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the health care practitioner's instructions.
   - OSH and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), I authorize the Office of School Health (OSH) to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. OSH will not need my signature for future MAFs.
   - This form represents my consent and request for the allergy services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment for my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

SELF-ADMINISTRATION OF MEDICATION (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.
- I consent to the school nurse or trained school staff giving my child epinephrine if my child is temporarily unable to carry and give him or herself medicine.

NOTE: If you decide to use stock, you must send your child's epinephrine, asthma inhaler and other approved self-administered medications on a school trip day and/or after school programs in order that he/she has it available. Stock medications are only for use by OSH staff in school only.

Student Last Name	First Name	MI	Date of birth __ __ / __ __ / __ __ __ __	School
School ATSDBN/Name			Borough	District
Parent/Guardian's Name (Print)		SIGN HERE	**Parent/Guardian's Signature**	**Date Signed** __ __ / __ __ / __ __ __ __
Parent/Guardian's Email			**Parent/Guardian's Address**	

Telephone Numbers: **Daytime** (____)____-____ **Home** (____)____-____ **Cell Phone** (____)____-____

Alternate Emergency Contact's Name	**Relationship to Student**	**Contact Telephone Number** (____)____-____

For Office of School Health (OSH) Use Only

OSIS Number:

Received by: Name Date __/__/____ **Reviewed by:** Name Date __/__/____

☐ **504** ☐ **IEP** ☐ **Other** **Referred to School 504 Coordinator:** ☐ Yes ☐ No

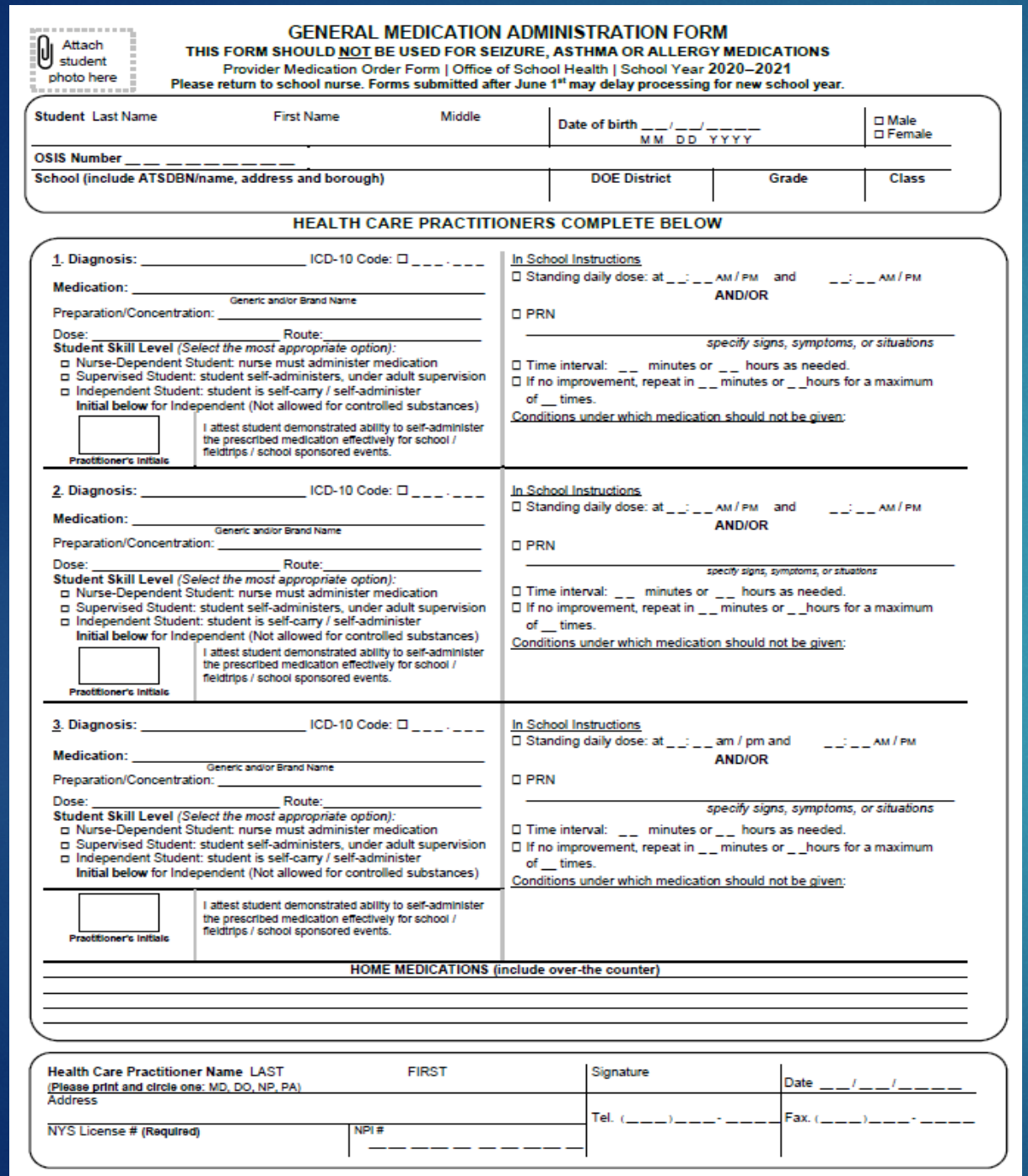
Services provided by: ☐ Nurse/NP ☐ OSH Public Health Advisor *(For supervised students only)* ☐ School Based Health Center

Signature and Title (RN OR SMD): **Date School Notified & Form Sent to DOE Liaison** __ / __ / ____

Revisions as per OSH contact with prescribing health care practitioner ☐ Modified ☐ Not Modified

*Confidential Information should not be sent by email FOR PRINT USE ONLY

Allergy / Anaphylaxis Page 2 - Parental/ Guardian Consent



Attach student photo here

GENERAL MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD NOT BE USED FOR SEIZURE, ASTHMA OR ALLERGY MEDICATIONS

Provider Medication Order Form | Office of School Health | School Year **2020–2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

Student Last Name | First Name | Middle | **Date of birth** __/__/____ (MM DD YYYY) | ☐ Male ☐ Female

OSIS Number __ __ __ __ __ __ __ __

School (include ATSDBN/name, address and borough) | **DOE District** | **Grade** | **Class**

HEALTH CARE PRACTITIONERS COMPLETE BELOW

1. Diagnosis: _____ ICD-10 Code: ☐ ___.___

Medication: _____ (Generic and/or Brand Name)

Preparation/Concentration: _____

Dose: _____ Route: _____

Student Skill Level *(Select the most appropriate option)*:

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry / self-administer

Initial below for Independent (Not allowed for controlled substances)

Practitioner's Initials

I attest student demonstrated ability to self-administer the prescribed medication effectively for school / fieldtrips / school sponsored events.

In School Instructions

☐ Standing daily dose: at __:__ AM / PM and __:__ AM / PM

AND/OR

☐ PRN

_____ *specify signs, symptoms, or situations*

☐ Time interval: __ minutes or __ hours as needed.

☐ If no improvement, repeat in __ minutes or __hours for a maximum of __ times.

Conditions under which medication should not be given:

2. Diagnosis: _____ ICD-10 Code: ☐ ___.___

Medication: _____ (Generic and/or Brand Name)

Preparation/Concentration: _____

Dose: _____ Route: _____

Student Skill Level *(Select the most appropriate option)*:

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry / self-administer

Initial below for Independent (Not allowed for controlled substances)

Practitioner's Initials

I attest student demonstrated ability to self-administer the prescribed medication effectively for school / fieldtrips / school sponsored events.

In School Instructions

☐ Standing daily dose: at __:__ AM / PM and __:__ AM / PM

AND/OR

☐ PRN

_____ *specify signs, symptoms, or situations*

☐ Time interval: __ minutes or __ hours as needed.

☐ If no improvement, repeat in __ minutes or __hours for a maximum of __ times.

Conditions under which medication should not be given:

3. Diagnosis: _____ ICD-10 Code: ☐ ___.___

Medication: _____ (Generic and/or Brand Name)

Preparation/Concentration: _____

Dose: _____ Route: _____

Student Skill Level *(Select the most appropriate option)*:

- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry / self-administer

Initial below for Independent (Not allowed for controlled substances)

Practitioner's Initials

I attest student demonstrated ability to self-administer the prescribed medication effectively for school / fieldtrips / school sponsored events.

In School Instructions

☐ Standing daily dose: at __:__ am / pm and __:__ AM / PM

AND/OR

☐ PRN

_____ *specify signs, symptoms, or situations*

☐ Time interval: __ minutes or __ hours as needed.

☐ If no improvement, repeat in __ minutes or __hours for a maximum of __ times.

Conditions under which medication should not be given:

HOME MEDICATIONS (include over-the counter)

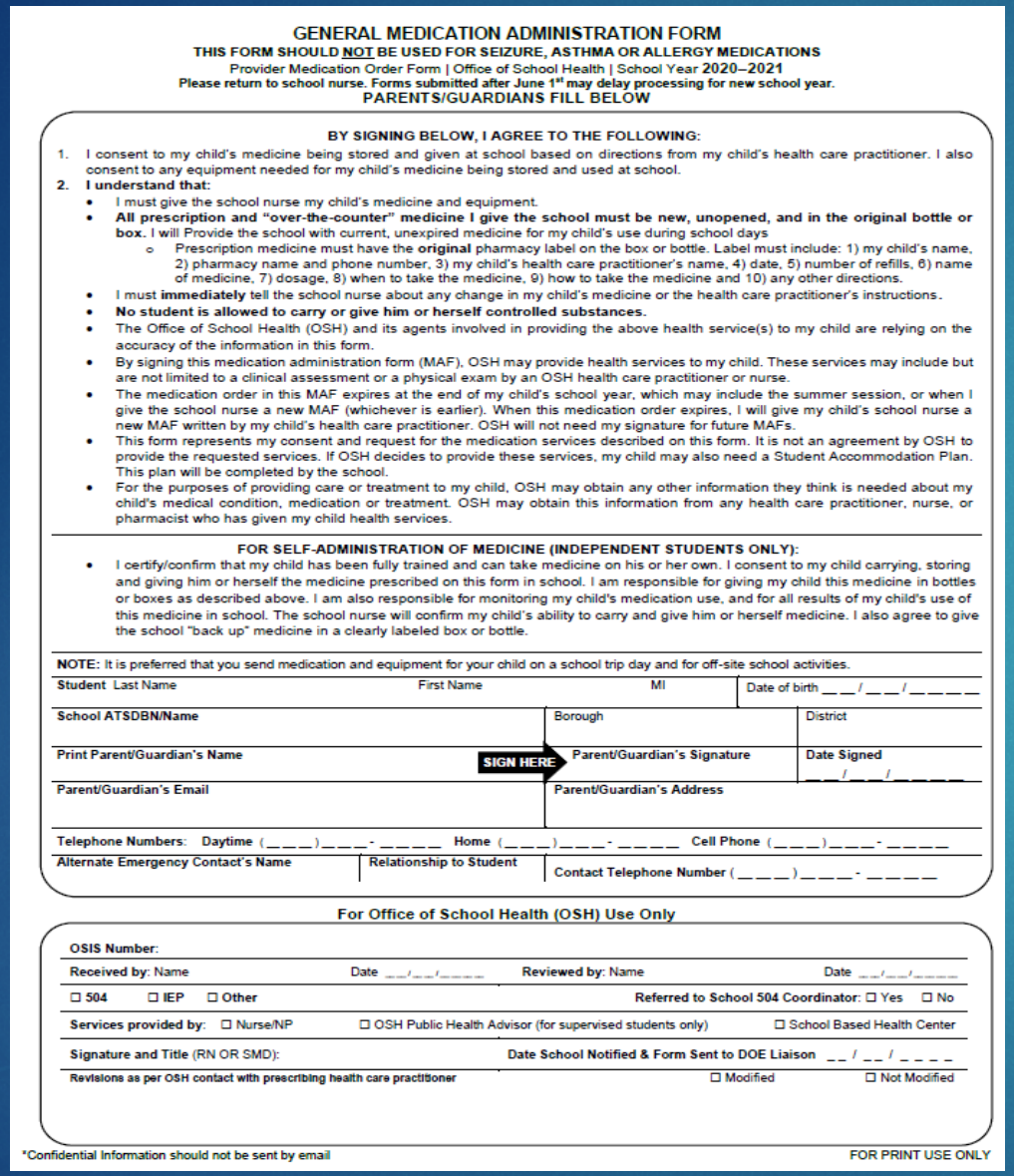
Health Care Practitioner Name LAST | FIRST | Signature | Date __/__/____

(Please print and circle one: MD, DO, NP, PA)

Address | Tel. (___)___-____ | Fax. (___)___-____

NYS License # (Required) | NPI # _____

General MAF



GENERAL MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD NOT BE USED FOR SEIZURE, ASTHMA OR ALLERGY MEDICATIONS

Provider Medication Order Form | Office of School Health | School Year **2020–2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. **I understand that:**
   - I must give the school nurse my child's medicine and equipment.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box.** I will Provide the school with current, unexpired medicine for my child's use during school days
     - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the health care practitioner's instructions.
   - **No student is allowed to carry or give him or herself controlled substances.**
   - The Office of School Health (OSH) and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), OSH may provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. OSH will not need my signature for future MAFs.
   - This form represents my consent and request for the medication services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment to my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

FOR SELF-ADMINISTRATION OF MEDICINE (INDEPENDENT STUDENTS ONLY):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

Student Last Name	First Name	MI	Date of birth __ __ / __ __ / __ __ __ __
School ATSDBN/Name	Borough		District
Print Parent/Guardian's Name	SIGN HERE **Parent/Guardian's Signature**		**Date Signed** __ __ / __ __ / __ __ __ __
Parent/Guardian's Email	**Parent/Guardian's Address**		
Telephone Numbers: Daytime (___)___-____	**Home** (___)___-____	**Cell Phone** (___)___-____	
Alternate Emergency Contact's Name	**Relationship to Student**	**Contact Telephone Number** (___)___-____	

For Office of School Health (OSH) Use Only

OSIS Number:

Received by: Name Date __/__/____ **Reviewed by**: Name Date __/__/____

☐ **504** ☐ **IEP** ☐ **Other** **Referred to School 504 Coordinator:** ☐ Yes ☐ No

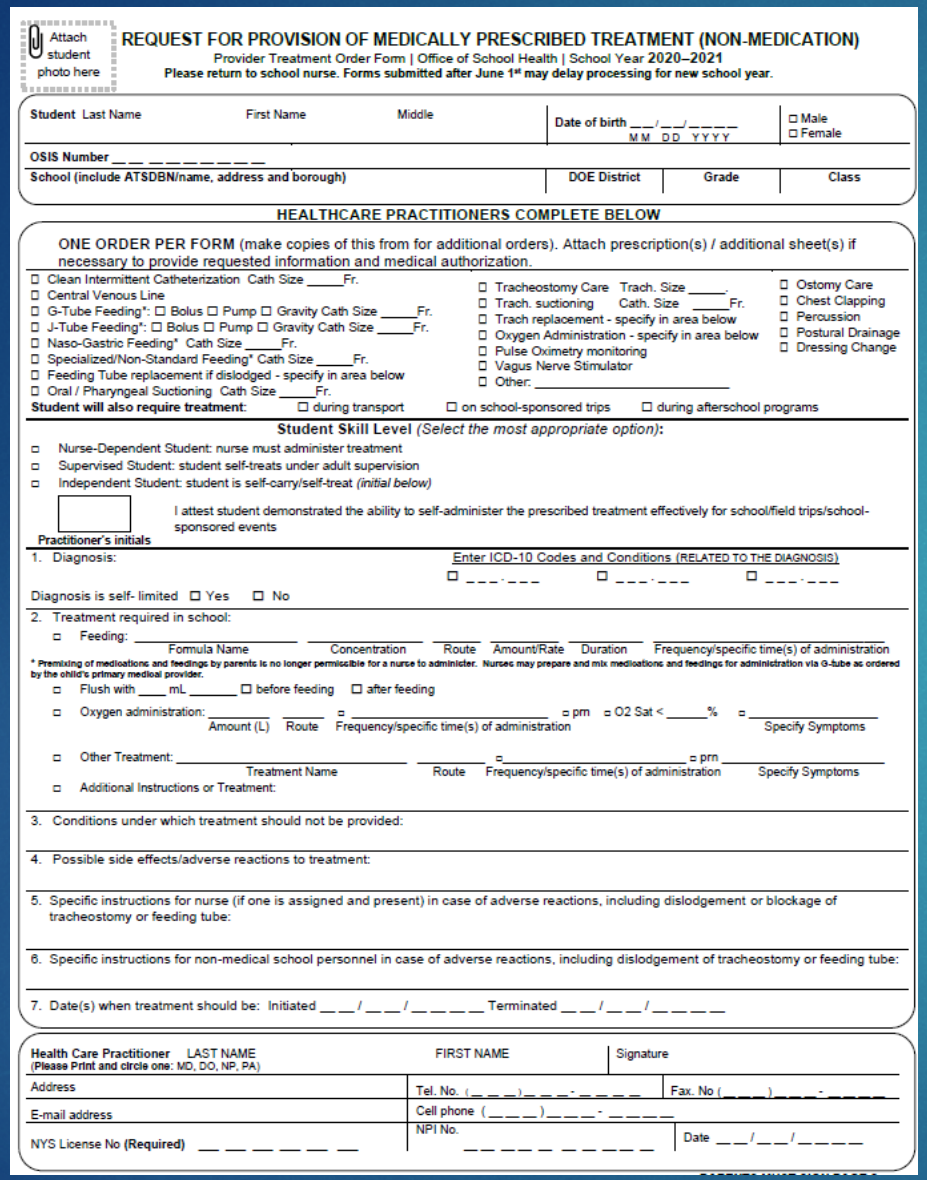
Services provided by: ☐ Nurse/NP ☐ OSH Public Health Advisor (for supervised students only) ☐ School Based Health Center

Signature and Title (RN OR SMD): **Date School Notified & Form Sent to DOE Liaison** __ / __ / ____

Revisions as per OSH contact with prescribing health care practitioner ☐ Modified ☐ Not Modified

*Confidential Information should not be sent by email FOR PRINT USE ONLY

General MAF Part 2 - Parental/Guardian Consent



Attach student photo here

REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

Provider Treatment Order Form | Office of School Health | School Year 2020–2021

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

Student Last Name First Name Middle | **Date of birth** ___/___/_____ MM DD YYYY | ☐ Male ☐ Female

OSIS Number __ __ __ __ __ __ __ __ __

School (include ATSDBN/name, address and borough) | **DOE District** | **Grade** | **Class**

HEALTHCARE PRACTITIONERS COMPLETE BELOW

ONE ORDER PER FORM (make copies of this from for additional orders). Attach prescription(s) / additional sheet(s) if necessary to provide requested information and medical authorization.

- ☐ Clean Intermittent Catheterization Cath Size _____Fr.
- ☐ Central Venous Line
- ☐ G-Tube Feeding*: ☐ Bolus ☐ Pump ☐ Gravity Cath Size _____Fr.
- ☐ J-Tube Feeding*: ☐ Bolus ☐ Pump ☐ Gravity Cath Size _____Fr.
- ☐ Naso-Gastric Feeding* Cath Size _____Fr.
- ☐ Specialized/Non-Standard Feeding* Cath Size _____Fr.
- ☐ Feeding Tube replacement if dislodged - specify in area below
- ☐ Oral / Pharyngeal Suctioning Cath Size _____Fr.
- ☐ Tracheostomy Care Trach. Size _____.
- ☐ Trach. suctioning Cath. Size _____Fr.
- ☐ Trach replacement - specify in area below
- ☐ Oxygen Administration - specify in area below
- ☐ Pulse Oximetry monitoring
- ☐ Vagus Nerve Stimulator
- ☐ Other: _____
- ☐ Ostomy Care
- ☐ Chest Clapping
- ☐ Percussion
- ☐ Postural Drainage
- ☐ Dressing Change

Student will also require treatment: ☐ during transport ☐ on school-sponsored trips ☐ during afterschool programs

Student Skill Level *(Select the most appropriate option)*:

- ☐ Nurse-Dependent Student: nurse must administer treatment
- ☐ Supervised Student: student self-treats under adult supervision
- ☐ Independent Student: student is self-carry/self-treat *(initial below)*

☐ I attest student demonstrated the ability to self-administer the prescribed treatment effectively for school/field trips/school-sponsored events

Practitioner's initials

1. Diagnosis: Enter ICD-10 Codes and Conditions (RELATED TO THE DIAGNOSIS) ☐ ___.___ ☐ ___.___ ☐ ___.___

Diagnosis is self- limited ☐ Yes ☐ No

2. Treatment required in school:

☐ Feeding: _____ (Formula Name) _____ (Concentration) _____ (Route) _____ (Amount/Rate) _____ (Duration) _____ (Frequency/specific time(s) of administration)

* Premixing of medications and feedings by parents is no longer permissible for a nurse to administer. Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child's primary medical provider.

☐ Flush with ____ mL _____ ☐ before feeding ☐ after feeding

☐ Oxygen administration: _____ (Amount (L)) _____ (Route) ☐ _____ (Frequency/specific time(s) of administration) ☐ prn ☐ O2 Sat < _____% ☐ _____ (Specify Symptoms)

☐ Other Treatment: _____ (Treatment Name) _____ (Route) ☐ _____ (Frequency/specific time(s) of administration) ☐ prn _____ (Specify Symptoms)

☐ Additional Instructions or Treatment:

3. Conditions under which treatment should not be provided:

4. Possible side effects/adverse reactions to treatment:

5. Specific instructions for nurse (if one is assigned and present) in case of adverse reactions, including dislodgement or blockage of tracheostomy or feeding tube:

6. Specific instructions for non-medical school personnel in case of adverse reactions, including dislodgement of tracheostomy or feeding tube:

7. Date(s) when treatment should be: Initiated __ __/__ __/__ __ __ __ Terminated __ __/__ __/__ __ __ __

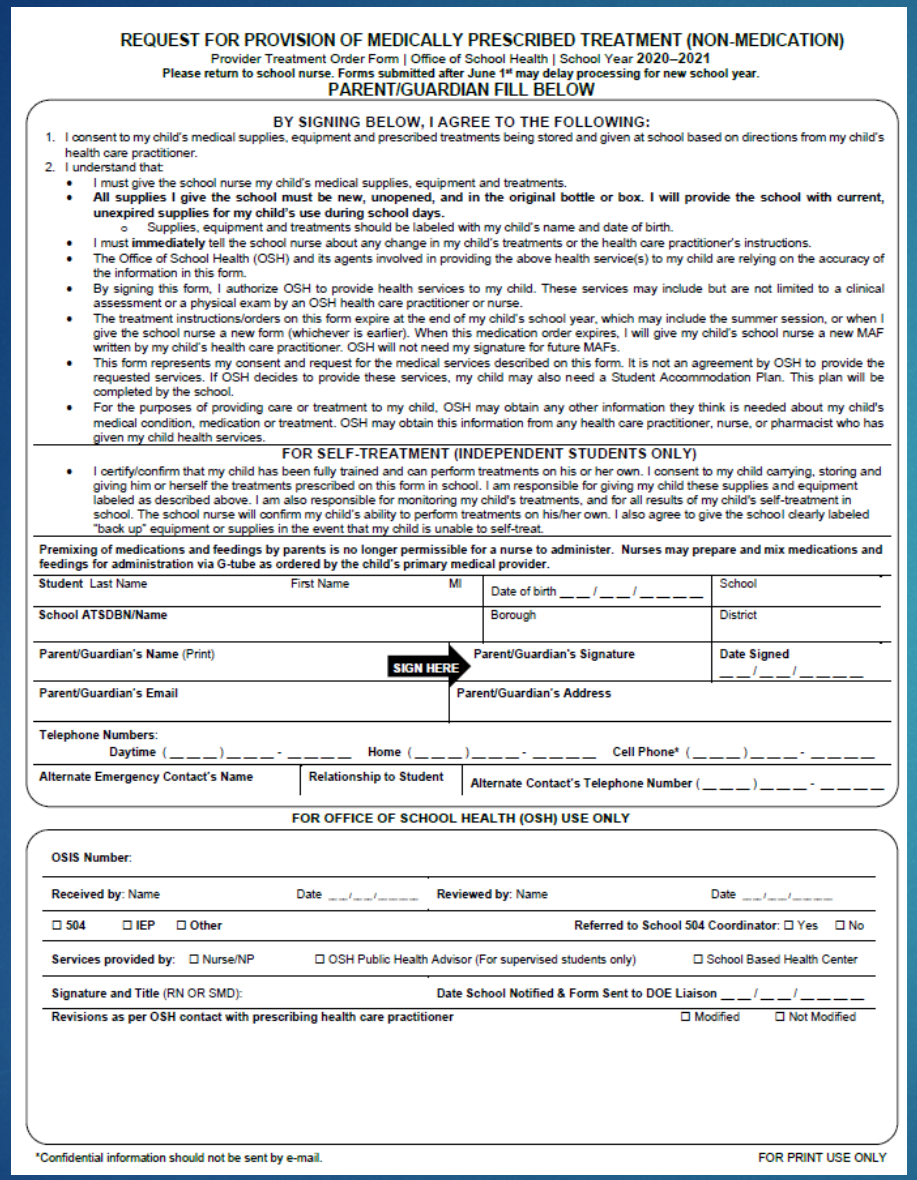
Health Care Practitioner LAST NAME (Please Print and circle one: MD, DO, NP, PA) FIRST NAME | Signature

Address | Tel. No. (___)___-____ | Fax. No (___)___-____

E-mail address | Cell phone (___)___-____

NYS License No **(Required)** __ __ __ __ __ __ | NPI No. __ __ __ __ __ __ __ __ __ __ | Date __ __/__ __/__ __ __ __

Request for Provision of Medically Prescribed Medical Treatment MAF (Non-Medication)



REQUEST FOR PROVISION OF MEDICALLY PRESCRIBED TREATMENT (NON-MEDICATION)

Provider Treatment Order Form | Office of School Health | School Year **2020–2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

PARENT/GUARDIAN FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medical supplies, equipment and prescribed treatments being stored and given at school based on directions from my child's health care practitioner.
2. I understand that:
   - I must give the school nurse my child's medical supplies, equipment and treatments.
   - **All supplies I give the school must be new, unopened, and in the original bottle or box. I will provide the school with current, unexpired supplies for my child's use during school days.**
     - Supplies, equipment and treatments should be labeled with my child's name and date of birth.
   - I must **immediately** tell the school nurse about any change in my child's treatments or the health care practitioner's instructions.
   - The Office of School Health (OSH) and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this form, I authorize OSH to provide health services to my child. These services may include but are not limited to a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The treatment instructions/orders on this form expire at the end of my child's school year, which may include the summer session, or when I give the school nurse a new form (whichever is earlier). When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. OSH will not need my signature for future MAFs.
   - This form represents my consent and request for the medical services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - For the purposes of providing care or treatment to my child, OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.

FOR SELF-TREATMENT (INDEPENDENT STUDENTS ONLY)

- I certify/confirm that my child has been fully trained and can perform treatments on his or her own. I consent to my child carrying, storing and giving him or herself the treatments prescribed on this form in school. I am responsible for giving my child these supplies and equipment labeled as described above. I am also responsible for monitoring my child's treatments, and for all results of my child's self-treatment in school. The school nurse will confirm my child's ability to perform treatments on his/her own. I also agree to give the school clearly labeled "back up" equipment or supplies in the event that my child is unable to self-treat.

Premixing of medications and feedings by parents is no longer permissible for a nurse to administer. Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child's primary medical provider.

Student Last Name	First Name	MI	Date of birth __/__/____	School
School ATSDBN/Name			Borough	District
Parent/Guardian's Name (Print)		SIGN HERE	**Parent/Guardian's Signature**	**Date Signed** __/__/____
Parent/Guardian's Email			**Parent/Guardian's Address**	

Telephone Numbers:
Daytime (___)___-____ **Home** (___)___-____ **Cell Phone*** (___)___-____

Alternate Emergency Contact's Name	**Relationship to Student**	**Alternate Contact's Telephone Number** (___)___-____

FOR OFFICE OF SCHOOL HEALTH (OSH) USE ONLY

OSIS Number:

Received by: Name	Date __/__/____	**Reviewed by:** Name	Date __/__/____

☐ 504 ☐ IEP ☐ Other **Referred to School 504 Coordinator:** ☐ Yes ☐ No

Services provided by: ☐ Nurse/NP ☐ OSH Public Health Advisor (For supervised students only) ☐ School Based Health Center

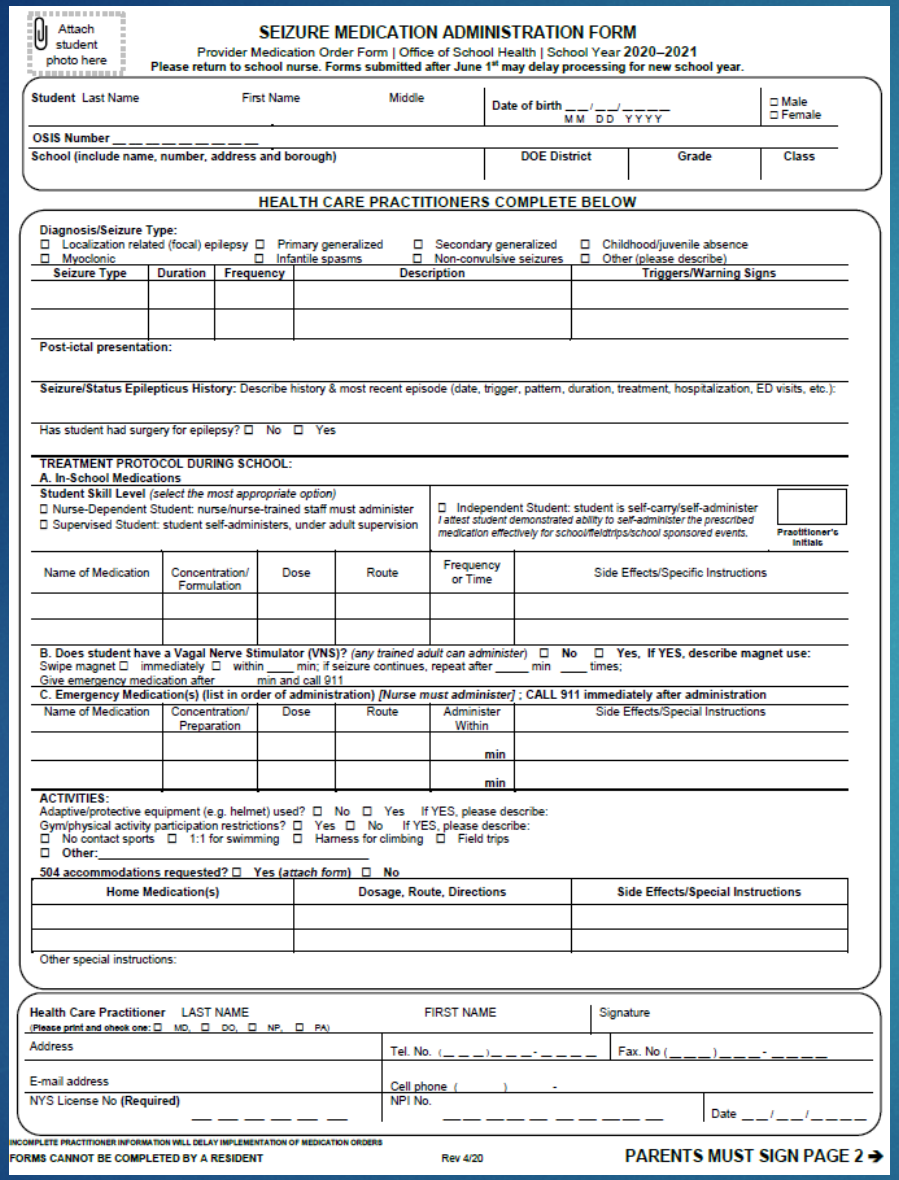
Signature and Title (RN OR SMD): **Date School Notified & Form Sent to DOE Liaison** __/__/____

Revisions as per OSH contact with prescribing health care practitioner ☐ Modified ☐ Not Modified

*Confidential information should not be sent by e-mail.

FOR PRINT USE ONLY

Request for Provision of Medically Prescribed Medical Treatment MAF (Non-Medication)Part 2 – Parent/Guardian Consent



Attach student photo here

SEIZURE MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2020–2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

Student Last Name | First Name | Middle | **Date of birth** __/__/____ (MM DD YYYY) | ☐ Male ☐ Female

OSIS Number _____

School (include name, number, address and borough) | **DOE District** | **Grade** | **Class**

HEALTH CARE PRACTITIONERS COMPLETE BELOW

Diagnosis/Seizure Type:

☐ Localization related (focal) epilepsy ☐ Primary generalized ☐ Secondary generalized ☐ Childhood/juvenile absence
☐ Myoclonic ☐ Infantile spasms ☐ Non-convulsive seizures ☐ Other (please describe)

Seizure Type	Duration	Frequency	Description	Triggers/Warning Signs

Post-ictal presentation:

Seizure/Status Epilepticus History: Describe history & most recent episode (date, trigger, pattern, duration, treatment, hospitalization, ED visits, etc.):

Has student had surgery for epilepsy? ☐ No ☐ Yes

TREATMENT PROTOCOL DURING SCHOOL:

A. In-School Medications

Student Skill Level *(select the most appropriate option)*

☐ Nurse-Dependent Student: nurse/nurse-trained staff must administer
☐ Supervised Student: student self-administers, under adult supervision
☐ Independent Student: student is self-carry/self-administer
I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school sponsored events.

Practitioner's Initials

Name of Medication	Concentration/ Formulation	Dose	Route	Frequency or Time	Side Effects/Specific Instructions

B. Does student have a Vagal Nerve Stimulator (VNS)? *(any trained adult can administer)* ☐ **No** ☐ **Yes, If YES, describe magnet use:**
Swipe magnet ☐ immediately ☐ within ___ min; if seizure continues, repeat after ____ min ___ times;
Give emergency medication after ___ min and call 911

C. Emergency Medication(s) (list in order of administration) ***[Nurse must administer]*** **; CALL 911 immediately after administration**

Name of Medication	Concentration/ Preparation	Dose	Route	Administer Within	Side Effects/Special Instructions
				min	
				min	

ACTIVITIES:

Adaptive/protective equipment (e.g. helmet) used? ☐ No ☐ Yes If YES, please describe:
Gym/physical activity participation restrictions? ☐ Yes ☐ No If YES, please describe:
☐ No contact sports ☐ 1:1 for swimming ☐ Harness for climbing ☐ Field trips
☐ Other:_____

504 accommodations requested? ☐ Yes ***(attach form)*** **☐ No**

Home Medication(s)	Dosage, Route, Directions	Side Effects/Special Instructions

Other special instructions:

Health Care Practitioner LAST NAME | FIRST NAME | Signature
(Please print and check one: ☐ MD, ☐ DO, ☐ NP, ☐ PA)

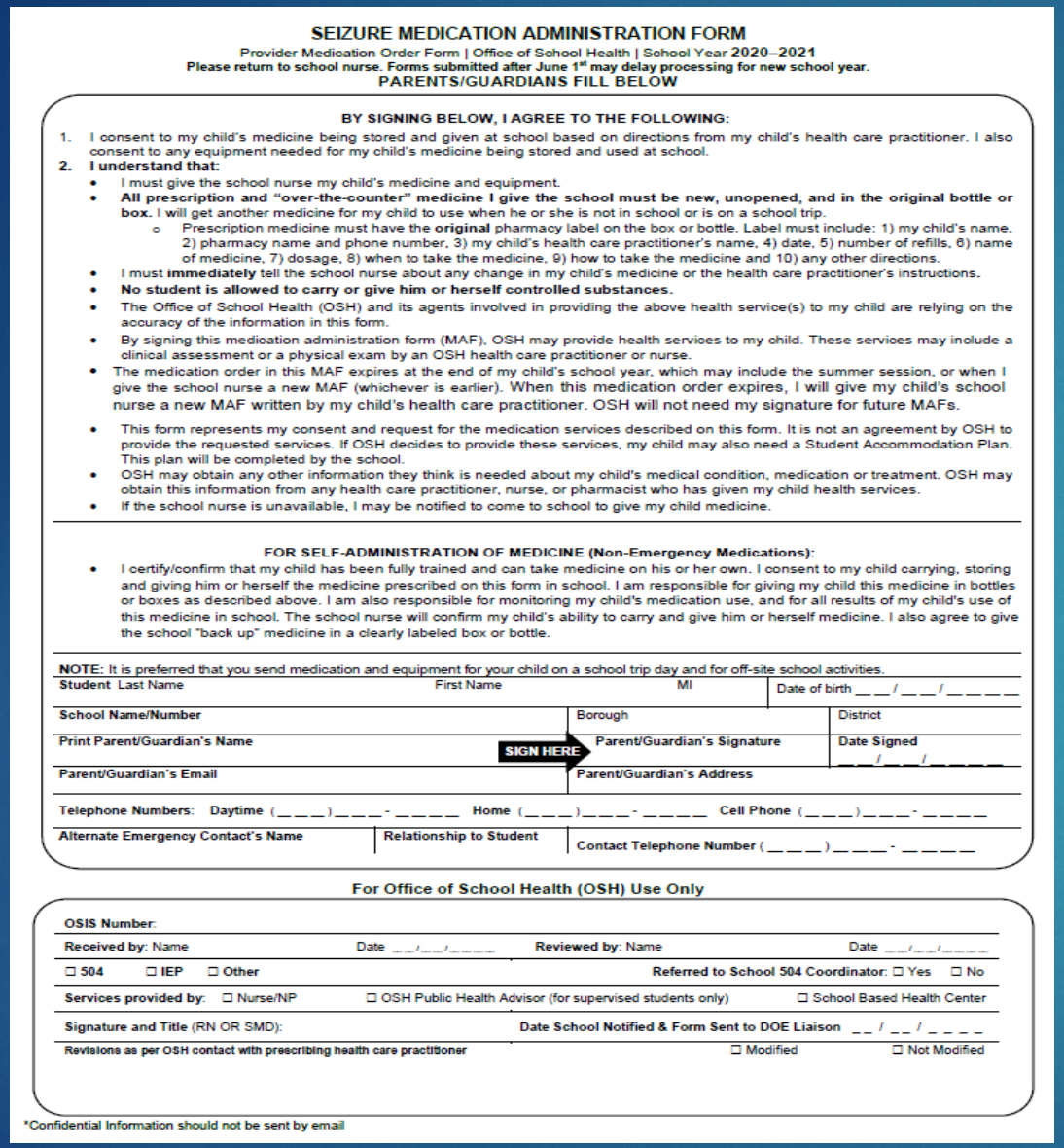
Address | Tel. No. (___)___-____ | Fax. No (____)____-____

E-mail address | Cell phone ( ) -

NYS License No **(Required)** _____ | NPI No. _____ | Date __/__/____

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS
FORMS CANNOT BE COMPLETED BY A RESIDENT Rev 4/20 **PARENTS MUST SIGN PAGE 2 ➔**

Seizure MAF – NEW for SY 20-21



SEIZURE MEDICATION ADMINISTRATION FORM

Provider Medication Order Form | Office of School Health | School Year **2020–2021**

Please return to school nurse. Forms submitted after June 1st may delay processing for new school year.

PARENTS/GUARDIANS FILL BELOW

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

1. I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.
2. **I understand that:**
   - I must give the school nurse my child's medicine and equipment.
   - **All prescription and "over-the-counter" medicine I give the school must be new, unopened, and in the original bottle or box.** I will get another medicine for my child to use when he or she is not in school or is on a school trip.
     - Prescription medicine must have the **original** pharmacy label on the box or bottle. Label must include: 1) my child's name, 2) pharmacy name and phone number, 3) my child's health care practitioner's name, 4) date, 5) number of refills, 6) name of medicine, 7) dosage, 8) when to take the medicine, 9) how to take the medicine and 10) any other directions.
   - I must **immediately** tell the school nurse about any change in my child's medicine or the health care practitioner's instructions.
   - **No student is allowed to carry or give him or herself controlled substances.**
   - The Office of School Health (OSH) and its agents involved in providing the above health service(s) to my child are relying on the accuracy of the information in this form.
   - By signing this medication administration form (MAF), OSH may provide health services to my child. These services may include a clinical assessment or a physical exam by an OSH health care practitioner or nurse.
   - The medication order in this MAF expires at the end of my child's school year, which may include the summer session, or when I give the school nurse a new MAF (whichever is earlier). When this medication order expires, I will give my child's school nurse a new MAF written by my child's health care practitioner. OSH will not need my signature for future MAFs.
   - This form represents my consent and request for the medication services described on this form. It is not an agreement by OSH to provide the requested services. If OSH decides to provide these services, my child may also need a Student Accommodation Plan. This plan will be completed by the school.
   - OSH may obtain any other information they think is needed about my child's medical condition, medication or treatment. OSH may obtain this information from any health care practitioner, nurse, or pharmacist who has given my child health services.
   - If the school nurse is unavailable, I may be notified to come to school to give my child medicine.

FOR SELF-ADMINISTRATION OF MEDICINE (Non-Emergency Medications):

- I certify/confirm that my child has been fully trained and can take medicine on his or her own. I consent to my child carrying, storing and giving him or herself the medicine prescribed on this form in school. I am responsible for giving my child this medicine in bottles or boxes as described above. I am also responsible for monitoring my child's medication use, and for all results of my child's use of this medicine in school. The school nurse will confirm my child's ability to carry and give him or herself medicine. I also agree to give the school "back up" medicine in a clearly labeled box or bottle.

NOTE: It is preferred that you send medication and equipment for your child on a school trip day and for off-site school activities.

Student Last Name	First Name	MI	Date of birth __ __ / __ __ / __ __ __ __
School Name/Number	Borough		District
Print Parent/Guardian's Name	SIGN HERE **Parent/Guardian's Signature**		**Date Signed** __ __ / __ __ / __ __ __ __
Parent/Guardian's Email	**Parent/Guardian's Address**		
Telephone Numbers: **Daytime** (__ __ __) __ __ __ - __ __ __ __ **Home** (__ __ __) __ __ __ - __ __ __ __ **Cell Phone** (__ __ __) __ __ __ - __ __ __ __			
Alternate Emergency Contact's Name	**Relationship to Student**	**Contact Telephone Number** (__ __ __) __ __ __ - __ __ __ __	

For Office of School Health (OSH) Use Only

OSIS Number:			
Received by: Name	Date __ __ / __ __ / __ __ __ __	**Reviewed by:** Name	Date __ __ / __ __ / __ __ __ __
☐ **504** ☐ **IEP** ☐ **Other**		**Referred to School 504 Coordinator:** ☐ Yes ☐ No	
Services provided by: ☐ Nurse/NP	☐ OSH Public Health Advisor (for supervised students only)		☐ School Based Health Center
Signature and Title (RN OR SMD):		**Date School Notified & Form Sent to DOE Liaison** __ __ / __ __ / __ __ __ __	
Revisions as per OSH contact with prescribing health care practitioner		☐ Modified	☐ Not Modified

*Confidential Information should not be sent by email

General MAF Part 2 – Parental /Guardian Consent

Seizure disorders

Seizure disorders vary and may include:

- Involuntary movement of arms and legs
- Loss of consciousness or staring
- Temporary post-seizure sleep (post –ictal)

Some students may report auras such as a smell, sound, anxiety, nausea

Staff with non-verbal students may report changes in affect of mood prior to seizure activity

Contributing factors to seizures activity:

- Lights, sounds prolonged computer use
- Blood sugars below or above target

Seizure Management

Administer emergency seizure medication or procedures prescribed on the New Seizure MAF

Follow MAF orders for post medication actions (E.g. 911, or student observation)

Call 911 for seizures as per the Seizure MAF:

- After administering Seizure Medication ordered on the MAF. EG. Diastat
- Administer medication as per MAF and follow directions for post ictal intervention
- Lasting more than 5 minutes or follow MD orders
- No documented history of seizures
- For unusual seizures/ different from baseline seizure

Contact parents

- Issue 12S for
- Notify school administration
- Notify Nursing supervisor

Seizure Disorders-Planning

Planning

- Review the medication Binder for:
- MAF's for emergency Medication order
- Chronic diagnosis list for history of seizures
- Issue 12S referrals for medical updates
- Communicate with school staff for s/s of seizures –record time on seizure log and notify nurse immediately
- **911 IS CALLED AFTER ADMINISTERING ORDERED DIASTAT**

Seizure

- Clear objects away from student and ask school staff to assist with removing other students from classroom
- Give medication if ordered on MAF
- Lay student flat on the ground and on the left side if able
- Time the seizure and related behavior
- Loosen tight clothing
- Maintain privacy whenever possible
- Follow Student Seizure Emergency Plan

DO NOT PUT ANYTHING IN STUDENTS' MOUTH

Vagus Nerve Stimulator(VNS) therapy

VNS therapy is a procedure used to improve seizure control. It is used in conjunction with medication

VNS therapy is delivered by a device(generator) resembling a pacemaker and a thin flexible wire(lead) which is surgically implanted under skin to deliver mild stimulation to the left vagus nerve

A magnet may be utilized during the day as a supplemental treatment to further enhance seizure control

Staff members with pacemakers should not be assigned to or trained in VNS magnet use

CONSULT OSH AND YOUR AGENCY SUPERVISOR IF AN ORDER FOR THIS IS NOTED

Osh medication & treatment policies and procedures

Ensure the six rights:

- Right Person
- Right Medication
- Right Dosage
- Right Time
- Right Route
- Right Documentation

Confirm the student's identity-name ,DOB, photo of student on MAF, class- school staff identify student

- Right to Refuse

Prior to ordered service:

- Confirm student's identity
- Review the photograph on the MAF
- Ask student to state his or her full name and DOB
- If the student is non-verbal, enlist the help of school staff to assist with student identification

Medication documentation

- Medication / Treatment time – Medication is administered within 1 hour of the designated time
- Document on MAR,TAR and /or DDF
- Notify PCPs parents, OSH SN and Agency SN if medications and or Treatments are not administered as prescribed

E.G. – document the reason on ASHR/103S

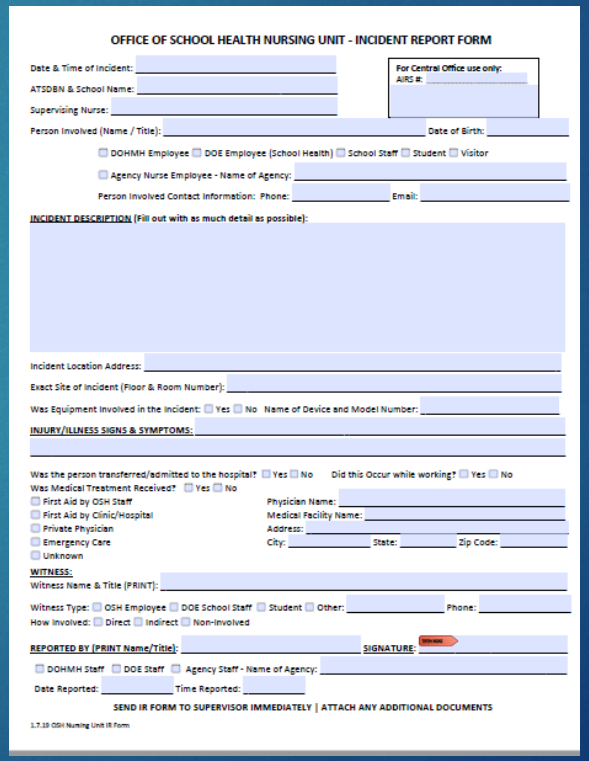
- Student's refusal
- Medication withheld for a therapeutic reason
- Medication withheld due to a contraindication
- Omissions of medication

Medication error

For Medication errors:

- Monitor student-vital signs
- Notify parent and secure student's safety
- Notify licensed prescriber
- Call OSH &Agency SN /BND immediately if there is an error in administering medication to a child
- Document process and observation
- Document event on the Reporting Incident Form (RM-1)

RM1 Form



OFFICE OF SCHOOL HEALTH NURSING UNIT - INCIDENT REPORT FORM

Date & Time of Incident:

For Central Office use only:
AIRS #:

ATSDBN & School Name:

Supervising Nurse:

Person Involved (Name / Title): Date of Birth:

DOHMH Employee DOE Employee (School Health) School Staff Student Visitor

Agency Nurse Employee - Name of Agency:

Person Involved Contact Information: Phone: Email:

INCIDENT DESCRIPTION (Fill out with as much detail as possible):

Incident Location Address:

Exact Site of Incident (Floor & Room Number):

Was Equipment Involved in the Incident: Yes No Name of Device and Model Number:

INJURY/ILLNESS SIGNS & SYMPTOMS:

Was the person transferred/admitted to the hospital? Yes No Did this Occur while working? Yes No

Was Medical Treatment Received? Yes No

First Aid by OSH Staff
First Aid by Clinic/Hospital
Private Physician
Emergency Care
Unknown

Physician Name:
Medical Facility Name:
Address:
City: State: Zip Code:

WITNESS:

Witness Name & Title (PRINT):

Witness Type: OSH Employee DOE School Staff Student Other: Phone:

How Involved: Direct Indirect Non-Involved

REPORTED BY (PRINT Name/Title): SIGNATURE:

DOHMH Staff DOE Staff Agency Staff - Name of Agency:

Date Reported: Time Reported:

SEND IR FORM TO SUPERVISOR IMMEDIATELY | ATTACH ANY ADDITIONAL DOCUMENTS

1.7.19 OSH Nursing Unit IR Form

Medication disposal

- Medication involving sharps should be disposed of in Red Containers in the Medical Room
- Inform OSH SN if sharps Containers are ¾ full

Oral Medication should be placed in a container and mixed with water or salt 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 (see Medication disposal form in front of medication binder)

D75 Program

D75 programs provide citywide educational, vocational and behavior support programs for students who:

- Are on the autism spectrum
- Have emotional needs
- Are Sensory impaired
- Have disabilities

Principals in D75 supervise multiple site and Schools Site administrators may supervise each site

D75 services may be in:

- Inclusive programs in districts school buildings
- Special inclusive classes in specialized schools
- Stand alone buildings

Example naming of D75 school - M138@05M039@P030M- D75 138 located in district 5 in Manhattan

OSH D75 School Coverage Folder

D75 Coverage Folder /Substitute Nurse Binder contains:

Coverage Folder Information and

An alert list in D75 contains student's names with and chronic dx list by:

- Asthma
- Allergies
- Seizures
- Diabetes

These are the only four (4) diagnosis to be shared with school staff. Staff may share emergency actions related to other diagnoses which remain confidential

Medical room standardization

Medical Room standardization:

- **Bulletin Board**
- **Placement of Medication Binders**

Medication Binders:

- Uniformly arranged as per OSH standard guideline
- Secured in locked file cabinet or in top medication drawer

Logbook:

- To log ALL nurse-student encounters, including those outside the medical room
- Secure the logbook in the locked file cabinet

Memo Folders (district/school specific)

- To place OSH memos

STANDARD TO BE POSTED ON MEDICAL ROOM BULLEITIN BOARD

File cabinet/Storage cabinet –stores extra supplies, forms

Items posted in the medical room:

- School/class organization list
- Lunch schedule/ bell schedule
- Beat Diabetes Manual
- HFA Placard for asthma inhaled and cleaning guidance
- Preparation guide of Covering Nurse
- EASI/ICS Policy
- Covid Like Illness (CLI) Policy
- Disinfection and Cleaning Schedule for OSH – see next slide

Posters in the medical room may be obtained from 311 or CDC

- Cover your cough
- Hand Hygiene
- Triage Poster

Cleaning Guidelines & Supplies

NYC | Department of Health and Mental Hygiene | Department of Education

Office of School Health

This schedule is posted conspicuously in the medical room:

DISINFECTION AND CLEANING SCHEDULE FOR OFFICE OF SCHOOL HEALTH

Area/Room	Surface	Disinfectant	Frequency	Responsible Person
Medical Room	Exam Table	CaviWipes Micro-Kill Plus	After each student use	Office of School Health Staff (Nurses, Public Health Advisors, Public Health Assistants)
	Medical Equipment	Alcohol Pads 70% Alcohol	After each student use	Office of School Health Staff (Nurses, Public Health Advisors, Public Health Assistants)
	Countertops (if any)	CaviWipes Micro-Kill Plus	Daily, or if visibly contaminated	Office of School Health Staff (Nurses, Public Health Advisors, Public Health Assistants)
	Tile Floor	Refer to Department of Education / School's General Housekeeping Procedures		School Custodian
	Walls	Refer to Department of Education / School's General Housekeeping Procedures		School Custodian

1. Maintain work sites in a clean and sanitary condition.
2. Implement cleaning schedules based on location, type of surface, and type of soil.
3. Immediately decontaminate all contaminated surfaces after spills or after contact with infectious materials.
4. Clean all surfaces that may have become contaminated during the day at the end of each shift.
5. Keep bins, pails, cans, and similar reusable receptacles clean of visible contamination on a regularly scheduled basis.
6. Do not pick up broken glassware that may be contaminated. Use a brush and dustpan, tongs or forceps.
7. Post this schedule where employees may refer to it.

All work surfaces will be decontaminated after completion of procedures and immediately, or as soon as feasible, after any spill of blood or other potentially infectious materials, as well as the end of the work shift if the surface has become contaminated since the last cleaning.

Decontamination will be accomplished by utilizing the following materials:
CaviWipes Disinfecting Towelettes
Micro-Kill+ (Micro-Kill Plus) Disinfecting, Deodorizing, Cleaning Wipes with Alcohol

As per the MSDS for Micro-kill+, safety handling includes:

- Wear gloves and protective clothing depending on condition of use
- Employees should be cautioned not to use with contact lens but should not be affected unless the room is very small and has absolutely no ventilation
- For those employees affected by use of wipes please contact your Regional Manager to request 70% Alcohol as an alternative

Continue to refer to your MSDS for CaviWipes and 70% Alcohol.

The OSH Exposure Control Plan section on Housekeeping and Regulated Waste Disposal -housekeeping and decontamination procedures is found on OSH site: https://a816-healthpsi.nyc.gov/healthweb/doc/school/list.html (←Not working)

Last revised 5/23/19

OSH Medical Room Standardization

- Emergency Bag – list of the same content – see next slide for list
- Red "Fanny Pack"

Each school will have the following forms for documentation: Call OSH SN if not available.

- 103S – hard copy of individual student medical record –slide
- List of different standard referral forms – upcoming forms section
- OSH policy and procedures to address multiple dx and emergencies, few examples:
- Asthma – EASI/ICS policy – Reviewed in Module 2
- Allergies – Reviewed in Module 2
- Diabetes- Reviewed in Module 3
- Seizures – Reviewed in Module 1

Standard Items in Medical Room

Equipment provided by OSH

- Medical exam table-to be used during MD exams **ONLY**
- Medication cabinet
- Digital or non-contact thermometer
- Band-Aid, gloves
- Stethoscope
- Sphygmomanometer
- Cavi-wipes
- 70% alcohol

Medications /supplies provided by OSH

- Stock Albuterol – follow Asthma EASI policy in Module 2 (need an MAF order)
- Flovent – reviewed ICS policy in Module 2 – needs an MAF order

Stock Epi pens _ there is a Standing order in school Health – reviewed Mod 2 (UPKs, all DOE buildings with a nurse assigned)

Safety retractable Lancets/ syringes /safety needles for diabetes management for students with diabetes orders (DMAF) (reviewed Module 3)

Masks/ Face Shields & hand sanitizers.

Medical Room Standard Items

Medication Binders:

- •Uniformly arranged as per OSH standard guideline
- •Secured in locked file cabinet or in top medication drawer
- **•Includes Medication and Treatment Documentation Forms**

Log Book:

- **•To log ALL nurse-student encounters, including those outside the medical room**
- **•Secure the log book in the locked file cabinet**
- Automate the Student Health Record (ASHR)-In DOE Public and Charter Schools
- Document if trained

•103S

- •Paper Medical Record for Individual Students

Medical Room Standard Supplies Delivered

Every September, OSH delivers:

- A medical kit with Band-Aids, gloves and other supplies

An emergency kit with the following medication:

- "Stock" Albuterol – kept in cabinet (EASI Protocol)
- Flovent – if there is a current or past order on an MAF
- Auvi_Q (epinephrine) 0.15 mg and 0.3 mg may be stocked at some sites
- Epi pens - (epinephrine) 0.15 mg and 0.3 mg may be stocked at some sites

- New sites will differ

Red Fanny Pack Supplies

- Red "Fanny Pack" – lists of same content
  - OSH Stock Epi pen 0.3 mg (adult dose)
  - OSH Stock Epi pen 0.15 mg (junior dose
  - CPR mask and gloves

Keep and carry the red fanny pack on or near your person for suspected medical emergencies. It contains stock epi pens.

****The Stock Epi pen is the only "standing order" medication used by OSH staff to treat anaphylaxis in a child or an adult without an order on school** premises

** Anaphylaxis is reviewed in Module 2

Format of Medication Binder

NYC | Department of Health and Mental Hygiene | Department of Education

Office of School Health

The following information is filed in the Medication Binder:

Section 1: Standing orders and Protocols Related to Medication/Treatment Services

- Standing Order for the Use of Epinephrine in a School Setting
- OSH Diabetes Protocol for Safety Sharps: Safety Retractable Lancets and Insulin Pen
- Safety Needles Updated December 2013
- Stock Ventolin Policy and Procedure
- NYS Education Department Memo: Training Unlicensed Individuals in the Injection of Glucagon in Emergency Situations
- Verbal Order Protocol/Verbal Order Form
- Disposal of Medication in Office of School Health Setting

Section 2: Delegation for Public Health Advisors: Checklists for tasks delegated to PH Advisors

Section 3: Special Health Services – Daily

- For ASHR schools – ASHR Daily Medication Profile Report
- For Non- ASHR schools – Daily Medication/Treatment Summary

Section 4: Special Health Services – PRN

- For ASHR schools – ASHR Medication Report
- For Non-ASHR schools – PRN Medication/Treatment Summary

Section 5: Field Trip Record

- For Field Trip Medication Record for Unlicensed Professionals Assisting Self-Directed Students with Administration of Medication filed by class

For ASHR schools, treatments should be documented on the Daily and/or PRN Medication/Treatment Summary Form.

Section 3 and Section 4 contains appropriate forms for each student receiving services. The forms for each student should be placed behind a divider labeled with the student's name. Forms to be included for each student are:

- ASHR Medication Profile
- Original Medication Administration Form (MAF - Allergies/Anaphylaxis/Asthma/Generic) with student's picture
- Original Treatment /Non-Medication Form, if applicable
- Original Diabetes Medication Administration Form, if applicable
- Medication Administration Record (one for each medication/treatment)
- Receipt of Medication/Equipment Form
- HFA Maintenance Form (if applicable)
- Controlled Substance Count Sheet (if applicable)
- Diabetes Documentation Form (if applicable)
- Asthma Action Plan (if applicable)
- School Allergy Response Plan (if applicable)
- Emergency Severe Low Blood Sugar Care Plan (if applicable)

Stock Ventolin HFA Maintenance Form is placed in front of Medication Binder
Chronic Diagnosis List is placed in front of Medication Binder

Red Fanny Pack Supplies

Check expiration dates

Pre-K Epinephrine storage

- Nurses in stand-alone Pre-K centers (UPKs) maintain the OSH stock Epi pens in fanny pack medical room until the UPK staff are trained by OSH
- After the UPK staff are trained in anaphylaxis management the UPK secures the Epi pen in a centrally accessible location
- UPK staff trained to give Epi pens can administer the Epi pen to any student or adult without a specific order for those who are showing signs of anaphylaxis symptoms
- Epi pen location should be noted in the Coverage folder

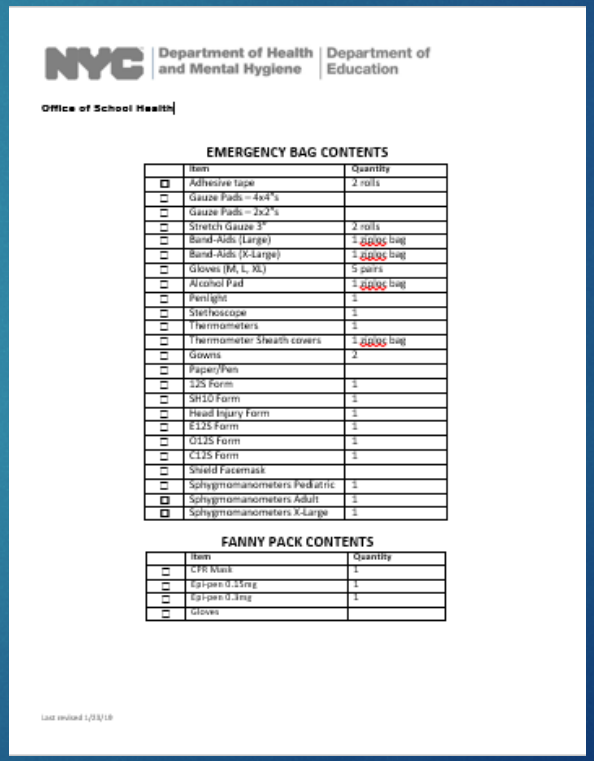
** used or expired Epi pens must be reordered using OSH re-order form and faxed to Karen Jackson Adams (reviewed in Module 2)

Emergency Supplies

Carry Emergency Supplies

- Calls for Nursing Assistance on school premises (school buildings, trailers, school yards)
- On Fire Drills
- Evacuations
- AED/Code Drills

Content list in emergency Bag



NYC Department of Health and Mental Hygiene | Department of Education

Office of School Health

EMERGENCY BAG CONTENTS

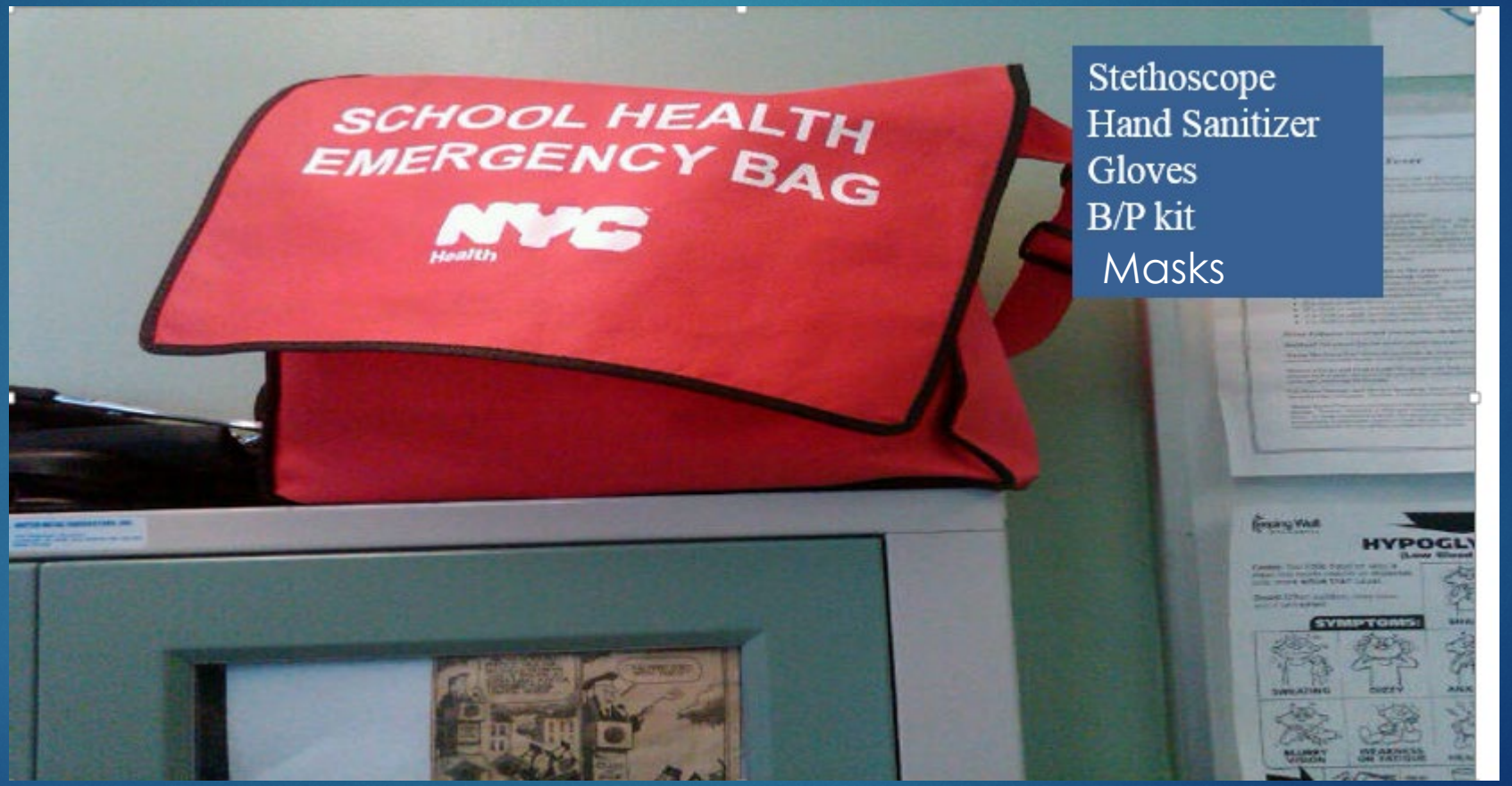
	Item	Quantity
☐	Adhesive tape	2 rolls
☐	Gauze Pads – 4x4"s	
☐	Gauze Pads – 2x2"s	
☐	Stretch Gauze 3"	2 rolls
☐	Band-Aids (Large)	1 appc bag
☐	Band-Aids (X-Large)	1 appc bag
☐	Gloves (M, L, XL)	5 pairs
☐	Alcohol Pad	1 appc bag
☐	Penlight	1
☐	Stethoscope	1
☐	Thermometers	1
☐	Thermometer Sheath covers	1 appc bag
☐	Gowns	2
☐	Paper/Pen	
☐	12S Form	1
☐	SH10 Form	1
☐	Head Injury Form	1
☐	E12S Form	1
☐	O12S Form	1
☐	C12S Form	1
☐	Shield Facemask	
☐	Sphygmomanometers Pediatric	1
☐	Sphygmomanometers Adult	1
☐	Sphygmomanometers X-Large	1

FANNY PACK CONTENTS

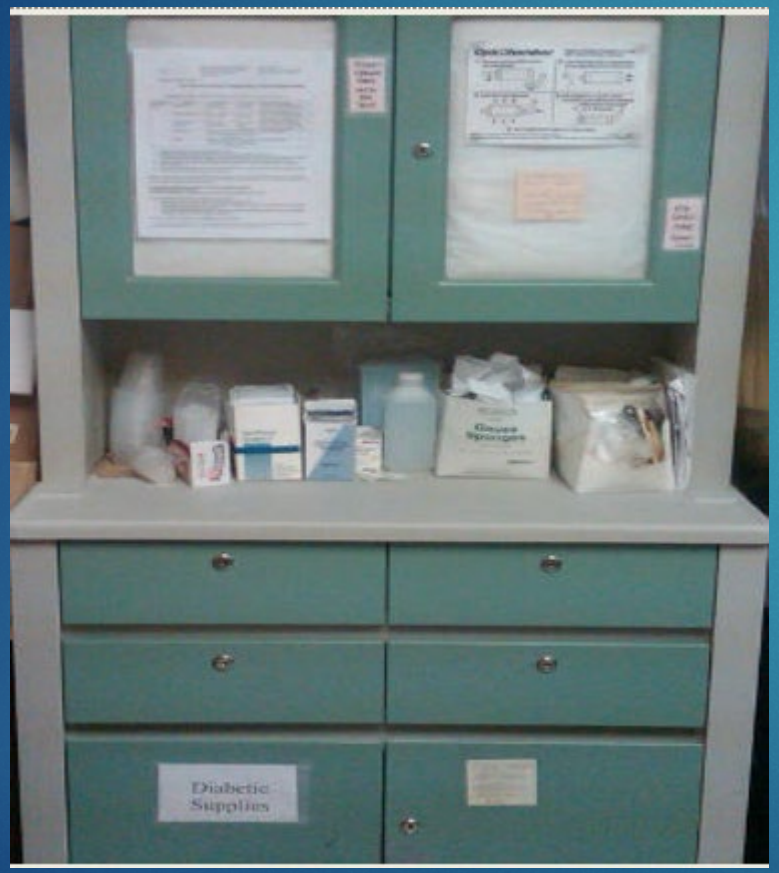
	Item	Quantity
☐	CPR Mask	1
☐	Epi-pen 0.15mg	1
☐	Epi-pen 0.3mg	1
☐	Gloves	

Last revised 1/23/18

OSH Emergency Bag

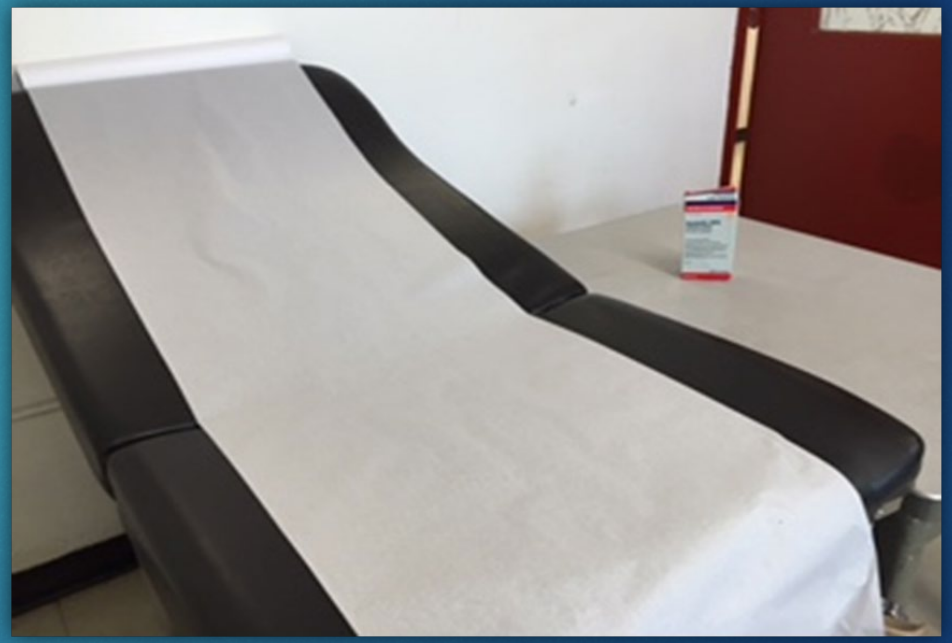


Medication Cabinet



- Supplies are stored/ labeled and locked in medication Cabinet
- Most Asthma medication is stored in this medicine cabinet
- “Stock “ Ventolin is usually stored in this cabinet

Items You May Find in Medical Room



School Emergencies

- Nurses follow the school's emergency plans for students, staff and community safety:
- •Medical
- •Behavioral Crisis for NYCDOE Public schools – refer to NYCDOE
  - •Chancellors **Regulations A-411**
- **•Environmental**
- **•Fire Drills and Medical Drills**
- Attend emergency drills
- Participate in fire drills
- Work with school administrations regarding nurse's station in emergencies
- **•See school Poster – BRT , Emergency evacuation and response –**
- **DOE Emergency readiness response**

School Health Emergencies/Evacuations

- Follow authorities' instructions for school evacuations
- Carry the red fanny pack, emergency bag, yellow BRT bag, the medication binder and necessary medication for the evacuation
- Contact your OSH Supervising Nurse (SN) , Borough Nursing Director ,BND as soon as able
- Contact Rightsourcing / H + H and/or its vendors where applicable
- Communicate with the school administration for students with medication orders and those needing medical assistance

- Non-public schools- Know the phone numbers or websites schools use for their emergencies

Building Response Team - BRT

DOE BUILDING RESPONSE LINK

The General Response Protocol (GRP) has been designed (in collaboration with the "I love U guys" Foundation) to provide all schools with the direction they will take when an emergency incident occurs. At its core is the use of *common language* to identify the initial measures all school communities will take *until first responders arrive*. In every incident, school administrators will need to assess the unique circumstances that will affect how the GRP is implemented.

Each protocol has specific staff and student actions that are unique to each response. In the event that a student or staff member identifies the initial threat, calling 911 and administration is required.

Lockdown (Soft/Hard) –*Soft lockdown* implies that there is no identified imminent danger to the sweep teams. Administrative teams, Building Response Teams, and School Safety Agents will mobilize at the designated command post for further direction. *Hard lockdown* implies that imminent danger is known and NO ONE will engage in any building sweep activity. All individuals, including School Safety Agents will take appropriate lockdown action and await the arrival of first responders

"Attention: We are now in soft/ hard lockdown. Take proper action"
(Repeated twice over the PA system)

Students are trained to:
1. Move out of sight and maintain silence

Teachers are trained to:
1. Check the hallway outside of their classrooms for students, lock classroom doors, and turn the lights off
2. Move away from sight and maintain silence
3. Wait for First Responders to open door or the "All Clear" message **"The Lockdown has been lifted"** followed by specific directions.
4. Take attendance and account for missing students by contacting main office

Evacuate – The fire alarm system is the initial alert for staff and students to initiate an evacuation. However, there may be times when the PA system and specific directions will serve as the alert initiating an evacuation. Announcements will begin with "Attention" and be followed with specific directions. (Repeated twice over the PA system).

Students are trained to:
1. Leave belongings behind and form a single file line. In cold weather, students should be reminded to take their coats when leaving the classroom. *Students in physical education attire WILL NOT return to the locker room.* Students without proper outdoor attire will be secured in a warm location as immediately as possible.

Teachers are trained to:
1. Grab evacuation folder (with attendance sheet and Assembly cards).
2. Lead students to evacuation location as identified on Fire Drill Posters. **ALWAYS LISTEN FOR ADDITIONAL DIRECTIONS**
3. Take attendance and account for students.
4. Report injuries, problems, or missing students to school staff and first responders using Assembly Card method.

Shelter-In – "Attention. This is a shelter-in. Secure the exit doors."
(Repeated twice over the PA system).

Students are trained to:
1. Remain inside of the building
2. Conduct business as usual
3. Respond to specific staff directions

Teachers are trained to:
1. Increase situational awareness
2. Conduct business as usual
3. The Shelter- In directive will remain in effect until hearing the "All Clear" message **"The Shelter- In has been lifted"** followed by specific directions.

BRT members, floor wardens, and Shelter- In staff will secure all exits and report to specific post assignments

Building Response Team (BRT) Cards

No issues noted

Nurse is needed

School Health Emergencies

- If, in the professional judgement of the OSH medical room staff , an EMS call is necessary, the OSH staff calls **911 and** remains with the student until EMS arrives. It is not necessary for the medical room staff to seek permission/approval before calling 911.

- The 911/EMS caller informs the school administration of the call and the reason for the call. Inform DOE Security Officers to prepare for the EMS arrival.

- If the nurse is called to an emergency and is not available to attend at that moment, the nurse can instruct the school staff to call 911 until the nurse is able to attend.
- School academic staff may also call 911 if they deem necessary.

- While it is not necessary to seek parents'/guardians' permission to call EMS, they must be notified of the call.
- Discuss procedures with school administrators during "meets and greets" or "talking points" at the beginning of the school year.

OFFICE of SCHOOL HEALTH (OSH) Encounters: Walk-ins, TRIAGE, Assessment

Walk-in Visits/Encounters

Walk-ins include student-Nurse encounters:

- **Illness or injuries**
- **Daily medications and Treatment on MAFs/DMAFs**
- **PRN medications and Treatment on MAFs/DMAFs**
- **Suspected or real emergencies on school premises**
- **A “same day” follow up after an earlier visit (** eg. Asthma, head injury)**
- **Follow up after an illness related absence**
- **Follow up for a recent 911 call**

Medical Room Referrals

- Teacher Referral Slips (passes) **194S are used by school staff to refer students to the medical room (enter in logbook and 103S)**
- "Passes" may be waived for bleeding, respiratory ,limited mobility
- **The Nurse assesses environmental safety and responds to requests for nurse assistance in other locations on school premises**
- DOE paraprofessionals (paras) assigned to D75 may escort students in D75 programs. 1:1 paras are with students during all school activities

Referrals to the Medical Room: 194S

Encounters:

Scheduled Daily medication or treatment

PRN medication or treatment

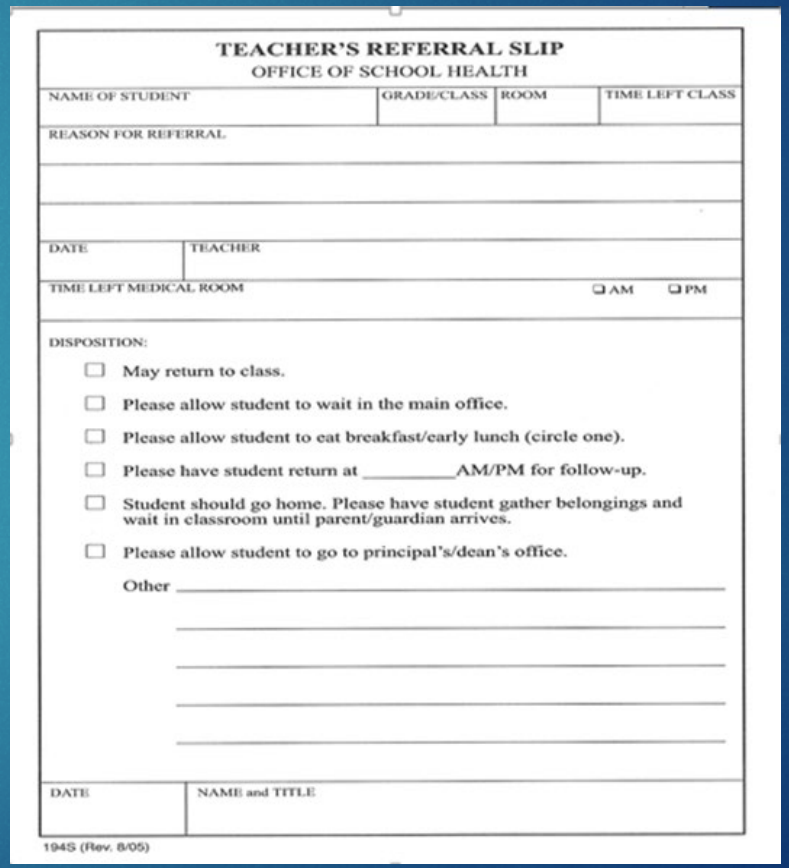
General complaint walk –in

Emergency walk-in

Called to an emergency another location within the building

All students should have a 194S when being seen in the medical room exceptions are made in emergencies, bleeding, respiratory complaints, and nurse's judgement

194S Form



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:

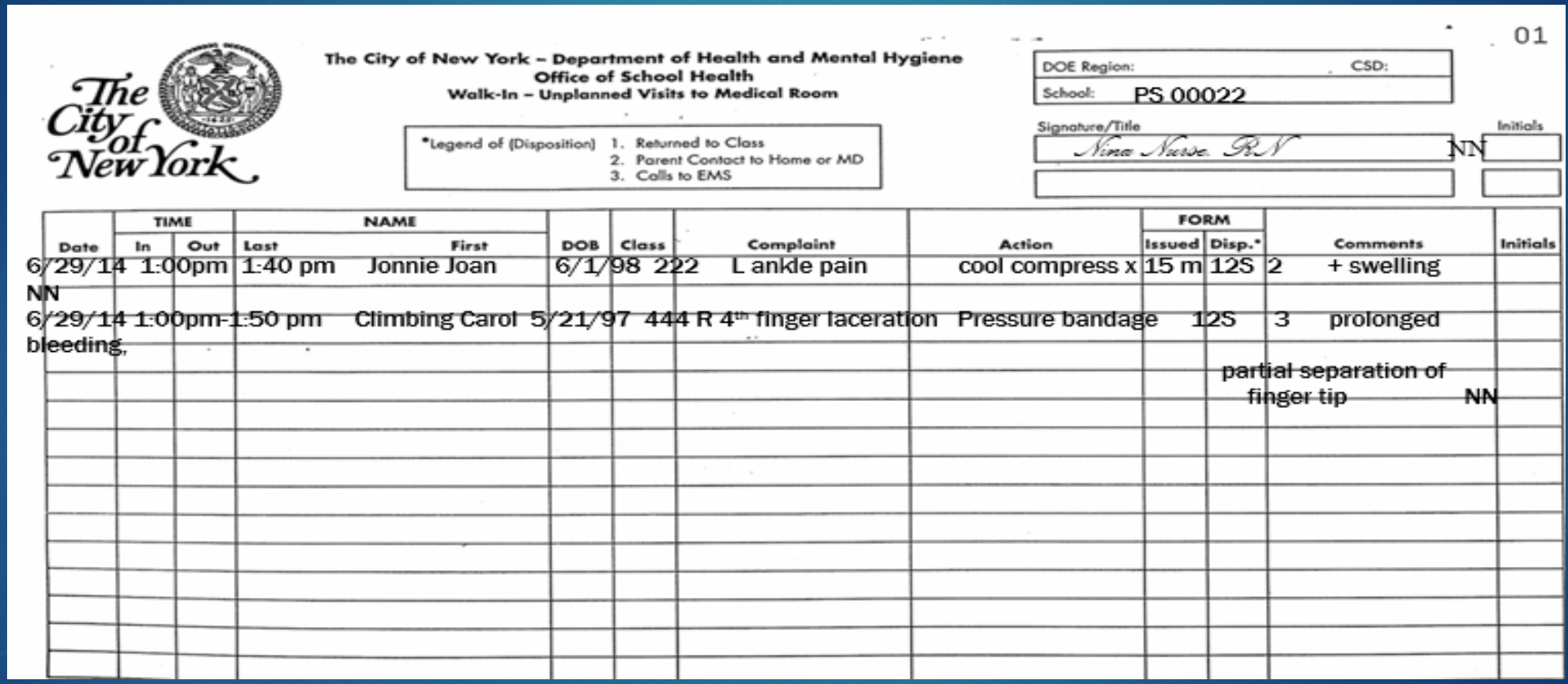
- ☐ May return to class.
- ☐ Please allow student to wait in the main office.
- ☐ Please allow student to eat breakfast/early lunch (circle one).
- ☐ Please have student return at _____AM/PM for follow-up.
- ☐ Student should go home. Please have student gather belongings and wait in classroom until parent/guardian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

Other _____

DATE	NAME and TITLE

194S (Rev. 8/05)

DOCUMENT IN LOG BOOK



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

01

DOE Region: CSD:
School: PS 00022

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

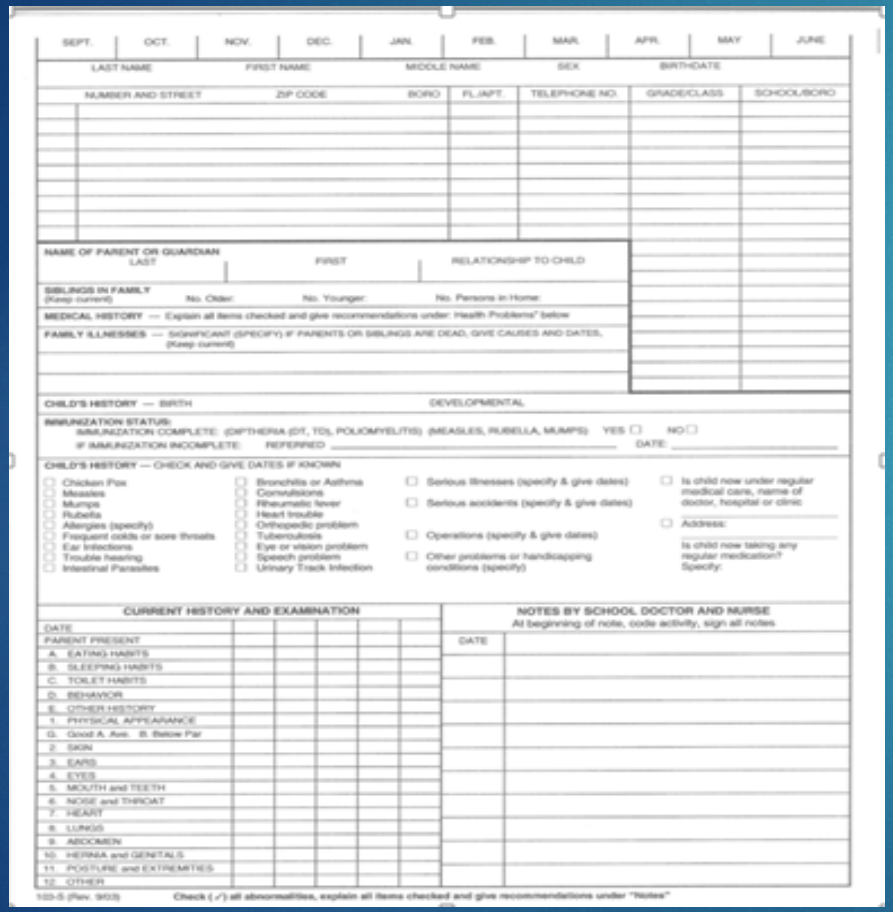
Signature/Title: Nina Nurse, RN — Initials: NN

Date	TIME In	TIME Out	NAME Last	NAME First	DOB	Class	Complaint	Action	FORM Issued	FORM Disp.*	Comments	Initials
6/29/14	1:00pm	1:40 pm	Jonnie	Joan	6/1/98	222	L ankle pain	cool compress x 15 m		12S	2 + swelling	NN
6/29/14	1:00pm	1:50 pm	Climbing	Carol	5/21/97	444	R 4th finger laceration bleeding	Pressure bandage		12S	3 prolonged partial separation of finger tip	NN

Document in the103S- Individual Student Paper Health Record

103 S –back- continuation-contract nurse will write up a new form if not found on specific student for documenting

103S - Front



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:

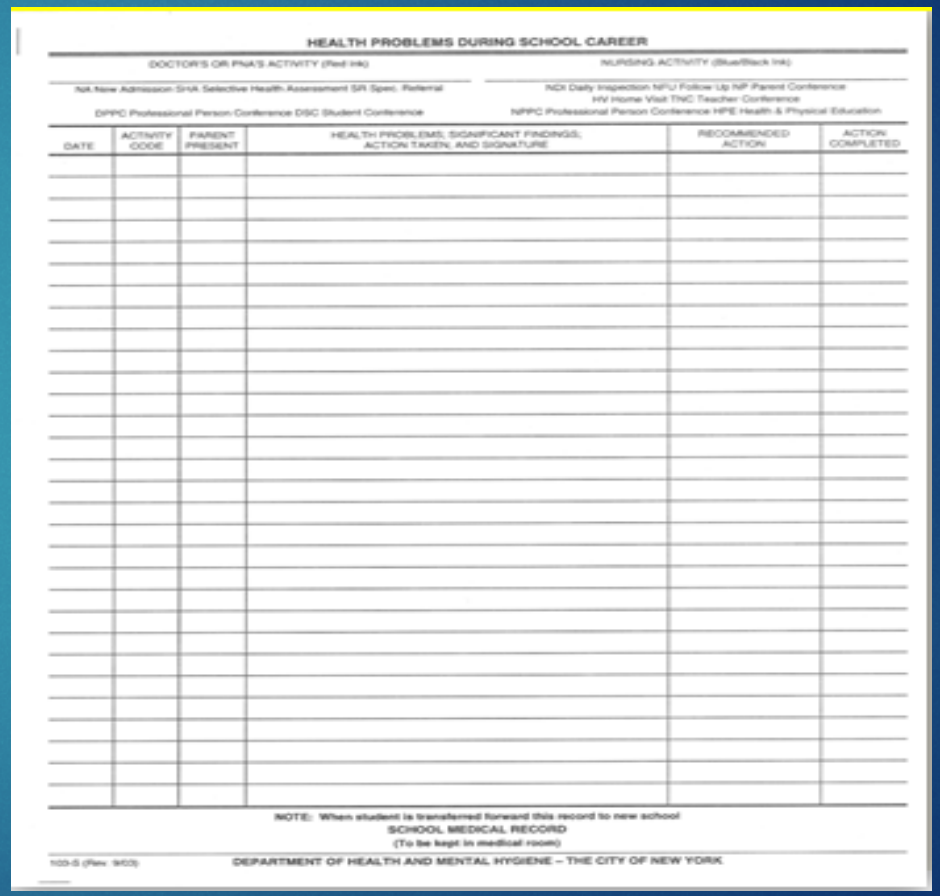
CURRENT HISTORY AND EXAMINATION

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) | NURSING ACTIVITY (Blue/Black Ink)

NA New Admission SHA Selective Health Assessment SPI Spec. Referral | NDI Daily Inspection NFU Follow Up NP Parent Conference HV Home Visit TNC Teacher Conference

DPPC Professional Person Conference DSC Student 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

Medical Records Confidentiality

- Automated School Health Records(ASHR) – OSH Electronic Medical Record (EMR)
- 103S Individual Paper Health Record is folded and secured in a locked file cabinet
- New Schools will need to initiate health files with new admission exams

(The New Admission Exam is a one time OSH requirement for each student and will be discussed later

A subpoena is required to duplicate or provide these records to non-medical room OSH staff

If a request is made for student's medical Records (103S) the Contract Nurse will:

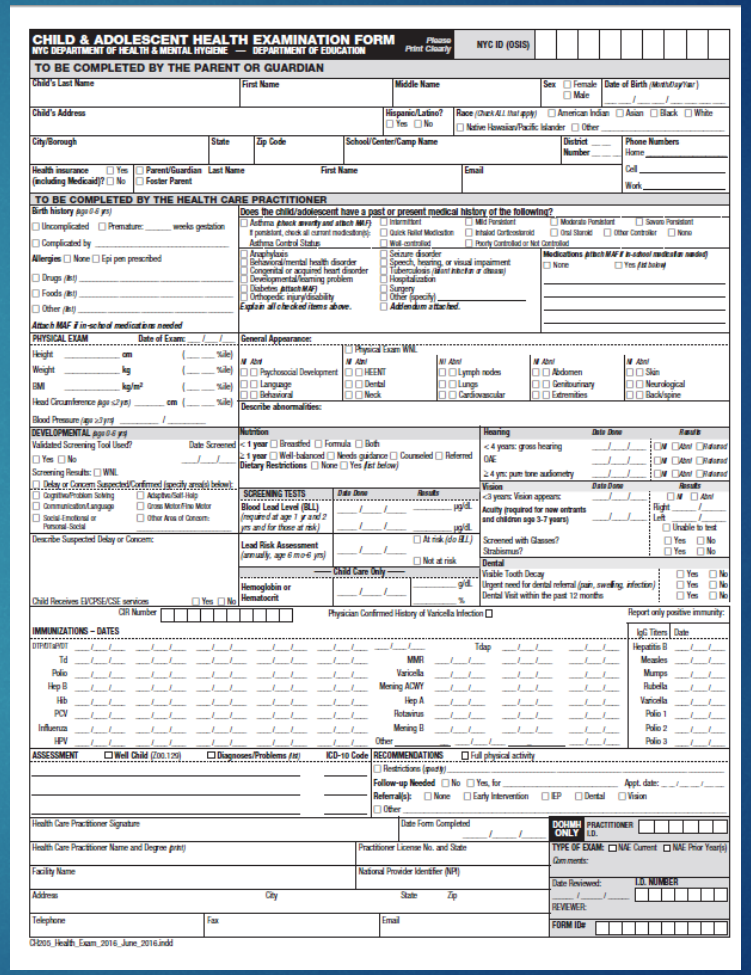
- Notify OSH Supervising Nurse
- Notify Agency Supervising nurse

All subpoenaed medical records are reviewed by OSH legal prior to complying

NYC New Admission Exam (NAE) or (CH205) requirement

- All students entering New York City public or private schools or child care (including Universal Pre-K classes) for the first time must submit a report of a physical examination performed within one year of school entry. (CH205 form)
- As per NYC Health Code, only one (1) physical exam dated after student's fifth (5th) birthday is required
- The CH205 (NAE)is placed in the new 103S and is a foundation for a student health record

Children develop and grow quickly in these early ages, if the initial examination is performed before the students' 5th birthday, a second examination will be needed



CHILD & ADOLESCENT HEALTH EXAMINATION FORM
NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION
NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex | Date of Birth
Child's Address | Hispanic/Latino? | Race
City/Borough | State | Zip Code | School/Center/Camp Name | District Number | Phone Numbers
Health insurance (including Medicaid)? | Parent/Guardian Last Name | First Name | Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history
Does the child/adolescent have a past or present medical history of the following?
Allergies
Medications (attach MAF if in-school medication needed)
Attach MAF if in-school medications needed

PHYSICAL EXAM — Date of Exam:
Height | Weight | BMI | Head Circumference | Blood Pressure
General Appearance:
Describe abnormalities:

DEVELOPMENTAL
Validated Screening Tool Used? | Date Screened
Screening Results:
Describe Suspected Delay or Concern:
Child Receives EI/CPSE/CSE services

Nutrition
Dietary Restrictions

SCREENING TESTS — Date Done — Results
Blood Lead Level (BLL)
Lead Risk Assessment
Hemoglobin or Hematocrit

Hearing — Date Done — Results
Vision — Date Done — Results
Dental

CIR Number
Physician Confirmed History of Varicella Infection
Report only positive immunity:

IMMUNIZATIONS – DATES
DTP/DTaP | Tdap | IgG Titers | Date
Td | MMR | Hepatitis B
Polio | Varicella | Measles
Hep B | Mening ACWY | Mumps
Hib | Hep A | Rubella
PCV | Rotavirus | Varicella
Influenza | Mening B | Polio 1
HPV | Other | Polio 2 | Polio 3

ASSESSMENT — Well Child (Z00.129) — Diagnoses/Problems — ICD-10 Code
RECOMMENDATIONS — Full physical activity — Restrictions (specify)
Follow-up Needed — Referral(s): None, Early Intervention, IEP, Dental, Vision, Other

Health Care Practitioner Signature | Date Form Completed
Health Care Practitioner Name and Degree | Practitioner License No. and State
Facility Name | National Provider Identifier (NPI)
Address | City | State | Zip
Telephone | Fax | Email

DOHMH ONLY — PRACTITIONER I.D. — TYPE OF EXAM: NAE Current, NAE Prior Year(s) — Comments: — Date Reviewed: — I.D. NUMBER — REVIEWER: — FORM ID#

CH205_Health_Exam_2016_June_2016.indd

- **OSH does not request annual physical exams** OSH referral forms are used for updated medical information
- DOE new admission examination

Triage, Triage, Triage

1:1 Nursing

The 1:1 Nurse is assigned to provide prescribed care to that student only and remain in close proximity to the student for care during the school day

1:1 Nurse should:

- •Meet the school Coverage Nurse
- •Give Medication Administration Form (MAF) copies to School Nurse to be recorded and maintained
- •Obtain a "portable chart" from the medical room with orders and OSH documentation
- •Have forms to travel with during the school day
- Inspect and maintain ordered equipment
- •Document daily. (Student Documentation for 1:1 cases is the property of OSH)

Use of Wheelchairs & Pulse Oximeter in OSH

Wheelchair Usage in OSH

- **OSH Nurses/ Contract Nurses do not use non-prescribed wheelchairs to transport students**
- If a student cannot walk due to an injury, pain, respiratory distress nurse:
- Will call or recommend EMS (911) for emergency treatment
- If the nurse is unavailable to attend to the possible emergency , the school would call EMS
- Injured Person should only be moved in the following circumstances:
  - Transferring to a hard surface to perform CPR
  - Removing them form immediate danger (e.g. risk of fire or explosion)
- Injuries may not be obvious; use of a non-prescribed wheelchair to transport an injured student may result in further injury

Pulse Oximeter used in OSH:

- Pulse Oximetry requires an MAF or written addendum for the nurse to perform
- **Pulse Oximetry orders should include parameters for assessing, reporting, treating and calling EMS**
- **An EMS call may be based on multiple factors**

Some Diagnoses In OSH

- Asthma
- Diabetes
- Seizure disorder
- Sickle cell disease
- Pulmonary hypertension
- Cognitive impairments
- Physical impairments
- Verbal communication problems
- Spina Bifida
- Respiratory illnesses
- Food intolerance
- Allergies/ anaphylaxis

Registered Nurse servicing OSH do not diagnose or "rule out" medical diagnosis

School year 20/21 – Covid-19 Like Illness (CLI)

The Different aspects of OSH
Managing asthma/diabetes
Reviewed in Module 2&3

Managing Diagnoses and Care in OSH

Insulin Pumps

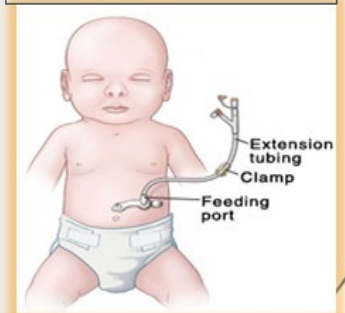
Medtronic-Minimed.com

Myomnipod.com

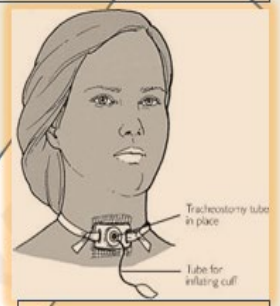
Animas.com

See the Diabetes Management module for separate diabetes training

Gastrostomy care and feeding



Tracheostomy care and suctioning



Assessing services

Seizure management

Oxygen therapy

Arrival in Medical Room

- Call Nursing Liaison, ideally within 20 minutes of arrival to assignment:
- Review the covering nurse folder and medication binder
- Locate emergency supplies
- Check the fanny pack and emergency bag content , expiration of epi pens
- Check “Stock” Ventolin – kept in cabinet , check expiration date
- Review the medication Binder (S) for Daily and PRN medication , treatments and procedure (what time is your first medication or treatment order ?)
- Do the daily narcotic count if applicable (call OSH SN for any missing or discrepancies in medication count or supplies asap)
- Review chronic Diagnosis list as available

- If care is needed before calling the liaison, tend to the person

Walk-in Visits & Encounters

Walk-ins include student-Nurse encounters:

- **Illness or injuries**
- **Daily medications and Treatment on MAFs/DMAFs**
- **PRN medications and Treatment on MAFs/DMAFs**
- **Suspected or real emergencies on school premises**
- **A "same day" follow up after an earlier visit (** eg. Asthma, head injury)**
- **Follow up after an illness related absence**
- **Follow up for a recent 911 call**
- ***New possible call from Isolation room with CLI concerns**

Medical Room Security

Students should not be alone in the medical room

Lock the medical room if leaving to go out of the area and at dismissal

- Medication cabinets should be locked when not in use
- Lights in the medical room remain on unless otherwise advised in a building emergency
- Carry keys and emergency bag + Red Fanny Pack when responding to an emergency call
- MAF Book/ Logbook /red Fanny pack is placed in place specified in Nurse Covering Folder (file cabinet/ medicine cabinet) and locked at the end of the day

Triage the Following scenarios

Check Student's 103S for possible history of medical or surgical conditions to guide actions
Ask parent or student same

Triage:

1. Stomach ache
2. Nose bleed
3. Known student with diabetes feeling "low"
4. Difficulty breathing
5. Pain to ankle , unable to bear weight
6. Student with known allergies is feeling "itchy"

Place in numerical order- first to assess and treat

In medical room Nurse is called to an emergency in the gym. what to do ?

Present in medical room:

1. 1 student with a stomach ache
2. 1 student waiting to be picked up by parent with an head injury
3. 1 student for a pre- exercise albuterol
4. 1 student escorted another student

Discuss triage

REFERRAL FORMS: ISSUE WITH ALL NURSE-STUDENT ENCOUNTERS

Walk – in notification

- SH10 – check off notification of a student encounter)
- 12S – General referral requesting PCP care and follow up
- Head injury form –given with a 12S for any head injury (follow concussion)

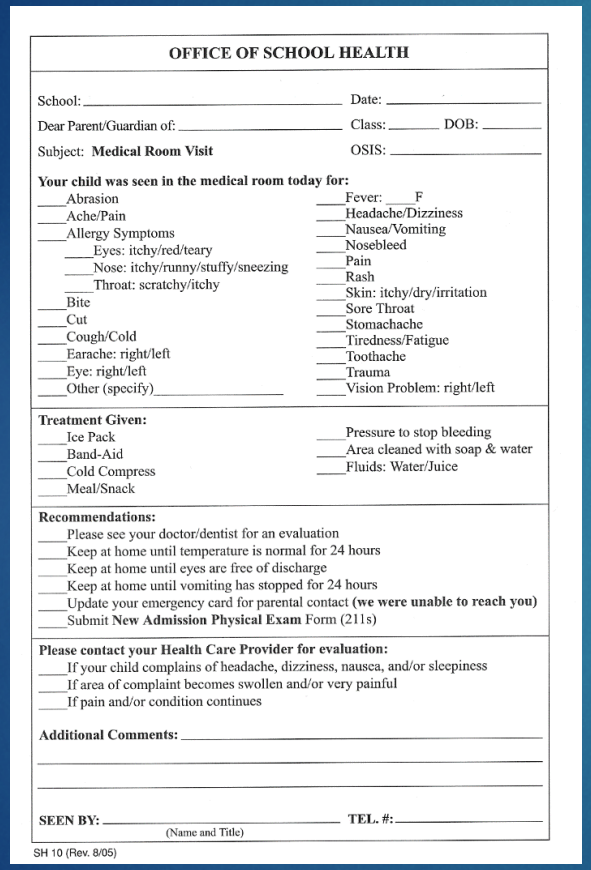
OSH policy – the nurse notifies parents by phone about the assessment and treatment of the student's complaint and issue a referral form

Referral to see a specialist:

- C12S- Cardiac referral
- E12S – Eye referral
- O12S- Orthopedic referral
- CH205- a New physical exam if there is none on file (only 1 is needed after age 5)
- MAF- medication Administration Form
- DMAF- Diabetes Medication Administration Form

SH 10 and 12S Referral forms

SH10 – inform of student's visit to med room



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:

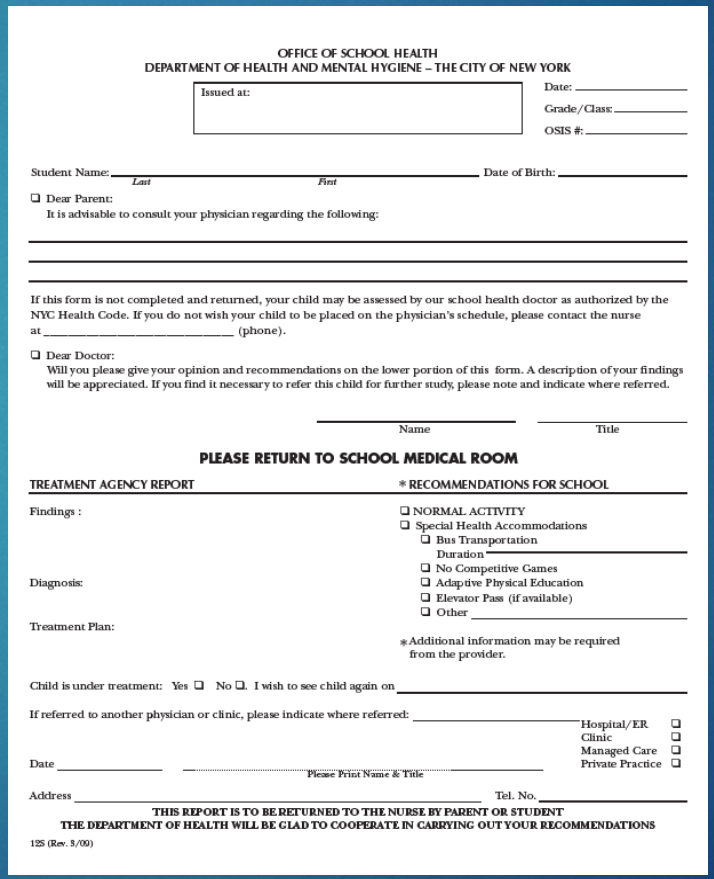
____If your child complains of headache, dizziness, nausea, and/or sleepiness
____If area of complaint becomes swollen and/or very painful
____If pain and/or condition continues

Additional Comments: _____

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

SH 10 (Rev. 8/05)

12s – recommendation to see a health care provider



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)

OSH referral to families (cont'd)

Issue a SH10 for encounter:

- Student's complaint
- Observation/self-observation
- Assessment
- Treatment
- Disposition – return to class/ pick up
- Call parent/guardian via phone or ask for help from main office to call
- Document in student's record 103S

Issue a 12S for PCP follow up:

- Student's complaint
- Observation/self observation
- Assessment
- Treatment
- Disposition – home, ER, back to class
- Document in student's record 103S
- Case manage and follow up on complaint

OSH Documentation Standards: 103S-Paper Health Records

RN is required to document in the 103S

All students complaints, assessments, treatment and relevant communications

Sign the medication administration Record(MAR), Treatment Administration Record (TAR) that's kept in Medication Binder

All Students with diabetes encounter on Diabetes Documentation Form (DDF) (reviewed in Module 3)

RNs are required to all encounters in Logbook

- All students seen in medical room or those seen elsewhere on school premises
- Brief description of encounter and disposition with date and time

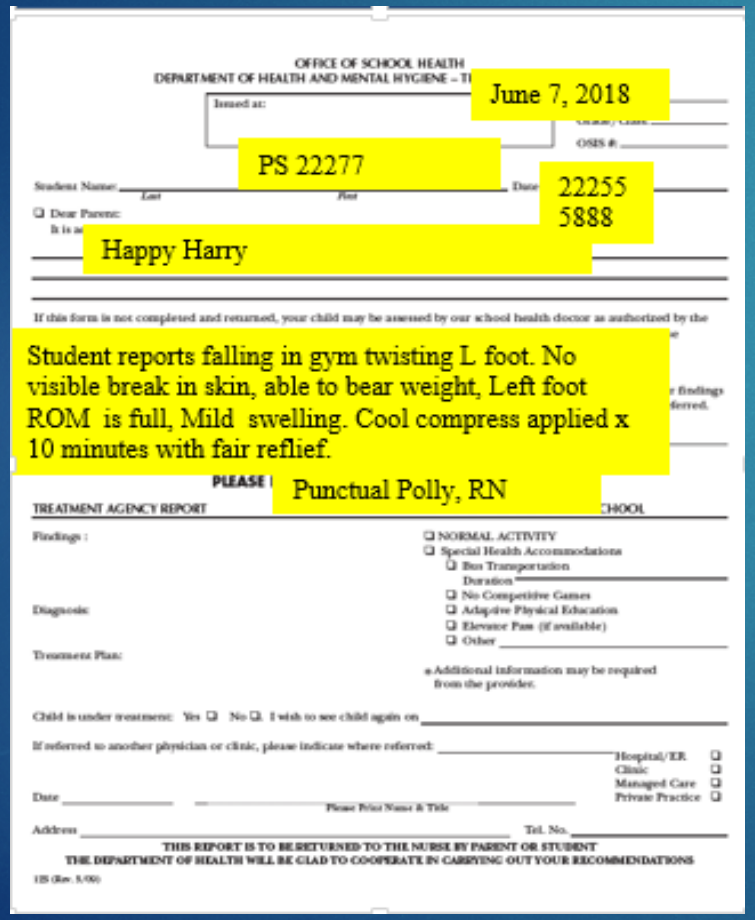
PARENT NOTIFICATIONS

Nurse :

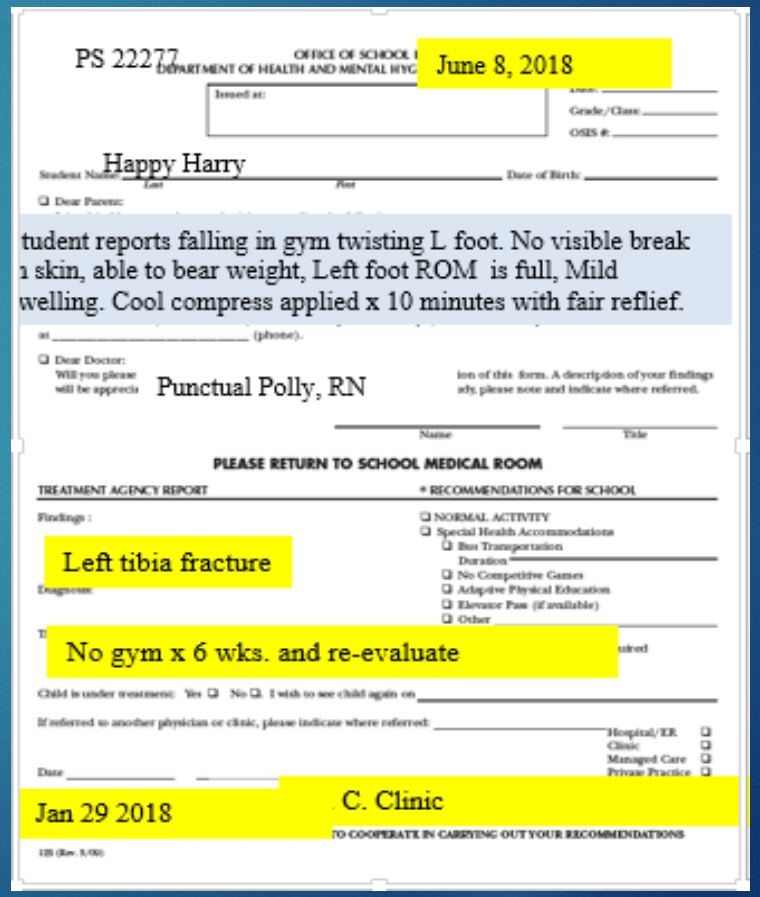
- Notifies parent or guardian with a phone call **and**
- Issue OSH referral forms
- Notify Principal, school administration, Nursing supervisors of 911 calls and significant events
- Notify the supervising nurse of any new OSH medications received
- Notify Primary Care Providers (PCP) and parents of students significant responses to medication or treatments
- Leave 911 forms in the log book (memo folder) for the returning nurse to review

Referrals: 12S sample

12S issued to parent/guardian



Transcribe 12S to the 103S when returned by parent



Medical Room Follow Ups

Notify OSH SN for all EMS calls and hospitalizations

Follow up on students sent by EMS

Next day :

If student is present- assess and gather any ER documentation for school activities

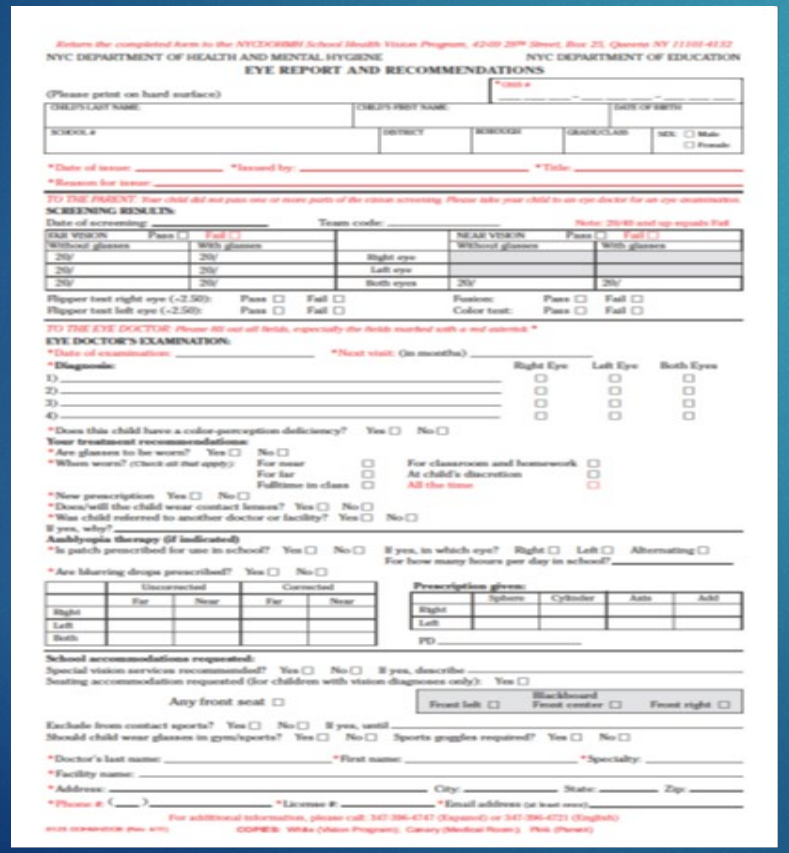
If student is absent-call parent for an updates of student status

Transcribe on ASHR/103S –EMS form and case manage. Place in next MD session

Inform school staff of recommendation (gym teacher, principal, AP

E12S – Vision referral form

Front of E12S Form



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

EYE REPORT AND RECOMMENDATIONS

(Please print on hard surface)

CHILD'S LAST NAME | CHILD'S FIRST NAME | DATE OF BIRTH | SCHOOL # | DISTRICT | BOROUGH | GRADE/CLASS | SEX: Male / Female

*Date of issue: _____ *Issued by: _____ *Title: _____

*Reasons for issue: _____

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

SCREENING RESULTS:

Date of screening: _____ Team code: _____ Note: 20/40 and up equals Fail

DATE VISION	Pass	Fail (*)		NEAR VISION	Pass	Fail (*)
Without glasses	With glasses			Without glasses	With glasses	
20/	20/		Right eye			
20/	20/		Left eye			
20/	20/		Both eyes	20/	20/	

Flipper test right eye (-2.50): Pass ☐ Fail ☐ Fusion: Pass ☐ Fail ☐

Flipper test left eye (-2.50): Pass ☐ Fail ☐ Color test: Pass ☐ Fail ☐

TO THE EYE DOCTOR: Please fill out all fields, especially the fields marked with a red asterisk *

EYE DOCTOR'S EXAMINATION:

*Date of examination: _____ *Next visit: (in months) _____

*Diagnosis:	Right Eye	Left Eye	Both Eyes
1) _____	☐	☐	☐
2) _____	☐	☐	☐
3) _____	☐	☐	☐
4) _____	☐	☐	☐

*Does this child have a color-perception deficiency? Yes ☐ No ☐

Your treatment recommendations:

*Are glasses to be worn? Yes ☐ No ☐

*When worn? (Check all that apply): For near ☐ For far ☐ Fulltime in class ☐ For classroom and homework ☐ At child's discretion ☐ All the time ☐

*New prescription Yes ☐ No ☐

*Does/will the child wear contact lenses? Yes ☐ No ☐

*Was child referred to another doctor or facility? Yes ☐ No ☐

If yes, why? _____

Amblyopia therapy (if indicated):

*Is patch prescribed for use in school? Yes ☐ No ☐ If yes, in which eye? Right ☐ Left ☐ Alternating ☐

For how many hours per day in school? _____

*Are blurring drops prescribed? Yes ☐ No ☐

	Uncorrected		Corrected	
	Far	Near	Far	Near
Right				
Left				
Both				

Prescription given:

	Sphere	Cylinder	Axis	Add
Right				
Left				

PD _____

School accommodations requested:

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

Seating accommodation requested (for children with vision diagnoses only): Yes ☐

Any front seat ☐

Blackboard: Front left ☐ Front center ☐ Front right ☐

Exclude from contact sports? Yes ☐ No ☐ If yes, until _____

Should child wear glasses in gym/sports? Yes ☐ No ☐ Sports goggles required? Yes ☐ No ☐

*Doctor's last name: _____ *First name: _____ *Specialty: _____

*Facility name: _____

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

*Phone #: (___) _____ *License #: _____ *Email address (at least one): _____

For additional information, please call: 347-396-4747 (Espanol) or 347-396-4721 (English)

E12S DOHMH/DOE (Rev. 4/11) COPIES: White (Vision Program); Canary (Medical Room); Pink (Parent)

Back of E12S form

PLEASE SEND ALL COMPLETED FORMS TO:

School Health Vision Program
42-09 28th Street, Box 25
Queens, NY 11101-4132

If you have questions about the form, please call one of the following numbers:

347-396-4747 (Espanol)
347-396-4759
347-396-4721

If your child has very low vision, he or she may be eligible for special services provided by the New York City Department of Education.

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.

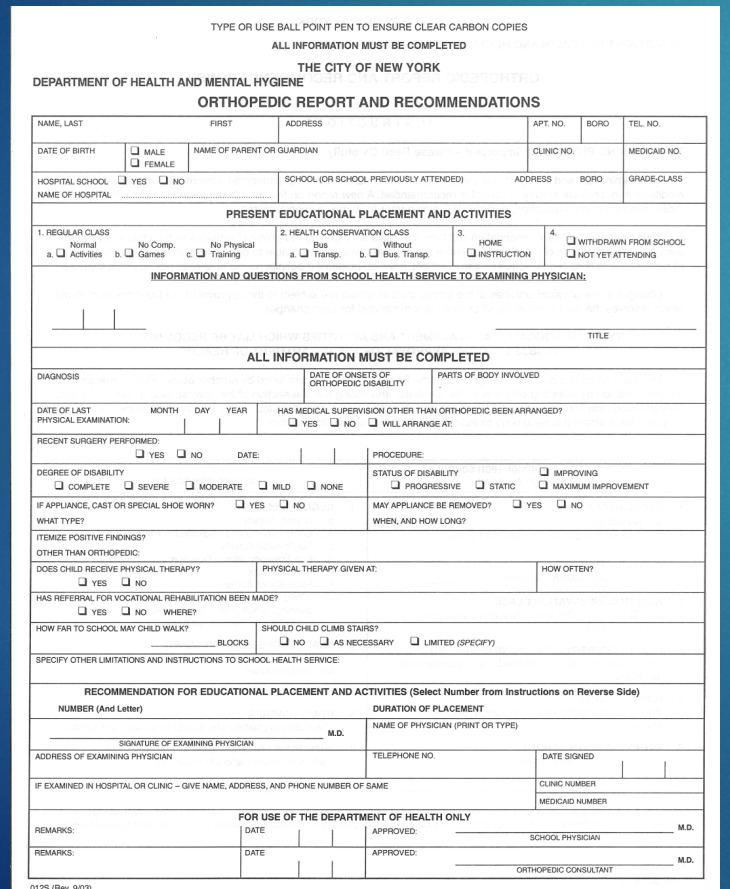
For further information contact:

Educational Vision Services
400 First Avenue, 7th Floor
New York, NY 10010

E12S DOHMH/DOE (Rev. 4/11)

O12S Form – Orthopedic referral form

Front of O12S Form



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 — a. ❑ Normal Activities b. ❑ No Comp. Games c. ❑ No Physical Training
2. HEALTH CONSERVATION CLASS — a. ❑ Bus Transp. b. ❑ Without Bus. Transp.
3. ❑ HOME INSTRUCTION
4. ❑ 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

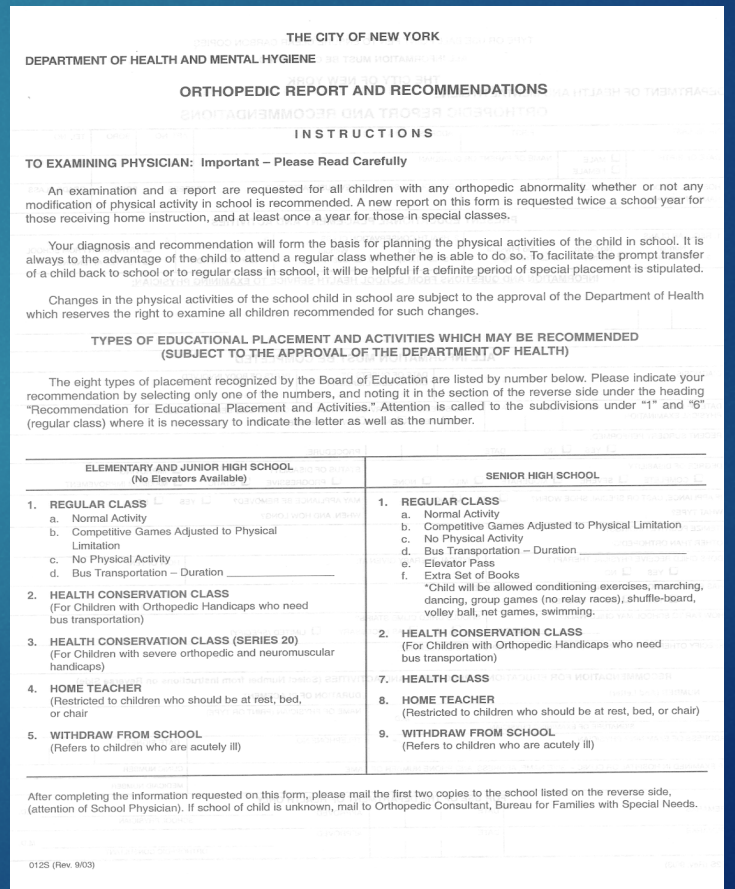
FOR USE OF THE DEPARTMENT OF HEALTH ONLY

REMARKS: | DATE | APPROVED: _____ M.D. SCHOOL PHYSICIAN

REMARKS: | DATE | APPROVED: _____ M.D. ORTHOPEDIC CONSULTANT

012S (Rev. 9/03)

Back of O12S Form



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)

1. **REGULAR CLASS**
   a. Normal Activity
   b. Competitive Games Adjusted to Physical Limitation
   c. No Physical Activity
   d. Bus Transportation – Duration _____
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)
4. **HOME TEACHER** (Restricted to children who should be at rest, bed, or chair
5. **WITHDRAW FROM SCHOOL** (Refers to children who are acutely ill)

SENIOR HIGH SCHOOL

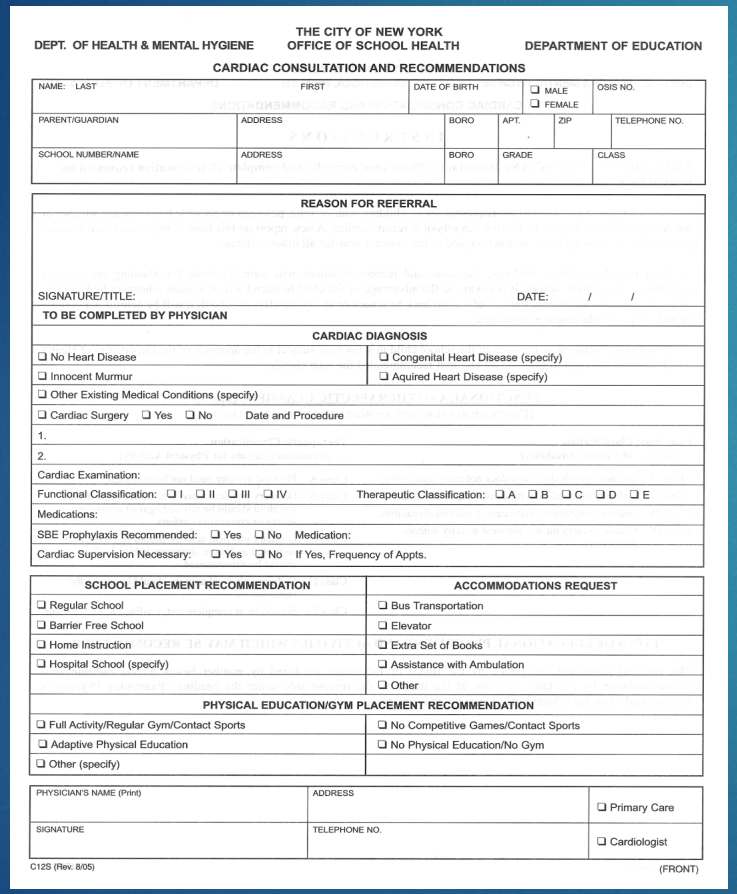
1. **REGULAR CLASS**
   a. Normal Activity
   b. Competitive Games Adjusted to Physical Limitation
   c. No Physical Activity
   d. Bus Transportation – Duration _____
   e. Elevator Pass
   f. Extra Set of Books
   *Child will be allowed conditioning exercises, marching, dancing, group games (no relay races), shuffle-board, volley ball, net games, swimming.
2. **HEALTH CONSERVATION CLASS** (For Children with Orthopedic Handicaps who need bus transportation)
7. **HEALTH CLASS**
8. **HOME TEACHER** (Restricted to children who should be at rest, bed, or chair)
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)

C12S- Cardiac referral form

Front of C12S Form



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

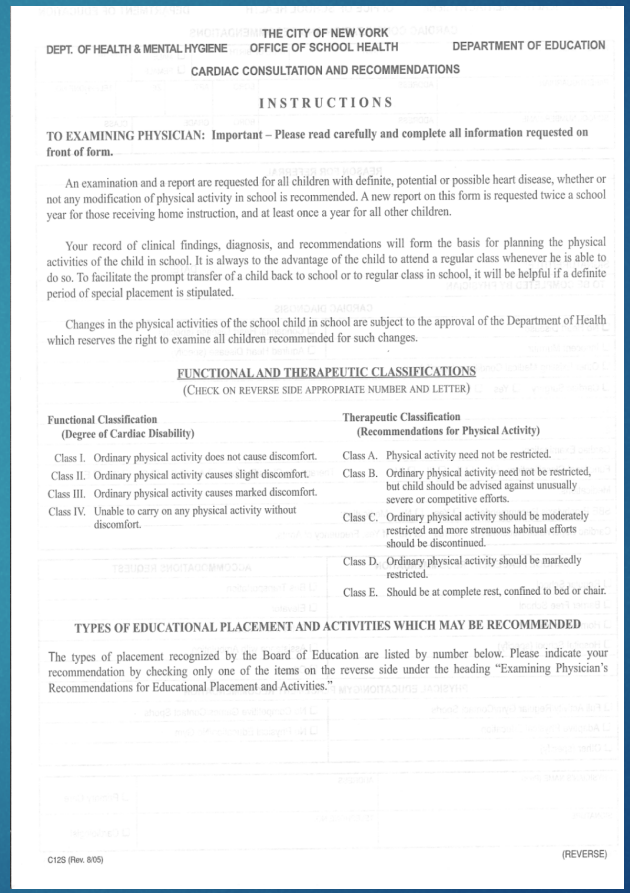
PHYSICAL EDUCATION/GYM PLACEMENT RECOMMENDATION

❑ 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)

Back of C12S form



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)		Therapeutic Classification (Recommendations for Physical Activity)	
Class I.	Ordinary physical activity does not cause discomfort.	Class A.	Physical activity need not be restricted.
Class II.	Ordinary physical activity causes slight discomfort.	Class B.	Ordinary physical activity need not be restricted, but child should be advised against unusually severe or competitive efforts.
Class III.	Ordinary physical activity causes marked discomfort.	Class C.	Ordinary physical activity should be moderately restricted and more strenuous habitual efforts should be discontinued.
Class IV.	Unable to carry on any physical activity without discomfort.	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)

Student with head injury

Check Student's History in the 103 S to determine any related problems such as Shunts, tumors, headaches

Student stayed in school

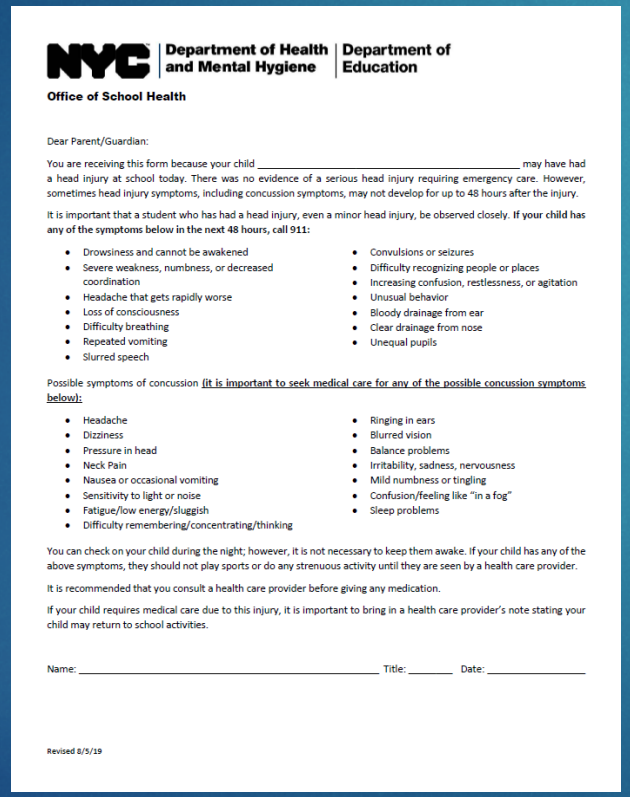
- Assess , monitor and document on 103S
- Call parent/guardian as soon as possible and discuss observed signs
- Disposition – communicate with school staff for student to return to medical room for any signs that you will discuss with them
- Issue a 12S and a Head injury form
- Reassess before dismissal and document , case manage and follow up next day

Home or EMS

- After assessment if student is symptomatic call EMS
- If parent is being picked up out of precautions – discuss head injury form when to seek ER of PCP
- Document and follow up next day
- If symptomatic after reassessment- call EMS and Document ,case manage and follow up

Walk-in head injury

12S is always issued with Head injury form



NYC | Department of Health and Mental Hygiene | Department of Education

Office of School Health

Dear Parent/Guardian:

You are receiving this form because your child _____ may have had a head injury at school today. There was no evidence of a serious head injury requiring emergency care. However, sometimes head injury symptoms, including concussion symptoms, may not develop for up to 48 hours after the injury.

It is important that a student who has had a head injury, even a minor head injury, be observed closely. **If your child has any of the symptoms below in the next 48 hours, call 911:**

- Drowsiness and cannot be awakened
- Severe weakness, numbness, or decreased coordination
- Headache that gets rapidly worse
- Loss of consciousness
- Difficulty breathing
- Repeated vomiting
- Slurred speech
- Convulsions or seizures
- Difficulty recognizing people or places
- Increasing confusion, restlessness, or agitation
- Unusual behavior
- Bloody drainage from ear
- Clear drainage from nose
- Unequal pupils

Possible symptoms of concussion **(it is important to seek medical care for any of the possible concussion symptoms below):**

- Headache
- Dizziness
- Pressure in head
- Neck Pain
- Nausea or occasional vomiting
- Sensitivity to light or noise
- Fatigue/low energy/sluggish
- Difficulty remembering/concentrating/thinking
- Ringing in ears
- Blurred vision
- Balance problems
- Irritability, sadness, nervousness
- Mild numbness or tingling
- Confusion/feeling like "in a fog"
- Sleep problems

You can check on your child during the night; however, it is not necessary to keep them awake. If your child has any of the above symptoms, they should not play sports or do any strenuous activity until they are seen by a health care provider.

It is recommended that you consult a health care provider before giving any medication.

If your child requires medical care due to this injury, it is important to bring in a health care provider's note stating your child may return to school activities.

Name: _____ Title: _____ Date: _____

Revised 8/5/19

Complaint of head injury

- Assess present and pass level consciousness (did student lose consciousness initially ?)
- Call parent/guardian as soon as possible
- Enlist the help of school administration to make calls if needed
- Call 911 if deemed necessary –(EMS form and case manage)
- Issue 12S and head injury form

Concussion Management for Public school Athletic (PSAL) student's Memo

- Contract Nurses will follow up by:
- Opening Case management for all head injury
- Issuing 12S plus Head Injury Form
- Document in ASHR or 103S any follow up information, any PCP communication
- Inform Athletic Director/Principal/ Site Coordinator of PCP recommendation for return to Play or learn

- Assess
- Monitor
- Record sign and symptoms
- Inform – parent/student and coaches
- Document in 103S
- Reassessed before dismissal
- Call EMS if deemed at any time in the process
- Case manage as per PCP- return to play, return to learn etc.

OSH Concussion Memos

NYC

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Oxiris Barbot, MD
Commissioner

NEW YORK CITY DEPARTMENT OF EDUCATION
Richard Carranza
Chancellor

OFFICE OF
SCHOOL HEALTH

Concussion Management for Public School Athletic League (PSAL) Students

Dear OSH Nurses,

As you may know, the Office of School Health is working more closely with the Public Schools Athletic League (PSAL) to identify and follow up with students who may have had a head injury or suspected concussion during sports. Many of you have already heard from us asking you to follow up with these students. We thank you for your efforts in reaching out and obtaining documentation.

School nurses have an important role to play in ensuring that students and families are educated about concussion symptoms and when to seek medical care. We know it's best practice for all students with concussion to be referred for evaluation by a medical provider who can treat their symptoms appropriately and manage their return to learn and return to play.

In addition, New York State law requires students who are removed from interathletic activity (e.g., PSAL activities) for suspected concussion to be evaluated and cleared by a **physician** before they can return to school and athletic activities. Students who sustain a concussion outside of PSAL activity may be cleared by a licensed medical provider (MD/DO, NP, or PA).

To support best practices for our students, we are developing a robust concussion protocol and concussion specific forms for healthcare providers in the community. We're also actively working with PSAL and DOE to improve follow-up and appropriate academic management of these students. School nurses may receive documentation regarding activity restrictions or return to learn plans while a student is recovering from concussion and should communicate this information to the appropriate school staff.

Please stay tuned for more information on this topic. In the meantime, the following link can be a helpful resource: https://www.cdc.gov/headsup/schools/nurses.html. Please be sure you are up to date with the concussion training that New York State requires for all school nurses every two years.

Right now, we're also encouraging you to reach out to the PSAL athletic director in your school and get to know this person so that you can work together effectively with these students. If you don't know the athletic director in your school, check the PSAL website (http://www.psal.org/profiles/profile.aspx and scroll down to your school) or reach out to Central Office.

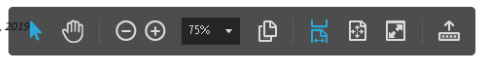
In some cases, someone from Central Office working on this concussion initiative may reach out to you for further follow-up with a specific student at your school.

Please feel free to contact Ann Marie Ashmeade (ahibbert@health.nyc.gov /718-310-2406), Dr. Marian Larkin (mlarkin5@health.nyc.gov /718-310-2687) or Joanne Casarella (jcasarella@health.nyc.gov /718-310-2467) with any questions or concerns.

Best,

Gail Adman

June 18, 2019



NYC | Department of Health and Mental Hygiene | Department of Education

Office of School Health

Concussion Management Updates for the 2019-2020 School Year

Dear OSH Nurses,

As you may know, the Office of School Health continues to work to improve how we identify and follow up with students who may have had a head injury or suspected concussion. Many of you heard from Central Office last school year asking to follow up with these students. We thank you for your efforts in reaching out and obtaining documentation.

As we begin the 2019-2020 school year, we wanted to share some updates on concussion management:

1. We have developed a formal concussion protocol which details what steps should be taken as soon as OSH staff are aware of a student with a possible concussion. We anticipate that the protocol will be shared widely this fall.
2. The Head Injury Letter has been updated to help better educate families by specifically listing symptoms that could be a sign of concussion. Please note the new letter is now live on Shareport and should be updated in ASHR shortly.
3. PSAL will continue to notify Central Office about students with suspected head injury. Central Office will reach out to nurses for follow-up.
4. Beginning this 2019-2020 SY, OSH will be notified of certain non-PSAL suspected head injuries via Online Occurrence Reporting System (OORS) reports provided by the Office of Safety and Youth Development (OSYD). Central Office will notify nurses for follow-up with these students. Please note these injuries may have a lower level of suspicion for concussion than the sports-related injuries reported by PSAL.

Please stay tuned for more information. In the meantime, the following link can be a helpful resource: https://www.cdc.gov/headsup/schools/nurses.html. Please be sure you are up-to-date with the concussion training that New York State requires for all school nurses every two years.

Please feel free to contact Ann Marie Ashmeade (ahibbert@health.nyc.gov /718-310-2406), Dr. Marian Larkin (mlarkin5@health.nyc.gov /718-310-2687), Maria Konica Mendez (mmendez1@health.nyc.gov /718-310-2934) or Joanne Casarella (jcasarella@health.nyc.gov /718-310-2467) with any questions or concerns.

Best,

Gail Adman, RN

Gail Adman, RN
Director of Nursing

Revised: October 11, 2019

Eye Injury

Foreign bodies in the eyes:

- Do not remove the foreign particles from the eye
- Flush eyes with running water
- Seek medical attention if foreign body remains in eye
- Contact parent/guardian, issue 12S

Do not attempt to remove embedded/impaled objects from eye and call 911

Assess student for example of :

- Unable to open eyes after injury
- Complain of continued pain
- Tearing continuously
- Complain of “light: hurting and
- Blurry vision, unable to see

Call parent , issue 12S and call 911 if needed

Walk-in Trauma Assessments

Cuts, Lacerations, Wounds

- **Actions:**
- Apply pressure to control bleeding
- Call 911/EMS if needed
- Cleanse area with soap and water only depending on location and wound size
- Cover with band aid or bandage
- Contact parent and issue 12S referral for further medical evaluation
- Inform school administration

:

- Abrasion – surface skin has been scraped
- Laceration – wound with open edges usually caused by a tear by an object or blunt trauma
- Incision – sharp object cutting the skin
- Puncture – a piercing in the skin made with sharp pointed object

OTC skin cleansers, ointments or home remedies must not be used by OSH without an MAF

Walk- In : Trauma

Walk-ins:

- Supervise and observe students while they are using cool compress
- Bruises may appear differently as time elapses
- Call parent/guardian-request office assistance as needed with emergency cards
- Document unscheduled visits in the log book
- Document assessments in 103S from onset of visit, assessment, treatment and dis
- Position. Document cut/wound size, any bleeding, ROM,
- Document administration of medications, treatments, procedures in the medication binder

WOUND DRESSINGS FROM HOME OR THE STUDENT'S PCP MAY BE REINFORCED AND CALL PARENT OR CALL 911 IF BLEEDING TO AREA IS UNCONTROLLED. DON NOT REMOVE HOME DRESSINGS

Trauma

Trauma may lead to swelling and bruising, not always immediately visible

- Assess area for skin breakage
- Cleanse area with soap and water
- Apply bandage as needed
- Document mobility, ROM, weight bearing
- Apply cool compress to injured part for 10-20 mins off 10 mins
- (Check for history of Sickle Cell Anemia and do not apply ice in this case)
- Call parent and DOCUMENT effect of treatments in 103S

911 SHOULD BE CALLED FOR ANY VISIBLE **DISFIGURATION OR VISIBLE BONE AFTER REPORTED TRAUMA**

Bones, muscles, joints

Call 911 for injuries to bones and joints and muscles that include:

- Deformed or discolored body parts, limbs
- Limited or no range of motion
- Student hears of feels broken limb
- Bone protruding out of skin
- Inability to walk or use limbs after injury
- Swelling or pain effecting mobility

Do not attempt to force weight-bearing, ambulation or movement after injuries

Notify parents/ guardians by phone and issue 12S/O12S Document

Amputations

Amputation – "the removal of a limb by trauma, medical illness or surgery"

- 911 is called for ALL amputations
- Apply pressure to bleeding areas
- Notify school administration
- Notify parent/guardian
- Issue 12S
- Notify OSH and Agency Supervisor

Place the separated part (if found) on clean wet gauze, place in plastic bag (to protect and keep clean)- baggie may be placed on cold compress (never place directly on cold surface)

TOOTH INJURY

Tooth avulsion –complete displacement of a tooth from its socket in alveolar bone:

- Administer first aid as needed
- Call EMS – this is a dental emergency
- Locate tooth (ask school staff for assistance as needed)
    - handle by the crown area only
    - place in milk or wrap in moistened paper towel and send Via EMS'

Issue 12S Referral form

Document in 103S and follow up with family the following day

None traumatic loss of tooth ("baby tooth")

- Administer First aid as needed
- Inform parent
- Issue a SH10 referral form
- Place tooth in a baggie for student to take home

Infection control/ Post exposure plan

- Contract nurses follow Standard Precautions for hand hygiene and using Personal Protective Equipment (PPE)
- Soap is supplied by school custodian
- Gloves are supplied by OSH
- Follow Communicable Disease Protocol by using appropriate PPE as per OSH specific instructions

Potential Blood Borne Exposure – Contract Nurse will follow their Agency specific Blood Borne Exposure plan

Communicable Diseases

The OSH Communicable Liaison Nurse communicates with the DOHMH Bureau of Communicable Disease (BCD) and the Bureau of Immunization (BOI) to determine:

- If any standard letters needs to be distributed to classes or to the school
- If any concerns meet the level of a public health concern

All communicable diseases and conditions must be reported to your Supervising Nurse (SN) or the Borough Nursing Director (BND) IMMEDIATELY

How to report a communicable disease

Reporting Illness concerns:

All vaccine preventable diseases are reported

Suspected Tuberculosis

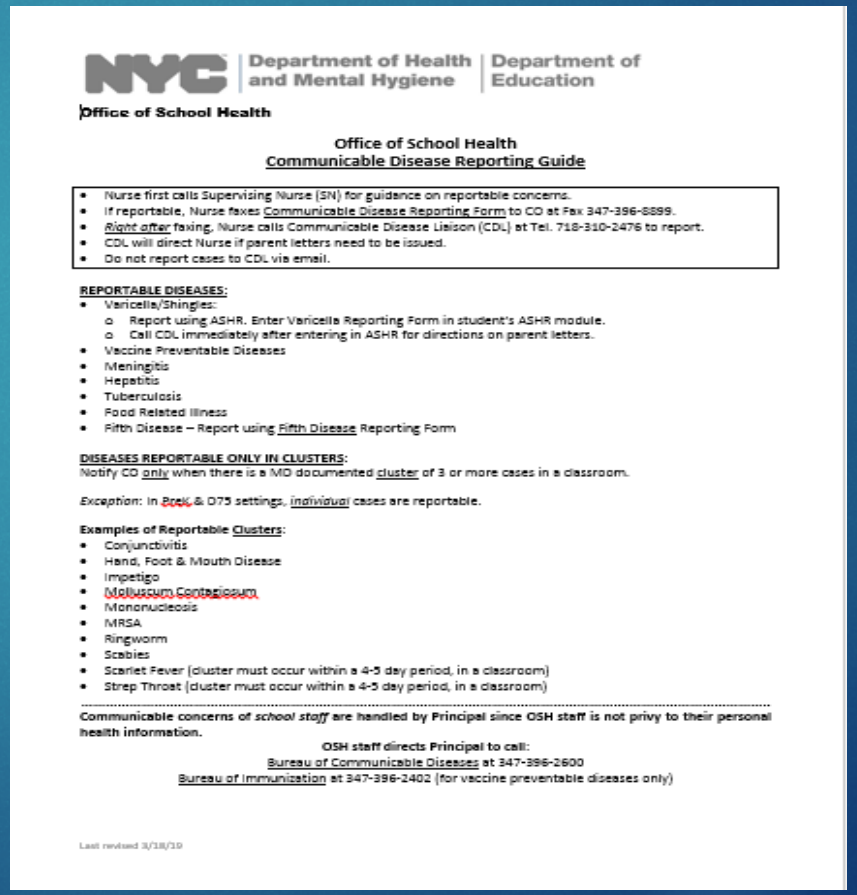
Suspected / md confirmed Meningitis, Hepatitis ,Meningitis

Food-related illness

GI related illness

REGISTERED NURSES DO NOT DIAGNOSE OR RULE OUT DIAGNOSES

COMMUNICABLE DISEASE REPORTING GUIDE



NYC | Department of Health and Mental Hygiene | Department of Education

Office of School Health

Office of School Health
Communicable Disease Reporting Guide

- Nurse first calls Supervising Nurse (SN) for guidance on reportable concerns.
- If reportable, Nurse faxes Communicable Disease Reporting Form to CO at Fax 347-396-8899.
- *Right after* faxing, Nurse calls Communicable Disease Liaison (CDL) at Tel. 718-310-2476 to report.
- CDL will direct Nurse if parent letters need to be issued.
- Do not report cases to CDL via email.

REPORTABLE DISEASES:
- Varicella/Shingles:
  - Report using ASHR. Enter Varicella Reporting Form in student's ASHR module.
  - Call CDL immediately after entering in ASHR for directions on parent letters.
- Vaccine Preventable Diseases
- Meningitis
- Hepatitis
- Tuberculosis
- Food Related Illness
- Fifth Disease – Report using Fifth Disease Reporting Form

DISEASES REPORTABLE ONLY IN CLUSTERS:
Notify CO only when there is a MD documented cluster of 3 or more cases in a classroom.

Exception: In PreK & D75 settings, *individual* cases are reportable.

Examples of Reportable Clusters:
- Conjunctivitis
- Hand, Foot & Mouth Disease
- Impetigo
- Molluscum Contagiosum
- Mononucleosis
- MRSA
- Ringworm
- Scabies
- Scarlet Fever (cluster must occur within a 4-5 day period, in a classroom)
- Strep Throat (cluster must occur within a 4-5 day period, in a classroom)

Communicable concerns of *school staff* are handled by Principal since OSH staff is not privy to their personal health information.

OSH staff directs Principal to call:
Bureau of Communicable Diseases at 347-396-2600
Bureau of Immunization at 347-396-2402 (for vaccine preventable diseases only)

Last revised 3/18/19

Immunization Compliance

- Schools issue immunization compliance requirements to parents
- Parents provide immunization information to the general office including compliance and medical exemptions
- If the school nurse receives immunization documentation, the school nurse provides it to the school general office
- The school nurse will consult with OSH SN and school administration for exclusions direction from Communicable Disease Liaison or Bureau of Immunization(BOI)

https://infohub.nyced.org/docs/default-source/default-document-library/immunization-parent-letter_102219_english.pdf

Immunizations on CH205

Contract Nurse (extended assignment)

- Reviews and case manage all CH205s for students with any chronic diagnosis
- Communicate the Immunization on CH205with Pupil Account Secretary
- Assist with questions about immunization, is NOT RESPONSIVBLE for immunizations

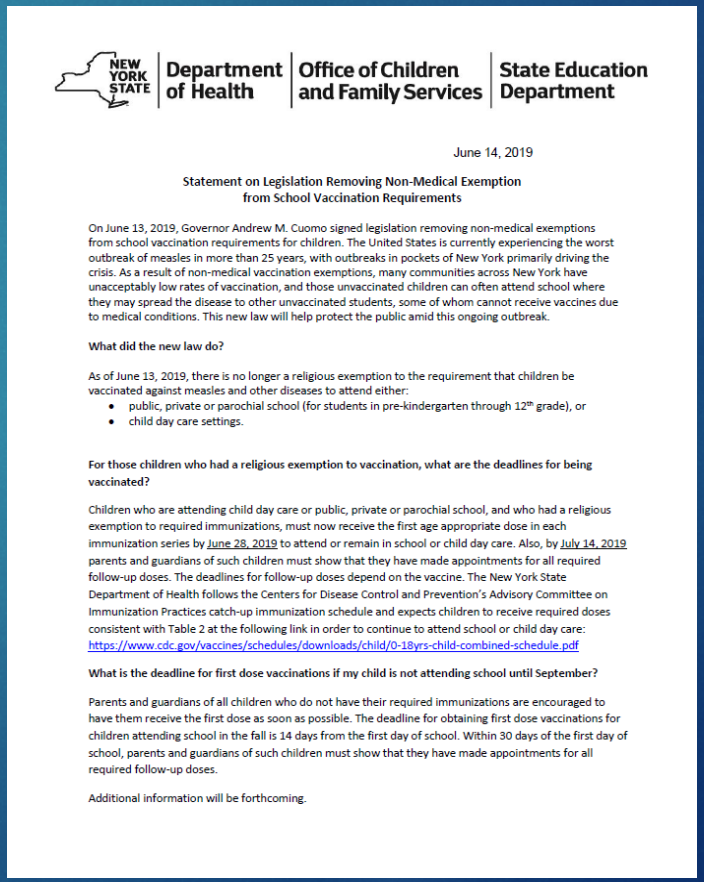
Keep records of any students with a medical immunization exemption

Transcribes medical information on CH205 onto student's medical records .(103S or ASHR)

School Administrators excludes students due to immunization ,

NURSES DO NOT EXCLUDE CHILDREN FOR ANY REASON

NYC DOE no longer accepts Immunization religious exemptions



NEW YORK STATE | Department of Health | Office of Children and Family Services | State Education Department

June 14, 2019

Statement on Legislation Removing Non-Medical Exemption from School Vaccination Requirements

On June 13, 2019, Governor Andrew M. Cuomo signed legislation removing non-medical exemptions from school vaccination requirements for children. The United States is currently experiencing the worst outbreak of measles in more than 25 years, with outbreaks in pockets of New York primarily driving the crisis. As a result of non-medical vaccination exemptions, many communities across New York have unacceptably low rates of vaccination, and those unvaccinated children can often attend school where they may spread the disease to other unvaccinated students, some of whom cannot receive vaccines due to medical conditions. This new law will help protect the public amid this ongoing outbreak.

What did the new law do?

As of June 13, 2019, there is no longer a religious exemption to the requirement that children be vaccinated against measles and other diseases to attend either:

- public, private or parochial school (for students in pre-kindergarten through 12th grade), or
- child day care settings.

For those children who had a religious exemption to vaccination, what are the deadlines for being vaccinated?

Children who are attending child day care or public, private or parochial school, and who had a religious exemption to required immunizations, must now receive the first age appropriate dose in each immunization series by June 28, 2019 to attend or remain in school or child day care. Also, by July 14, 2019 parents and guardians of such children must show that they have made appointments for all required follow-up doses. The deadlines for follow-up doses depend on the vaccine. The New York State Department of Health follows the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices catch-up immunization schedule and expects children to receive required doses consistent with Table 2 at the following link in order to continue to attend school or child day care: https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

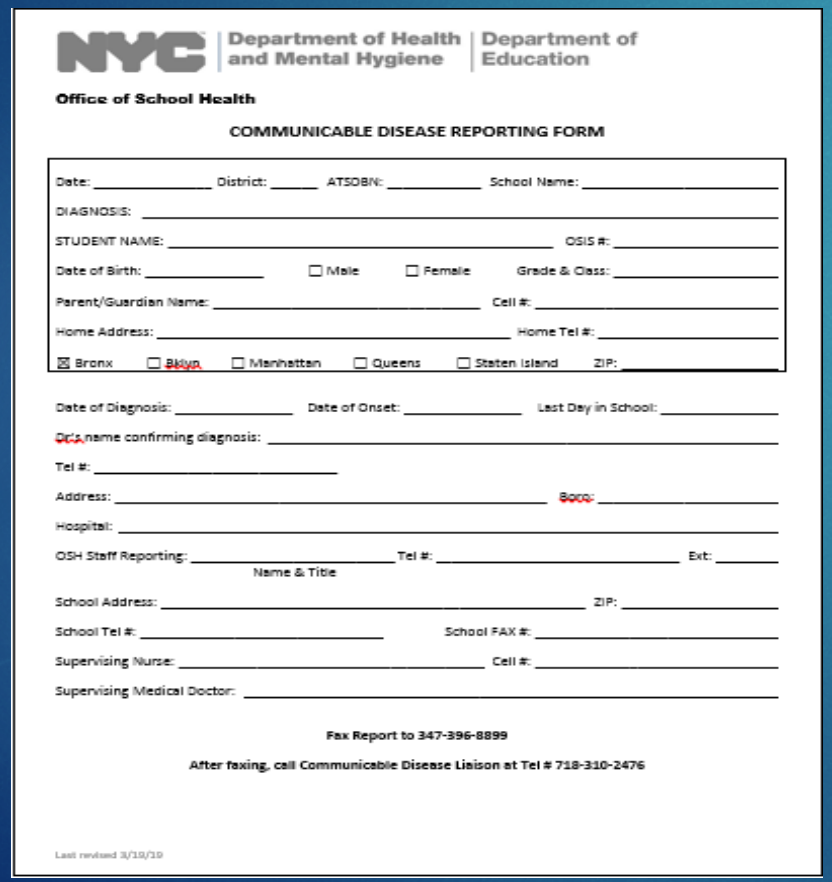
What is the deadline for first dose vaccinations if my child is not attending school until September?

Parents and guardians of all children who do not have their required immunizations are encouraged to have them receive the first dose as soon as possible. The deadline for obtaining first dose vaccinations for children attending school in the fall is 14 days from the first day of school. Within 30 days of the first day of school, parents and guardians of such children must show that they have made appointments for all required follow-up doses.

Additional information will be forthcoming.

Communicable reporting forms

Communicable reporting form



NYC | Department of Health and Mental Hygiene | Department of Education

Office of School Health

COMMUNICABLE DISEASE REPORTING FORM

Date: _____ District: _____ ATSDBN: _____ School Name: _____

DIAGNOSIS: _____

STUDENT NAME: _____ OSIS #: _____

Date of Birth: _____ ☐ Male ☐ Female Grade & Class: _____

Parent/Guardian Name: _____ Cell #: _____

Home Address: _____ Home Tel #: _____

☒ Bronx ☐ ~~Bklyn~~ ☐ Manhattan ☐ Queens ☐ Staten Island ZIP: _____

Date of Diagnosis: _____ Date of Onset: _____ Last Day in School: _____

~~Dr's~~ name confirming diagnosis: _____

Tel #: _____

Address: _____ ~~Boro:~~ _____

Hospital: _____

OSH Staff Reporting: _____ Tel #: _____ Ext: _____
Name & Title

School Address: _____ ZIP: _____

School Tel #: _____ School FAX #: _____

Supervising Nurse: _____ Cell #: _____

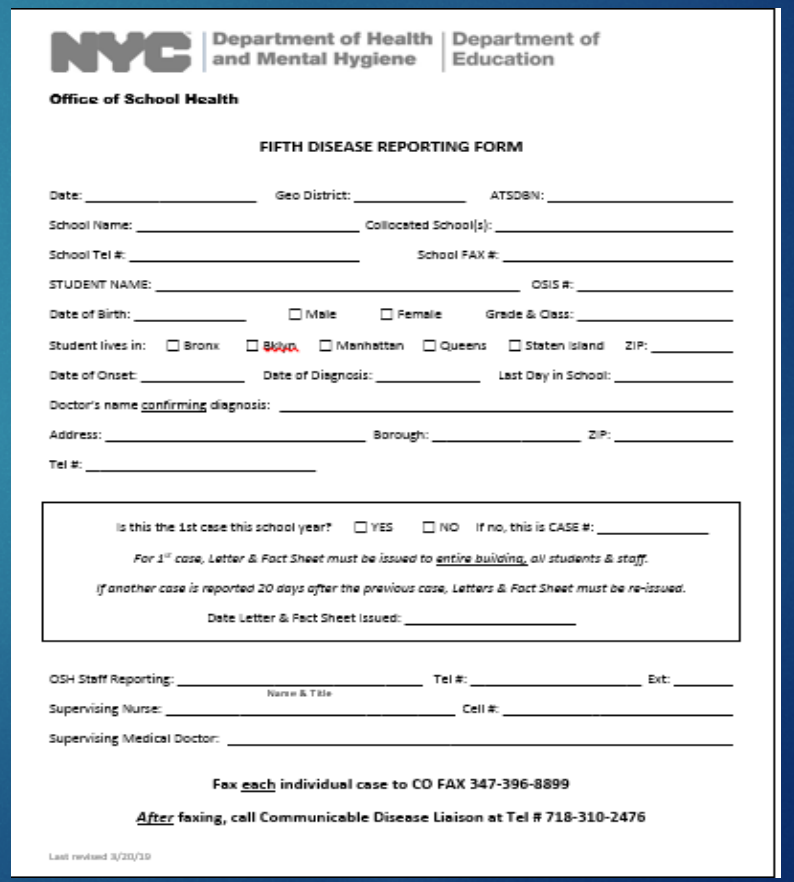
Supervising Medical Doctor: _____

Fax Report to 347-396-8899

After faxing, call Communicable Disease Liaison at Tel # 718-310-2476

Last revised 3/19/19

Fifth disease reporting form



NYC | Department of Health and Mental Hygiene | Department of Education

Office of School Health

FIFTH DISEASE REPORTING FORM

Date: _____ Geo District: _____ ATSDBN: _____

School Name: _____ Collocated School(s): _____

School Tel #: _____ School FAX #: _____

STUDENT NAME: _____ OSIS #: _____

Date of Birth: _____ ☐ Male ☐ Female Grade & Class: _____

Student lives in: ☐ Bronx ☐ ~~Bklyn~~ ☐ Manhattan ☐ Queens ☐ Staten Island ZIP: _____

Date of Onset: _____ Date of Diagnosis: _____ Last Day in School: _____

Doctor's name confirming diagnosis: _____

Address: _____ Borough: _____ ZIP: _____

Tel #: _____

Is this the 1st case this school year? ☐ YES ☐ NO If no, this is CASE #: _____

For 1st case, Letter & Fact Sheet must be issued to entire building, all students & staff.

If another case is reported 20 days after the previous case, Letters & Fact Sheet must be re-issued.

Date Letter & Fact Sheet Issued: _____

OSH Staff Reporting: _____ Tel #: _____ Ext: _____
Name & Title

Supervising Nurse: _____ Cell #: _____

Supervising Medical Doctor: _____

Fax each individual case to CO FAX 347-396-8899

***After* faxing, call Communicable Disease Liaison at Tel # 718-310-2476**

Last revised 3/20/19

Reporting Gastro-intestinal (GI) illness

GI Symptoms

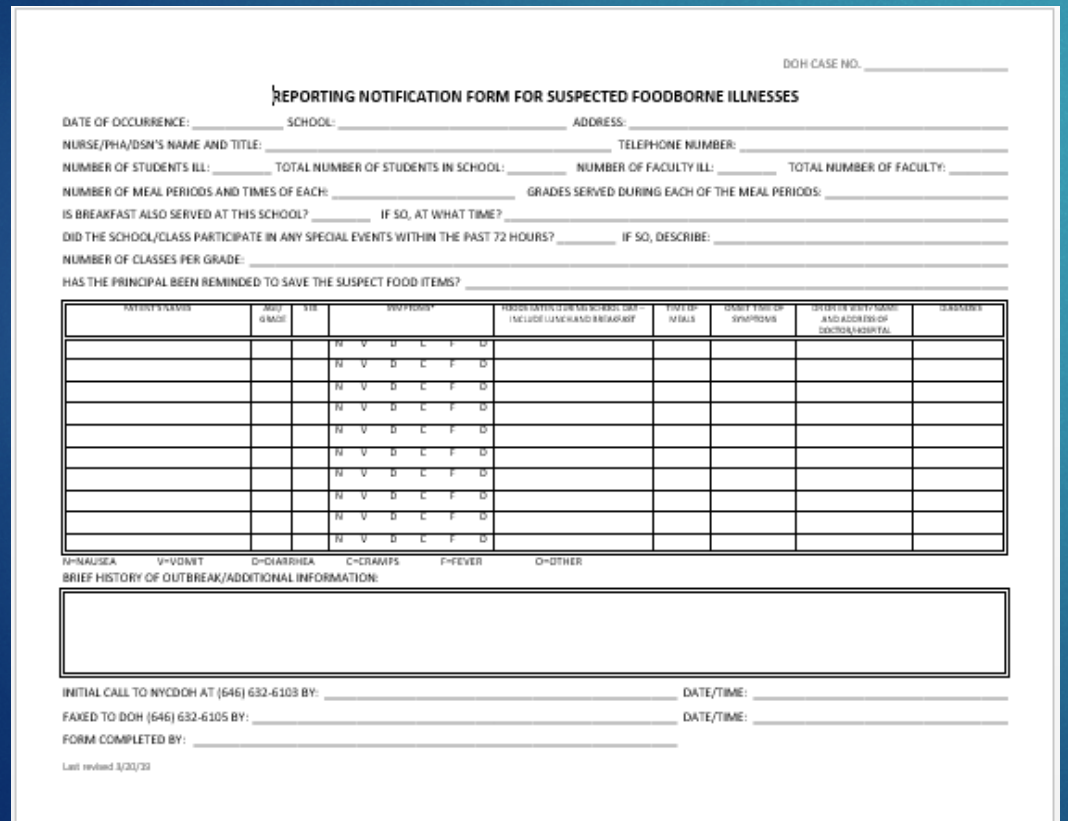
- Assess the student
- Notify parent /guardian by phone
- Issue 12S too students with symptoms
- Complete the foodborne tracking sheet
- Notify the OSH SN
- Notify the principal of students complaints
- Call 911 for acute abdominal pain as needed

Post GI incident

- Day after suspected GI illness event:
- Review any returned 12S for doctor's findings and recommendations on ASHR or students' 103S
- If any involved student(s) , contact parent and note reason and doctor's findings on ASHR or 103S
- Maintain the GI Daily log for tracking the trend of complaints and fax to communicable Liaison

Gastro –intestinal (GI) illness forms

Foodborne illness reporting Form



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 NAME	AGE/ GRADE	SEX	SIGNS/SYMPTOMS*	FOOD EATEN DURING SCHOOL DAY – INCLUDE LUNCH AND BREAKFAST	TIME OF ONSET OF ILLNESS	LENGTH OF TIME OF SYMPTOMS	DATE OF VISIT TO DOCTOR/HOSPITAL AND ADDRESS OF DOCTOR/HOSPITAL	DISPOSITION
			N V D C F O					
			N V D C F O					
			N V D C F O					
			N V D C F O					
			N V D C F O					
			N V D C F O					
			N V D C F O					
			N V D C F O					
			N V D C F O					
			N V D C F O					

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

BRIEF HISTORY OF OUTBREAK/ADDITIONAL INFORMATION:

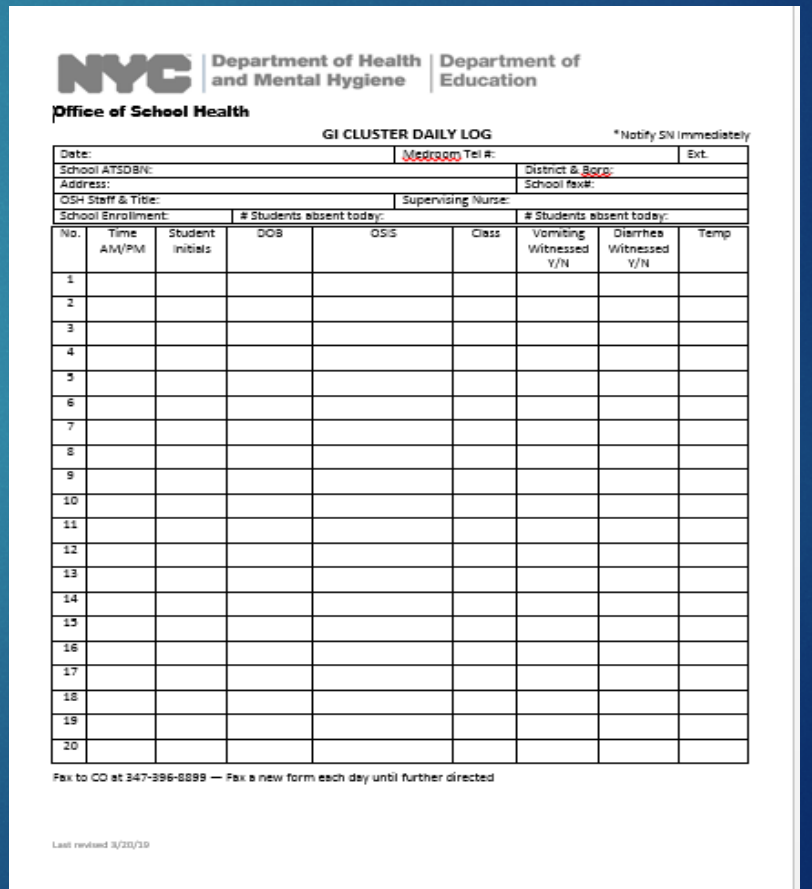
INITIAL CALL TO NYCDOH AT (646) 632-6103 BY: _____ DATE/TIME: _____

FAXED TO DOH (646) 632-6105 BY: _____ DATE/TIME: _____

FORM COMPLETED BY: _____

Last revised 3/20/19

GI Cluster Daily Log



NYC | Department of Health and Mental Hygiene | Department of Education

Office of School Health

GI CLUSTER DAILY LOG *Notify SN Immediately

Date:		Medroom Tel #:	Ext.
School ATSDBN:		District & Boro:	
Address:		School fax#:	
OSH Staff & Title:		Supervising Nurse:	
School Enrollment:	# Students absent today:		# Students absent today:

No.	Time AM/PM	Student Initials	DOB	OSIS	Class	Vomiting Witnessed Y/N	Diarrhea Witnessed Y/N	Temp
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								

Fax to CO at 347-396-6899 — Fax a new form each day until further directed

Last revised 3/20/19

Blood Exposure Reporting

Wound management

Follow Standard Precautions

Provide First Aid to student or staff

- Thoroughly clean wound with soap and water
- Flush wound under fast running water
- Apply pressure
- Cover wound lightly and clean, dry dressing

School Staff may be assessed for emergencies or calls to EMS if needed

Refer the staff to the principal for administrative follow up

Follow respective agency plan for medical evaluation

Student Blood exposure

Assess student

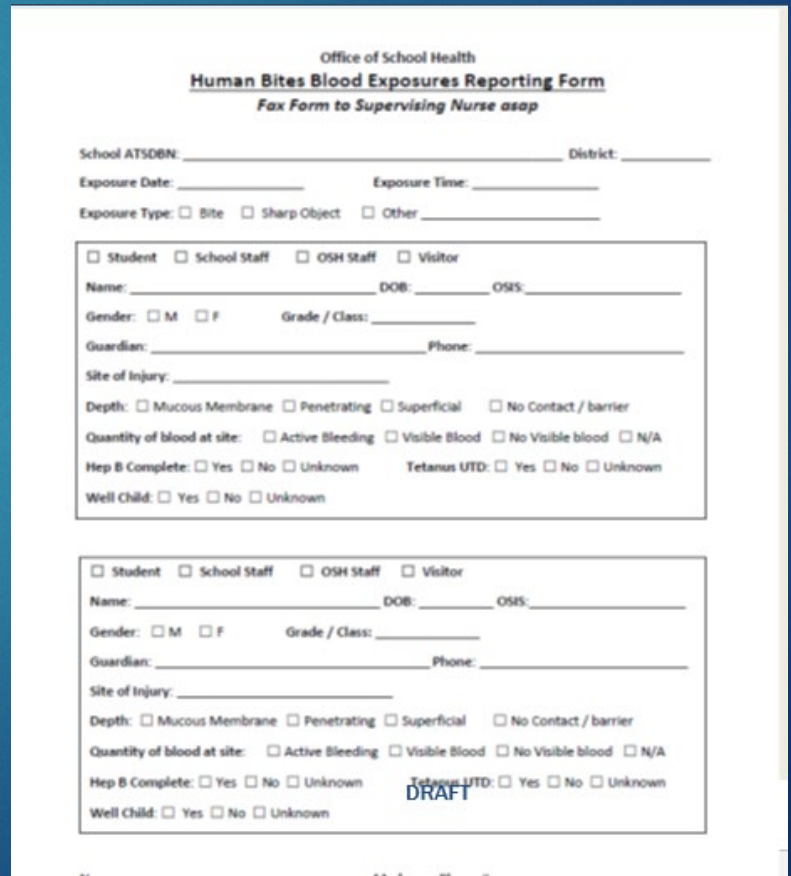
- Immediately inform parent of all students involved in Blood exposure
- Consider 911 after assessing risk of exposure and speaking to OSH SN
- Issue 12 S ad document in ASHR/103Notify BND/ for guidance

Human bites blood Exposure Reporting

Any blood exposure (E.g. bites)

- Assess area – document break in skin, bruising, bleeding on ASHR/103S
- Contact parent/guardian
- Issue 12S referral and encourage PCP follow up to both students involved in biting exposure
- Consider 911 if deemed
- Inform OSH SN and fill out Blood exposure form- opposite

Human Bites blood exposure reporting Form



Office of School Health

Human Bites Blood Exposures Reporting Form

Fax Form to Supervising Nurse asap

School ATSDBN: _____ District: _____

Exposure Date: _____ Exposure Time: _____

Exposure Type: ☐ Bite ☐ Sharp Object ☐ Other _____

☐ Student ☐ School Staff ☐ OSH Staff ☐ Visitor

Name: _____ DOB: _____ OSIS: _____

Gender: ☐ M ☐ F Grade / Class: _____

Guardian: _____ Phone: _____

Site of Injury: _____

Depth: ☐ Mucous Membrane ☐ Penetrating ☐ Superficial ☐ No Contact / barrier

Quantity of blood at site: ☐ Active Bleeding ☐ Visible Blood ☐ No Visible blood ☐ N/A

Hep B Complete: ☐ Yes ☐ No ☐ Unknown Tetanus UTD: ☐ Yes ☐ No ☐ Unknown

Well Child: ☐ Yes ☐ No ☐ Unknown

☐ Student ☐ School Staff ☐ OSH Staff ☐ Visitor

Name: _____ DOB: _____ OSIS: _____

Gender: ☐ M ☐ F Grade / Class: _____

Guardian: _____ Phone: _____

Site of Injury: _____

Depth: ☐ Mucous Membrane ☐ Penetrating ☐ Superficial ☐ No Contact / barrier

Quantity of blood at site: ☐ Active Bleeding ☐ Visible Blood ☐ No Visible blood ☐ N/A

Hep B Complete: ☐ Yes ☐ No ☐ Unknown Tetanus UTD: ☐ Yes ☐ No ☐ Unknown

Well Child: ☐ Yes ☐ No ☐ Unknown

DRAFT

Head Lice & Bed Bugs – DOE Policy on both

OSH Memo on Headlice

- https://infohub.nyced.org/docs/default-source/default-document-library/lice-policy-memo.pdf

DOE has guidance:

- No School Suruviellance
- DOE staff is trained go check indiviual stuudnents

DOE Guidance on Bedbugs

School Administraiong have guidance to follow:

Nurses:

- Do not dagnosed or speculate on cause
- Complete Nursing Assesment
- 12S for S/S observed
- Do not collect specimenas

Covid Like Illness (CLI)-Pending

Infection Control in the medical room:

Covid Like Illness (CLI) Guidelines for September are in development and will be shared shortly to include:

- Social distancing
- Personal Protective Equipment
- Face masks must be worn continuously and Face shields for all clinical encounters
- Temperature Checks - Pending discussions

Child Abuse/Neglect reporting

- 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 of must report the suspicion to the NYS Central Registry.

Registered Nurses (RN) are mandated reporters – in an event of a possible conflict about calling, the nurse would make a professional judgement about initiating the call to the State Central Registry (SCR)

Call the SCR mandated reporter's line 1-800-635-1522 to report a case –obtain a case number

- DOE personnel are mandated reporters and is directed under their DOE policy

Social Service Law requires only one report from an institution

If another school personnel called SCR, the nurse should obtain the case number before the end of the day and leave information in the log book secured for the next day follow up

Reporting child abuse

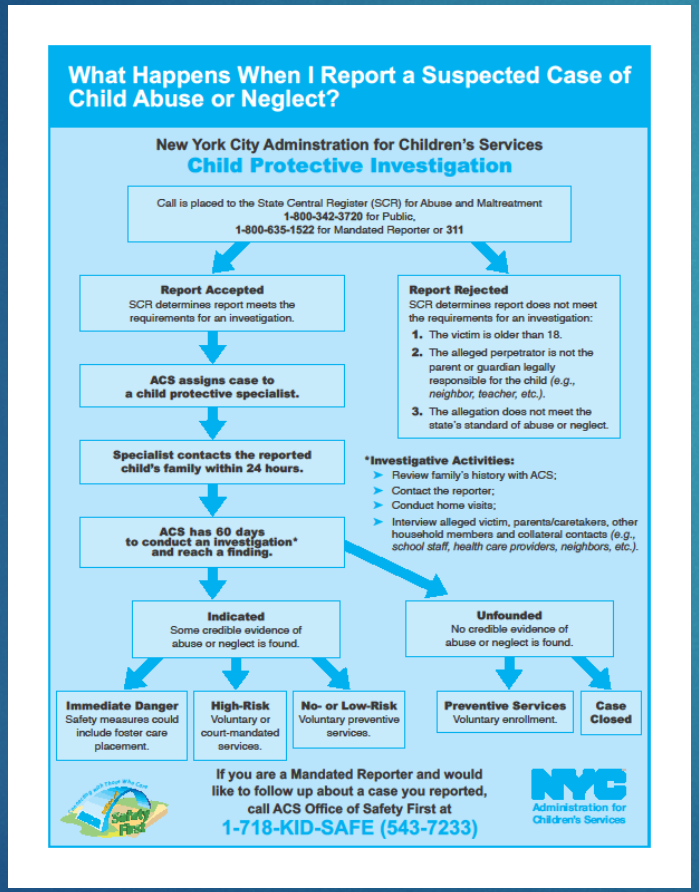
- Proof of the suspected abuse/ neglect is not required to make a report
- Parental notification is not required
- Photo-documentation is part of reporting visible injuries for suspected abuse
- Immediately discuss suspected abuse /neglect case with principal or school's designee (every school has a child abuse Liaison)
- Inform OSH SN

School may implement further actions if needed to ensure child's safety

- Assess if student is in need of immediate medical care and call 911 if deemed necessary
- Notify Administration of Children's Services of the action (ACS)
- If student verbalizes he/she/they do not feel safe to go home, call 911 and inform school administration
- Notify OSH team- SN, SMD, BND if unable to reach OSH SN

Parental notification is not mandatory for ACS calls or for 911 ACS related calls

ACS pocket guidelines and flow chart



What Happens When I Report a Suspected Case of Child Abuse or Neglect?

New York City Adminstration for Children's Services

Child Protective Investigation

Call is placed to the State Central Register (SCR) for Abuse and Maltreatment
1-800-342-3720 for Public,
1-800-635-1522 for Mandated Reporter or **311**

Report Accepted
SCR determines report meets the requirements for an investigation.

Report Rejected
SCR determines report does not meet the requirements for an investigation:
1. The victim is older than 18.
2. The alleged perpetrator is not the parent or guardian legally responsible for the child *(e.g., neighbor, teacher, etc.)*.
3. The allegation does not meet the state's standard of abuse or neglect.

ACS assigns case to a child protective specialist.

Specialist contacts the reported child's family within 24 hours.

ACS has 60 days to conduct an investigation* and reach a finding.

***Investigative Activities:**
- Review family's history with ACS;
- Contact the reporter;
- Conduct home visits;
- Interview alleged victim, parents/caretakers, other household members and collateral contacts *(e.g., school staff, health care providers, neighbors, etc.)*.

Indicated
Some credible evidence of abuse or neglect is found.

Unfounded
No credible evidence of abuse or neglect is found.

Immediate Danger
Safety measures could include foster care placement.

High-Risk
Voluntary or court-mandated services.

No- or Low-Risk
Voluntary preventive services.

Preventive Services
Voluntary enrollment.

Case Closed

If you are a Mandated Reporter and would like to follow up about a case you reported, call ACS Office of Safety First at
1-718-KID-SAFE (543-7233)

NYC Administration for Children's Services

How to Report Child Abuse and Neglect

Step 1: Oral Report

- As soon as you suspect child abuse or neglect, immediately call the State Central Register (SCR) Mandated Reporter Hotline at 1-800-635-1522, or 311. The SCR is open 24 hours-a-day, 7 days-a-week.
  If a child is in immediate danger, call 911.
- Provide as much information as possible to the protective specialist at the SCR. If available, give information to help identify and locate the child or parents in question.

Step 2: Written Report

- A signed written report must be filed with the local Child Protective Services (CPS) written 48 hours of an oral report.
- To obtain a copy of the mandated reporter form, contact your local CPS office or visit the New York State Office of Children and Family Services (OCFS) at www.ocfs.state.ny.us and go to the "Forms" and "LDSS-2221A" links.
- Submit the written mandated reporter form to the local Administration for Children's Services field office in the borough where the child resides. You may request the address from the child protective specialist at the time you make the oral report to the SCR.

If you are a mandated reporter and there is reasonable cause to suspect child abuse or neglect, report the case immediately.
Call 1-800-635-1522 or 311

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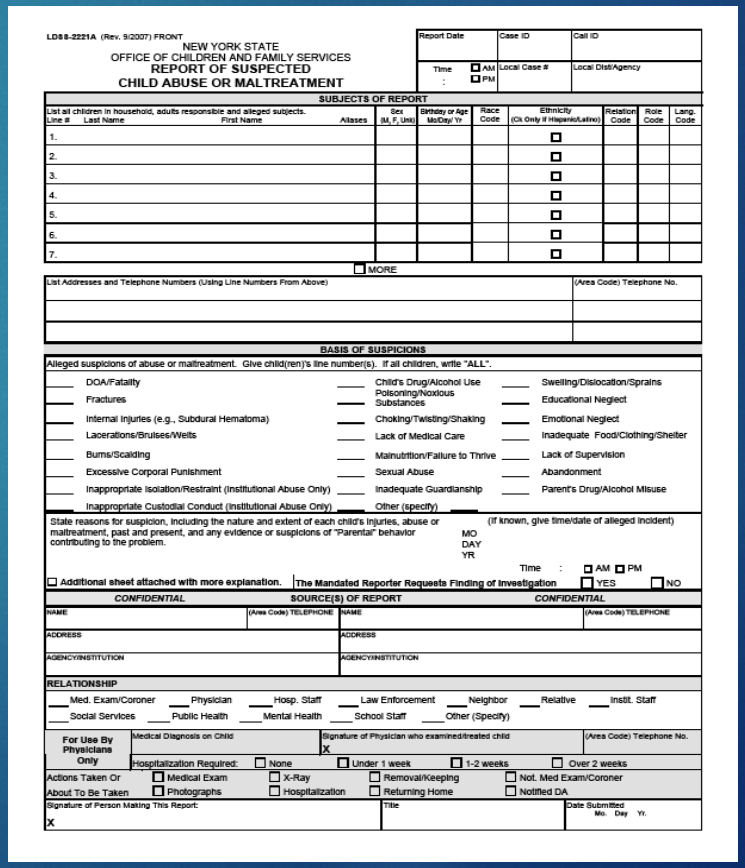
Documentation of ACS calls

ACS Documentation

- Administration for Children Services requires a written report be submitted with 48 hours of the oral report (Form 2221-A)
- If the nurse made the call , they will complete 2221-A form by the close of the work day
- The nurse should forward the completed form to the OSH SN/BND for review and follow up
- The OSH SN will forward the report to the local ACS office and to OSH Central Office
- Copy of report is forwarded to OSH Central Office

2221-A Form – filled out by contract nurse



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

CONFIDENTIAL — **SOURCE(S) OF REPORT** — **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.

Photo documentation of suspected child abuse/neglect

ACS laws

- Social Service Law is the foundation for evolving OSH policies and procedures
- RN will be taught to take Photographs with a DOE designated device only
- School Child Abuse liaison will transmit the pictures to ACS

Nurse will only take photograph if trained and if an ACS reporting number was obtained

ACS Documentation

- All information is confidential and should be confined to an objective description of physical findings
- Document the event on the student's 103s by using the initial SCAN (Suspected Child Abuse and Neglect) indicating call to SCR and form 2221A was submitted
- Document the case number before you leave

Child Abuse follow up

Day to Day coverage Nurse:

- Will call and report to ACS as per mandated requirements – obtain ACS registry number
- Speak with School child abuse Liaison
- Notify OSH SN Agency SN for further guidance
- Fill out 2221-A form and forward to OSH SN /leave in secured log book for next day follow up

- Contract nurses in extended assignments have more of opportunities to collaborate with principals, school guidance counselors, social workers and ACS case workers to assist with the follow up within the OSH nursing capacity

ACS follow up:

- ACS workers may call or visit school site
- OSH has a subpoena process for request to share verbal or written OSH medical records the nurse should (call OSH SN immediately for guidance as needed)
- The nurse may share basic verbal information in person to the ACS representative after they show identification in person
- The nurse may take a return phone number and follow up with OSH SN

Calling 911 "EMS"

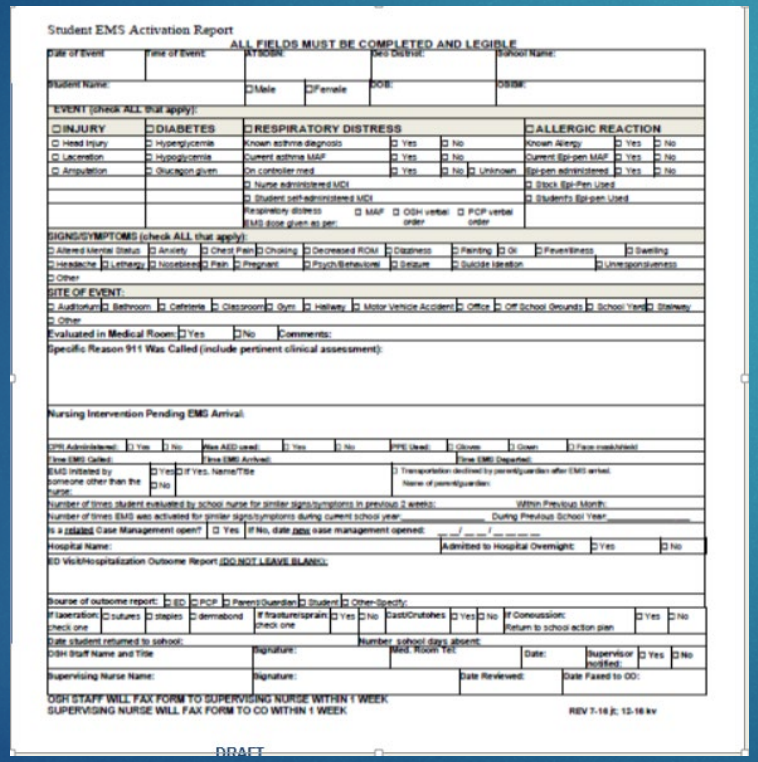
After your Professional assessment deems an "EMS" call, the nurse should:

1. Remain with student and provide all necessary medical care until EMS arrives
2. Notify the Principal of 911 call – the principal is responsible for the transportation of any student with an acute health problem from school to home or to a treatment facility (they assign a DOE staff member to accompany student to ER)
3. Notify the OSH SN or BND and Agency SN immediately or asap
4. Fill out EMS activation Form – Document in students medical record " 103S"
5. Follow up is to be done the next day by the returning nurse

OSH staff members may not leave the medical room unattended and therefore are not permitted to ride in the ambulance with student . (exception1:1 nurse goes with student)

When EMS is Called

EMS form :



Student EMS Activation Report

ALL FIELDS MUST BE COMPLETED AND LEGIBLE

Date of Event | Time of Event | AT SOBRA | OHS District | School Name

Student Name | ☐Male ☐Female | DOB | OSIM#

EVENT (check ALL that apply):

☐INJURY	☐DIABETES	☐RESPIRATORY DISTRESS			☐ALLERGIC REACTION		
☐ Head Injury	☐ Hyperglycemia	Known asthma diagnosis	☐ Yes	☐ No	Known Allergy	☐ Yes	☐ No
☐ Laceration	☐ Hypoglycemia	Current asthma MAP	☐ Yes	☐ No	Current Epi-pen MAP	☐ Yes	☐ No
☐ Amputation	☐ Glucagon given	On controller med	☐ Yes	☐ No ☐ Unknown	Epi-pen administered	☐ Yes	☐ No
		☐ Nurse administered MDI			☐ Stock Epi-Pen Used		
		☐ Student self-administered MDI			☐ Student's Epi-pen Used		
		Respiratory distress EMS dose given as per: ☐ MAP ☐ OSH verbal order ☐ PCP verbal order					

SIGNS/SYMPTOMS (check ALL that apply):

☐ Altered Mental Status ☐ Anxiety ☐ Chest Pain ☐ Choking ☐ Decreased ROM ☐ Dizziness ☐ Fainting ☐ Oil ☐ Feverishness ☐ Swelling
☐ Headache ☐ Lethargy ☐ Nosebleed ☐ Pain ☐ Pregnant ☐ Psych/Behavioral ☐ Seizure ☐ Suicide Ideation ☐ Unresponsiveness
☐ Other

SITE OF EVENT:

☐ Auditorium ☐ Bathroom ☐ Cafeteria ☐ Classroom ☐ Gym ☐ Hallway ☐ Motor Vehicle Accident ☐ Office ☐ Off School Grounds ☐ School Yard ☐ Stairway
☐ Other

Evaluated in Medical Room ☐ Yes ☐ No Comments:

Specific Reason 911 Was Called (include pertinent clinical assessment):

Nursing Intervention Pending EMS Arrival:

CPR Administered ☐ Yes ☐ No Was AED used ☐ Yes ☐ No PPE Used ☐ Gloves ☐ Gown ☐ Face mask/shield

Time EMS Called: Time EMS Arrived: Time EMS Departed:

EMS initiated by someone other than the nurse: ☐ Yes ☐ No If Yes, Name/Title ☐ Transportation declined by parent/guardian after EMS arrived. Name of parent/guardian:

Number of times student evaluated by school nurse for similar signs/symptoms in previous 2 weeks: Within Previous Month:

Number of times EMS was activated for similar signs/symptoms during current school year: During Previous School Year:

Is a related Case Management open? ☐ Yes If No, date new case management opened: __/__/__ __:__ __

Hospital Name: Admitted to Hospital Overnight: ☐ Yes ☐ No

ED Visit/Hospitalization Outcome Report (DO NOT LEAVE BLANK):

Source of outcome report: ☐ ED ☐ PCP ☐ Parent/Guardian ☐ Student ☐ Other-Specify:

If laceration: check one ☐ sutures ☐ staples ☐ dermabond | If fracture/sprain check one ☐ Yes ☐ No | Cast/Crutches ☐ Yes ☐ No | If Concussion: Return to school action plan ☐ Yes ☐ No

Date student returned to school: Number school days absent:

OSH Staff Name and Title | Signature: | Med. Room Tel: | Date: | Supervisor notified: ☐ Yes ☐ No

Supervising Nurse Name: | Signature: | Date Reviewed: | Date Faxed to OD:

OSH STAFF WILL FAX FORM TO SUPERVISING NURSE WITHIN 1 WEEK
SUPERVISING NURSE WILL FAX FORM TO CO WITHIN 1 WEEK

REV 7-16 jc; 12-16 kv

DRAFT

Fill out an EMS form when:

- Anytime EMS is called for a student
- After all EMS calls notify OSH Supervisors, Agency Supervisors for guidance
- Leave the EMS form in the Log book, or folder for returning nurse follow up
- Document in student's individual paper record – 103S

Automated External Defibrillator (AED)s

- **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 AED's may be placed strategically as needed i.e. outside cafeteria or gym
- Each school must have school staff members 9 their permanent personnel) certified in AED/CPR to respond to emergencies (Building Response Team - BRT)

- Nursing Staff is not responsible for the maintenance of the AED

Automated external defibrillator (AED)

- When a medical emergency is identified , a “Code Blue” is called and 911 is initiated
- Nurses participates in “code drills” if nurse is not participating in a daily treatment or emergency in the medical room
- 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

- **When, in the judgement of any OSH staff member, a student of other individual requires immediate medical attention, it is the person’s responsibility to call 911 and then notify the principal**

Automated external defibrillator -AED

Automated External Defibrillator

Example of adult pad placement ()

MD/ Doctor Session in Office of School Health

***COVID-19 ALERT- OSH PHYSICIAN EXAMS ARE POSTPONED UNTIL FURTHER NOTICE

COVID-19 Alert: Student Exams by OSH Physicians in school are postponed until further notice

Gowns must be worn:

Gowns must be worn As per NYSED School Health Examination Guidelines, August 2013

"The student must be separately and carefully examined, with due regard for privacy and comfort (Education Law Article 19 Section 904) Movable screens may be used for an examination area …Best practice is that another adult such as the school nurse is present for the examination. Students should remove all clothing except undergarments. This can be accomplished in stages for young or apprehensive students. Disposable drapes/capes may be provided as needed. Students dignity and privacy should be a priority the physical examination should include a full body screening and conducted as indicted in both a seated and supine position…"

Privacy

- OSH Staff should be Mindful 0f cultural sensitivity

Accommodate students that:

- Wears garments for cultural or religious reasons
- Does not wear underwear
- Are sensitive about disrobing (done in stages)
- Use of Privacy screens
- Closed-off area to discuss confidential information
- Notify ODH SN/ if there are any issue with privacy screens
- Notify SN if there are any structural issues in med room

OSH Physician Exams

Planning MD session

OSH Medical Unit and regions determine school physician Schedules

OSH SN informs school nurse (agency Nurse) of date of MD session

OSH informs the Principal of the school of the schedule (Contract nurse would remind school)

The Contract nurse prepares the sessions by pulling 103s for students who are assigned to be seen by OSH Physician and preparing blank forms

The Nurse, Public Health Advisor or the Public Health Assistant takes the vital signs, weight, and height

MD sessions:

- Physicians sessions:
- NAE current or pending exams-Asthma Exams (Module 2)
- Consultations- all students with MAFs/ DMAFs and other chronic diagnosis
- Sports Exams – in middle school grades and higher
- Working paper exams – in select schools

PREPARING FOR MD EXAMS

The Nurse / PHADV in consult with nurse

- Prepares list of students to be seen in MD session and invite parent
- issue 21SN and or 218S-A
- Ensures the parent of scheduled students are contacted and informed of session (Call parent to remind of session) Document parent refusals
- Act as the chaperone during session

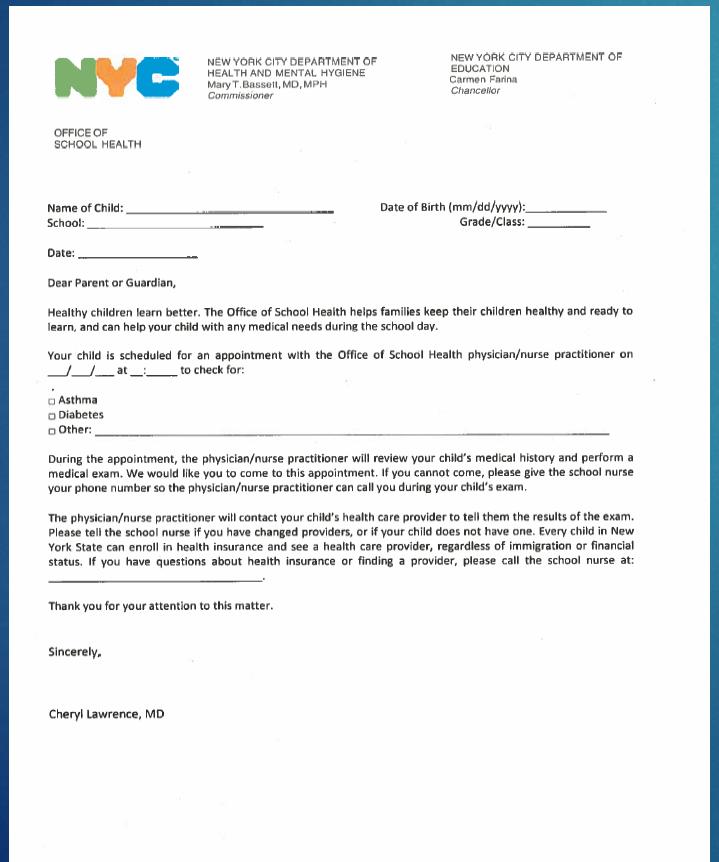
Chaperones are OSH staff or Contract nurse

OSH MD / NP

- Confirm parents were contacted
- May conduct and "asthma focus visit" and/ or exam for students
- Review Asthma records and OTHER CASES as necessary
- May consult with students, parents , PCP regarding health matters referred by OSH and Contract staff
- NO CHAPERONE = NO EXAM
- NO GOWNS = NO EXAM

Forms for Md session

218S – parent notification MD Exam



NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Mary T. Bassett, MD, MPH
Commissioner

NEW YORK CITY DEPARTMENT OF EDUCATION
Carmen Farina
Chancellor

OFFICE OF
SCHOOL HEALTH

Name of Child: _____ Date of Birth (mm/dd/yyyy):_____
School: _____ Grade/Class: _____

Date: _____

Dear Parent or Guardian,

Healthy children learn better. The Office of School Health helps families keep their children healthy and ready to learn, and can help your child with any medical needs during the school day.

Your child is scheduled for an appointment with the Office of School Health physician/nurse practitioner on ___/___/___ at __:____ to check for:

- ☐ Asthma
- ☐ Diabetes
- ☐ Other: _____

During the appointment, the physician/nurse practitioner will review your child's medical history and perform a medical exam. We would like you to come to this appointment. If you cannot come, please give the school nurse your phone number so the physician/nurse practitioner can call you during your child's exam.

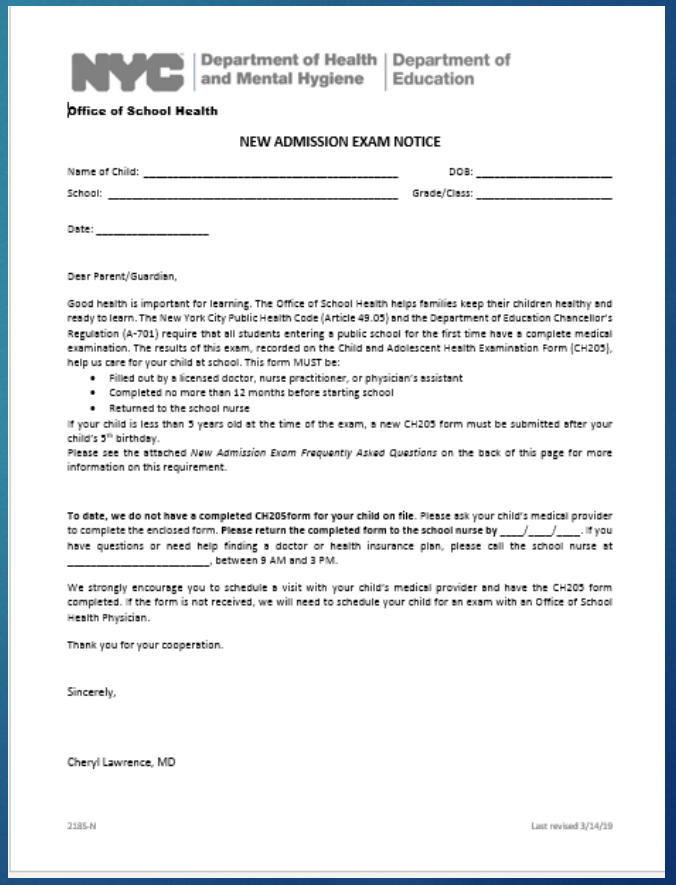
The physician/nurse practitioner will contact your child's health care provider to tell them the results of the exam. Please tell the school nurse if you have changed providers, or if your child does not have one. Every child in New York State can enroll in health insurance and see a health care provider, regardless of immigration or financial status. If you have questions about health insurance or finding a provider, please call the school nurse at: _____.

Thank you for your attention to this matter.

Sincerely,

Cheryl Lawrence, MD

New Exam Notice



NYC Department of Health and Mental Hygiene | Department of Education

Office of School Health

NEW ADMISSION EXAM NOTICE

Name of Child: _____ DOB: _____
School: _____ Grade/Class: _____

Date: _____

Dear Parent/Guardian,

Good health is important for learning. The Office of School Health helps families keep their children healthy and ready to learn. The New York City Public Health Code (Article 49.05) and the Department of Education Chancellor's Regulation (A-701) require that all students entering a public school for the first time have a complete medical examination. The results of this exam, recorded on the Child and Adolescent Health Examination Form (CH205), help us care for your child at school. This form MUST be:

- Filled out by a licensed doctor, nurse practitioner, or physician's assistant
- Completed no more than 12 months before starting school
- Returned to the school nurse

If your child is less than 5 years old at the time of the exam, a new CH205 form must be submitted after your child's 5th birthday.
Please see the attached *New Admission Exam Frequently Asked Questions* on the back of this page for more information on this requirement.

To date, we do not have a completed CH205form for your child on file. Please ask your child's medical provider to complete the enclosed form. **Please return the completed form to the school nurse by** ____/____/____. If you have questions or need help finding a doctor or health insurance plan, please call the school nurse at _____, between 9 AM and 3 PM.

We strongly encourage you to schedule a visit with your child's medical provider and have the CH205 form completed. If the form is not received, we will need to schedule your child for an exam with an Office of School Health Physician.

Thank you for your cooperation.

Sincerely,

Cheryl Lawrence, MD

218S-N

Last revised 3/14/19

Questions

1- What is the only medication that can be given in OSH without an MAF/DMAF

A - Epinephrine B- Glucagon

2- Covering nurse should always check expiration of Epipens, daily narcotic count

A. True B. False

3- Best way to identify a student

A- Ask student full name, DOB and class

B - Check student pass for his/her name

4-You should only document in the Log Book

A .True B. False

5-You should always document in the log book and 103S

A. True B. False

6 -Contract Nurse does not have to **call a parent**

A True **B. False**

7- After every student encounter Nurse

A- issues a referral form and call parent

B- tell the student to inform their parent

Q&A

8-Student with a known allergen complaining of an itchy throat after eating peanuts you should consider:

A- Assess and give stock epi – pen

B - call parent to pick up student

9- Contract Nurse does not go to hospital with sick student

- A. true B. False

10 - Contract Nurse does not respond to an emergency outside of the Medical room?

A. True B. False

11-The only (4) diagnosis that can be shared with DOE staff are Seizures, Asthma, Diabetes and Allergies

A. True B. False

12.You should always call EMS after administering Epinephrine or Diastat ?

A. True B. False

13.Contract Nurse does not need a MAF order to administer antibiotic cream on an abrasion ?

A. True B .False

Q&A continues

14. **1:1** Nurses accompany their student to Emergency Room if there is an EMS all ?

A. True B. False

15. 1:1 Nurses write daily progress notes on their student ?

A. True B. False

16. EMS should be called for Student with head injury and symptomatic

A. True B. False

17. Nurse should **not** call the OSH Supervising Nurse if there is an Emergency in the school I am covering?

A. True B. False

18. Trip nurses do not need a verbal report on students going on trip

A. True B. False

19. Trip nurse can take "stock albuterol" on a trip ?

A true B. False

20. Contract nurse does not have to report a medication error ?

A. True B. False