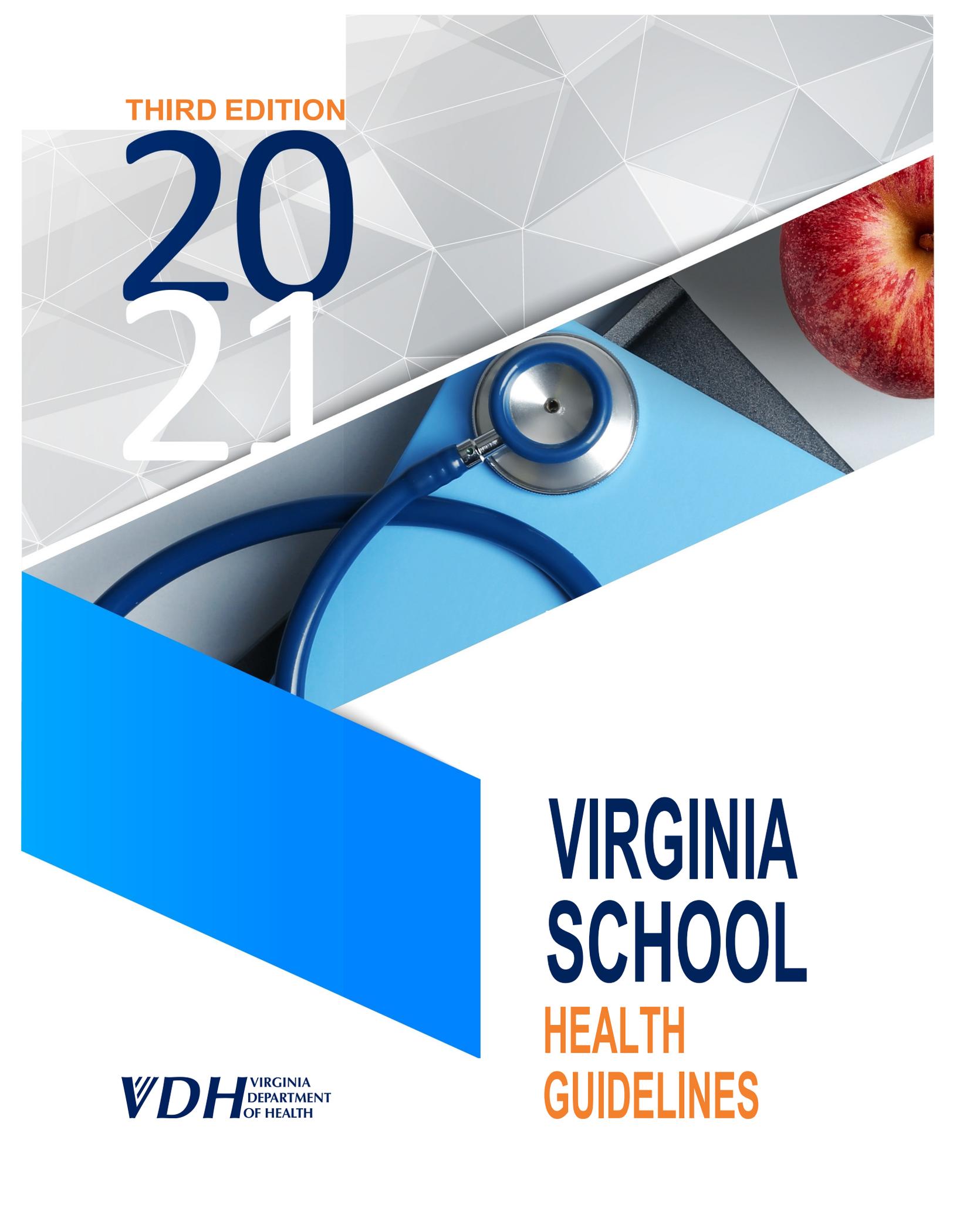


THIRD EDITION

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**VIRGINIA
SCHOOL**
HEALTH
GUIDELINES

VDH VIRGINIA
DEPARTMENT
OF HEALTH



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Virginia School Health Guidelines

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FOREWORD

The Virginia Department of Health is pleased to present the *Virginia School Health Guidelines, Third Edition (2021)*, a resource document for school and public health personnel. It was developed, approved and published under the leadership of the Virginia Department of Health in collaboration with the Virginia Department of Education.

This document is intended to enhance the educational process by providing guidance to and resources for school administrators, school nurses, teachers, and other staff members on the development, implementation, and evaluation of a comprehensive or coordinated approach to school health. It presents up-to-date, evidence based best practices, health information, and recommendations for developing local programs and policies related to school health programs. Federal and state laws and regulations, local needs, professional personnel from educational and health care fields, and resource will influence how this publication can be adapted for local use.

The Virginia Department of Health and Virginia Department of Education maintain a strong collaborative relationship to ensure that all schools in the Commonwealth have a safe and healthy learning environment. The revised *Virginia School Health Guidelines* exemplifies the continued partnership and collaboration between the Departments of Health and Education.



M. Norman Oliver, MD, MA
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8/30/2021

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A resource document of this type cannot be put together without the assistance, expertise, and support of many people. Special thanks are extended to Mary Kay Jessen, MSN, RN, the primary editor of the revised *Guidelines*, Dr. Bethany Geldmaker, PhD, PNP, RN, Virginia Department of Health, Tracy White, MA, RN, Virginia Department of Education, and the reviewers listed below—by providing expert advice and adept review—to revise this document. These individuals took time from their work obligations to assist with feedback and recommendations, and their efforts are greatly appreciated.

Sincere thanks are extended to Cailin W. Richardson, consulting formatting editor and Keeley A. Wright, graphic artist. The consulting editors are Janet B. Wright, BSN, RN, NCSN, Independent School Nurse Consultant and retired School & Adolescent Health Specialist, Virginia Department of Health, Office of Family Health Services; and Tia Campbell, MSN, RN, NCSN-E, FNASN, retired Coordinator, Chesterfield County Public Schools.

A final word of thanks must be given to the many other participants in this effort who have not received formal acknowledgment but who provided comments and suggestions that were helpful in the preparation of the *Virginia School Health Guidelines, Third Edition*.

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PREFACE

This manual is a resource book that contains basic information, guidelines, and recommendations for establishing and enhancing a school health program. It reflects an increasing emphasis on the role of school health that focuses on collaboration within the school community to achieve improved student health and wellness through health promotion and disease prevention efforts. Local school divisions and private schools, in collaboration with health departments, can utilize these guidelines to develop or strengthen the school health program at the individual, school program, or community level.

These guidelines are intended to:

- Provide direction for school divisions to develop a school health program at the local level.
- Increase the awareness of school health issues and strategies that can be used to address these issues.
- Provide guidelines for primary prevention and health promotion.
- Serve as a guide for appropriate practices that relate to school health.
- Provide a guide for development of local school health policies and programs.
- Serve as a tool for orienting new school personnel.
- Provide an extensive list of resources relevant to school health and school health programs.

Intended Audience. The intended audience for this manual is the professional who has responsibility for one or more components of a school health program. The professionals may include, but are not limited to, the following:

- School health services personnel, such as school nurses (public, private, parochial), nurse practitioners, physicians, school-based health center staff, and health educators.
- Administrators, such as superintendents, assistant superintendents, and principals.
- Teachers and school personnel such as school counselors, school psychologists, and therapists.

Although this manual is written for professionals, it may also be used by other persons who are involved in a school health program to increase their understanding of the issues involved in school health. These persons might include:

- School health aides
- Classroom aides
- Parents and parent advocates
- Students, when appropriate

Overview. A school health program includes the following eight components: (1) parent/community involvement; (2) healthful school environment; (3) health services; (4) health education; (5) physical education; (6) nutrition services; (7) counseling, psychological, and social services; and (8) health promotion for school staff.

This manual addresses, in detail, the areas of health services; health education; healthful school environment; and parent and community involvement. In addition, information and resources for counseling, psychological, and social services; nutrition services; physical education; and health promotion for staff are discussed. References and resources on all aspects of the school health program are provided throughout this manual, with works cited listed at the end of each section.

Organization. This manual is organized into 7 Parts (further divided into Chapters), and 3 Appendices, as follows:

1. **Part I, School Health Programs:** Provides an overview of school health programs including models, historical development, and planning steps.
2. **Part II, Parent and Community Involvement:** Describes ways of involving parents and the community in school health programs through local school health advisory boards and partnerships.
3. **Part III, School Health Services:** Provides information on school health services models; facilities; appraisal, preventive, and remedial aspects; and evaluation guidelines.
4. **Part IV, Health Education:** Provides information about school health education assessment, standards, planning steps, and resources.
5. **Part V, Healthful Environment:** Provides information on school building and environmental standards, indoor air quality and other environmental concerns, school maintenance and sanitation, disposal of medical waste, school food service, water supply, and lighting.
6. **Part VI, Authorizations and Legal Requirements:** Provides information on all relevant *Code of Virginia* citations, legal requirements, and recommendations for immunizations.
7. **Part VII, Universal Precautions and Infectious Diseases:** Provides an overview of universal precautions and how to apply them in the school health setting, as well as a discussion of common infectious diseases, including symptoms, communicability, treatment, and prevention.

8. **Appendices:** Includes *Code of Virginia* citations, data collection tools, special education terminology definitions, required forms, sample letters, and immunization and infectious disease information.

In each of these sections, there are guidelines for assessing the school health component, guidelines for establishing or enhancing the component, requirements associated with the component as defined by the *Code of Virginia* or federal guidelines, and recommended practice guidelines. Although these guidelines reflect the most up-to-date information at the time of publication, users of the *Virginia School Health Guidelines* are advised to confirm federal, state, and local laws, regulations, and policies when using this manual to plan, implement, and evaluate school health programs.

The Need for School Health Programs. Parents have the primary responsibility to assure the health and well-being of their children. Children spend most of their awake hours in school and research has demonstrated that healthier children perform better in school, making school health programs a vital piece in assisting parents to assure the health and well-being of their children. Health problems can adversely affect not only a young person's physical well-being, but also social and emotional well-being; thus, affecting their ability to learn. School health programs today are faced with challenges as an increasing number of children with special health care needs and chronic illnesses are entering school daily. They require specialized care in order for them to access their education. In addition, schools are seeing higher incidences of students suffering from issues such as adverse childhood experiences, substance abuse, physical and sexual abuse, eating disorders, chronic illnesses, grief and depression, teen pregnancy, sexually transmitted diseases, and violence. Such physical, mental, and emotional health problems cause students to miss school, lack energy, be distracted, or have significant problems that may impair their ability to learn within the school setting.

The collaborative involvement and participation of school personnel, parents, and community in a school health program help to provide students with a safe and stable learning environment.

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PART I: INTRODUCTION TO SCHOOL HEALTH PROGRAMS

This section provides an overview of the most commonly used model for school health programs, including information on development, planning, and implementation for school health programs (both new and existing). A review of relevant legislative studies is provided to demonstrate the evolution of school health programs in Virginia.

Chapter 1: [Describing the Components of a School Health Program](#)

- Eight-Component Model
- Whole School, Whole Community, Whole Child (WSCC) Model

Chapter 2: [Reviewing History: Legislative Studies](#)

- The Health Needs of School-Age Children
- A Study on Ways to Encourage Local School Divisions to Recognize the Importance of School Nurses and the Feasibility of Establishing Standards for School Health Services
- Current Health Programs in the Public Schools of Virginia and the Efficacy and Appropriateness of Adopting a Comprehensive Approach to Health Education
- Report on the Needs of Medically Fragile Students
- Findings and Recommendations of the Blue Ribbon Commission on School Health
- Report of the Virginia Commission on Youth to the Governor and the Virginia General Assembly: Youth Suicide Prevention Plan
- Review of Emergency Medical and Mental Health Services in Public Schools
- Final Report of the Virginia Commission on Youth to the Governor and the Virginia General Assembly: Childhood Obesity
- Report of the Secretary of Health and Human Services to the Governor and the Virginia General Assembly: Suicide Prevention Across the Life Span Plan for the Commonwealth of Virginia

Chapter 3: [Developing a Program: Infrastructure and Planning Process Steps](#)

- Infrastructure
- Planning Process Steps

Chapter 4: [Establishing a School Health Team: Position Descriptions](#)

- School Nurse: Registered Nurse
- School Nurse: Licensed Practical Nurse

- School Nurse Practitioner
- School Health Supervisor/Coordinator: Registered Nurse
- Unlicensed Assistive Personnel
- School Health Volunteer
- School Health Physician

Chapter 5: [Delineating Roles and Responsibilities for the Safe Delivery of Specialized Health Care](#)

Chapter 1: Describing the Components of a School Health Program

Overview

Definition. The Institute of Medicine (IOM) (1997) defined a [Coordinated] School Health Program as:¹

An integrated set of planned, sequential, school-affiliated strategies, activities, and services designed to promote the optimal physical, emotional, social, and educational development of students. The program involves and is supportive of families and is determined by the local community based on community needs, resources, standards, and requirements. It is coordinated by a multidisciplinary team and accountable to the community for program quality and effectiveness.

It is the belief of those who support coordinated school health that healthy children make better learners. Children cannot effectively learn if they are hungry, depressed, afraid, tired, sick, stressed, or abusing drugs and alcohol. By using a coordinated school health approach to address these problems, children will be more likely to achieve academic excellence. According to McKenzie and Richmond (1998):²

A coordinated approach to student's health helps schools achieve their goals and enhance well-being and achievement, clarifies the importance of the school's involvement, and describes ways to strengthen and coordinate a school and community's education and health resources for the benefit of children and their families (p. 3).

Recommendations

Essential Elements. Regardless of the school health model used, the following essential elements should be considered in program design and implementation:³

- **Services**, which include *health services* (which depend on the needs and preference of the community and include services for students with disabilities and special health care needs and the traditional first aid, medication administration, and screening services), *counseling, psychological, and social services* (which promote academic success and address the emotional and mental health needs of students), and *nutrition and food services* (which provide nutritious meals, nutrition education, and a nutrition-promoting school environment).
- **Education**, which includes *health education* (which addresses the physical, mental, emotional, and social dimensions of health), *physical education* (which teaches the knowledge and skills necessary for lifelong physical fitness), and *other curricular areas*

(which promote healthful behavior and an awareness of health issues as part of their core instruction).

- **School Environment**, which includes the *physical environment* (involving proper building design, lighting, ventilation, safety, cleanliness, freedom from environmental hazards that foster infection and handicaps, safe transportation policies, and having emergency plans in place), the *policy and administrative environment* (consisting of policies to promote health and reduce stress, and regulations ensuring an environment free from tobacco, drugs, weapons, and violence), the *psychosocial environment* (including a supportive and nurturing atmosphere, a cooperative academic setting, respect for individual differences, and involvement of families), and *health promotion for staff* (in order that staff members can become positive role models and increase their commitment to student health).
- **Community Participation**, which includes *parent and community involvement* (which consists of involving a wide range of community stakeholders - parents, students, educators, health and social service personnel, insurers, and business and political leaders - to develop and form the structure of the school health program tailored to meet each local community's needs, resources, perspectives, and standards).

Although the schools are accountable to the community and provide a critical facility within which many agencies can work together to maintain the well-being of students, they cannot be expected to address the student's serious health and social problems in the school setting without assistance from the community. Families, healthcare workers, the media, religious organizations, community organizations that serve children and adolescents, and young people themselves must also be involved.

Eight-Component Model: The eight-component coordinated school health model is outlined below. Each of the components works to help promote the health and well-being of both students and staff, working together to provide a coordinated effort in achieving health promotion in the schools.⁴

- **Comprehensive school health education:** Classroom instruction that addresses the physical, mental, emotional, and social dimensions of health, develops health knowledge, attitudes and skills, and is tailored to each age level. Designed to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors.
- **Physical education:** Planned sequential instruction that promotes lifelong physical activity. Designed to develop basic movement skills, sports skills, and physical fitness as well as to enhance mental, social and emotional abilities.
- **School health services:** Preventive services, education, emergency care, referral and management (care coordination) of acute and chronic health conditions. Designed to promote the health of students, identify and prevent health problems and injuries, and ensure care for students.
- **School nutrition services:** Integration of nutritious, affordable, and appealing meals, nutrition education, and an environment that promotes healthy eating behaviors for all children. Designed to maximize each child's education and health potential for a lifetime.
- **School counseling, psychological, and social services:** Activities that focus on cognitive, emotional, behavioral, and social needs of individuals, groups, and families. Designed to prevent and address problems, facilitate positive learning and healthy behavior, and enhance healthy development.
- **Healthy school environment:** The physical, emotional, and social climate of the school. Designed to provide a safe physical plant, as well as a healthy and supportive environment that fosters learning.
- **School-site health promotion for staff:** Assessment, education, and fitness activities for school faculty and staff. Designed to maintain and improve the health and well-being of school staff, who serve as role models for students.
- **Family and community involvement in schools:** Partnerships among schools, families, community groups, and individuals. Designed to share and maximize resources and expertise in addressing the healthy development of children, youth, and their families.

The ASCD (formerly known as the Association for Supervision and Curriculum Development and the Centers for Disease Control and Prevention (CDC) convened a workgroup of subject matter experts in 2013 from academia, public health, and education to combine the components of a coordinated school health (CSH) model and the Whole Child model into “a unified model that supports a systematic, integrated, and collaborative approach to health and learning”.⁵

Whole School, Whole Community, Whole Child (WSCC) Model: The WSCC model is CDC’s framework for addressing health in schools. It focuses on the student, the associations between health and academic achievement, the significance of evidence-based school policies and practices, with an emphasis on the role of the community in supporting the school. The [ten-component WSCC model](#) is outlined below.⁶

1. **Physical education and physical activity**
2. **Nutrition environment and services**
3. **Health education**
4. **Social and emotional school climate**
5. **Physical environment**
6. **Health services**
7. **Counseling, psychological and social services**
8. **Employee wellness**
9. **Community involvement**
10. **Family engagement**



WHOLE SCHOOL, WHOLE COMMUNITY, WHOLE CHILD
A collaborative approach to learning and health

Chapter 2: Reviewing History - Legislative Studies

Overview

Historical Perspective. Prior to the mid-1800s, efforts to introduce health into public schools were isolated and sparse. The “modern school health era” began in the mid-1800s⁷ after the release of the Shattuck report, which recognized the role schools could play in controlling communicable disease with their “captive audience” of children and young people.⁸

The era of “medical inspection” began at the end of the nineteenth century when “medical visitors” went to schools and examined children thought to be “ailing.”⁹ The role and advantages of school nurses began to be recognized around the turn of the century after Lillian Wald, in 1902, demonstrated that nurses working in schools could reduce absenteeism due to contagious diseases by 50 percent in a matter of weeks.¹⁰ The range of school-linked health services was broad in the early twentieth century, and school-based medical and dental clinics were set up to provide services, especially to indigent students.

World War I marked a turning point in the history of school health programs, with the advent of the war making the problems of poverty more visible.¹¹ New health promotion philosophies and movement began to replace outmoded methods. During the years immediately following World War I, the image of modern school health programs began to emerge. Between 1918 and 1921, almost every state enacted laws related to health education and physical education for school children, and school-based medical inspection and screening continued into the 1930s. A number of school health demonstration projects and studies were carried out between the 1920s and 1940s.

Although the Great Society programs of the 1960s and 1970s brought an influx of funding for school health, most of these programs focused on disadvantaged and special populations.¹² During the 1980s, the role of health and physical education in the curriculum, as well as the perceived importance of school health for mainstream students, came under question. However, since the mid- to late-1980s there has been a renewed focus on the potential for schools to address health and social problems.¹³

Evolution of Comprehensive School Health Programs in Virginia. The evolution of school health programs in recent years in Virginia can be followed by reviewing recent school health-related legislation and legislative studies. Key legislation related to school health are cited throughout this manual and are contained in Part VI. In addition, summaries of key school health-related legislative studies are provided in the following subsections.

The following are summaries of school health-related legislative studies that were conducted in Virginia, including background information and recommendations.

- [*The Health Needs of School-Age Children, Senate Document No. 22, Commonwealth of Virginia, 1987.*](#)
- [*A Study on Ways to Encourage Local School Divisions to Recognize the Importance of School Nurses and the Feasibility of Establishing Standards for School Health Services, House Document No. 19, Commonwealth of Virginia, 1989.*](#)
- [*Current Health Programs in the Public School of Virginia and the Efficacy and Appropriateness of Adopting a Comprehensive Approach to Health Education, House Document No. 21, Commonwealth of Virginia, 1992.*](#)
- [*Report on the Needs of Medically Fragile Students, Senate Document No. 5, Commonwealth of Virginia, 1995.*](#)
- [*Findings and Recommendations of the Blue Ribbon Commission on School Health, Senate Document No. 29, Commonwealth of Virginia, 1996.*](#)
- [*Report of the Virginia Commission on Youth to the Governor and the Virginia General Assembly: Youth Suicide Prevention Plan, House Document No. 29, Commonwealth of Virginia, 2001.*](#)
- [*Review of Emergency Medical and Mental Health Services in Public Schools, House Joint Resolution No. 43, Commonwealth of Virginia, 2003.*](#)
- [*Final Report of the Virginia Commission on Youth to the Governor and the Virginia General Assembly: Childhood Obesity, Commission on Youth Document, Commonwealth of Virginia, 2003.*](#)
- [*Report of the Secretary of Health and Human Services to the Governor and the Virginia General Assembly: Suicide Prevention Across the Life Span Plan for the Commonwealth of Virginia, Senate Document No. 17, Commonwealth of Virginia, 2004.*](#)

Copies of Legislative Reports. To obtain a complete copy of any of the above reports, please visit the [Commonwealth of Virginia, Division of Legislative Services.](#)

The Health Needs of School-Age Children (Senate Document No. 22, 1987)

Background

In 1986, the Secretary's Task Force on the Health Needs of School-Age Children was assembled as an outgrowth of Senate Joint Resolution No. 76. The resolution requested the Secretary of Human Resources to study the health needs of school-age children. The recommendations are summarized below.

Recommendations

1. The number of school nurses providing school health services should be increased to allow for at least one school nurse in every school or a ratio of one school nurse per 1,000 students.
2. Minimum standards for school health services in Virginia should be developed jointly by the Departments of Education and Health.
3. The Departments of Education and Health should establish a nursing position within the State Department of Education to supervise and coordinate the provision of school health services in the Commonwealth.
4. The Department of Education should mandate family life education curriculum in grades K-12 with an emphasis on promoting parental involvement and the fostering of positive family living skills in all public schools in the Commonwealth.
5. The Departments of Health and Education along with the Virginia Dental Association should work together on a state and local level to coordinate dental care resources and to increase dental screenings and educational programs.
6. A formal memorandum of agreement should be developed between the Secretary of Human Resources and the Secretary of Education to address overlapping concerns related to the health needs and care of school-age children.
7. The Boards of the Departments of Education and Health should establish a formal agreement to meet jointly at a minimum of twice yearly to advise each of the designated agencies on matters pertaining to school health services policy.
8. The Governor's Task Force on indigent care as well as the Secretary of Human Resources should specifically address the special health care needs of the school-age child especially the medically indigent.

9. The Departments of Education, Health, and Mental Health and Mental Retardation should co-sponsor at regular intervals continuing education opportunities for school nursing personnel on a regional basis.
10. The Departments of Health, Education, and Mental Health and Mental Retardation should provide for school personnel continuing education opportunities about the new morbidity facing today's school-age children.
11. Every school division within the state should have a school health advisory body composed of public and private sector representatives to assist with school health policy.
12. An interdisciplinary health care plan for school-age children at the local level should be developed with technical assistance from the State Departments of Education, Health, and Mental Health and Mental Retardation as requested. Such a plan should include a component on methods of financing health care services to school age children.
13. Each school division within the state should establish formal interagency agreements with appropriate community resources involved in the provision of health care to school-age children. Appropriate community resources may include, but should not be limited to, local health departments, community services boards, social services agencies, institutions of higher education, private sector health professionals, and others.
14. Local school boards should develop, whenever possible, strong relationships with volunteer organizations and the business community for improving the delivery and financing of health care for school-age children.
15. The Virginia Chapter of the American Academy of Pediatrics should encourage its membership to provide a leadership role at the local level in advocating for and providing a coordinated system of health care for school-age children.
16. The Virginia Congress of Parents and Teachers (PTA) and all other parent organizations should vigorously undertake a parent awareness campaign to educate parents about the health needs of school-age children and to increase parental involvement in their children's health.
17. Every school division should establish a cooperative agreement with a health care provider to serve in the capacity of consulting medical director to provide medical care consultation and backup to nursing personnel.
18. Formal, written emergency medical procedures should be developed in every school division within the state.
19. The State Department of Education should direct all school divisions to maintain appropriate documentation on all student injuries as part of a program of comprehensive risk management.
20. The State Department of Education should continue to monitor and insist that all schools comply with state laws pertaining to vision and hearing assessments.

21. The Department of Education should direct all school divisions to provide time in the curriculum for health education. Further, there should be a strong emphasis on health promotion and disease and injury prevention programs.
22. The Department of Education should assist all school divisions with guidance on the physical education curriculum to develop and emphasize individual fitness programs.
23. The Department of Education should encourage all school divisions to establish after-school programs addressing health issues and concerns.

A Study on Ways to Encourage Local School Divisions to Recognize the Importance of School Nurses and the Feasibility of Establishing Standards for School Health Services (House Document No. 19, 1989)

Background

The Department of Education, in cooperation with the Department of Health, was requested by the 1988 General Assembly of Virginia to study ways to encourage local school divisions to recognize the importance of school nurses and the feasibility of establishing standards for health services in the public schools in the Commonwealth (House Joint Resolution Number 33 [HJR 33]). A study committee was established to respond to the task as defined by HJR 33.

Recommendations

1. Qualified school nurses should be required in every school division contingent upon appropriate funding.
2. The goal for nurse/student ratios should conform to the standards set by the National Association of School Nurses, American Nurses Association, and the American School Health Association.
3. School health advisory boards, composed of public and private sector representatives, should be established to enhance community support for school health services and to assist in the development of local school health policy.
4. Minimum standards for school health services in Virginia should be developed jointly by the Departments of Education and Health.
5. A nursing position should be established by the Departments of Education and Health within their respective departments to supervise and coordinate the provision of school health services.
6. School nurses should be involved as members of school teams to facilitate learning by providing care and treatment to students with chronic and handicapping conditions.
7. Students and school personnel should be counseled as a means of reducing the “new morbidities.”
8. A cooperative agreement should be established in every school division with a health care provider to serve in the capacity of consulting medical director to provide medical care, consultation, and backup to nursing personnel.

9. Formal written emergency medical procedures should be developed in every school division within the state.
10. Appropriate documentation on all student injuries should be maintained by all school divisions as part of a program of comprehensive risk management.
11. Continuing education opportunities, especially in the new morbidities, should be co-sponsored by the Departments of Education, Health, Mental Health and Mental Retardation on a regional basis, and at regular intervals for school nursing personnel.
12. Qualifications for school nurses should be developed jointly by the Departments of Education and Health.

Current Health Programs in the Public School of Virginia and the Efficacy and Appropriateness of Adopting a Comprehensive Approach to Health Education (House Document No. 21, 1992)

Background

This study was conducted during the spring and summer of 1991 in response to House Joint Resolution (HJR) 343 (1991 session). The resolution requested that the Department of Education study current health education programs, as well as the efficacy and appropriateness of adopting a comprehensive approach to health education in the public schools. The study was conducted in conjunction with the study required by HJR 437 (1991 session) on HIV/AIDS education.

Recommendations

1. All persons teaching health education in the elementary and middle school grades without a health education endorsement should be encouraged to complete training essential for quality instruction. This training should be a minimum of one undergraduate or graduate course in health education.
2. Minimum standards for school health education curricula and health services should be developed jointly by the Departments of Education and Health, in conjunction with school divisions in Virginia.
3. The Department of Education should design and implement a plan for evaluating the effectiveness of comprehensive school health programs.
4. The Board of Education and the Department of Education should commit to the further development of Comprehensive School Health Programs, addressing all health education and health service needs in a coordinated and comprehensive manner, and to the promotion of the program in the public schools of Virginia. This would include consideration for expanding the Health Standards of Learning to include grades 11 to 12 and developing a K-12 health education curriculum guide using the Health Standards of Learning Objectives as a foundation. To be funded in the 1994-96 biennium.
5. The Department of Education should continue to provide on-going education on timely health topics. This should be accomplished through the Blue Ridge School Health Conference and regional and local conferences.

Report on the Needs of Medically Fragile Students (Senate Document No. 5, 1995)

Background

During its 1993 legislative session, the Virginia General Assembly adopted a senate resolution (SJR 306) requesting that the Department of Education in conjunction with the Department of Health study the needs of medically fragile children in Virginia.

Recommendations

1. Local school divisions should develop policies that address the provision of services to students who are medically fragile to include staff selection and training, roles, and responsibilities.
2. Local school divisions should develop policies to address the emergency medical needs of students, including those who are medically fragile.
3. The local school health advisory board, required by §22.1-275.1 of the *Code of Virginia*, should take an active role in assisting school divisions in developing policies related to children who are medically fragile.
4. School divisions should provide periodic in-service or opportunities for school staff to attend programs to increase staff awareness and understanding of the general health issues faced by schools and the needs of medically fragile students, specifically.
5. For risk management purposes, school divisions should document the health services provided to any medically fragile or other students.
6. Nursing homes in the Commonwealth that elect to establish pediatric units should be licensed under both Chapter 5 of Title 32.1 of the *Code of Virginia* and under Chapter 10 of Title 63.1 of the Code.
7. School divisions should review and evaluate their policies and procedures relative to Section 504 of the Rehabilitation Act of 1973.
8. The Department of Education, in conjunction with the Attorney General's Office, should review and evaluate the need for legislation establishing statutory immunity for school personnel performing acts within the scope of their employment while providing health-related services to the medically fragile population.

9. The Department of Education, in collaboration with the Department of Health, should develop and update procedural guidelines.
10. The General Assembly may wish to consider further study, focusing on the needs of families with medically fragile children.

Findings and Recommendations of the Blue Ribbon Commission on School Health (Senate Document No. 29, 1996)

Background

The Blue Ribbon Commission on School Health Study was conducted during 1995 in response to Senate Joint Resolution No. 155, requesting the Governor to establish a Blue Ribbon Commission on School Health to collaborate in developing, implementing, and evaluating school health programs (1994).

Recommendations

1. School superintendents should recognize the importance of school health advisory boards as a means of parent and community involvement and of assisting with the development of school health policies and the evaluation of school health programs.
2. The Department of Education, in collaboration with the Department of Health, should provide periodic training and technical assistance to school health advisory board members and school health administrators to assist them in strengthening the boards' effectiveness in localities.
3. Recommendations Nos. 1-6 and 8 of Senate Document No. 5, "Report on the Needs of Medically Fragile Students (1995)," should be implemented.
4. School divisions should develop a "health service plan" for each student who is a medically fragile child as defined by Senate Document No. 5 (1995).
5. Local school divisions should develop policies that address the provision of services to students who are medically fragile, including staff selection and training and roles and responsibilities.
6. Local school divisions should develop policies to address the emergency medical needs of students, including those who are medically fragile.
7. The local school health advisory board, required by §22.1-275.1 of the *Code of Virginia*, should take an active role in assisting school divisions in developing policies related to children who are medically fragile.
8. School divisions should provide periodic in-service education or opportunities for school staff to attend programs to increase staff awareness and understanding of the general health issues faced by schools and the needs of students who are medically fragile.

9. For risk management purposes, school divisions should document school health services provided to all students, including those who are medically fragile.
10. School divisions should review and evaluate their policies and procedures relative to Section 504 of the Rehabilitation Act of 1973.
11. Students with special health care needs and chronic illnesses should have their medical care managed at school by a professional nurse in collaboration with the child's parents and primary health care provider.
12. The Virginia Board of Nursing efforts to address delegation of nursing services in the school setting to unlicensed assistive personnel while ensuring that the professional nurse retains authority for nursing assessment, nursing evaluation, and nursing judgment should be supported.
13. The Department of Health, in collaboration with the Department of Education, should distribute guidelines to assist qualified personnel in the assessment and ongoing management of students with specialized health care needs in the school setting. Such guidelines should be sent to all public and private schools in the Commonwealth.
14. School divisions should require that specialized health care procedures be provided by licensed health care professionals or by personnel who have received training from persons qualified to provide such training and are certified or licensed to perform the procedure being taught.
15. School divisions are encouraged to devote a portion of their professional development resources to assist staff in developing skills and strategies for working with parents and increasing parental involvement in the planning and implementation of school health programs.
16. School divisions are encouraged to review physical education, grades K-12, and determine ways by which the program could be improved.
17. The Department of Medical Assistance Services' studies on Virginia managed care Medicaid programs—MEDALLION II and OPTIONS—should include the impact of these programs on school health services.
18. The Department of Medical Assistance Services should study the appropriateness and feasibility of contracting for school health services, including school nursing services, especially in medically underserved areas or health manpower shortage areas.
19. School divisions, especially those in medically underserved areas, are encouraged to develop public-private contracts (e.g., HMO-Health Maintenance Organization, CHIP-Comprehensive Health Investment Project of Virginia) that include formal reimbursement for school health services (e.g., school nursing services) provided by qualified personnel.

Report of the Virginia Commission on Youth to the Governor and the Virginia General Assembly: Youth Suicide Prevention Plan (House Document No. 29, 2001)

Background

Senate Joint Resolution 148 directed the Commission on Youth, with the assistance of the Departments of Health, Education, and Mental Health, Mental Retardation, and Substance Abuse Services, to develop a comprehensive youth suicide prevention plan. The study resolution recognized suicide as the third leading cause of death among adolescents, as well as the significant increase in the rate of suicide among Virginia youth aged 10-19 since 1975. With the support of the departments identified above and significant input from survivors, service providers, and other stakeholders, the Commission undertook development of the plan.

Recommendations

1. Amend §32.1 of the *Code of Virginia* to designate the Virginia Department of Health (VDH) as the lead agency for youth suicide prevention in Virginia and require reporting to the Governor and General Assembly on the status of suicide prevention initiatives.
2. Increase funding for the VDH and the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) for their development and/or adoption of materials and dissemination of youth suicide prevention information throughout the Commonwealth.
3. VDH should make available to media professionals throughout the Commonwealth information about the responsible reporting of suicide (including specific guidelines developed by the U.S. Centers for Disease Control and Prevention) in order to reduce the risk of subsequent suicides.
4. The Department of Education (DOE) should revise the Suicide Prevention Guidelines to include criteria for follow-up with parents of students expressing suicidal intentions after initial contact is made.
5. VDH and DMHMRSAS should develop and deliver Gatekeeper Training to designated audiences throughout the Commonwealth.
6. The Board of Health Professions and all state agencies responsible for licensing or certification of youth-serving personnel should require suicide prevention education as a requirement for licensure or certification.

7. DMHMRSAS should continue to develop and implement the plan to provide comprehensive mental health services for children, adolescents, and their families.
8. DMHMRSAS and VDH should increase the capacity of local communities to provide community-based crisis intervention and support services for children, adolescents, and their families.
9. DMHMRSAS should continue to expand the availability of comprehensive mental health services for children and youth at-risk for suicide, particularly helping localities to offer skill-building and support groups, school-linked mental health services, and family support I survivor services.
10. DMHMRSAS and VDH, in cooperation with university medical centers, health science centers, and professional organizations should develop, implement, and evaluate curriculum and training plans to increase the knowledge and skills of clinicians and others who work with youth at-risk for suicide and their families.
11. VDH should design and implement an adolescent suicide attempt data collection system to determine the magnitude of the problem, as well as the following 9 characteristics of youth who attempt suicide: demographics, service access, and behavioral characteristics.
12. VDH should improve the system for reporting external cause of injury (e-codes) by providing training to designated reporters and by requiring e-code reporting for emergency room admission in selected sites around the Commonwealth.
13. VDH should coordinate comprehensive evaluation of all aspects of the suicide prevention program.
14. The General Assembly should appropriate funds to the Department of Health, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, and the Department of Education to implement the youth suicide prevention initiatives described in this plan.

Review of Emergency Medical and Mental Health Services in Public Schools (House Joint Resolution No. 43, 2003)

Background

Provisions included in House Joint Resolution (HJR) 43 of the 2002 General Assembly Session as introduced, directed the Joint Commission on Health Care to study emergency medical and mental health services in public schools. Although HJR 43 was passed by indefinitely in the House Committee on Rules, a member of Joint Commission on Health Care (JCHC) agreed to include the study as part of the Commission's 2002 Workplan. The provisions included within HJR 43 direct the Joint Commission to conduct its study with technical assistance provided by the Departments of Education and Health, as necessary. Specifically, HJR 43 directs the Joint Commission to: i) review the delivery of emergency medical services and emergency mental health services in the public schools, ii) evaluate the evolving need for nursing and mental health care in the public schools, iii) evaluate the staffing patterns for school health providers, particularly school nurses and school psychologists, iv) recommend the staffing patterns needed to result in the greatest benefits to and improvements in the physical and mental health of Virginia's school children, and v) estimate the cost to the Commonwealth and the localities of any new staffing patterns.

Recommendations

The following Policy Options were offered for consideration by the Joint Commission on Health Care:

1. Take no Action.
2. Introduce legislation to recommend that the staffing ratio for school nurses be 1:750 students and the ratio for school psychologists be 1:1000 students:
 - A. Introduce legislation to amend the *Code of Virginia* to make the ratios suggested guidelines that would be phased-in within three years. Provide no funding.
 - B. Introduce legislation to amend the *Code of Virginia* to mandate the ratios and require the schools to meet the ratios within three years. Introduce a budget amendment (amount to be determined) to provide initial funding.
3. Introduce a joint resolution directing the Department of Education, the Department of Health, and the Virginia Center for School Safety to examine their data collection efforts to design a plan to provide comprehensive information on the provision of school health services in the public schools. This information

should include the provision of emergency medical and mental health services. The interim plan should be reported by September 1, 2003 to the Chairmen of the House Appropriations Committee, the Senate Finance Committee, and the Joint Commission on Health Care with a final report being presented by September 1, 2004.

4. Include in the 2003 workplan for the Joint Commission on Health Care, further study and analysis of issues related to emergency medical and mental health services in the public schools. This will include working with the Department of Education, the Department of Health, and the Virginia Center for School Safety to examine their data collection practices to improve and potentially consolidate them in an effort to provide comprehensive information on school health services.

Final Report of the Virginia Commission on Youth to the Governor and the Virginia General Assembly: Childhood Obesity (Commission on Youth Document, 2003)

Background

Section 30-174 of the *Code of Virginia* establishes the Commission on Youth and directs it to "...study and provide recommendations addressing the needs of and services to the Commonwealth's youth and their families." This section also directs it to "...encourage the development of uniform policies and services to youth across the Commonwealth and provide a forum for continuing review and study of such services. Under Section 30-175 of the *Code of Virginia*, the Virginia Commission on Youth has the power and duty to "undertake studies and to gather information and data in order to accomplish its purposes as set forth in Section 30-174 of the *Code of Virginia*, and to formulate and present its recommendations to the Governor and the General Assembly." In addition, "at the direction or request of the legislature by concurrent resolution or of the Governor, or at the request of any department, board, bureau, commission, authority or other agency created by the Commonwealth or to which the Commonwealth is party, study the operations, management, jurisdiction or powers of any such department, board, bureau, commission, authority or other agency which has responsibility for services to youth."

This report addresses the problem of obesity among children and adolescents in Virginia. It discusses research both at the state and national levels regarding the prevalence, causes, and consequences of childhood obesity. It provides information about the role of parents and schools in improving the eating habits and physical activity of children in Virginia and suggests ways that these parties can take action to improve the health and nutrition of Virginia's youth.

Recommendations

1. Virginia Action for Healthy Kids, at the direction of Virginia Cooperative Extension, Virginia Tech, be requested to report to the Commission on Youth on the most effective and cost-efficient ways to prevent greater proliferation of overweight and obesity among the youth in Virginia by November 17, 2003. This report was published in 2004 and a summary is available through the Virginia Legislative Information System (LIS). Recommendations from this report are as follows:
 - a. Request the Department of Education to report on the feasibility of implementing the recommendations of the Virginia Action for Healthy Kids' approved by the Commission on Youth at its November 17, 2003

meeting as part of its study of Childhood Obesity in Virginia. The Department of Education will report to the Commission on Youth prior to the 2005 General Assembly Session.

- i. Revise the Board of Education's regulations as approved by the Board of Health for health and physical education in public school curriculum, to be in compliance with Section 22.1-207 of the *Code of Virginia* to:
 - Require K-10 instruction in health and physical education to be delivered by a qualified, endorsed health and physical education teacher;
 - Require annual fitness report cards for each student, including information on abdominal and upper body strength, aerobic activity, flexibility, and height and weight and body mass index-for-age calculations, to be sent home to parents during standard testing times (fall, spring); and
 - Require Standards of Learning testing for elementary, middle, and high school students by July 1, 2007.
- ii. Establish a team to investigate the feasibility of implementing agricultural programs in schools, within the current Standards of Learning framework, such as the USDA-funded Farm-to-School program and school gardening programs.
- iii. Modify the Standards of Accreditation to require a minimum of 30 minutes of daily recess during the regular school year for elementary school students, not to include physical education requirements. Recess is not to be taken away for remediation or disciplinary action.
- iv. Modify the Standards of Accreditation to require health and physical education instruction in 8th grade.
- v. Require schools to provide at least 20 minutes to eat lunch, once seated, and schedule lunch periods at reasonable hours around midday (11:00–1:00).
- vi. Require that every newly built elementary school have space for recess and recreation.

Report of the Secretary of Health and Human Services to the Governor and the Virginia General Assembly: Suicide Prevention Across the Life Span Plan for the Commonwealth of Virginia (Senate Document No. 17, 2004)

Background

In 2003, the General Assembly agreed to Senate Joint Resolution 312 requesting the Secretary of Health and Human Resources, in cooperation with the Secretaries of Education and Public Safety, to formulate a comprehensive Suicide Prevention across the Life Span Plan for the Commonwealth. The General Assembly directed the Department of Health (VDH) and the Department for the Aging (VDA) to develop the plan, with participation from the Departments of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS); Social Services; Education; Juvenile Justice; Criminal Justice Services; State Police; Corrections; and any other state agency with an interest, responsibility, or role in suicide prevention. While most of the goals and relevant recommendations listed below are community based, much of this can also be integrated into a Coordinated School Health Program as part of comprehensive student health.

Recommendations

1. Goal 1: Develop Broad-based Support for Suicide Prevention.
 - The Department of Mental Health, Mental Retardation, and Substance Abuse Services (lead agency) should form a Private/Public Suicide Prevention Steering Committee to support the agency in implementing, monitoring, evaluating, and revising the Plan by coordinating strategies and promoting collaboration at the state, regional and local levels.
 - Based on available data, DMHMRSAS and Steering Committee should identify areas where local coalitions and interventions are most needed.
 - Leaders and organization representatives in each specified region/locality should form or identify a coalition to take on the leadership for suicide prevention.
2. Goal 2: Improve and expand surveillance systems.
 - DMHMRSAS, in collaboration with agencies represented by the Steering Committee, should produce and disseminate a comprehensive report every three years on suicide and suicide attempts, integrating data from multiple data systems.

- DMHMRSAS should identify those localities or population groups that could most benefit from such studies.
3. Goal 3: Promote and support research, including evaluation, on suicide and suicide prevention.
 - Member agencies of local coalitions should conduct comprehensive needs assessments in localities with high suicide rates to identify specific local problems and gaps in services.
 4. Goal 4: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.
 - DMHMRSAS, in collaboration with member organizations of the Steering Committee, should launch a public education campaign to improve awareness of mental health and substance abuse issues and the importance of disclosing symptoms and obtaining care with the aim of reducing stigma, myths, and denial of mental health conditions and substance abuse.
 5. Goal 5: Promote awareness that suicide is a public health problem that is preventable.
 - DMHMRSAS should:
 - Launch a public education campaign to educate the public about the problem of suicide, its cost, warning signs, causes, available resources, and what the public can do.
 - Local coalitions should hold special outreach and community events, speakers and training to local religious, civic, leaders and organization representatives.
 6. Goal 6: Develop and implement community-based suicide prevention programs.
 - DMHMRSAS should provide education for regional/local coalition members and other leaders on the problem of suicide and its prevention.
 - DMHMRSAS and Steering Committee members should meet with state representatives/leaders of family, youth, elderly, and other community service organizations to educate them on the problem of suicide and provide materials for and promote the integration of suicide prevention components into their programs.
 7. Goal 7: Promote efforts to reduce access to lethal means and methods of self-harm.
 - DMHMRSAS and State Police should:
 - Train health professionals and other gatekeepers about firearm fatality statistics and the safe storage and handling of firearms.
 - Train health professionals and other providers about the importance of discussing the safe storage and handling of firearms and other lethal means with family members or close contacts of individuals who are in crisis or have mental disorders, substance abuse problems, or suicidal thoughts.

8. Goal 8: Implement training for recognition of at-risk behavior and delivery of effective treatment.
 - Meet with regional/local coalition leaders to provide the tools for and request their promotion of suicide prevention training to local leaders, including business, educational, religious, media, human services, foundation, and civic leaders.
 - Promote establishment and utilization of family education programs through the regional/local coalitions, community service boards, local foundations, civic groups, and major employers.
9. Goal 9: Develop and promote effective clinical and professional practices.
 - The Department of Mental Health, Mental Retardation and Substance Abuse Services should work with local/regional coalitions, especially those in areas with high suicide rates, to assess the barriers patients and providers face in assuring completion or regular maintenance of treatment. Reduce these barriers through increased funding, training, or policy changes.
10. Goal 10: Increase access to and community linkages with mental health and substance abuse services.
 - The Department of Mental Health, Mental Retardation and Substance Abuse Services should:
 - Continue to expand and improve local mental health services.
 - Promote integration of suicide prevention activities into existing programs targeting populations at high risk for suicide.
 - Local/regional coalitions should convene community leaders to identify and implement collaborative opportunities for more effective service.
11. Goal 11: Improve reporting and portrayals of suicidal behavior, mental illness and substance abuse in the entertainment and news media.
 - DMHMRSAS should, in collaboration with local/regional coalitions, meet with representatives of the radio, TV, news media and journalism schools, in each of the major media markets, to inform them on suicide risk in their geographical area, risk factors, and solutions.

Chapter 3: Developing a Program - Infrastructure and Planning Process Steps

Overview

The development and implementation of a Coordinated School Health (CSH) program can initially seem overwhelming. However, most components of the infrastructure that are needed to support CSHs—the basic underlying framework of policies, financial and human resources, organizational structures, and communication channels that will be needed for the program to become established and grow—already exist or are emerging.

According to the 2012 School Health Policies and Practices Study¹⁴, 66.0% of states had a person, such as a state school health coordinator, responsible for overseeing or coordinating all of the state's school health and safety policies and activities and 53.7% of districts had a district-level school health coordinator who oversees the district's health and safety policies and activities. In addition, all eight components are addressed on some level, both at the state and local (district) level. However, there is still significant room for improvement in the planning and coordination of the components within state and local educational agencies or with comparable programs in state or local health agencies.

Subsections

The following two subsections summarize resources available at the national, state, and local levels and the steps in developing a plan to implement a CSH program. It is important to bear in mind that these are general guidelines, and that each school and district will have different needs, gaps in services, and programs already in place. New programs and interventions will be tailored to meet the needs of individual school and communities.

- [Infrastructure](#)
- [Planning Process Steps](#)

Infrastructure

Building the Infrastructure for a School Health Program

National Infrastructure. According to *School & Health: Our Nation's Investment*,¹⁵ here are many federal agencies that have developed programs to improve the health of children and adolescents. These programs can be a source of technical assistance and funding that states and local school divisions can use to create the infrastructure and develop a school health program.

Federal Programs and Funding Streams for School Health	
Agency	Examples of Programs
CDC, Division of Adolescent and School Health	<ul style="list-style-type: none"> - Coordinated School Health - Whole School, Whole Community, Whole Child (WSCC) - School Health Surveillance - Health & Academics
Centers for Medicaid and Medicare Services	<ul style="list-style-type: none"> - Medicaid - Early Periodic Screening and Diagnosis and Treatment (EPSDT) Program - Child Health Insurance Program (CHIP)
U.S. Department of Agriculture	<ul style="list-style-type: none"> - Healthy Meals Resource System - Healthier School Day: Tools for Schools
U.S. Department of Education	<ul style="list-style-type: none"> - Title I of the Elementary and Secondary Education Act (ESEA) - Title IV of ESEA, Safe and Drug-Free Schools - Title XI of ESEA, Coordinated Services - Projects Individuals with Disabilities Act (IDEA)
U.S. Department of Health and Human Services: Maternal and Child Health Bureau (MCHB)	<ul style="list-style-type: none"> - MCH Title V State Block Grants - Family to Family Health Information Centers - Healthy Start - Community Integrated Service Systems - Combat Autism Act Initiative - Maternal, Infant, and Early Childhood Home

Federal Programs and Funding Streams for School Health

Agency	Examples of Programs
	Visiting

Furthermore, there are many national organizations that are involved in supporting school health programs, including many nonprofit and philanthropic organizations that support school health programs. Some of these organizations are listed below:

National Organizations Supporting School Health Programs

Organization	Description
Alliance for a Healthier Generation: Healthy Schools Program	An evidence-based initiative that will help schools create and sustain healthy environments where students can learn better and flourish. Aimed at helping schools improve physical education, health education, and nutrition.
American Academy of Pediatrics (AAP)	The AAP and its member pediatricians dedicate their efforts and resources to the health, safety and well-being of infants, children, adolescents, and young adults.
American Cancer Society, Health for Success	It is the American Cancer Society's goal to eliminate cancer as a major health problem. The Society has determined that strengthening school health education is the best and most economic way to fight this devastating disease.
American School Health Association (ASHA)	The ASHA promotes comprehensive and coordinated school health programs comprising health services, health education, and a healthful school environment.
Association of State and Territorial Health Officials (ASTHO)	The mission of ASTHO is to formulate and influence sound national health policy and to assist state health departments in the development and implementation of programs and policies to promote health and prevent disease.
National Association of School Nurses (NASN)	The mission of the NASN is to advance the practice of school nursing and provide leadership in the delivery of quality health programs to the school community.
National Association of State School Nurse Consultants (NASSNC)	The mission of the NASSNC is to provide a forum for state-level nurse consultants to share information,

National Organizations Supporting School Health Programs

Organization	Description
Robert Wood Johnson Foundation	develop expert consensus on issues, and impact policies related to the practice of school nursing and the health and education of the nation's school children and youth. The Robert Wood Johnson Foundation is the nation's largest philanthropy devoted exclusively to health and health care.

State Infrastructure. As noted in *School & Health: Our Nation's Investment*,¹⁶ a major task of the state's leadership is to integrate education, physical and mental health, and other related programs and services for children and families. An effective approach for anchoring the state infrastructure is to establish an official state interagency coordination council for school health with designated authority and responsibilities, along with an advisory council of representatives from relevant public and private sector agencies, including representatives from managed care and indemnity insurers.

In Virginia, in 1992, the Virginia Maternal and Child Health Council was created to improve the health of the Commonwealth's mothers and children by promoting and improving programs and service delivery systems related to maternal and child health. When the Council was first convened, a School Health Subcommittee was formed to make recommendations to the Council on school health-related issues. In 1997, the Subcommittee presented a report on school health services to the MCH Council. More recently, these tasks have been delegated to Virginia Performs, an initiative of the Council on Virginia's Future. Virginia Performs focuses on sustaining and improving the quality of life in the Commonwealth, specifically in the areas of economy, education, health & family, public safety, natural resources, transportation, and government & citizens. In addition, there are many state agencies that can provide localities with child health information and technical assistance, which can help communities, enhance or establish a school health program. Some of the key agencies are listed below:

Key Child Health-Related State Agencies

Agency	Description
Virginia Department of Education (DOE)	The mission of Virginia's public education system, first and foremost, is to educate students in the fundamental knowledge and academic subjects that students need to become capable, responsible, and self-reliant citizens. Therefore, the mission of the Board of Education and Superintendent of Public Instruction, in cooperation with local school boards, is to increase student learning and academic achievement.

Key Child Health-Related State Agencies	
Agency	Description
Virginia Department of Health (VDH)	The mission of the VDH is to achieve and maintain optimum personal and community health by emphasizing health promotion, disease prevention, and environmental protection.
Virginia Department of Medical Assistance Services (DMAS)	DMAS is the agency that administers Medicaid and the State Children's Health Insurance Program (CHIP) in Virginia. The CHIP program in Virginia is called Family Access to Medical Insurance Security (FAMIS). Our mission at DMAS is to provide a system of high quality and cost-effective health care services to qualifying Virginians and their families.
Virginia Department of Behavioral Health and Developmental Health Services (DBHDS)	Virginia's public mental health, intellectual disability and substance abuse services system is comprised of 16 state facilities and 40 locally run community services boards (CSBs). The CSBs and facilities serve children and adults who have or who are at risk of mental illness, serious emotional disturbance, intellectual disabilities, or substance abuse disorders.
Virginia Department of Social Services	<p>VDSS' programs are designed to help Virginia's most vulnerable citizens find permanent solutions to life's many challenges. The Department is responsible for administering a variety of programs, including Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Medicaid, Adoption, Child Care Assistance, Refugee Resettlement Services, and Child and Adult Protective Services.</p> <p>Our goal is to promote the well-being of our citizens through the delivery of essential services and benefits to ensure families are strengthened, and individuals achieve their highest level of self-sufficiency.</p>

Local Infrastructure. A formal organization with broad representation - a coordinating council for school health - should be established in every school district, to anchor the infrastructure at the community or district level.¹⁷

In Virginia, such coordinating councils, known as school health advisory boards (SHABs) should exist in all school divisions. SHABs were established by the 1992 General Assembly ([Code of Virginia, § 22.1-275.1](#)), to assist with the development of health policy in the school division and the evaluation of the status of school health, health education, the school environment, and health services. Please refer to Part II, Chapter 7, *Establishing and Enhancing School Health Advisory Boards* in the *Guidelines* for further information on SHABs in Virginia.

School Level. According to *School & Health: Our Nation's Investment*,¹⁸ individual schools should establish a school health committee and appoint a school health coordinator to oversee

the school health program. Please see the following section, “Establishing School Health Team: Position Descriptions,” for recommendations on establishing a school health team.

CDC Guidance on Developing the Coordinated School Health (CSH) Program Infrastructure ¹⁹

The Centers for Disease Control and Prevention (CDC) provides guidance to those responsible for developing coordinated school health programs both at state and local levels. Summarized below are some infrastructure-related terminology and important considerations for planning:

CSH Definition. CSH is a systematic approach to improving the health and well-being of all students so they can fully participate and be successful in school. The process involves bringing together school administrators, teachers, other staff, students, families, and community members to assess health needs; set priorities; and plan, implement, and evaluate all health-related activities. CSH typically integrates health promotion efforts across eight interrelated components that already exist to some extent in most schools. These components include health education, physical education, health services, nutrition services, counseling, psychological and social services, healthy and safe school environments, staff wellness, and family and community involvement.

CSH Infrastructure. The CSH infrastructure is the basic system on which the larger CSH program depends for continuance and growth. State agencies collectively build the support systems to plan, implement, and evaluate fully functioning coordinated school health programs. By coordinating the allocation of new resources and using existing resources more efficiently, state agencies can help schools to meet the health needs of students and their families. To build a state-level infrastructure that supports coordinated school health programs, health and education agencies must work with other relevant state agencies such as social services, mental health, and environmental health as well as with nongovernmental organizations in the state. The heads of state government agencies must commit to supporting the process of infrastructure development.

CSH Infrastructure Supports. The four main units that comprise infrastructure are (1) authorization and funding, (2) personnel organization and involvement, (3) technical assistance and resources, and (4) communication and linkages. Each support can be broken down into multiple subcategories.

CSH Institutionalization. The CSH as an integrated, self-sustaining part of health and education agencies that is subject to minimal disruption caused by changes.

Planning Process Steps

When developing or enhancing a school health program - whether at the national, state, local, or school level - planning is essential for success. It is critical to set the stage by choosing the appropriate community participants and school health professionals. A team with the appropriate mixture of responsibility, knowledge, and experience can lead the schools in an improvement project that will make a difference for students and staff. The team should define the problem from a national, state, local, or school level perspective as needed. The next step is for the team to conduct an assessment of the problem or need, set goals and objectives, develop an action plan with strategies to be used, implement the plan, and evaluate the results. The six key steps in a planning process are listed below:

1. Establish the planning team.
2. Assess health problems and service needs.
3. Set goals and objectives.
4. Develop an action plan.
5. Implement the plan.
6. Evaluate effectiveness of the planning process and program.

This sub-section, “Planning Process Steps,” summarizes the steps of a logical planning process, which can be used at the school level for enhancing or establishing a school health program. The information presented can be modified according to what is appropriate at the national, state, or local level. For additional information on building support for a comprehensive or coordinated approach to school health programs, please refer to Part II, Chapter 10 of the *Guidelines, Building Support for School Health Programs*.

Establish Planning Team

Role Assignment. When developing a school health team, it may be customary to assign roles on the team based on the team members’ responsibilities associated with their existing school health role. For example, the school nurse may be assigned school health services because the school nurse is responsible for school health services as part of the school nurse role. However, there are no clear-cut responsibilities and members may contribute in several areas. While health services may be considered by many to be the domain of the school nurse, every staff member should refer students who exhibit health problems, such as vision and hearing disorders or substance abuse, for early detection and correction of health problems. In another

example, the healthy school environment component is often assigned to administrators. The principal may typically set the tone for the school; however, without the cooperation of all staff, efforts to make the school environmentally safe and aesthetically pleasing may fall short.

Using a variety of individuals who each bring specific attributes to a particular plan strengthens the school health improvement team. An effective school health system uses a team approach to guide programming and facilitate collaboration between the school and the community. Ideally, the school health team includes at least one representative from each of the eight components, and school administrators, parents, students, and community representatives involved in the health and well-being of students, such as a representative from the local health department and the school district's medical consultant.

Primary Team Members. It is important to remember that each person can bring more attributes than those based on their identified role in school health. The following list identifies potential team members and describes attributes they may bring to the team based on their functional responsibility:²⁰

Primary Team Member	Attributes
<ul style="list-style-type: none"> School Administrators 	Sets the tone for the school environment and can facilitate implementation of the plan.
<ul style="list-style-type: none"> School Nurses Nurse Practitioners Clinic Aides/UAP (Unlicensed Assistive Personnel) 	Understands student health needs, can link school and community programs, can provide case management for student health needs, and can serve as a health resource for all staff.
<ul style="list-style-type: none"> Health Educators 	Can coordinate supplemental health instruction with the health curriculum and provide access to a variety of health resources.
<ul style="list-style-type: none"> Physical Educators Coaches Trainers 	Can coordinate the physical education program with special wellness-related fitness programs, as well as implement special physical activity events.
<ul style="list-style-type: none"> Food Service Directors Food Service Managers 	Can organize supplemental nutrition education programs.
<ul style="list-style-type: none"> Guidance Counselors School Psychologists Social Workers 	Can direct peer instructional programs, small group process, and support groups, as well as teach within the guidance program the generic skills needed to address a variety of health problems.
<ul style="list-style-type: none"> Worksite Health Promotion Directors 	Can organize health promotion activities and coordinate community health promotion resources.

Primary Team Member	Attributes
<ul style="list-style-type: none"> • Community Professionals • Physicians • Parents/Family • Community Leaders • SHAB (School Health Advisory Board) Members • Law Enforcement Officials (e.g., D.A.R.E. Officers, Resource Officers) 	Have access to human and material resources and leverage within the community to assure implementation of projects.

Additional Team Members. Although the previous list contains the major players who have some responsibility for the school health program, other individuals can facilitate the accomplishment of program goals because of their unique role in the school. The following list identifies individuals who could assist in health programs:²¹

Additional Team Members	Attributes
<ul style="list-style-type: none"> • Librarians 	Have access to school media resources and can prepare exhibits for students.
<ul style="list-style-type: none"> • Special Education Teachers 	Teach students with disabilities and provide instruction about healthy environments and community inclusion for all students.
<ul style="list-style-type: none"> • Occupational Therapists • Physical Therapists • Speech-Language Pathologists 	Implement IEP requirements. Provide suggestions for improving the health of all students, faculty, and staff in the classroom setting.
<ul style="list-style-type: none"> • Work and Family Studies Teachers • Science Teachers 	Can provide significant health programming within their respective discipline.
<ul style="list-style-type: none"> • English Teachers 	Can assign homework with health themes.
<ul style="list-style-type: none"> • Office Secretaries 	Are aware of available school resources and have contact with students waiting in office for professional staff.
<ul style="list-style-type: none"> • Music Teachers • Art Teachers • Drama Teachers 	Can use a variety of channels to provide health messages. Additionally, any teacher or school staff member who works with students can be valuable in this endeavor.
<ul style="list-style-type: none"> • Students 	Although students routinely have not been placed on committees to improve school health programs, it is

Additional Team Members	Attributes
	appropriate to consider their value. Students have the attention of their peer group, the idealism and energy to complete projects, and the need to engage in meaningful activity. They also can promote behavioral change among students more effectively than adults.
<ul style="list-style-type: none"> • Consultants 	Outside consultants, who are trained health education specialists and understand the theories of individual and organizational change and the process of program implementation, can facilitate institutionalization of an interdisciplinary approach to school health programming. Consultants may be based at the district office, secured from a local university, or hired through a consulting firm.

Health program team members who represent various disciplines foster greater dissemination of information and innovations. The team members can share activities of the team with their respective professional groups and can request assistance from these groups in implementing specific parts of the action plan. Please see the following section, “Establishing School Health Team: Position Description,” for guidelines for selected school health program personnel.

Assess Health Problems and Service Needs

Data Collection and Interpretation.²² Once the team is formed, is an assessment of the school community health status and available resources. Assessment involves the regular collection, analysis, and sharing of information about the health conditions, risks, and resources in a community. Assessing the school community is needed to identify (1) trends in illness, injury, high-risk health behaviors, and death, and the factors that may cause these events; and (2) available school health resources and their application, unmet needs, and community perceptions about school health issues. Data are then interpreted, and school community health problems and capabilities are identified.

Assessment Questions. To identify the unique needs of the students in the school division, data are collected to answer such questions as:

- What are the major health problems? What are the priorities based on the needs of the student population?
- What is the current status of programming that addresses these health problems?
- What are the gaps in needed programming?
- What health problems should be addressed first?

Data Collection Methods. Data can be collected from a variety of sources that might include:

- Students' knowledge, attitudes, and behaviors about health in general or in any priority area.
- School health programming in each of the eight-component areas.
- Community resources.
- Programming within the school and community that addresses specific priority areas.
- Epidemiological data (e.g., mortality/morbidity) and social indicator data (e.g., injury reports, school health records, crimes, driving-under-the-influence arrests).
- Parents.

Data Collection Tools. Some examples of tools that may be used for assessment include:

- Blue Ribbon Commission on School Health Evaluation Survey, which is a modification of the above survey that was developed by the Virginia Department of Education. (available in Part VI of this manual)
- [Youth Risk Behavior Surveillance System \(YRBSS\)](#), which was developed by the Centers for Disease Control and Prevention to assess health-related risk behaviors in youth. The survey focuses on behaviors in six priority areas: (1) physical fitness, (2) nutrition, (3) intentional injuries, (4) unintentional injuries, (5) reproductive health, and (6) substance abuse. Local programmers can compare local students' behavior with the behavior of students at the national or state level.
- [School Health Profiles](#), which is a report designed to help state education agencies and local education agencies monitor the status of school health education at the middle/junior high school level in their school divisions. The profile addresses the quantity and quality of school health education provided in schools.
- Guidelines for Evaluation of Health Services, which is an evaluation of general school health services, such as school health procedures and cumulative health records and specific school health services, such as nursing and screening programs. Refer to Part III, Chapter 11, *Overview of School Health Services*, for more detailed information.
- [School Health Index \(SHI\): Self-Assessment & Planning Guide](#), is an online self-assessment and planning tool that schools can use to improve their health and safety policies and programs. The SHI was developed by CDC in partnership with school administrators and staff, school health experts, parents, and national nongovernmental health and education agencies to enable schools to identify strengths and weaknesses of health and safety policies and programs, develop

an action plan for improving student health, and engage teachers, parents, students, and the community in promoting health-enhancing behaviors and better health.

Problem Analysis and Prioritization.²³ After the data collection is complete, problem analysis should be completed by the school health team. This analysis can include (1) identification of the origins (i.e., precursors of the problem) and impact (i.e., consequences) of the problem, (2) the point at which interventions (e.g., health services, health education) might be undertaken and the adequacy of existing services, and (3) the community representatives that have an interest in the problem and its solution.

Communities are constantly facing the dilemma of addressing a large number of health problems with limited human, financial, and other resources. Therefore, it is critical to prioritize the identified problems in order to decide how to allocate resources to address them. To allow a variety of perspectives and criteria to be fully represented, the school health team should consider using a problem analysis and prioritization framework that encourages consideration of all of them in a balanced, rational way.

Various models or decision frameworks exist for conducting problem analyses and health services needs assessments. The school health team might consider using an already-developed process and substantive experts to facilitate problem analysis and problem prioritization.

Set Goals and Objectives

Goals. After the needs are identified, goals and objectives are specified. Goals are broad statements that identify long-term outcomes the school health program is to achieve.

Objectives. After the goals have been identified, specific objectives are identified that will help facilitate the achievement of the goal. Objectives are the incremental steps that must be accomplished and identify the action to be performed. Each objective should be stated in specific, measurable terms, as they will become the focus of the evaluation plan that will be developed.

Develop an Action Plan

Action Plan. The next step in developing a school health program is creating an action plan. This is a strategy or blueprint for meeting the identified priority needs from the assessment. The action plan answers the question of what can be done to resolve the identified needs or problems. It focuses on analysis of the need, setting priorities for goals and objectives, identifying the strategies to facilitate attainment of the objectives and goals, delineating the

specific activities needed to complete each strategy, establishing timelines, and identifying evaluation procedures.

Strategies. The team should formulate specific strategies to achieve each objective. A strategy is a set of activities designed to bring about the desired change. These can take the form of a policy development, formal instruction, informal modeling of behavior, social support, facility modification, direct intervention, or mass media campaigns to change behavior. As the action plan is implemented, attention to the reception and the progress of the program is paramount. In this phase, there is a formative evaluation that provides guidance for program modification. If the plan is not proceeding according to schedule or if unexpected outcomes are discovered, revision and restructuring of the action plan are warranted.

Factors to Consider. When developing the action plan, it is important to consider the following:

- Involve as many people as possible in the planning process. The more people who have ownership of the plan, the more people who will support the plan when it is implemented. Successful school health improvement projects link professionals within the school and integrate school activities with the community.
- Identify the key stakeholders associated with the identified problem and encourage their involvement.
- Anticipate potential problems with the plan and develop contingency plans.
- Ensure that the plan is communicated to everyone who will be affected by it.
- Determine if the plan is manageable and reasonable.
- The work of the school health team is enhanced if the community has mounted a similar campaign and if there is a link integrating the programming in the community with what is occurring in the school. Various options are available for school community partnerships, such as community agency professionals and parents working on school health improvement teams, and formal task forces that include coalitions or consortiums. As the organizational unit becomes more formal and complex, the roles and responsibilities of participating individuals and agencies should be clarified.

School Health Advisory Boards. The school health advisory board (SHAB) is an excellent vehicle to assist in the development of the school health program. The SHAB may be the group that can assist in the assessment of the health conditions, risks, and resources in a school community, or may assist persons associated with the school division to plan for an identified school health need. In many situations, the SHAB members are key stakeholders associated with a particular school health need. Please refer to Part II, Chapter 7, *Establishing and Enhancing School Health Advisory Boards*, for more information on SHABs.

Implementing a Plan

After plan development is completed, the next phase is implementation of the program. As each school division has unique needs, each school division will develop plans that are specific to their school's situation. For example, a plan developed to meet the accessibility needs of a small rural school division will not be appropriate for the accessibility needs of a large urban school division. One system may have only 5 students with special needs, while the other has 100 students with special needs.

General Guidelines. General guidelines for implementing the action plan include:

- Involve the community and community leaders in implementation of the action plan.
- Communicate the plan to all persons who need to be involved.
- Identify the appropriate resources at the state level, such as the Virginia Department of Education and the Virginia Department of Health, and at the local level, such as school health advisory boards, school administration, area health professionals, local health departments, and school boards.
- Build partnerships and develop interdisciplinary collaboration as needed.
- Obtain a written agreement with all involved agencies and partners so that each person's/organization's role is clearly defined in the action plan.

Evaluate Effectiveness

The final component of the planning process is evaluation. The purpose of this phase is to determine the effectiveness of the school health program and progress towards the outlined goals and objectives. Evaluation can be either ongoing (formative) or outcome (summative), or a combination of both. Ongoing evaluation guides program implementation, while outcome evaluation determines program effectiveness. Evaluation should focus on progress and achievement of the goals, objectives, as well as effectiveness of the strategies, activities, personnel, and time frames selected.

Basic Steps. The basic steps in the evaluation process are:

1. Develop questions that should be answered to determine whether the program is successful.
2. Identify procedures and persons to answer the questions.
3. Obtain information and data that specifically address the questions asked.
4. Analyze and interpret collected information and data.
5. Use evaluation results to plan for future programs.

Evaluation Questions for Program Planning Process. Examples of questions that may be asked regarding evaluation of the program planning process as presented in the following table: ²⁴

Evaluation Area	Sample Questions
Goals	<ul style="list-style-type: none"> • Are the chosen goals congruent with needs identified in the assessment? • Are the chosen goals capable of being attained?
Objectives and Outcomes	<ul style="list-style-type: none"> • Are the objectives and outcomes comprehensive? • Are the objectives and outcomes attainable? • Are the objectives and outcomes measurable? • Are the objectives and outcomes congruent with goals and strategies?
Strategies	<ul style="list-style-type: none"> • Are the chosen strategies congruent to the attainment of goals? • Are the chosen strategies comprehensive? • Are the chosen strategies attainable? (Resources available amenable to student developmental levels?) • Are the chosen strategies acceptable to community standards and values?
Activities	<ul style="list-style-type: none"> • Are the activities attainable? (Resources available?) • Are the activities developmentally appropriate? • Are the activities comprehensive? • Are the activities congruent with strategies and goals? • Are the individuals in charge of each activity or strategy competent, well-organized, interesting, and effective?
Time Frame	<ul style="list-style-type: none"> • Is the time frame reasonable?
Outcome of Action Plan	<ul style="list-style-type: none"> • How effective were the specific health promotion strategies that were implemented by the components of the school health program (health services, health instruction, healthful school environment) in changing knowledge? attitudes? behavior? • Have new policies been implemented? • Has health status improved?

Chapter 4: Establishing a School Health Team - Position Descriptions

Authorization

Code of Virginia, Section 22.1-274, School Health Services

Excerpt:

“Each school board shall ensure that in school buildings with an instructional and administrative staff of 10 or more (i) at least three employees have current certification or training in emergency first aid, cardiopulmonary resuscitation, and the use of an automated external defibrillator and (ii) if one or more students diagnosed as having diabetes attend such school, at least two employees have been trained in the administration of insulin and glucagon. In school buildings with an instructional and administrative staff of fewer than 10, school boards shall ensure that (a) at least two employees have current certification or training in emergency first aid, cardiopulmonary resuscitation, and the use of an automated external defibrillator and (b) if one or more students diagnosed as having diabetes attend such school, at least one employee has been trained in the administration of insulin and glucagon. “Employee” includes any person employed by a local health department who is assigned to the public school pursuant to an agreement between the local health department and the school board. When a registered nurse, nurse practitioner, physician, or physician assistant is present, no employee who is not a registered nurse, nurse practitioner, physician, or physician assistant shall assist with the administration of insulin or administer glucagon. Prescriber authorization and parental consent shall be obtained for any employee who is not a registered nurse, nurse practitioner, physician, or physician assistant to assist with the administration of insulin and administer glucagon.”

Recommendations

Local School Health Team. The basic school health team consists of the parents, primary health care provider, school physician or public health medical director, and school nurse. A school nurse practitioner functioning in an expanded role may also be a member of the school health team per school division policy. Ideally, this group will collaborate with administrators, teachers, guidance counselors, occupational therapists, physical therapists, speech-language pathologists, audiologists, social workers, psychologists, educational diagnosticians, food services, dentists, court services, legal services, and child welfare services.

The school health team recognizes that parents or guardians have the basic responsibility for the health of their children. School health services supplement, rather than substitute for,

parental care and concern for the health of the student. Parents are to be advised of health problems, encouraged to secure needed medical or dental care, and made aware of various private and public community resources available to them.

Interdisciplinary Team. The intervention of an interdisciplinary team is the ideal method to be used in solving problems of a student with complex medical, social, and emotional needs. The team works in collaboration to develop a comprehensive plan to meet the needs of each student who has problems. Individual disciplines represented on the team will vary according to the needs of the student.

The appropriate lead member of the interdisciplinary team should be based upon the student's primary need. Interdisciplinary team membership may vary among school divisions; smaller school divisions are more likely to have personnel who are assigned multiple roles. The key to the interdisciplinary approach is not just specific disciplines represented but the coordinated approach to problem solving and to meeting the needs of each student. For example, children with social and emotional problems are the concern of school guidance counselors, social workers, psychologists, mental health workers, and special education teachers, as well as of the school physician and school nurse. Collaboration is necessary to prevent duplication of services and to ensure a coordinated approach in meeting the student's health needs. Coordination of interventions by the interdisciplinary team is the ideal method to be used in solving problems of a student with complex medical/social/emotional needs.

For an interdisciplinary team to function cohesively, each member must understand the role of the other members of the team. The following guidelines contain recommended functions and responsibilities of various school health program personnel. The information contained under staff personnel is an overview, and not intended to be a complete position description.

- [School Nurse: Registered Nurse](#)
- [School Nurse: Licensed Practical Nurse](#)
- [School Nurse Practitioner](#)
- [School Health Supervisor/Coordinator: Registered Nurse](#)
- [Unlicensed Assistive Personnel](#)
- [School Health Volunteer](#)
- [School Health Physician](#)

School Nurse: Registered Nurse

The following are recommendations for school divisions to consider when developing a position description for a school nurse - Registered Nurse (RN).

Scope of Responsibilities

The RN is responsible for developing, implementing, and managing a school health program for a school population as defined by the school division. The school nurse serves in a pivotal role, providing expertise and oversight for the provision of school health services and promotion of health education. Using clinical knowledge and judgment, the school nurse provides health care to students and staff, performs health screenings and coordinates referrals to the medical home or private healthcare provider. In addition, the school nurse serves as a liaison between school personnel, family, community and healthcare providers to advocate for health care and a healthy school environment.²⁵ Responsibilities include program management, nursing services, collaboration, health education, community health planning, professional practice, and a commitment to continuing education.

Supervision Received

The RN reports to the school nursing supervisor (if available) and to the chief administrator of the school building. In some cases, the RN reports to the local health department nursing supervisor. School Physicians, Nurse Practitioners or Medical Health Directors may also be available for consultation.

Supervision Given

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

Required Qualifications

- Must have a valid license to practice as a Registered Nurse in the Commonwealth of Virginia as part of the Nursing Licensure Compact.
- Must complete required continued competency, as outlined by the Virginia Board of Nursing
- Must maintain current certification in cardio-pulmonary resuscitation and first aid from a recognized provider (e.g., American Heart Association).
- Should have a minimum of two years of supervised nursing experience, preferably in community health or child health prior to entry into school nursing practice.

Recommended Qualifications

- Hold a baccalaureate degree in nursing from an accredited college or university program in nursing.
- Work toward attaining certification in school nursing by the National Board for Certification of School Nurses (NBCSN).

It is recommended that the administrator and school nurse review and revise the position description at a minimum of every two years based on changing student health and school population needs.

Responsibilities ^{25, 26}

School nursing is a multi-faceted profession, supporting the physical, mental, emotional, and social health of students; thus, contributing to their health and wellness in the school setting. Outlined below are the general roles and responsibilities of the school nurse that can be adapted to meet the needs of the specific population being served. As such, the school nurse may take on additional roles to meet the needs of the school community.

Program Management. School nurses provide leadership in promoting health and safety, including a healthy environment. Nurses establish and manage a school health program consistent with Virginia guidelines, regulations, and statutes governing nursing and school health, and local school division and health department policies. Specific duties may include:

- Advises the local school health advisory board (SHAB).

- Consults with the school physician, school administrators, and others to establish, review, and revise policies, procedures, and specific programs for school health education and services.
- Works with others to develop a needs assessment and data collection procedures.
- Ensures the orientation, training, supervision, and evaluation of paraprofessionals, as needed, to comply with the nurse practice act and other relevant statutes and regulations.
- Works to provide a safe and healthy school environment including monitoring of immunizations, managing communicable diseases, and spearheading infection control measures.
- Promotes positive safety practices both within and outside of school buildings, collaborates on development of school safety plans and ensures that the school has an emergency plan that is communicated to personnel and students.
- Maintains comprehensive school health records.
- Collaborates with school administrators and personnel in assessing and improving the social and emotional climate of students and faculty and involves them in maintaining a healthful school environment.
- Uses population-based data to plan and evaluate the school health program.
- Prepares regular written reports for school officials and other agencies describing the services provided by the program, numbers of students served, interprets school health service needs and the role of the school nurse to the school and community.
- Carries out communicable disease prevention and infection control based on current guidelines for universal precautions, prevention of bloodborne pathogens exposure and hazardous medical waste disposal.

Nursing Services. School nurses provide quality health care and intervene with actual and potential health problems. Using the nursing process, collaborates with the parent/guardian and student, where appropriate, to develop and implement an individualized health care plan for the student. Key services include:

- Collects information about the health and developmental status of the student and his/her family, and significant others, in a systematic and continuous manner, including health and social histories, screening results, physical assessment, emotional status, performance level and health goals, and makes home visits as needed.
- Develops a nursing diagnosis and health care plan with specific goals and interventions delineating school nursing actions specific to student needs and

coordinated with the efforts of other providers and school personnel; implements plans in a manner aimed at improving health and educational status.

- Provides medically prescribed interventions, medication administration (based on state regulations), health care procedures, and provides care to ill children on a daily basis.
- Organizes and implements state-mandated health screenings (examples, vision, hearing) often based on local and state regulations.
- Responds to frequently encountered health issues, providing counseling and crisis intervention as required by state and local policy (e.g., adolescent pregnancy, substance abuse, death of a family member, suicide, and child neglect or abuse issues).
- Assesses student response to nursing actions in order to revise the database, nursing diagnoses, and nursing care plan and to determine the progress made toward goal achievement; documents pertinent information in student records or confidential nursing notes.
- Provides first aid to injured children and staff, provides everyday care of acutely ill children, and manages children with communicable diseases.

Collaboration. School nurses actively collaborate with other professionals, team members, and community providers to build student and family capacity for adaptation, self-management, self-advocacy and learning. Collaboration aids the nurse in assessing, planning, implementing, and evaluating programs and other school health activities, so as to maximize and coordinate services and prevent duplication.

- Establishes a process to identify students at risk for physical and psychosocial problems. Communicates health needs to other school personnel, as appropriate, and establishes a referral system using both internal and community resources.
- Participates as a team member—with parental consent, when indicated. Shares information with other team members about children with special health care problems that affect learning and growth; acts as an advocate for the student and family when appropriate; attends special education team meetings.
- Includes the student and parent in the team conference whenever possible and appropriate.
- Identifies health-related needs and barriers to overcome when working as a member of the Committee on Special Education, the Individualized Educational Plan (IEP) team and the Section 504 Team.
- Serves as a member of pertinent committees and teams (e.g., crisis intervention team, support groups for grieving students, and so forth).
- Assists families in obtaining health insurance as needed.

- Can represent the school on community coalitions.

Health Education. The school nurse provides health-related education to students and staff in individual and group settings and provides consultation to other school professionals, including food service personnel, physical education teachers, coaches, and counselors.

- Serves as the health care expert in the school to meet student health needs with an understanding of normal growth and development in children and youth as well as students with special needs.
- Identifies need for health education; teaches the basic principles of health promotion and disease prevention to students and staff, using principles of learning and appropriate teaching methods.
- Encourages students to be health educated people and knowledgeable health consumers.
- Assumes responsibilities for in-service programs for school personnel for first aid, emergency care procedures, medication administration training, and current health issues.
- Acts as a resource in health education for school personnel, students, and families.
- Facilitates normal development and positive student response to interventions.

Community Health Planning. Participates with other members of the community to assess, plan, implement, and evaluate school health services and community services that include the broad continuum of primary, secondary, and tertiary prevention.

- Uses population-based data.
- Uses community resources for referral of students with unmet health needs, including the need for a primary care provider.
- Participates in planning and implementing new services.
- Interprets school health service needs and the role of the school nurse to the school and community.
- Works with the media to convey important health information.

Professional Practice. School nurses use clinical judgment in providing case management services. Applies appropriate nursing theory as the basis for decision-making in the school

setting while expanding knowledge and skills in response to the student health needs and participating in research.

- Demonstrates current knowledge in such areas as (1) professional issues in school nursing, (2) school and community health, (3) communicable disease control, (4) growth and development, (5) health assessment, (6) special health conditions—both chronic and acute, (7) injury prevention and emergency care, (8) health counseling, health education and promotion, and (9) current adolescent issues.
- Assumes responsibility for continuing professional development; obtains expert consultation, supervision, and peer review as needed.
- Collaborates with local schools of nursing to provide student nurse practicums in community health, as well as to obtain nursing education resources.
- Makes decisions related to the appropriate delegation of healthcare tasks as directed by state laws and professional practice guidance.

Continuing Education. The school nurse is a registered professional nurse who has a commitment to lifelong learning. School nurses should pursue professional development and continuing nursing education opportunities to maintain best practice standards, and in accordance with the [Virginia Board of Nursing Continued Competency License Renewal Requirements](#).²⁵

Note: The administrator and school nurse should periodically review the job description to accurately reflect the specific job expectations and employee qualifications.²⁷

Resources

- Virginia Department of Education's [Online Orientation for School Nurses](#)

A series of video clips provided by School Health Consultants. Offers nurses the information necessary for the successful transition of nurses into the specialty of school nursing. Information is provided to enhance and/or supplement the formal orientation process at the local level.

School Nurse: Licensed Practical Nurse

The following are recommendations for school divisions to consider when developing a position description for a school nurse - Licensed Practical Nurse.

Scope of Responsibilities

The Licensed Practical Nurse (LPN) is responsible for implementing a school health program for a school population as defined by the school division under the direction of a licensed health professional. Responsibilities include selected nursing acts and collaboration with licensed health professional to implement school health services.

Supervision Received

The LPN reports to the school nursing supervisor (if available) and to the chief administration of the school building. The LPN receives direction or supervision from a licensed medical practitioner, a registered nurse, or other licensed health professional authorized by regulations of the Virginia Board of Nursing.

Required Qualifications

- Must have a valid license to practice as a Licensed Practical Nurse as part of the Nursing Licensure Compact.
- Should have a minimum of two years of supervised nursing experience, preferably in community health or child health prior to entry into school nursing practice.
- Must maintain current certification in cardio-pulmonary resuscitation and first aid from a recognized provider (e.g., American Heart Association).
- Must complete required continued competency, as outlined by the Virginia Board of Nursing.

Note: The administrator and school nurse should periodically review the job description to accurately reflect the specific job expectations and employee qualifications. ²⁷

Responsibilities ²⁸

Nursing Services. Collaborates with a supervising licensed health professional, where appropriate, to develop and implement an individualized health care plan for the student with the assistance of the parent/guardian and students.

- Collects information about the health and developmental status of the student and student's family and significant others, in a systematic and continuous manner, including health and social histories, screening results, physical assessment, emotional status, performance level and health goals; makes home visits as needed.
- Provides medically prescribed selected nursing²⁹ interventions, including medication administration (based on state regulations), and provides care to ill children on a daily basis.
- Initially responds to frequently encountered health issues and to child neglect or abuse issues (as required by state and local policy), and reports to appropriately trained and licensed health professional so that counseling and crisis intervention can be provided when required (e.g., adolescent pregnancy, substance abuse, death of a family member, suicide).
- Assesses student response to nursing actions in order to work with supervising licensed health professional to revise the database and individualized care plan and to determine the progress made toward goal achievement; documents pertinent information in student records or confidential nursing notes.
- Provides first aid to injured children and staff; provides everyday care of acutely ill children and manages children with communicable disease.

Health Education. Assists students, families, and groups to achieve optimal levels of wellness through health education and promotion.

- Encourages students to be health educated people and knowledgeable health consumers.
- Acts as a resource in health education to school personnel, students, and families.

School Nurse Practitioner

Overview

The following are recommendations for school divisions to consider when developing a position for a school nurse practitioner - Licensed Nurse Practitioner (LNP).

Scope of Responsibilities

The Licensed Nurse Practitioner's responsibilities vary according to the specific school division. In some school divisions, the LNP is the primary care provider for students who are registered in the school-based health center. In other divisions where there is no school-based health center, the LNP practices in an expanded role for the general student population.

Supervision Received

The Licensed Nurse Practitioner receives clinical consultation from a designated physician. When functioning as part of the school health service team, the LNP receives administrative supervision from the school nurse manager as defined in the specific position description.

Supervision Given

The Licensed Nurse Practitioner functioning as the primary care provider within a school-based health center (SBHC) provides supervision to those licensed and unlicensed persons functioning within the SBHC and as defined by the LNP's position description. If the LNP functions within the general school health program, the LNP likewise is responsible for those licensed and unlicensed personnel as defined by the position description. Refer to the [Virginia Nurse Practice Act](#) for a description of this expanded role.

Required Qualifications

- Must have a valid license to practice as a Registered Nurse in the expanded role in Virginia.

- Must possess a minimum of a baccalaureate in nursing from an accredited nursing program; possess/maintain certification as a School/Pediatric or Family Nurse Practitioner.
- Have an identified physician who provides consultation and collaboration with a written practice agreement in place, per the Virginia Board of Nursing, [Nurse Practitioner Laws and Regulations](#).

Recommended Qualifications

- Master's degree in primary health care nurse specialist practitioner with emphasis in pediatric, family, or school health. Under the recommendations from the [American Association of Colleges of Nursing](#), a Doctor of Nursing Practice (DNP) is encouraged.
- Have a minimum of three years experience in school nursing or a related field.
- Maintain certification in cardio-pulmonary resuscitation and first aid.
- Assume responsibility for updating knowledge and skill in community health, management, and related fields as new information emerges.
- Experience and/or education in the areas of school law and school health.
- Complete ongoing continuing education programs pertinent to the evolving specialty area of school health and school nursing practice, as well as meet the continuing education requirements for licensure in the expanded role in Virginia.

Responsibilities ³⁰

The Licensed Nurse Practitioner practicing within the school setting is responsible for many of those areas listed in the position description for the school nurse. In addition, the LNP role may include the following responsibilities:

- Consultation and collaboration with a pediatrician and medical specialist in adolescent medicine or other related field in addressing medical issues presented by the students and in developing practice guidelines.
- Provision of primary care to students.
- Management of the health care of students with chronic and acute conditions while providing intervention and/or referral as necessary.
- Provision of physical examinations to identified students at appropriate intervals, including prior to participation in sports, prior to obtaining work permits, and so forth.

- Provision of physical examinations to identified school staff according to school board requirements (e.g., school bus driver annual physical exam).
- Consultation with teachers on health issues and provision of clinical in-service education as needed.

Registered Nurse School Health Supervisor/Coordinator

Overview

The following are recommendations for school divisions to consider when developing a position description for a registered nurse school health supervisor/coordinator.

Scope of Responsibilities

The Registered Nurse School Health Supervisor/Coordinator manages the entire school nursing/school health program, providing nursing leadership within the school system. The supervisor coordinates the clinical aspects of the school health program, collaborating with other members of the health services and health education team.

Supervision Received

The Registered Nurse School Health Supervisor/Coordinator reports to the school administrator as defined in her/his position description and collaborates with the designated school physician in developing and implementing the school health service program.

Supervision Given

The Registered Nurse School Health Supervisor/Coordinator supervises all clinical nursing staff providing services in the school health program, as well as those unlicensed personnel (e.g., health aides as designated in the organizational chart).

Recommended Qualifications

- Must have a valid license to practice as a Registered Nurse in Virginia as part of the Nursing Licensure Compact.
- Possess a minimum of a baccalaureate in nursing from an accredited nursing program. A master's degree in nursing or related field is preferred with an emphasis on nursing, education, or public health.
- Have a minimum of three years' experience in school nursing or a related field.

- Experience in personnel management.
- Experience in program administration.
- Certification by a national organization of school nurses.
- Maintain certification in cardio-pulmonary resuscitation; CPR-instructor certification for the supervisor or the supervisor's delegate is recommended.
- Assume responsibility for updating knowledge and skill in community health, management, and related fields as new information emerges.
- Complete ongoing continuing education programs pertinent to the evolving specialty area of school health and school nursing practice.

Responsibilities³⁰

Needs Assessment

- Using available demographic, health, and school system data, identifies health needs of the student population.
- Selects or develops surveys, questionnaires, and other tools for obtaining information.

Planning

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

Implementation

- Employs, orients, and assigns qualified personnel to implement the school health program.
- Implements communication systems that promote participatory management.
- Participates in the development of an interdisciplinary plan for each building to ensure that students in need of services are identified in a timely manner and appropriate intervention is initiated.
- Develops and implements written policies and procedures for the clinical services and programs addressing health issues (e.g., immunizations, medication administration, services for children with special health care needs, school-wide

injury prevention programs, and such special programs as groups addressing eating disorders, smoking cessation, and violence prevention).

- Develops and implements documentation systems at both the individual student level and the programmatic level.
- Provides clinical consultation to the health education staff, physical educators, and other administrative and teaching staff.
- Participates in interdisciplinary teams (e.g., crisis team, child abuse team) to ensure that integrated systems are in place that address the comprehensive health needs of the student population.
- Carries out communicable disease prevention and infection control measures based on current guidelines for universal precautions, prevention of bloodborne pathogens exposure, and hazardous medical waste disposal.
- Ensures that there is an emergency care plan in place that is communicated to all staff and is closely coordinated with community emergency care procedures.
- Collaborates with other school administrators and teachers and promotes a physically and psychologically healthy school environment.
- Promotes positive linkages and referral mechanisms to community providers for a range of services addressing child and adolescent health.
- Seeks opportunities to interpret the health needs of school-age children and adolescents, the goals of the health service program, and the importance of health education to administrators, school committee members, faculty, families and the general community, through special reports, the media, health fairs, and other special events.
- Prepares and administers the health services budget; seeks opportunities to apply for outside sources of funding for the school health services program.

Evaluation

- Compiles statistical reports as required by the school system and state agencies.
- Evaluates nursing and other health service staff.
- Reviews changing trends in health needs and the outcomes of programs to determine need for revision of goals and objectives.

Staff Development

- Implements an ongoing continuing education program for staff.

- Encourages health services staff to participate in pertinent conferences and workshops addressing a range of school health issues.
- Provides ongoing formal and informal feedback to staff about their progress in achieving the goals of the program, encouraging their continued educational and professional development.

Other

- Collaborates with local nursing education institutions (e.g., provides student practice in the school health programs, guest lectures, participates in nursing research), seeks opportunities to give consultation on the specific issues of school-age children and adolescents, and publishes when possible.

Unlicensed Assistive Personnel

Overview

The following are recommendations for school divisions to consider when developing a position description for unlicensed assistive personnel.

Scope of Responsibilities

The Unlicensed Assistive Personnel (UAP) is a paraprofessional trained to provide care to individuals under the supervision of a registered nurse (RN).²⁷ The term UAP includes, but is not limited to, patient care technicians, nursing assistants, clinic aides, and health aides. The UAP assists in the school health program as determined by the school nurse (RN). Therefore, the scope of responsibilities will vary according to school health program needs, the capabilities of the UAP, and the availability of the school nurse to provide supervision. The UAP job description should include who supervises the UAP and who completes the UAP performance evaluation. When the RN determines that certain tasks may be delegated to the UAP, such delegation shall be under the supervision of the RN and consistent with the Virginia Board of Nursing regulations.

Minimum Qualifications

- Possess a high school diploma or its equivalent.
- Demonstrate sound judgment.
- Ability to communicate with verbal and written language.
- Be able to read and write English.
- Respect and protect the confidentiality of students, staff, and families.
- Be willing to accept nursing supervision.
- Complete training in both cardio-pulmonary resuscitation and a basic first aid program and maintain the necessary certifications.
- Demonstrate clerical proficiency.

Recommended Qualifications

- Post high school education.
- Office management skills, such as typing, computer literacy, and filing.
- Experience in the care of the school-age child.

Supervision Received

The UAP receives supervision from the registered nurse appointed under the provisions of Virginia Nurse Practice Act.

Responsibilities

A Registered Nurse assigns responsibilities to the UAP. These responsibilities may include but are not limited to the following activities:

Assisting in health care activities

- Assists with vision and hearing screenings and related tasks, such as recording results, sending letters to parents/guardians.
- Weighs and measures students; completes graphs of heights and weights.
- Assists with preparation for health activities, such as physical examination of students, immunizations, and Mantoux testing.
- Administers medications as designated by the building administrator, and administers treatments as delegated by the school nurse (RN), after having received the required training (if provided for in the policy of the local school division or local health department).
- Reports major health concerns to the supervising school nurse and/or school administrator within appropriate time limits.
- Provides first aid care to students with minor injuries.
- Follows guidelines contained in the VDH *First Aid Guide for Child Care and School Emergencies* (2015 revision) flipchart.
- Reports all illnesses and injuries to the school nurse for professional review, care, and/or follow-up.
- Contacts parents of ill or injured students.

Maintains confidentiality on student information

- Maintains a clean and orderly health office/clinic.
- Attends ongoing in-service education programs.

Performing clerical functions

- Records health information (e.g., results of various screening tests, immunization information).
- Maintains an up-to-date master file of student health emergency information.
- Sends notices to parents, tabulates returns, and follows up on non-respondents.
- Provides ongoing communication to the school nurse regarding the status of health notices.
- Distributes information/forms to teachers and administrative staff.
- Develops computer skills as needed.
- Initiates and distributes incident and accident reports according to school division policy.

School Health Volunteer

The health, safety, and welfare of students are of primary concern when deciding to use volunteers in the school health setting.³⁰ Volunteers should be selected and function according to local school division policy and should be used in accordance with Virginia Nurse Practice Acts. School nurses are responsible for provision of assignments, training, and supervision. Whether licensed or unlicensed, volunteers should not be used in place of the school nurse. Volunteers should not administer medications or perform treatments unless specifically covered by local school board policy. In addition, they should not have access to confidential student records.

School Health Physician

Overview

In elementary, middle, and high schools in Virginia, the physician might have the following roles in the school health program.

Primary Care Provider. According to the American Academy of Pediatrics, the most valuable role of the physician as primary care provider in a school program is that of general resource and liaison between the child, the family, and school personnel.³¹ By interpreting the health problems of a student for school personnel, the physician helps the staff to modify the student's program as needed. Conversely, the school helps the primary care provider by providing pertinent information, and by reporting observations about the student's physical and emotional behavior. In certain circumstances, the school can help the physician manage some aspects of health problems, such as psychosocial disorders, chronic disease, and physical disabilities.

School Health Physician. The role of the school physician is to serve in the capacity of consulting medical director to provide medical evaluations, consultation, and support to nursing personnel. The duties of the school physician are to provide consultation to the school health program, provide medical evaluations where appropriate, and maintain two-way communication between the school and the student's primary care physician. The school health physician usually serves as advisor for medical concerns related to medically fragile/unstable students, special education placement, and issues related to Section 504 of the Rehabilitation Act.

The school physician may be employed by a single school division or by a group of school divisions.

Medical Director of the Local Health Department. The role of the medical director of the local health department (Health District Director) is to serve as a consultant and/or advisor to the local school division regarding school health laws, immunization regulations, control of communicable diseases, and enforcement of environmental laws and regulations.

Recommendations

The following are recommendations for school divisions to consider when developing a contract for a school health physician.

Scope of Responsibilities³²

The school physician/physician consultant contracts with the local school division to provide medical expertise and consultation in the development and implementation of the school health program. The school nurse may request consultation on individual students or groups of students with specific health issues at any time. The school physician acts as a resource.

Qualifications

- Must have a valid license to practice medicine in the Commonwealth of Virginia.
- Knowledgeable about the health needs of children and adolescents.
- Additional Suggested Qualifications: The school physician/physician consultant should, in addition, be board certified or board eligible in pediatrics or family practice. When the primary student population includes adolescents, the medical consultant or school physician should have education and experience in adolescent medicine.

Responsibilities

The school physician/physician consultant may include the following responsibilities.

Consultation to the school health program

- Provides general consultation to school nurse and to the school division on matters relating to the health of the school population.
- Collaborates with the school nurse in identifying the need for and developing policies and procedures governing school health services for individuals or groups of students, which are then shared with the school health advisory board for adoption.
- Participates as a member of the school health advisory board.
- Provides consultation on the development of policies pertinent to the health and safety of the school (e.g., emergency care plan, first aid program, bee sting protocol, HIV/AIDS, environmental safety, athletic safety).
- Collaborates with the school nurse, school administrators, and other pertinent school personnel, as well as the local health department, to develop and implement a program for immunization against communicable diseases and

control of infectious illnesses (e.g., bloodborne illnesses, parasitic diseases, and tuberculosis) and assists in developing policies on exclusion and readmission of students based on the aforementioned conditions.

- Collaborates with the interdisciplinary comprehensive school health education staff to develop educational programs specific to the current needs of student, faculty, and parent groups on such topics as nutrition, child development, family life, and HIV/AIDS prevention.
- Collaborates with the school nurse, teachers, support staff, and parents on specific health issues of individual students as they relate to the school setting, including classroom management of the student with physical or emotional problems.
- When indicated or requested by the school nurse, communicates with the student's primary physician on medical issues pertinent to the school setting.
- When indicated or requested by the school nurse, reviews the reports of physical examinations performed by the student's primary care provider.

Physical assessment

- Completes the health assessments on such students who do not have this service performed by a primary care provider.
- Provides the physical examination of students participating in competitive or contact sports, prior to that participation (for students who do not have this service performed by a primary care provider).
- Examines students referred by the school nurse or other personnel because of health issues identified during screening and/or frequent school absences (if this service is not provided by a primary care provider).
- Conducts physical examinations on students as needed for special education assessment.

Health education

- In collaboration with the comprehensive health education staff, assists in presenting educational programs as needed by faculty, parents, and students.

Coordination with community providers

- In collaboration with the school nurse, interprets the needs and responsibilities of the school health program to the school committee, the community, and other health care providers within the community.
- Collaborates with other medical and public health professionals in prevention programs designed to enhance the health of children and adolescents

Chapter 5: Delineating Roles and Responsibilities for the Safe Delivery of Specialized Health Care

Authorization

Code of Virginia, Sections 22.1-274, School Health Services. The *Code of Virginia* states that each school board may strive to employ, or contract with local health departments for, nursing services consistent with a ratio of at least one nurse (i) per 2,500 students by July 1, 1996; (ii) per 2,000 students by July 1, 1997; (iii) per 1,500 students by July 1, 1998; and (iv) per 1,000 students by July 1, 1999. In those school divisions in which there are more than 1,000 students in average daily membership in school buildings, this section shall not be construed to encourage the employment of more than one nurse per school building. Further, this section shall not be construed to mandate the aspired-to ratios.

Code of Virginia, Section 54.1-3000, Definitions. The *Code of Virginia* defines “professional nurse,” “professional nursing,” “practical nurse,” and “practical nursing.”

Excerpt:

Registered Nurse

"Professional nurse," "registered nurse" or "registered professional nurse" means a person who is licensed or holds a multistate licensure privilege under the provisions of this chapter to practice professional nursing as defined in this section. Such a licensee shall be empowered to provide professional services without compensation, to promote health and to teach health to individuals and groups. The abbreviation "R.N." shall stand for such terms.

"Professional nursing," "registered nursing" or "registered professional nursing" means the performance for compensation of any nursing acts in the observation, care and counsel of individuals or groups who are ill, injured or experiencing changes in normal health processes or the maintenance of health; in the prevention of illness or disease; in the supervision and teaching of those who are or will be involved in nursing care; in the delegation of selected nursing tasks and procedures to appropriately trained unlicensed persons as determined by the Board; or in the administration of medications and treatments as prescribed by any person authorized by law to prescribe such medications and treatment. Professional nursing, registered nursing and registered professional nursing require specialized education, judgment, and skill based upon knowledge and application of principles from the biological, physical, social, behavioral and nursing sciences.

Licensed Practical Nurse

"Practical nurse" or "licensed practical nurse" means a person who is licensed or holds a multistate licensure privilege under the provisions of this chapter to practice practical nursing as defined in this

section. Such a licensee shall be empowered to provide nursing services without compensation. The abbreviation "L.P.N." shall stand for such terms.

"Practical nursing" or "licensed practical nursing" means the performance for compensation of selected nursing acts in the care of individuals or groups who are ill, injured, or experiencing changes in normal health processes; in the maintenance of health; in the prevention of illness or disease; or, subject to such regulations as the Board may promulgate, in the teaching of those who are or will be nurse aides. Practical nursing or licensed practical nursing requires knowledge, judgment and skill in nursing procedures gained through prescribed education. Practical nursing or licensed practical nursing is performed under the direction or supervision of a licensed medical practitioner, a professional nurse, registered nurse or registered professional nurse or other licensed health professional authorized by regulations of the Board.

Code of Virginia, Section 54.1-3005, Specific powers and duties of the Board. The Code of Virginia confers specific powers and duties to the Board (of Nursing). One specific power/duty involves delegation:

Excerpt:

To promulgate regulations for the delegation of certain nursing tasks and procedures not involving assessment, evaluation or nursing judgment to an appropriately trained unlicensed person by and under the supervision of a registered nurse, who retains responsibility and accountability for such delegation.

Overview

Role Delineation. Advances in health care technology and procedures have resulted in increased numbers of children with special health care needs in the school setting. The trends toward out-patient and home-based treatments, federal mandates for educating special education students in the regular classroom, and parental expectations have all reinforced the need for school divisions to clearly define roles and responsibilities in addressing the specialized health care needs of these children.

Delegation. The issue of delegation involves the responsibilities of Registered Nurses (RNs) in delegating patient or client care activities to unlicensed persons.³³ The American Nurses Association (ANA) and National Council for State Boards of Nursing (NCSBN) both defined delegation as “the process for a nurse to direct another person to perform nursing tasks and activities”. NCSBN describes this as the nurse “transferring authority” while ANA calls this “a transfer of responsibility”. Both define delegation as a registered nurse directing another individual to do something outside their normal roles and responsibilities and both stress that the nurse retains accountability for the delegation.

Recommendations

Role Delineation. Specialized health care procedures should be performed by qualified personnel who have received child-specific training as defined by the student’s primary health care provider(s) and the student’s family. Every student who has a special health care need requiring nursing care, intervention, and/or supervision should have a nursing care plan written by a registered nurse.

The National Joint Task Force for the Management of Children with Special Health Needs with membership from the American Federation of Teachers, the Council for Exceptional Children, the National Association of School Nurses, and the National Education Association developed the matrix, *Guidelines for the Delineation of Roles and Responsibilities for the Safe Delivery of Specialized Health Care in the Educational Setting*, <https://files.eric.ed.gov/fulltext/ED322705.pdf>, (attached at the end of this section).³⁴ Many of the special health care procedures that some children may need in the educational setting are regulated by professional standards of practice. The matrix delineates the persons qualified to perform specific procedures, who should perform them, and the circumstances under which these persons would be deemed qualified. The term “qualified” assumes that the individual has received appropriate training and has been certified as competent to perform the procedure by a registered nurse or physician. The matrix may be useful to administrators, health care providers, and educators in planning educational programs for staff who provide care for children with special health care needs. It must be emphasized that this matrix is a guide and state law (Nurse Practice Act) supersedes the information provided.

Delegation. In the Commonwealth of Virginia, a registered nurse can delegate certain nursing tasks to an appropriately trained unlicensed person who is under the RN’s supervision. When delegating, the RN retains responsibility and accountability for such delegation. As defined in the *Code of Virginia*, RNs cannot delegate nursing tasks and procedures that involve assessment, evaluation, or nursing judgment. RNs cannot delegate medication administration in Virginia. The building administrator can designate the person(s) who will administer medication and the RN can train and supervise the individual. For further information on medication administration, refer to the Virginia Department of Education’s [Manual for the Training of Public School Employees in the Administration of Medication.](#)

**GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES
FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING ***

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL	PARA PROFESS SIONALS	OTHERS ¹
1.0 ACTIVITIES OF DAILY LIVING							
1.1 Toileting/Diapering		A	A	A	A	(A)	A
1.2 Bowel/Bladder Training (Toilet Training)		A	A	(A)	A	S	S
1.3 Dental Hygiene		A	A	A	A	S	S
1.4 Oral Hygiene		A	A	(A)	A	S	S
1.5 Lifting/Positioning		A	A	(A)	A	S	S
1.6 Feeding							
1.6.1 Nutrition Assessment		A	X	X	N	X	X
1.6.2 Oral-Motor Assessment		X	X	X	(SP/TH)	X	X
1.6.3 Oral Feeding		A	A	A	A	(S)	S
1.6.4 Naso-Gastric Feeding	*	(A)	(S)	X	X	(S/HA)	X
1.6.5 Monitoring of Naso-Gastric Feeding		A	S	S	S	S	X
1.6.6 Gastrostomy Feeding	*	(A)	(S)	X	X	(S/HA)	X
1.6.7 Monitoring of Gastrostomy Feeding		A	S	S	S	S	X
1.6.8 Jejunostomy Tube Feeding	*	(A)	(S)	X	X	X	X
1.6.9 Total Parenteral Feeding (Intravenous)	*	(A)	(S)	X	X	X	X
1.6.10 Monitoring of Parenteral Feeding		A	S	S	S	S	X

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- TH Occupational or physical therapist only
- SP Speech/language Pathologist only
- Person who should be designated to perform task
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*** DELINEATION OF RESPONSIBILITIES MUST ADHERE TO EACH STATE NURSE PRACTICE ACT.**

**GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES
FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING ***

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL	PARA PROFESSIONALS ¹	OTHERS ²
1.6.11 Naso-Gastric Tube Insertion	*	(A)	(S)	X	X	X	X
1.6.12 Naso-Gastric Tube Removal	*	(A)	(S)	EM	EM	EM/HA	X
1.6.13 Gastrostomy Tube Reinsertion	*	(A)	(S)	X	X	X	X
2.0 CATHETERIZATION							
2.1 Clean Intermittent Catheterization	*	(A)	(S)	X	X	S/HA	X
2.2 Sterile Catheterization	*	(A)	(S)	X	X	X	X
2.3 Crede	*	A	S	S	S	(S/HA)	S
2.4 External Catheter	*	(A)	(A)	S	S	(S/HA)	X
2.5 Care of Indwelling Catheter (Not Irrigation)	*	(A)	(S)	S	S	(S/HA)	X
3.0 MEDICAL SUPPORT SYSTEMS							
3.1 Ventricular Peritoneal Shunt							
3.1.1 Pumping	*	(EM)	(EM)	X	X	X	X
3.1.2 Monitoring	*	(A)	S	S	S	S	X
3.2 Mechanical Ventilator							
3.2.1 Monitoring	*	(A)	(S)	EM	EM	S/HA	X
3.2.2 Adjustment of Ventilator	*	X	X	X	X	X	X
3.2.3 Equipment Failure	*	(A)	(S)	EM	EM	EM	EM

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DELINEATION OF RESPONSIBILITIES MUST ADHERE TO EACH STATE NURSE PRACTICE ACT.

**GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES
FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING ***

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3.3 Oxygen	*	(A)	(S)	EM	EM	EM	X
3.3.1 Intermittent	*	(A)	(S)	EM	EM	EM	X
3.3.2 Continuous (Monitoring)	*	A	S	S	S	S	S
3.4 Hickman/Broviac/VAC/MED	*	(A)	(S)	X	X	X	X
3.5 Peritoneal Dialysis	*	(A)	(S)	X	X	X	X
3.6 Apnea Monitor	*	A	S	S	S	S/HA	X

4.0 MEDICATIONS

Medications may be given by LPN's and Health Aides only where the Nurse Practice Act of the individual state allows such practice, and under the specific guidelines of that nurse practice act.

4.1 Oral	*	(A)	(S)	X	X	S/HA	X
4.2 Injection	*	(A)	(S)	X	X	X	X
4.3 Epi-Pen Allergy Kit	*	(A)	(S)	EM	EM	EM	EM
4.4 Inhalation	*	(A)	(S)	EM	EM	EM/HA	EM
4.5 Rectal	*	(A)	(S)	X	X	EM/HA	X
4.6 Bladder Instillation	*	(A)	(S)	X	X	X	X
4.7 Eye/Ear Drops	*	(A)	(S)	X	X	S/HA	X

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4.8 Topical	*	(A)	(S)	X	X	S/HA	X
4.9 Per Nasogastric Tube	*	(A)	(S)	X	X	S/HA	X
4.10 Per Gastrostomy Tube	*	(A)	(S)	X	X	S/HA	X
4.11 Intravenous	*	(A)	(S)	X	X	X	X
4.12 Sphygmometer	*	(A)	(S)	X	X	S/HA	X
5.0 OSTOMIES							
5.1 Ostomy Care	*	(A)	(S)	EM	EM	EM	X
5.2 Ostomy Irrigation	*	(A)	(S)	X	X	X	X
6.0 RESPIRATORY ASSISTANCE							
6.1 Postural Drainage	*	(A)	(S)	S	S	S/HA	S
6.2 Percussion	*	(A)	(S)	S	TH	S/HA	S
6.3 Suctioning	*	(A)	(S)	S	S	S/HA	X
6.3.1 Pharyngeal	*	(A)	(S)	S	S	S/HA	X
6.3.2 Tracheostomy	*	(A)	(S)	S	S	S/HA	X
6.4 Tracheostomy Tube Replacement	*	(EM)	(EM)	EM	EM	EM	EM
6.5 Tracheostomy Care (Cleaning)	*	(A)	(S)	X	X	X	X

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***LINEATION OF RESPONSIBILITIES MUST ADHERE TO EACH STATE NURSE PRACTICE ACT.**

GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING *

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL ¹	PARA PROFESSIONALS ²	OTHERS ³
7.0 SCREENINGS							
7.1 Growth		(A)	(S)	S	S	S	X
7.2 Vital Signs		(A)	(S)	X	X	SHA	X
7.3 Hearing		(A)	(S)	X	(SP)	SHA	X
7.4 Vision		(A)	(S)	X	X	SHA	X
7.5 Scoliosis		(A)	(S)	S	TH	SHA	X
8.0 SPECIMEN COLLECTING/TESTING							
8.1 Blood Glucose	*	(A)	(S)	X	X	SHA	X
8.2 Urine Glucose	*	(A)	(S)	X	X	SHA	X
9.0 OTHER HEALTH CARE PROCEDURES							
9.1 Suture Procedures	*	(A)	(S)	X	TH	SHA	X
9.2 Soaks	*	(A)	(S)	X	X	X	X
9.3 Dressings, Sterile	*	(A)	(S)	X	X	X	X

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**GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES
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PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL	PARA PROFESS- IONAL ³	OTHER ³
10.0 DEVELOPMENT OF PROTOCOLS							
10.1 Health Care Procedures		A	X	X	X	X	X
10.2 Emergency Protocols	*	A	X	X	X	X	X
10.3 Individual Education Plan Health Objectives		A	X	X	X	X	X
10.4 Nursing Care Plan		A	X	X	X	X	X

(WITH PHYSICIAN CONSULTATION)

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TH Occupational or physical therapist only

SP Speech/language Pathologist only

Person who should be designated to perform task

2 Paraprofessionals include teacher aides, health aides, uncertified teaching personnel.

3 Others include secretaries, bus drivers, cafeteria workers, custodians.

HA Health Aide only

End Notes

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²¹ Adapted from Allensworth, D., Symons, C., and Olds, R. (1994). *Healthy students 2000: An agenda for continuous improvement in schools*. (p. 20). Kent: American School Health Association.

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PART II: FAMILY AND COMMUNITY INVOLVEMENT

This section presents guidelines for increasing family and community involvement in schools, an essential component of a school health program. Included is information about related codes, policies, and recommendations for engagement, and a wide range of resources and support to enhance the health and well-being of students.

Chapter 6: [Involving Families and Community](#)

Chapter 7: [Establishing and Enhancing School Health Advisory Boards](#)

Chapter 8: [Involving Parent and Teacher Groups](#)

Chapter 9: [Developing Partnerships](#)

Chapter 10: [Building Support for School Health Programs](#)

Chapter 6: Involving Families and Community

Family and community involvement is essential to a successful school health program. According to the CDC, an integrated school, family, and community approach can enhance the health and well-being of students.³⁵ Research shows that parent engagement in schools is closely linked to better student behavior, higher academic achievement, and enhanced social skills.³⁶ Parent engagement in schools can promote positive health behaviors among children and adolescents. Students who feel supported by their parents are less likely to experience emotional distress, practice unhealthy eating behaviors, consider or attempt suicide, or disengage from school and learning. Parent engagement also makes it more likely that children and adolescents will avoid unhealthy behaviors, such as tobacco, alcohol, and other drug use. Additionally, children with involved parents are more likely to adhere to the guidelines for physical activity.

School health advisory councils, coalitions, and broadly-based constituencies for school health can build support for school health program efforts. Schools actively solicit parent involvement and engage community resources and services to respond more effectively to the health-related needs of students. Examples of family and community involvement in school health include school health advisory boards (SHABs), parent teacher organizations such as the PTA, and partnerships with organizations within the community.

Definitions. Although a universally accepted definition of the term “Parent and Community Involvement” has not been adopted, *Health Is Academic: A Guide to Coordinated School Health Programs* presents describes family and community involvement in schools³⁷:

*Partnerships among schools, families, community groups, and individuals.
Designed to share and maximize resource and expertise in addressing the
healthy development of children, youth, and their families.*

Additionally, the CDC defines parent engagement in schools as³⁸:

Parents and school staff working together to support and improve the learning, development, and health of children and adolescents. Parent engagement in schools can promote positive health and academic behaviors among children and adolescents.

Recommendations

School efforts to promote parent engagement can be part of a Coordinated School Health (CSH) or Whole School, Whole Community, Whole Child (WSCC) framework, one that engages families and is based on community needs, resources, and standards. Both frameworks recognize the importance of modeling healthy behaviors through staff health promotion and

considering parent engagement to be an integral part of child and adolescent health promotion at school.

Parent engagement in their children's school activities contributes to their children getting better grades, choosing healthier behaviors, and having better social skills.³⁶ Additionally, parents tend to be more involved if they perceive that school staff and students both want and expect their involvement. It is important that school staff demonstrate to parents how their children's health and education can be enhanced by their engagement in school health activities.

To increase parent engagement in school health, schools must make a positive connection with parents and should provide a variety of activities and opportunities to fully engage parents. Schools can sustain parent engagement by addressing the common challenges and developing creative solutions.³⁶ The school nurse can serve to identify individuals who can provide support and guidance for parents and provide them evidence-based information, as well as help maintain open lines of communication between parents and community partners.

Each school is unique, and it is not possible to develop one prescribed plan for parent engagement that is appropriate for all schools. Some of the actions are small changes in school processes that can be done in the short term with relative ease, whereas others might be much broader, longer-term goals that require administrative or budgetary changes. Individual schools and school districts should determine which actions are most feasible and appropriate, based on the needs of the school and parents, school level (elementary, middle, or high school), and available resources. Schools should also evaluate their efforts to increase parent engagement in school health to learn which actions have the greatest impact.³⁸ The form and structure of a school health program should be determined through a deliberate planning process by a broad range of stakeholders—those who will be involved in and affected by the program.³⁹

Refer to Part I, Chapter 3, *Developing a Program: Planning Process Steps*, for information on how to develop a program.

Chapter 7: Establishing and Enhancing School Health Advisory Boards

Authorization

[Code of Virginia, Section 22.1-275.1, School Health Advisory Board](#). The *Code of Virginia* states that each school board may establish a school health advisory board of no more than 20 members which shall consist of broad-based community representation including, but not limited to, parents, students, health professionals, educators, and others. If established, the school health advisory board shall assist with the development of health policy in the school division and the evaluation of the status of school health, health education, the school environment, and health services.

Overview

Research demonstrates a direct link between the health of young people and school success. There are also links between the implementation of coordinated school health program or Whole School, Whole Community, Whole Child (WSCC) model components and student success in schools. Cooperative partnerships among schools, parents, and community groups can enhance a student's ability to lead a healthy and productive life. Each of these partners has a critical role to play and they contribute unique strategies and resources that promote a positive impact on the behaviors of children and youth. However, the coordination of these efforts requires interacting and planning toward common goals. School health advisory boards (SHAB) serve as the catalyst for systemic changes in school divisions for promoting student health, which directly impacts educational outcomes.

The promotion and protection of the health of students and the well-being of staff members has been a historic and ongoing task of schools across the nation and in Virginia. In the early 1990s, a Governor's Task Force on Child Health was formed. The Task Force recommended that the secretaries of education and health and human resources work together to encourage school divisions to increase the school's role in improving the health of children in the Commonwealth. The 1992 General Assembly amended and re-enacted §22.1-275.1 of the *Code of Virginia* to require each school division to have a school health advisory board in place by December 1992. In 1999, the *Code of Virginia* was further amended to suggest that local school boards request from the local school health advisory board recommendations on procedures related to children with acute or chronic illnesses or conditions, and designation of school personnel to implement the appropriate emergency procedures. The 2012 General Assembly amended §22.1-275.1 of the *Code of Virginia* to replace "shall" with "may", stating each school board may establish a school health advisory board.

For more than two decades school divisions have utilized school health advisory boards to help foster family and community support in developing and implementing coordinated school health programs. These programs include health instruction; healthy school environment; school health services; school counseling, psychological and social services; prevention services; physical education; school nutrition services; and health promotion for staff members.⁴⁰

Recommendations

Membership. As described in [Promoting Healthy Students: A Guide to Establishing and Maintaining School Health Advisory Boards](#)⁴⁰ local school health advisory boards (SHABs) are organized to include no more than 20 members, with a broad base of representation including parents, students, health professionals, and educators. Many boards have included representatives from community agencies, the local school board, business and industry, child advocacy groups, volunteer health agencies, the school division staff, and institutions of higher education. Each board is to meet at least semiannually and to report annually on the status and needs of student health in the school division, to any interested school, the local school board, the Virginia Department of Education, and the Virginia Department of Health. SHABs should use a variety of local data from parents, students, and community agencies to set priorities and program objectives. Each board may have up to 20 members. Each member should:

- Be interested and involved in youth-related activities.
- Have a general understanding or awareness of the community.
- Have professional abilities to contribute to the SHAB.
- Be willing to devote time to the SHAB.
- Be representative of the community's population.
- Be respected by the community.

Potential SHAB members should include members from some of the following categories:

- Parents or parent groups, such as parent of a school-aged child, PTA representative, resource center representative, and parents of a medically fragile student.
- Health professionals, such as medical, dental, mental health, public health, prevention specialist, and substance abuse specialist.
- Business/industry.
- Volunteer health agencies.
- Churches/synagogues.
- Hospitals/clinics.
- Public health agencies.
- Civic and service organizations.

- Community service boards.
- Colleges/universities.
- Public media.
- Attorneys and law enforcement officials.
- School personnel, such as students, school health director/coordinator, supervisor, school nurse (RN), Safe and Drug-Free School (SDFS) coordinator, school resource office, school counselor, School Nutrition, Staff Wellness Coordinator, School Social Worker, principals, teachers, custodian, transportation coordinator, Audiologist, Speech-Language Pathologist, School Psychologist, Central Office Administrator, and Student Assistance Specialist.
- Community youth groups.
- Local government officials.

Functions. School health advisory board members facilitate understanding and cooperation among those interested in developing and improving the local school health program. In addition to their overall purpose of guiding and supporting coordinated school health programs, school health advisory boards perform many other functions including: The following is a summary of required and recommended functions of a SHAB.⁴⁰

- **Visibility for Coordinated School Health:** An active school health advisory board provides visibility for coordinated school health within the school division and community. The board should communicate to school personnel and community members a message of concern for the health of children and staff. In an era when schools have many complex and diverse goals to accomplish, the school health advisory board can serve as a reminder that health is important for academic achievement and efficient school operations.
- **Parent and Community Involvement:** A school health advisory board can promote parent, citizen, and professional involvement in the schools. A well-organized advisory board provides an opportunity for participation by parents in activities and decisions influencing the lives of their children. It also serves as a mechanism for involvement by other community members, including those from business, religious organizations, civic groups, human service agencies, law enforcement, city council members, or county supervisors.
- **Advocacy for Coordinated School Health:** The school health advisory board can conduct or facilitate activities that bring attention to the benefits of high-quality coordinated school health programming. Such activities often generate further support and momentum for a coordinated school health program. Perhaps of equal importance to the group's work are the individual acts by current and former board members that cause others to become aware of the important role of each component of the coordinated school health program.

- **Forum for Health Issues:** Often there are health issues affecting students and school staff members that need a specific place in the community for discussion, decision-making, and planning. Occasionally, these issues are controversial and require the opportunity for the presentation and consideration of different points of view. The school health advisory board can provide a positive environment for constructive reviews of issues through its meetings, subcommittee structure, and representatives.
- **Recruitment of Community Health Resources:** The identification of needs in the coordinated school health program may require the participation of multiple community health resources. The school health advisory board can coordinate the involvement of individuals and agencies for a specific need in the school division.
- **Facilitate Understanding of Schools and Communities:** Participation in school health advisory board activities provides opportunities for parents and other community members to gain further insight into the life of schools. Similarly, it allows school personnel to learn more about the varied backgrounds and points of view within the community.
- **Public Relations:** In addition to advocacy-related activities, many school health advisory boards function as an effective public relations extension of the school division. Informing the community and school personnel about aspects of the coordinated school health program can enhance the image of the school division. The involvement of media representatives and influential community decision makers within the school health advisory board is an effective way of implementing this public relations function.
- **Facilitate Innovation:** The school health advisory board can become an advocate for introducing new health program components in the school community. Through their advisory role, members can share special interests or approaches to components of the coordinated school health program with school personnel. In some situations, the school health advisory board may become the major supporter of change within the school division. Using this group as a sounding board for new approaches can be a valuable step in bringing school health issues to local or other decision-makers.

Implementation. Implementation can begin with the schools, the school division, or the school health advisory boards. Regardless of where ideas originate, the support of the school division is critical for successful review and implementation of recommendations for change. The school health advisory board is dependent on the leadership and support of the school division for maintaining its effectiveness as an advisory board. To strengthen the effectiveness of school health advisory boards, school division personnel should consider the following supportive actions:

- Promote the Coordinated School Health or CDC Whole School, Whole Community Whole Child (WSCC) Model.
- Strengthen the communication channels among the school health advisory board, school division personnel, the school board, and the community.

- Encourage school health advisory board members to increase their understanding of the existing coordinated school health programs and policies so that they may be strong advocates.
- Work with the school health advisory board to identify the general functions and areas of concern that need attention by the board, including a working definition of coordinated school health programming that is standard to all within the school division.
- Identify potential members (no more than 20) for the school health advisory board, the membership selection process, the length of terms, and the potential categories of membership.
- Appoint members to the local board and acknowledge the value of their contributions. Designate a school division administrator to serve as the primary contact for school health advisory board activities. Recognize and utilize the support of the school health advisory board in improving the coordinated school health program within the school division.

Resources

- Virginia Department of Education - [Health & Medical: School Health Advisory Boards \(SHAB\)](#)

Chapter 8: Involving Parent and Teacher Groups

Overview

Another way to involve the community and parents is through parent and teacher groups, such as the local parent teacher organization (PTO) or local/state chapter of the National Parent Teacher Association (PTA). PTOs/PTAs are local organizations with guidelines developed by each local organization. The local PTA chapter is part of the national association and abides by the national association guidelines for Parent Teacher Associations. In Virginia, the state association is called the Virginia Congress of Parents and Teachers (also known as the Virginia PTA). Involving parents and the community through such established organizations as the PTA or local PTO can provide support for a school health program in the form of administrative support, actual personnel to staff the programs, program advocates, and financial support.

National PTA.⁴¹ The overall purpose of PTA is to make every child's potential a reality by engaging and empowering families and communities to advocate for all children. PTA addresses issues that are important to parents and public school administrators. PTAs advocate for funding, quality teachers, and capabilities for schools to thrive. This group is a network of millions of families, students, teachers, administrators, and business and community leaders devoted to the educational success of children and the promotion of family engagement in schools. There are five core values⁴¹ that serve as the building blocks for the work of the PTA, both at the National, State, and local levels:

1. **Collaboration:** We work in partnership with a wide array of individuals and organizations to enhance our ability to serve and advocate for all children and families.
2. **Commitment:** We are dedicated to promoting children's health, well-being, and educational success through strong parent, family, and community involvement.
3. **Diversity:** We acknowledge the potential of everyone without regard, including but not limited to: age, culture, economic status, educational background, ethnicity, gender, geographic location, legal status, marital status, mental ability, national origin, organizational position, parental status, physical ability, political philosophy, race, religion, sexual orientation, and work experience.
4. **Respect:** We value the individual contributions of members, employees, volunteers, and partners as we work collaboratively to achieve our association's goals.
5. **Accountability:** All members, employees, volunteers, and partners have a shared responsibility to align their efforts toward the achievement of our association's strategic initiatives.

The National PTA⁴² has updated their standards for parent/family involvement programs to promote meaningful parent and family participation in schools, to raise awareness regarding

the components of an effective program, and to provide guidelines for schools that wish to improve their programs. These six standards identify what parents, schools, and communities can do together to support student success:

1. Welcoming all families into the school community—Families are active participants in the life of the school, and feel welcomed, valued, and connected to each other, to school staff, and to what students are learning and doing in class.
2. Communicating effectively—Families and school staff engage in regular, two-way, meaningful communication about student learning.
3. Supporting student success—Families and school staff continuously collaborate to support students' learning and healthy development both at home and at school and have regular opportunities to strengthen their knowledge and skills to do so effectively.
4. Speaking up for every child—Families are empowered to be advocates for their own and other children, to ensure that students are treated fairly and have access to learning opportunities that will support their success.
5. Sharing power—Families and school staff are equal partners in decisions that affect children and families and together inform, influence, and create policies, practices, and programs.
6. Collaborating with community—Families and school staff collaborate with community members to connect students, families, and staff to expanded learning opportunities, community services, and civic participation.

[Virginia PTA](#)⁴³ The single largest factor in student success is an environment of active and engaged families, educators and communities.⁴⁴ The Virginia PTA works to make parents, teachers and students aware of the potential negative impact of bullying, unhealthy lifestyles or the Internet. Most importantly, we are raising awareness among families that positive adult-role models and supporting children as parents and mentors can make a huge difference. For almost 100 years, the focus of the Virginia PTA has been on three primary objectives; parent education, parent involvement and advocacy. The Virginia PTA provides relevant, meaningful resources to help achieve those goals. The goal of the Virginia PTA's health and safety programming is to be a resource for PTA parents and leaders in partnering with schools to create safe environments which encourage healthy, safe choices and social and emotional support for all students.

PTAs have a role in advocating for or supporting health and safety changes at every level of a child's learning environment. PTA also gives families the tools needed to create an environment at home that supports the positive changes happening at school. Through established partnerships, leveraging of best practice resources, creating educational tools, and providing training, the Virginia PTA provides local PTAs with diverse, dynamic, up-to-date tools and resources to use in partnering with schools and engaging families in identifying and addressing barriers to providing healthy and safe learning and home environments.

Recommendations

According to the National PTA's guidelines, the first step to engaging parents is to form a school action team focused on promoting family and community involvement. Include parents, other caregivers and family members, school staff, community members, and even students. Have the whole team familiarize themselves with the guide, but also consider establishing a sub-team for each standard. Offer opportunities for a diverse group of individuals to lead those sub-teams. Once the organizational structure is in place, the National PTA's standards and six steps for implementation, found in [*PTA National Standards for Family-School Partnerships: An Implementation Guide*](#)⁴², will serve as a framework for implementation:

- Step 1: Assess your school's current practices for engaging families and the community in improving school climate and student success.
- Step 2: Begin planning based on the assessment, survey findings, and your discussions with the school principal.
- Step 3: Present the action plan to the school community for feedback and buy-in.
- Step 4: Put the plan into action and monitor your progress throughout the school year.
- Step 5: At the end of the school year, document your successes and share them with the school community, which includes families, students, teachers, the superintendent, school board members, the local newspaper and other media, community members, businesses and other potential donors, and partnering organizations.
- Step 6: As you plan for the next school year, explore how you can build on your accomplishments.

Similarly, the Virginia Department of Education developed six action items based on community, school, and parent responses to a questionnaire of parent involvement in schools.⁴⁵ These are:

1. Host events and activities that bring parents and families into the school.
2. Communicate with parents frequently, using a variety of methods.
3. Create a warm, respectful, and welcoming school environment.
4. Be flexible in accommodating parents and families.
5. Provide a variety of resources for parents.
6. Support parents in helping their children at home.

As with any volunteer positions, there are often obstacles to overcome in gaining the necessary help. The National PTA highlights some of the more common problems and outlines strategies to use when seeking parental involvement in [Overcoming Obstacles to Parent Involvement](#):⁴⁶

1. Not knowing how to contribute.
2. Not understanding the school system.
3. Parents in need/without adequate resources.
4. Childcare.
5. Language barriers.
6. Special needs.
7. Transportation.

Parent Involvement and Engagement in a Whole School, Whole Community, Whole Child (WSCC) Model Program. A key factor in gaining parent support for school health is for school staff to demonstrate to parents how their children's health and education could be enhanced by their engagement in school health activities. Parents tend to be more involved if they perceive that school staff and students both want and expect their involvement. The Center for Disease Control and Prevention's (CDC), [Parent Engagement: Strategies for Involving Parents in School Health](#)⁴⁷, provides suggested actions schools can use to increase parent engagement in school health activities.

Chapter 9: Developing Partnerships

Overview

Many local school divisions do not have the resources to provide the type of school health program that the community needs. The school health program team should look outside the school division to meet these needs. These outside avenues may include the development of a partnership with other community organizations.

- **Potential Partnerships.** Potential partnerships that the school division might explore include nonprofit agencies, corporations, or managed care organizations. Examples of these partnerships are summarized below.
- **Nonprofit Agency.** A partnership could be developed with a nonprofit agency, such as the American Cancer Society (ACS). ACS has a strong school health division that has many volunteers and educational programs that include printed materials, videos, posters, and handouts.
- **Corporate.** A corporate partnership could be developed with a large corporation with large numbers of employees who have children in a school division. The corporation may be willing to fund specific project or provide the expertise and staff for a school health program.
- **Local Healthcare Organization or Health Maintenance Organization.** A school division entering into a partnership with local health entities to manage a school-based health center or to partner in school-based education and community outreach.
- **Local Small Business.** Employees of a small company could read to students.
- **Local Civic Organizations.** A senior citizen group could team with students to be “lunch buddies.”
- **Individuals.** Parents with medical backgrounds (e.g., nurses) could volunteer to assist with screening programs.

Recommendations

Guidelines for Developing New Partnerships. The following guidelines are key concepts when developing a new partnership:

- **Involve all key players:** This includes all persons who have a stake in the proposed program such as organizational representatives, influential people in the community, and children and families who will impacted.

- Develop a realistic strategy: Choose a strategy that reflects the level of commitment by all partners. The potential partner may not be ready for a true collaborative relationship but would rather commit to a cooperative relationship. For example, a local health department may be able to provide nurses two days a week to assist with immunizations for a school health program. This level of commitment could be used to build trust and a sense of accomplishment that could lead to a more ambitious collaborative commitment.
- Establish a shared vision: When partners share a vision of the issues and priorities concerning school health, it is much easier to establish common goals and objectives. The shared vision may occur over time through cooperative partnerships that lead to a collaborative relationship.
- Allow for open communication: Develop a communication process that provides the means to express disagreement. This conflict and its resolution may help the program to move forward rather than becoming bogged down in a process.
- Set SMART goals: Create momentum and a sense of accomplishment through setting attainable goals.
- Build ownership at all levels: Include representatives from involved agencies and keep all staff members informed of changes. Solicit ideas and feedback throughout the process and be open to suggestions and changes.
- Institutionalize change: Objectives developed from the partnership must be incorporated into the institution's organization so that proposed changes can endure.
- Share your story: Publicizing successful results can lead to attracting more funding and opportunities for more innovation, as well as inspire other schools and communities to take action.

Funding Sources and Reimbursements. When looking for partnerships, the school division is also looking for funding sources. The funding source may be in a partnership, but it may also come from other sources. Funding sources may include, but are not limited to, the following:

- Grants from state agencies.
- Grants from nonprofit organizations, such as the March of Dimes, American Cancer Society, American Heart Association.
- Centers for Disease Control and Prevention, Division of Adolescent and School Health
- Local businesses.
- Large corporations.
- Web search.
- Local Parent Teacher Association/Parent Teacher Organization.
- Medicaid reimbursement.

The Coordinator Role. In most school divisions, the school health coordinator is a school nurse or an administrator with direct responsibilities for school health. The school health coordinator oversees the implementation of the school health services plan and coordinates school health services with the other components of the school health program. Therefore, the role of the coordinator is important in the development and implementation of partnerships. For example, the school health coordinator can provide leadership by coordinating school health services with community-based medical and mental health providers, school-based or school-linked health center staff (if one exists), and local public health officials. The coordinator can act as a liaison between the schools and public health staff and local health care providers who can provide consultation on issues involved with students with special health care needs, school wide health, and health policy. In addition, the coordinator can involve local health care providers in the planning, implementation, and evaluation of programs as well as in policies to develop them.⁴⁸

Example of a Partnership: School-Based Health Centers and Managed Care Organizations. An example of a partnership in a school health program is between a school-based health center and a managed care organization. When developing a partnership with a managed care organization, the following principles developed by a national workgroup on structuring the relationships between school-based health centers and managed care organizations should be considered:⁴⁹

- **Principle 1: Common Mission** - The school health program and the organization with which the partnership is formed should have a common mission. For example, a partnership between a primary care delivery service and a school-based health center may have the common mission to promote quality of care by increasing access to care and providing risk-reduction services, user satisfaction, and early intervention.
- **Principle 2: Scope of and Authorization for Services** - When developing the partnership, the scope of services or what services each party will provide and how those services will be authorized should be defined in writing in a contract.
- **Principle 3: Linkages Between the Partners** - Each partner should commit to ongoing communication and mutual assistance to ensure quality of care. A policy should be developed to define the frequency and type of communication
- **Principle 4: Linkages Between Agencies Outside the Partnership** - Any linkages between agencies outside the partnership (e.g., laboratories, pharmacies, or referrals) should be specified in writing.
- **Principle 5: Confidentiality** - Each partner should commit to ongoing collaboration to ensure that confidentiality is maintained.
- **Principle 6: Quality Improvement** - Both partners should commit to the development and maintenance of quality improvement. This may include a joint approach to data collection, agreed-upon standards of practice, assessments, and joint mutual utilization review.

- **Principle 7: Reimbursement** - A formula for reimbursement should be determined between the partners and specified in writing in a contract.

Chapter 10: Building Support for School Health Programs

Information in this section is compiled from the following references:

- Centers for Disease Control and Prevention
 - [Whole School, Whole Community, Whole Child \(WSCC\) Model](#)
 - [School Health Index](#)
 - [Parent Engagement: Strategies for Involving Parents in School Health](#)
 - Program Performance and Evaluation Office
 - [A Framework for Program Evaluation.](#)
- Missouri Department of Health and Senior Services
 - [Manual for School Health Programs](#)
- Selekman, J. (2013). *School Nursing: A Comprehensive Text (2nd Ed)*. Philadelphia, PA: F.A. Davis Company.
- Virginia Department of Education
 - [Promoting Healthy Students: A Guide to Establishing and Maintaining School Health Advisory Boards](#)
- Virginia Department of Education and the Center for Family Involvement at the Partnership for People with Disabilities at Virginia Commonwealth University. (2010)
 - https://partnership.vcu.edu/media/partner/documents/Partnership_Tips_and_Strategies_for_Increasing_Parent_Involvement.pdf
- Virginia PTA
 - [Parent Resources](#)

Overview

One of the biggest benefits of a successful school health program can be a closer working relationship between parents/families and schools. Working with parents, families, businesses, local health officials, and other community groups, a school can form powerful coalitions to identify and address the health needs of students. The idea of a successful approach will vary widely for each school and locality, as it should be tailored to the specific needs and issues identified. While developing a school health program may seem difficult at first, the reality is that many schools and communities across the country are already utilizing some of the eight

components of [Coordinated School Health](#) or the ten components of the [Whole School, Whole Community, Whole Child \(WSCC\) Model](#). Regardless of the program or framework being used, the following steps outline the process for assessing needs and identifying areas of focus within the school population:

1. **Assess Strengths and Weaknesses.** Study the local, community, city, and state policies and public health mandates to determine what the law says is necessary in terms of school health. Assessments sometimes involve interviews with key people, written questionnaires distributed to others (including parents, principals, teachers, and staff), and a review of current curriculum, materials, and existing school/community efforts. School districts and local health and education departments collect data on the education and health status of children, which can be a valuable resource as well in determining the population health, as well as health needs and disparities. A review of current health related media, both locally, statewide, and nationally can also provide insight into areas to target in program development.
2. **Identify Structure and Support Networks in Place.** The next step is to identify those components of a coordinated approach, or other existing framework that already exist. Additionally, this is the time to determine what support is already in place and relationships that have been developed, considering the following areas:
 - a. Parents
 - b. Religious organizations
 - c. Public health departments
 - d. Social service agencies
 - e. Business
 - f. Government
 - g. Mass media/reporters
 - h. Social media
 - i. Youth organizations
 - j. Community groups
 - k. Health care providers and health organizations
 - l. State and local departments of education and health can be strong resources – find out what programs are already in place, or what other localities have implemented, as well as what resources might be available.
3. **Build School Support.** Regardless of the framework, location, or issues, the common element essential to a successful school health program: school personnel who recognize the importance and value of such an effort. The principal is a key opinion leader and his or her words and actions set the tone for the entire school. Other leaders to involve in building a consensus for school health include:

- a. Parents
 - b. Teachers
 - c. Counselors
 - d. School board members
 - e. Social workers
 - f. Psychologists
 - g. Nurses
 - h. Food service directors
 - i. School resource officers
 - j. School volunteers
 - k. Drug and alcohol prevention coordinators
 - l. Physicians
 - m. Health department administrators and staff
 - n. State or local voluntary health organization executives
4. **Overcoming Objections.** As with any change, or new program, there is likely to be objection. Often, this is a reaction to a lack of information, misconceptions, or misunderstandings. A key in avoiding this is inclusion of all involved persons as much as possible. However, when objections still arise, some questions to consider are:
- a. What are some of the common misconceptions about the program?
 - b. Have they encountered a similar program or approach in the past that wasn't successful? Can they provide insight as to what could have been improved?
 - c. What are the differing views about how these programs will affect children, parents, and the community?
 - d. Is there information that needs to be clarified or further explained?
 - e. Does the person vocalizing the objection have a skill that can be drawn upon as a resource?

Putting It All Together

Now that a needs assessment has been completed, the next step is program development and implementation. In terms of a starting point, carefully consider which issues and programs are important, but also identify those that may require the least amount of resources - both human and financial - to implement fully and successfully.

Ask Questions to Help Set Priorities. The following questions are a starting point in determining what the programs, priorities, goals, and specific objectives will be. Once the purpose and desired end results are in place, they can be refined through the following questions:

1. How much time and commitment—money, personnel, and materials—will making the change require?
2. Is the change “better”—faster, cheaper, and more beneficial—than the existing way of doing things?
3. To what degree is the change consistent with existing practices, values, and political realities?
4. How complex is the change and how many people (e.g., one department or multiple departments) will be involved in the process?
5. How easy is it to describe the change you envision?
6. Do the benefits—tangible and intangible—outweigh the costs?
7. How much risk and uncertainty does the change involve?
8. Can parts of the change be made over time? Can it be modified to fit the individual school or classroom?
9. Can the elements be modified or “undone” if the desired results are not achieved?
10. Set S.M.A.R.T. goals for the program and be realistic about what can be accomplished with the time and resources available.

Design a Structure. Successful school-community partnerships can exist on many levels, including the school, district, or state. They can be task forces, coalitions, advisory committees, or subcommittees to existing groups. Carefully consider the organizations in the community and where they stand on school health to determine if it is possible to work with an existing group, or if school health would best be served by formation of a new group. Regardless of the approach, when recruiting members for a group, it is important to keep in mind the following:

- Identify the skills and expertise group members will need.
- Target individuals and/or organizations with attributes such as interest in and commitment to the issue, familiarity and experience with the political system, credibility in the community, financial or in-kind resources or fundraising ability, and contacts with other potential resources.
- Take time to get to know potential members; make certain there is a good match between skills and needs.
- Be clear on the time commitment and expectations.
- Build support in the community through media relations, such as fliers, open houses, local television/radio, and social media.

- Develop a leadership structure and set of operating procedures, including:
 - A chair to lead the group and an agenda for the group.
 - A mission statement with goals and objectives.
 - Rules of operation (such as how often the group will meet, how decisions are made, how the work will get done, rules of attendance, who has authority to speak on behalf of the group, and more...).
 - Delegation of tasks and a timeline.
 - Process for resolving disagreements and differences of opinion.

Implementation. Successful implementation requires support from the community, parents, teachers, school personnel, and school health supervisors and staff. The time and process needed to implement interventions will depend on the scope and size of the project. Careful planning and timeline development in earlier stages of program development are keys to achieving the desired outcomes. When approaching community and school partners for their help, it is important to include the following information:

- Educate them about the advantages of a coordinated effort and how a successful school health program can be a mutually beneficial relationship.
- Present concrete steps they can take to support the approach and get involved.

Each person involved in the implementation process should receive training and education ahead of time and be aware of resources they can utilize for help if questions or challenges arise. Everyone should be clear on the goals, their role, and that the big picture desire is the health and wellness of the students and school community.

A step-by-step implementation plan will ease the burden and allow for a smoother process. Consider a visual representation or handout so that team members can refer back to the plan for clarity and understanding.

During the implementation process, it is important to remain flexible and understand that issues may arise. Even with the optimal planning, there may be things that had not been considered or that do not work the way they were intended. An ongoing evaluation should take place during the implementation phase, as well as a formal evaluation process at set intervals.

Evaluation. It is paramount to determine how the program has met the outlined goals and objectives, and whether the desired outcomes were achieved, and to what extent. The data analysis can provide a solid foundation for this step. Key steps in evaluation involve:

1. **Data Collection and Analysis.** As part of the planning and development phase, the team must decide what data will be collected, by who, and using what methodology. Data is a critical piece of the evaluation process, and allows those in charge of the program to determine what changes should be made and how the interventions should be adapted to best serve the students and school, as well as achieve maximum results. Detailed

information on methods and analysis can be found through the Centers for Disease Control, [Analyzing Quantitative Data for Evaluation](#). The state and local health department epidemiologists can also serve as valuable resources in development the data collection and analysis strategy.

2. **Feedback.** In addition, consider less formal analysis using surveys – not just for the students and those that the program was directed towards, but for team members and those involved in the implementation process (including teachers and other school personnel). This feedback may provide insight on the process and planning stages, and suggestions for improved delivery and implementation.
3. **Evolution over time.** Many school health programs are not one-time occurrences and are either ongoing in nature or will be used again at a future date. To meet the changing needs of students and the school community, programs should be able to adapt and grow over time. Some of this growth should be a natural progression as part of the evaluation process, and some should be the result of ongoing research into current standards and best practices, as part a continuous program development cycle.

Resources

- [Healthy People 2030](#)
- [Parent Engagement: Strategies for Involving Parents in School Health Family Friendly Schools](#)
- [Centers for Disease Control and Prevention: Division of Adolescent and School Health](#)
- [Virginia Department of Education](#) and the Center for Family Involvement at the Partnership for People with Disabilities at Virginia Commonwealth University
 - [Improving Student Achievement and Outcomes Through Parent and Family Involvement: Tips and Strategies for Increasing Parent and Family Involvement in Virginia Schools](#)
- [The SEDL National Center for Family and Community Connections with Schools](#)

End Notes

³⁵ Centers for Disease Control and Prevention (2018). Components of the Whole School, Whole Community, Whole Child (WSCC). Retrieved November 28, 2018 from <https://www.cdc.gov/healthyschools/wsc/index.htm>

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³⁷ Marx, E., and Wooley, S.F. (1998) *Health Is Academic: A Guide to Coordinated Health Programs* (p. 4). New York, N.Y: Teachers College Press.

³⁸ Centers for Disease Control and Prevention. (2012). *Promoting Parent Engagement in School Health: A Facilitator's Guide for Staff Development*. Retrieved November 28, 2018 from https://www.cdc.gov/healthyyouth/protective/pdf/parentengagement_facilitator_guide.pdf

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⁴⁶ New Mexico Public Education Department and the Center for the Education and Study of Diverse Populations at New Mexico Highlands University. (2016). *Overcoming Obstacles to*

Parent Involvement. Retrieved November 30, 2018 from <http://nmengaged.com/wp-content/uploads/2017/06/a-Overcoming-Obstacles-to-Parent-Involvement-Toolkit-2017.pdf>

⁴⁷ Centers for Disease Control and Prevention (CDC). (2012). *Parent Engagement: Strategies for Involving Parents in School Health*. Retrieved November 30, 2018 from https://www.cdc.gov/healthyyouth/protective/pdf/parent_engagement_strategies.pdf

⁴⁸ Marx, E., and Wooley, S.F. (1998). *Health is Academic: A Guide to Coordinated Health Programs*. (pp. 184-185). New York, N.Y.: Teachers College Press.

⁴⁹ *A Partnership for Quality and Access: School-Based Health Centers and Health Plans*. (1996). School Health Initiative Policy: New York, N.Y. A Special Report on the 1995 Work Group Meetings.

PART III: SCHOOL HEALTH SERVICES

This section presents guidelines for use in planning, implementing, and evaluating *school health services*, a component of a school health program, and a component of the CDC Whole School, Whole Community, Whole Child (WSCC) model. Included within this section is information about related codes, policies, and recommendations for appraisal, preventive, and remedial aspects of school health services. Also included is information on planning the school health services facility.

Chapter 11: [Overview of School Health Services](#)

- Deciding on a Model to Provide School Health Services
- Planning the School Health Services Facility
- Evaluating Health Services

Chapter 12: [Conducting Health Assessments](#)

- Four Common Health Conditions Encountered in the School Health Office
- Health Information Form Requirements
- School Entrance Physical Examination Requirements
- Immunization Requirements
- Athletic Pre-Participation Physical Examination Requirements
- Career & Technical Education Medical Assessment

Chapter 13: [Population-Based Screening Programs](#)

- Blood Pressure Screening
- Dental Screening and Oral Health
- EPSDT, Medicaid (FAMIS Plus), and CHIP (FAMIS)
- Hearing Screening
- Height and Weight Screening
- Scoliosis Screening
- Speech and Language Screening
- Vision Screening

Chapter 14: [Implementing Special Education: Students with Special Needs](#)

- Implementing IDEA
- Implementing Part C of IDEA
- Implementing Section 504 of the Rehabilitation Act
- Special Education Health Assessment
- Role of the School Nurse

Chapter 15: [General Guidelines for Administering Medication in School](#)

- Epinephrine Protocol

Authorization/Parental Consent for Administering Medication
Procedure for Administering Medication

Chapter 16: [Infectious Disease Control](#)

- Prevention Guidelines for Diseases Spread Through Direct Skin Contact
- Prevention Guidelines for Diseases Spread Through the Intestinal Tract
- Prevention Guidelines for Diseases Spread Through the Respiratory Tract
- Prevention Guidelines for Diseases Spread During Sexual Activity
- Prevention Guidelines for Sports-Related Diseases and Medical Concerns

Chapter 17: [Other School Health Services](#)

- Managing First Aid Emergencies, Disasters, and Crises
- Referring to Child Protective Services
- Home Visits
- Nursing Liaison Services to Homebound Students
- Students Requiring Specialized Health Care Procedures

Chapter 11: Overview of School Health Services

School health services, depending on the needs and preference of the community, may include services for students with disabilities and special health care needs and the traditional first aid, medication administration, and screening services. Communities must decide based on their needs and the level of health services required. Once these decisions are made, planning and implementation of health services can take place. Following implementation, an evaluation of school health services should be conducted to determine if the level of school health services is meeting the needs of the school community. The following subsections contain information on determining a model for health services, how to plan or implement health services, and a tool for evaluating health services.

- [Deciding on a Model to Provide School Health Services](#)
- [Planning the School Health Services Facility](#)
- [Evaluating Health Services](#)

Deciding on a Model to Provide School Health Services

Authorization

There is no requirement that specifies a school-based health services model, and several different models are available for the delivery of school health services. The appropriateness of an approach for a school division typically depends on the educational preparation and the scope of practice of the available personnel, the funding available in the particular community, the scope of services available in the community, attitudes, and objectives of the community.⁵⁰

Overview

Definition. Although a universally accepted definition of the term “school health services” has not been adopted, *Health Is Academic: A Guide to Coordinated School Health Programs* presents the following definition: ⁵¹

School Health Services: *Prevention services, education, emergency care, referral, and management of acute and chronic health conditions. Designed to promote the health of students, identify and prevent health problems and injuries, and ensure care for students.*

The goals and program elements of school health services are derived from “student needs, community resources for health care, available funding, local preference, leadership for providers of school health services, and the view of health services held by school administrators and other key decision-makers in the school divisions.” ⁵² The types of services vary based on the goals and objectives of school health services.

The CDC defines “health services” (as described in the context of the Whole School, Whole Community, Whole Child Model) as:

“School health services intervene with actual and potential health problems, including providing first aid, emergency care and assessment and planning for the management of chronic conditions (such as asthma or diabetes). In addition, wellness promotion, preventive services and staff, student and parent education complement the provision of care coordination services. These services are also designed to ensure access and/or referrals to the medical home or private healthcare provider. Health services connect school staff, students, families, community and healthcare providers to promote the health care of students and a healthy and safe school environment. School health services actively collaborate with school and community support services to increase the ability of students and families to adapt to health and social stressors, such as chronic health conditions or social and economic barriers to health, and to be able to manage these stressors and advocate for their own health and learning needs. Qualified professionals such as school nurses, nurse practitioners, dentists, health educators, physicians, physician assistants and allied health personnel provide these services.” ⁵³

Common Elements. While there is no one best model of school health services, there are common elements provided by programs in schools across the country. A study conducted by the Institute of Medicine Committee on Comprehensive School Health Programs in Grades K-12 found that although the scope of school health services varies from one school district to another, most schools provide the following services:

- Screenings.
- Monitoring student immunization status.
- Providing first aid.
- Administering medication.
- Providing wide range of health services for students with disabilities and special health care needs.⁵⁴

The CDC Whole School, Whole Community, Whole Child (WSCC) Model serves as a framework for addressing health in schools, and includes ten components:⁵³

1. Physical education and physical activity.
2. Nutrition environment and services.
3. Health education.
4. Social and emotional school climate.
5. Physical environment.
6. Health services.
7. Counseling, psychological and social services.
8. Employee wellness.
9. Community involvement.
10. Family engagement.

Models. The literature identifies the following three major approaches for providing or facilitating access to primary health care, a primary goal of school health services: (1) screenings, referrals, education, and care by school nurses, (2) nurse practitioners providing primary care, and (3) school-based clinics providing comprehensive health care services.⁵⁰ Each of these models is described below.

Care by School Nurses

School Nurses. This is the traditional model that usually consists of school nurses who provide the following health services:⁵⁵

- Assessment of the health needs of students and staff.
- Health screening.
- Health promotion and disease prevention activities.
- Individual health education and counseling.
- First aid and emergency care.
- Chronic care services for children with disabilities.
- Referral of children with health problems to community health care providers for further diagnosis and treatment.
- Serves in a leadership role from provision of health services, as well as policies and programs.
- Serves as a liaison between school personnel, family, health care professionals, and the community.

Physician consultation. In the traditional model, physician consultation is typically provided by a consulting medical director/physician who is available to the school health program for providing medical evaluations, consultation, and support to nursing personnel.

Nurse Practitioners Providing Primary Care

Nurse Practitioners. This model expands the direct services provided to the students. In this model, nurse practitioners provide the following comprehensive preventive and primary health care services:⁵⁶

- Diagnosis and treatment of a range of health conditions in accordance with treatment protocols established by a supervising physician.
- Health screenings.
- Assistance to families in visiting appropriate health care providers.
- Monitoring chronic illnesses.

The school nurse and unlicensed assistive personnel should be a part of this team to provide the traditional school health services.

School-Based Health Clinics Providing Comprehensive Health Care Services

School-Based Health Clinics (SBHCs). This model provides for the following comprehensive health care services that are to be delivered by an interdisciplinary team usually made up of physicians, nurses, counselors, lab and medical assistants, and other health care professionals.⁵⁷

- Comprehensive primary health care services.
- Promoting positive health behaviors.
- Preventing such “new morbidities” as intentional and unintentional injuries, teenage pregnancy, and tobacco and substance use and abuse.
- SBHCs can decrease interruption to work for parents, increase class attendance and decrease tardiness for students, decrease the use of emergency services, and provide more prompt and focused care for the students.

The school nurse and unlicensed assistive personnel should be a part of this team to provide the traditional school health services.

Recommendations

Need for School Health Services. Schools bring together large populations of students and staff with health needs to include first aid management, detection of contagious diseases, routine medication administration, and specialized health care procedures for students with special health care needs. To address these issues, some of which are legislative mandates, a system needs to be in place to reduce risks and liability. In addition, because education and health are linked, health services are needed to promote student health and prevent disease. Therefore, although the primary goal of schools is education, basic school health services are an essential component of today’s education program. Roles and responsibilities for school health services should be determined with community input.⁵⁸

Coordination with Student’s Health Care Provider/Parents/Guardian. An important component of a school health program is the direct delivery of health care services to students. Health care services include health assessments, population-based screenings, providing emergency care and managing crisis situations, and addressing the day-to-day health care needs of the students. School health services should be coordinated with the student’s health care at home. There should be ongoing communication between the school health services personnel and the student’s parents/guardians and health care provider so that the student is able to participate in school at the highest level.

Choosing a Model. Each school health services model can be successful in facilitating or providing access to primary health care - if properly designed and aggressively implemented.⁵⁰ Therefore, a school health services model should be determined locally, based on which model, or model combination, best matches a community's needs and characteristics.⁵⁹

Planning the School Health Services Facility

Authorization

[Guidelines for School Facilities in Virginia's Public Schools, Section 5.2.](#)⁶⁰

Excerpt:

A. In new schools and schools where the health unit is being altered, health service facilities should be provided.

- 1. An examining room, with private access to an accessible toilet for persons with disabilities.*
 - 2. Cot area should be adjacent and directly accessible from the examining room, and shall have access to an accessible toilet for person(s) with disabilities. Cots should be adjacent to nurse's desk with curtains for privacy.*
 - 3. Middle and high schools should provide separate cot areas for boys and girls.*
 - 4. Nurse work area for desk, chair, file, phone, and other equipment should be provided.*
 - 5. Enough space to accommodate eye screening, twenty-two feet in length, should be provided. Clinic corridors may be used for this purpose.*
 - 6. Locked cabinet and locked refrigeration for medicines.*
 - 7. Nonabsorbent, nonslip floor in all clinic areas.*
 - 8. A lavatory with gooseneck faucet with aerator, wrist handles, and grid drain. Place sink in a separate area from toilet, accessories to include liquid soap and paper towel dispensers.*
- B. An accessible shower should be provided in the Health Unit area.*

Overview

The school health office should be planned to meet the needs of emergency care and outpatient clinic services. Planning of a clinic should involve outlining and obtaining the appropriate facilities, equipment and supplies, and personnel to meet the needs of the students and staff. Additionally, the design and equipment should support infection control measures. All clinics should have a plan for handling injuries or illnesses of students and staff and making the faculty and staff familiar with the plan.⁶¹

Planning for the Facility. In planning a school health facility, the clinic personnel and space or structure should be adequate and provide appropriate privacy for:⁶¹

- Projected school enrollment
- The number of staff

- Availability of a nurse's workstation with appropriate electronic communications systems
- A private treatment and consultation area, with space for clinical technological equipment
- Storage space

Ideally, the space should be located within proximity to guidance counseling services. This allows for coordinated student care, facilitation of referrals, and respecting of confidentiality. New spaces should be designed with flexibility, so that additional services may be added as the needs of the community change. When planning a new school clinic space, or in a redesign of a current clinic, refer to the Virginia Department of Education's [Guidelines for School Facilities in Virginia's Public Schools](#) for additional guidance and information.

Facility Functions. The functions of the facility may include the following:^{56, 61}

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

Basic Clinic Environment. At a minimum, the basic clinic environment should provide space for the following:

- Waiting and triage
- Assessment and treatment
- Counseling
- Storage

Recommendations

Furniture and Equipment for a School Health Office. The supervisor/director/ coordinator of school health services should be an active part of the advisory group designing any new health services area. The following guidelines provide recommendations for the school health clinic that should be considered when new construction is being planned or when school buildings are being renovated: ^{56 60 61}

School Health Office: Recommendations for Furniture and Equipment

Location	<p>Located, ideally, in a quiet area of the building, on the ground floor, near administrative offices, with easy access for students and staff.</p> <p>Conveniently accessible for the disabled—designed with a door(s) leading to the outside, outer hallway, and/or main office to provide for emergency transport and to be wheelchair accessible.</p> <p>An area that is used <i>only</i> for health-related services and that allows for individual privacy.</p> <p>An area 600 square feet minimum, including the bathroom (which should be approximately 130 square feet).</p>
Ventilation and Lighting	<p>Heating and air-conditioning controls that solely control the health facility environment.</p> <p>Adequate ventilation. Access to fresh air and exhaust fans is optimal for adequate ventilation. One outside window without fixed panes for natural lighting and ventilation or an operable skylight would be advantageous.</p> <p>Proper illumination in health clinic and the bathroom areas, including adjustable overhead lights in rest areas, in the storage closet, and over the first-aid area station.</p>

School Health Office: Recommendations for Furniture and Equipment
Plumbing and Sanitation

Adequate plumbing to ensure hot and cold running water for assessment and treatment area.

At least one handicapped-accessible toilet facility with hot and cold running water.

Private lavatories adjacent to examination room, with toilets, toilet paper, sinks with hot and cold running water, foot-operated soap dispensers, paper towels, and pedal-controlled waste receptacle lined with polyethylene bag.

Pedal-controlled, covered trash receptacles, lined with polyethylene trash bags at various places throughout the facility.

Hospital faucets (with long handle on/off levers and overhanging spout faucet) in lavatories and first-aid station.

Filled wall-mounted paper towel holders and air hand dryers adjacent to all sinks in lavatories.

Easily cleaned hard surfaces on floors and walls, with availability of disinfectant and bleach cleaning materials.

Electrical Outlets

Double electrical outlets throughout the space.

Surge protectors.

Floor and Wall Covering

Tile or seamless anti-microbial resinous floor is the preferred floor covering to facilitate proper disinfecting of soiled areas. If the facility includes a private nurse's office, this room may be carpeted. (Note: Carpet is difficult to keep clean and may contain allergens, such as latex.)

Easily cleanable—hard walls are preferred.

School Health Office: Recommendations for Furniture and Equipment**Storage**

A locked storage cabinet or, preferably, a walk-in closet with floor-to-ceiling shelves for medical and other supplies. A walk-in closet is preferable for storage of scale, crutches, stretcher, wheelchair, privacy screen, and other large items.

Medicine cabinet (either inside or outside closet).

Base cabinets that have counter tops would provide a more functional treatment area and storage for supplies and screening equipment.

Refrigerator with a separate freezer for the storage of medication, snacks for students with special needs, and cold packs. An icemaker would be beneficial.

Blankets, sheets, pillows, and disposable pillow paper covers.

Sharps container for disposal of hazardous medical waste.

**Area Design
Configuration**

The clinic design should include four specific areas, including:

1. A waiting and triage area.
 2. An assessment and treatment area.
 3. A private area for conference, counseling, and isolation.
 4. The bathroom area. (See "Assessment and Treatment.")
-

School Health Office: Recommendations for Furniture and Equipment	
Waiting and Triage	<p>Adequate number of chairs for seating in the waiting area (approximately four chairs) and one cot (for approximately every 200 students).</p> <p>Desk or other suitable writing surface that is visible to the waiting area and has at least one drawer that can be locked. A telephone outlet should be nearby.</p> <p>Telephone with a direct line outside.</p> <p>Computer with monitor, CD-/DVD-ROM, internet access, and printer on table.</p> <p>Filing cabinets (two or more four-drawer cabinets, depending on the student population) that can be secured and locked for storage of current health records, emergency response cards, instructional information, and daily maintenance files.</p>
Assessment and Treatment	<p>Adequate private rest areas that have cots or beds. (Note: It is recommended that beds/cots have washable surfaces that can be disinfected between student use.) The number of rest spaces should correspond to student enrollment and frequency of use.</p> <p>Folding screen or draperies to provide privacy in the rest area.</p> <p>Rest area visible from the clinic personnel's work station.</p> <p>Rest area fitted with an outlet for its own light source.</p> <p>Private room (area) for examination and consultation, preferably with an examination table.</p> <p>Bathroom that is wheelchair accessible, has grab bar next to toilet, is well lit and ventilated, and has a sink and storage area for supplies and special needs equipment. (ADA guidelines recommend a changing table, washer dryer, and shower area with seat.) (Note: Bathroom should have a mirror.)</p> <p>First-aid station that has washable counter tops (preferably stainless steel), under-counter drawers for storage, and over-counter hanging cabinets with see-through sliding doors are preferable. (Note: May prefer wooden, locked doors to prevent theft.)</p> <p>At least 15 feet of unobstructed space should be available in the school health clinic, if screening programs (e.g., vision and hearing) are conducted in the clinic.</p>
Counseling and Treatment	<p>Space that ensures privacy of sight and sound and is easily accessible.</p> <p>Private telephone line as well as an extension telephone.</p>

Expendable (Consumable) Supplies for a School Health Office. The following table lists recommended supplies that should be available in a school health office:

Recommendations for Expendable (Consumable) Supplies

Movable Equipment

Automated External Defibrillator

Bookcases

Bulletin boards

Clock that has a second hand

Flashlight or pen light with battery

Gooseneck lamp

Magnifying light (either floor or table model)

Nebulizer (for inhalation therapy) with disposable accessories

Otoscope/ophthalmoscope with battery

Physician's scale that has a height rod and is balanced

Portable crisis kit

Portable first-aid kit

Pure tone audiometer (calibrated annually), tympanometer

Reflex hammer

Sphygmomanometer (calibrated annually) and appropriate cuff sizes

Stethoscope

Stretcher

Table for vision and hearing testing equipment

Tape measure

Two-way communication device (walkie-talkie)

Vision testing equipment, such as Random Dot E and HOTV tests, consistent with current standards

Wall-mounted height measuring tool

Wheelchair

Recommendations for Expendable (Consumable) Supplies

Weight scales

Suggested First Aid and Other Supplies

Ace bandages

Airway/Ambu bags

Bandages, including adhesive (e.g., Band-Aids) and elastic, of various types and materials

Basins (emesis, wash)

Cold packs

Cotton-tip applicators (swabs)

Cotton balls

CPR masks (pediatric and adult)

Dental floss

Disinfectant for surfaces, spills (fresh [within 24 hours] 1:10 bleach solution or disinfectant approved by the U.S. Environmental Protection Agency)

Disposable gowns

EpiPens[®] (adult and junior) with expiration dates checked regularly

Eye cup

Eye irrigating bottle

Eye pads

Eye wash solution

Flashlight/penlight

Fingernail clippers

Latex and non-latex gloves

Magnifying glass

Masks

Office supplies

Paper cups (drinking, medicine, and pill)

Paper towels

Plastic bags (small and large, resealable)

Physician roll paper (optional)

Record forms (e.g., emergency cards, medication administration forms, accident reports, state forms)

Recommendations for Expendable (Consumable) Supplies

Ring cutter
 Safety pins
 Salt
 Sanitary pads, individually wrapped (may be used for compression) Scissors (blunt end)
 Slings
 Soap (must be in a dispenser)
 Splints (assorted)
 Surgi-pads
 Tape (different widths and hypo-allergenic)
 Tissues
 Thermometer (disposable) or other mechanism for measuring temperature, such as temp dots and thermometer sheaths, if applicable
 Tongue depressors
 Triangular bandage
 Tweezers
 Washcloths (disposable)

Suggested Reference or Resource Books

- [*Guidelines for Healthcare Procedures in Schools*](#). (2017). Virginia Department of Health.
- [*First Aid Guide for Child Care and School Emergencies*](#). (2015). Virginia Department of Health.
- Selekman, J. (2013). *School nursing: A comprehensive text* (2nd Ed). Philadelphia, PA: F.A. Davis Company.
- Donoghue, E.A. and Kraft, C.A. (Eds). (2019). *Managing chronic health needs in child care and schools: A quick reference guide* (2nd ed.). Elk Grove Village, IL: American Academy of Pediatrics.
- Aronson, S.S. and Shope, T.R. (Eds). (2016). *Managing infectious diseases in child care and schools: A quick reference guide* (4th ed.). Elk Grove Village, IL: American Academy of Pediatrics.
- Pharmacological reference
- Medical dictionary
- Physical assessment book

Evaluating Health Services

Authority

[Regulations Establishing the Standards for Accrediting Public Schools in Virginia \(2018\).](#)

Recommendations

The following guidelines are adapted from:

- American Nurses Association (ANA) and National Association of School Nurses (NASN). (2017). *School nursing: Scope and standards of practice* (3rd Ed). Silver Spring, MD: Nursebooks.org.
- Colorado State Department of Education. (2008). [Essential School Health Services Guidelines: Self-Assessment Checklist.](#)
- Connecticut State Department of Education. (2009). [Competency in School Nurse Practice.](#)
- Knutson, S. and Levassuer, S. (n.d.). [Introduction to Competency in School Nurse Practice.](#)
- National Association of School Nurses. (2015). *School nurse workload: Staffing for safe care* (Position Statement). Silver Spring, MD: Author.
- National Association of School Nurses. (2018). *Supervision and evaluation of the school nurse* (Position Statement). Silver Spring, MD: Author.
- Selekman, J. (2013). *School nursing: A comprehensive text* (2nd Ed). Philadelphia, PA: F. A. Davis Company.
- Virginia School Nurse Institute Partnership (SNIP). (2013). *School Nurse (Registered Nurse) Self-Evaluation Form*. Retrieved from <http://www.vdh.virginia.gov/content/uploads/sites/58/2016/12/SchoolNurseEvaluationForm.pdf>

Guidelines for Evaluation of School Health Services	
Criteria	Documentation/ Comments
I. GENERAL SCHOOL HEALTH SERVICES	
<p>A. The purpose and scope of the school health program are defined by written policies. The program should align with national and state standards and be based on current research and best practices.</p> <ol style="list-style-type: none"> 1. All reports should be submitted (monthly, quarterly, annual) to school administrators, school health supervisors, and local and state boards. 2. Collect evidence-based data and implement as appropriate to improve and support the school health program. 3. Perform periodic evaluation of the school health services using outcomes-based metrics. Program and implementation techniques should be adjusted based data attained. 	
<p>B. Specific, written school health procedures are available for:</p> <ol style="list-style-type: none"> 1. Emergency care of ill or injured students. 2. Medications given in the schools (including appropriate storage under double lock). 3. Control of communicable and infectious diseases. 4. Reporting of suspected child abuse. 5. Compliance with immunization requirements and tracking/follow-up of students with incomplete immunization records. 6. Following and implementing the health component of Individuals with Disabilities Education Act (IDEA) and Section 504. 	
<p>C. Responsibilities and roles of all school health personnel are clearly defined and applied.</p>	
<p>D. Community health resources and collaboration with local organizations are utilized as part of the comprehensive school health program.</p> <ol style="list-style-type: none"> 1. School nurses should communicate and coordinate with other school programs to ensure best practices in school health services and participate in an exchange of ideas. 2. School nurses serve as a liaison between student, school, parent, and community health care providers and organizations. 	
<p>E. A school health advisory board has been organized and is functioning effectively.</p>	
<p>6. Consultative services:</p>	

Guidelines for Evaluation of School Health Services	
Criteria	Documentation/ Comments
<ol style="list-style-type: none"> 1. Physicians are available for consultation and advice. 2. Dentists are available for consultation and advice. 3. The public health department is available to the schools. 	
G. Personnel currently certified in first aid, CPR/AED, and glucagon and epinephrine administration are available and on duty at all times during the school day and school sponsored activities.	
<p>H. Cumulative health records are maintained K-12 on all students and include:</p> <ol style="list-style-type: none"> 1. Major health problems that may be significant educationally or pertain to the child's safety or the safety of others with whom the child interacts. 2. Designated screening programs are recorded for both pass and fail. 3. All health information obtained on the student is recorded on and/or filed in the health record. 4. Health records are readily accessible to appropriate school personnel. 5. Clinic staff and appropriate school personnel are knowledgeable about confidentiality and storage of student records. 6. Health records are kept in locked files. 	
I. The school health services program undergoes periodic evaluation and revision.	
II. SPECIFIC SCHOOL HEALTH SERVICES	
A. There is a written job description for the school nurse, clinic aide/unlicensed assistive personnel (UAP), and other health personnel working in the school health program.	
B. There are written objectives for the school health program.	
C. School nurses are licensed to practice under the scope of the Nursing Licensure Compact (NLC).	
D. A qualified school nurse supervisor, coordinator, or consultant is available to give direction and advice.	
E. Channels of communication between the supervisor, administrator, and staff are clearly established and understood.	
F. Individual staff evaluations are conducted by peer and/or supervisor.	

Guidelines for Evaluation of School Health Services	
Criteria	Documentation/ Comments
<p>G. The number of school nurse personnel is adequate to fulfill the objectives of the school health service program “determined at levels sufficient to provide the range of health care necessary to meet the needs of school populations”.⁶²</p> <p>Per the <i>Code of Virginia</i> § 22.1-274. School Health Services, a school board may employ nursing services consistent with a ratio of at least one nurse per 1,000 students by July 1, 1999.⁶³</p>	
<p>H. In-service training is available and a reasonable amount of release time is available to permit health personnel to attend staff meetings, workshops, and continuing education programs.</p>	
<p>I. The school nurse assists in monitoring incident/accident/injury reports, as well as visits to the school clinic that may indicate trends in absenteeism, mental health, or physical health. In addition, nurses should be able to assess for risk behaviors and protective factors.</p> <ol style="list-style-type: none"> 1. Potential trends and increases in illnesses or certain complaints should be discussed with the principal and school health supervisor. 2. Data can be used to coordinate appropriate school health interventions. 	
<p>J. Health assessments by the school nurse are:</p> <ol style="list-style-type: none"> 1. Completed on all kindergarten students. 2. Completed on all new students in the school division. 3. Completed on students enrolled in special educational programs. 4. Completed on all students referred by school personnel or parents for a suspected health problem. 5. Completed as needed on students with a known health problem. 	
<p>K. School entrance physical examinations by a physician or nurse practitioner are:</p> <ol style="list-style-type: none"> 1. Required for all new students entering the school division K-5. 2. Required annually for all students competing in school athletics. 3. Reviewed by the school nurse to identify and follow up on all health problems. 	

Guidelines for Evaluation of School Health Services

Criteria	Documentation/ Comments
<p>L. Screening programs are conducted as designated by the school nurse or other trained personnel.</p> <ol style="list-style-type: none"> 1. Written procedures are available and being followed for: <ul style="list-style-type: none"> • Identification of health problems. • Vision. • Hearing. • Scoliosis. • Dental. • Height and weight. • Other (List). _____ 2. The school nurse initiates follow-up steps to contact parents/guardians to ensure further evaluation or care for all students failing screening procedures. 3. The teachers are notified of any preferences needed for the student to participate in the classroom. 4. Follow-up checks are made on students for further evaluation or care to see that such services were provided. 5. The school nurse shares evaluation recommendations with the teachers and records them on the student's health record. 6. Efforts are made to ensure that students with severe conditions receive professional care. 	
<p>M. School personnel - nurse referrals and conferences:</p> <ol style="list-style-type: none"> 1. School personnel are advised and encouraged to observe each student for possible health deviations. 2. Classroom teachers are provided with information on signs to watch for in referring students for health screening and have necessary forms or written procedures to make such referrals. 3. There is an established system by which school personnel can make referrals to the school nurse. 4. The school nurse provides feedback to school personnel on referrals. 5. Teacher-nurse conferences are held when a teacher may have a legitimate professional educational interest in reviewing a student's health information. ⁶⁴ 	

Guidelines for Evaluation of School Health Services	
Criteria	Documentation/ Comments
<p>6. In-service training is held, as needed, to educate teachers/school personnel on factual disease information, how to respond to health emergencies in the school setting; i.e., seizures, hypo/hyperglycemia, life threatening allergies; reporting serious accidents or illness; using universal precautions.</p>	
<p>N. Health education and counseling is available to public, parents, and school personnel.</p> <ol style="list-style-type: none"> 1. Parents are encouraged to confer with the school nurse when a school program adjustment is needed for a student with a health issue. 2. Time and privacy are available for students to talk with the school nurse about their concerns or for the school nurse to discuss his/her screening findings with the student. 3. The school nurse can make home visits to pupils with special health issues. 4. Parents are informed of the results of health assessments and failures in screening programs either by telephone, electronic or written notice per local school division policy. 5. Parents are assisted in locating resources for care of identified health issues. 6. Students are assisted in becoming knowledgeable health consumers. 7. Initiate prevention programs based on assessment of high-risk behaviors. Provide interventions to promote healthy behaviors and prevent child and adolescent morbidity/mortality. 8. Participate in comprehensive health education programs and school health policy development. 9. Educate about infectious and communicable diseases. 10. Provide health related case management services and assist families in accessing resources. 	
<p>O. Students with special health care needs are identified in the school division.</p> <ol style="list-style-type: none"> 1. Parent-school nurse conferences are conducted to ascertain the student's current health status. 2. Current recommendations are obtained from the student's source of medical care. 	

Guidelines for Evaluation of School Health Services	
Criteria	Documentation/ Comments
<ul style="list-style-type: none"> 3. Special instructions and services are provided for students with special health care needs as indicated. 4. School personnel are informed of the specific needs of students with special health care needs if educationally appropriate. 5. The school environment is adapted to accommodate students with disabilities. 6. The school nurse develops Individual Health Care Plans for students with special health care needs. 	
<p>P. The school nurse is responsible for participating in the appropriate placement of students with exceptional needs.</p> <ul style="list-style-type: none"> 1. Obtains health history and current health status information on students prior to determining placement. 2. Helps to identify the relationship between the health status and the student's ability to learn. 3. Serves as a team member to identify and interpret the physical findings and health needs of the student. 4. The school nurse serves on the school team to write goals, objectives, and characteristics for the health component of the individualized education program (IEP) and determines health factors that are pertinent to the student's most appropriate educational placement. 5. Serves as a liaison between other school personnel, parents, and the student's health care providers. 	
<p>Q. Communicable disease control is part of the school health services program.</p> <ul style="list-style-type: none"> 1. School personnel are trained to recognize signs of suspected communicable diseases in students. 2. School nurses report to the principal and local health department an outbreak of suspected or confirmed disease using the method by which they are to be reported per the State Board of Health Regulations for Disease Reporting and Control. 3. School nurses report on a designated basis to the principal and the local health department any other communicable disease. 4. Provisions are made for isolating students with a communicable disease until they are removed from school. 	

Guidelines for Evaluation of School Health Services	
Criteria	Documentation/ Comments
<ul style="list-style-type: none"> 5. Students with a communicable disease do not return to school until the condition has been remedied or the student is under treatment. 6. The school health service correlates its plans for disease prevention and control with the community program. 	
<p>R. A school health office or adequate workspace is available in every school.</p> <ul style="list-style-type: none"> 1. The nurse has the following equipment available: a desk with drawers, files or cupboards for health records and supplies, and an appropriate number of chairs. 2. A telephone is available in the clinic for confidential conversations concerning student health problems. 3. First aid supplies, including ice, are readily available. 4. Privacy is possible in the school health office for conducting health counseling and health assessments. 5. One cot is available for every 200 students in the school. 6. The cot has a washable surface or disposable cover. 7. A locked cabinet or container is provided for storing prescription medications. 8. A sink, separate from the bathroom facility, is located in the clinic for use in first aid/skilled care. 9. Bathroom facilities that also accommodate students with special health care needs are available within the clinic area. 10. AEDs are available, as required by building codes, in every school. 	

Chapter 12: Conducting Health Assessments

Overview

Process. Health assessment consists of day-to-day health encounters, planned and unplanned, that school health personnel have with students and staff; population-based screening programs; and routine physical examinations. A comprehensive health assessment process involves:⁶¹

- School health personnel collecting subjective and objective data related to the student's health and illness behaviors.
- Analyzing the data for accuracy and completeness.
- Collecting more data as needed.
- Analyzing the information for identification of student health risks, problems, and potential stressors.

Student Health Encounters.⁶¹ Students present a range of complaints, from potentially life-threatening situations to more common problems, such as colds and coughs. Students also seek advice, support, or just time out from stress in both the classroom and at home. Although most students go to the health room, informal encounters may occur in any number of locations in the school; for example, a student interacts with a school nurse in the hallway, cafeteria, or playground; a teacher stops the school nurse in the hallway to refer a student; or a school nurse conducts a follow-up visit with a student in the hallway or some other place in the school (following the student's visit to the health room).

Some school nurses are assigned to cover more than one school, and as such, they are not always readily accessible to students. Often a teacher, health aide, or school secretary is the initial person to see the student, so it is important for them to understand the parameters of a school health encounter and what types of questions should be asked to assist licensed health personnel in making an assessment. Making a health assessment remains the responsibility of the school nurse or other fully qualified and licensed health care professional.

History of the Complaint.⁶¹ When assessing a student, the school nurse needs to obtain subjective data about the complaint or the history of the complaint. The initial person seeing the student must skillfully explore the presenting symptom by analyzing the complaint. Information on the location, frequency, duration and severity, quality, quantity, setting, associated symptoms, and factors that make the symptom better or worse will guide the action taken, including referral to a health care provider, observation in the health office, and/or notifying parents/guardians.

Health History.⁶¹ The health history provides additional subjective data as part of the assessment process. School health personnel should ask open-ended questions that encourage a student to describe the problem. It is important to encourage discussion around different areas of the student's life (e.g., home, work, and school), especially if the problem seems to be chronic. For today's student, especially the adolescent, a psychosocial review of systems is as important as the physical examination. A brief psychosocial assessment, including asking questions about any risk behaviors the student may be engaged in, may include the following questions:

- "Tell me about it."
- "When did it start?"
- "Has it ever happened before?"
- "What did you do?"
- "How did it make you feel?"
- "Did you tell your parents?"
- "What did they do?"
- "Are you taking any medication?"
- "Are you having problems in your classes?"
- "What class do you have now?"

Questions may focus on the following categories: home life, food, activities, shelter, supervision, health care, and support systems. Chronic reoccurring symptoms may be associated with psychosocial problems, such as abuse.

The school nurse should be aware of different cultural, ethnic, or socioeconomic backgrounds of students. Nurses should take time to ask questions in a sensitive and appropriate manner, be aware and respectful of differences in communication, and be cognizant of varying beliefs and understandings of health and healthcare.

Physical Assessment. Assessment also includes objective data or a physical assessment. The person assessing the student obtains information about signs of an illness (e.g., vital signs) and takes appropriate measures, such as having the student rest in the health room and either returning to class or calling parents if the student is to be sent home, suggesting any follow-up with the student's health care provider, or calling emergency services.

Resources

Selekman, J. (2013). *School Nursing: A Comprehensive Text* (2nd Ed). Philadelphia, PA: F.A. Davis Company.

The following subsections identify common health conditions encountered in the school health office, and explain traditional individual student health assessments encountered by health care providers in the school environment:

- [Common Health Conditions Encountered in the School Health Office](#)
- [Health Information Form Requirements](#)
- [School Entrance Physical Examination Requirements](#)
- [Immunization Requirements](#)
- [Athletic Pre-Participation Physical Examination Requirements](#)
- [Career & Technical Education Medical Assessment](#)

Common Health Conditions Encountered in the School Health Office⁶¹

Frequent health conditions encountered in the school health office are (1) headaches, (2) sore throat, (3) abdominal pain, and (4) general malaise. The focus of this subsection is on the initial stage of assessment and does not include medical management. The following four examples of encounters were contributed by Simmons College Graduate Program in Primary Health Care Nursing and represent some suggested processes in assessing students. These guidelines are based on current practice and the clinical experience of contributors. If any of these symptoms are brought to the attention of an untrained school staff member, that staff member should refer the student to the appropriate licensed health professional (i.e., registered nurse, school physician, or licensed nurse practitioner).

Headaches

Headaches can be classified as acute, chronic, and recurrent. Acute headaches are of recent onset and frequently are associated with infectious illnesses, such as colds and influenza. Chronic and recurrent headaches may be associated with stress and tension, migraines, or potentially serious medical problems, such as sinusitis, dental problems, concussion, or brain lesion. Up to 20 percent of all school age children experience frequent, recurrent headaches. The following list of key questions and key physical examination components are commonly used to obtain subjective and objective information when assessing the student who complains of a headache:

Headache: Questions (Subjective Data)

Question	Action
1. Name and age of student?	Obtain health record.
2. Has there been any recent head injury?	Examine the student's head for evidence of lacerations, bleeding, bumps, or bruises.
3. Where is the location of the headache? What is the severity? How long has the headache persisted?	Any headaches that are characterized as severe, unilateral, or have persisted beyond 12 hours should be evaluated by a licensed health professional immediately.
4. Are there any associated symptoms: vomiting, stiff neck, difficulty with vision, drowsiness, recent behavior, or personality changes?	If positive, the student should be seen by a licensed health professional immediately. These symptoms can be associated with a life-threatening infection, such as meningitis.

Headache: Questions (Subjective Data)

Question	Action
5. Does the student have any other serious chronic medical disorders?	If positive, there may be an association. The student should be evaluated by a licensed health professional that same day.
6. How often does the student get headaches? What has made them feel worse or better?	There may be certain measures the student can take to treat the headache: lie down and rest, offer a drink of water, take an analgesic (for example; acetaminophen), and apply a cool washcloth to forehead. Medication may require an authorized prescriber's order and parental consent depending on state laws and school policy.
7. Is the student feeling ill in any other way: sore throat, stomachache, chills?	Headaches can be associated with common infectious illnesses, such as colds, strep, pharyngitis, or flu. The student should be seen by a licensed health professional that same day for appropriate testing, diagnosis, and treatment.
8. Has the student eaten recently?	Headaches may be associated with hypoglycemia or dehydration.

Headache: Physical Examination Components (Objective Data)

Action	Plan
1. Check the temperature.	If temperature is elevated or if there is tenderness or pain on motion of neck, inequality of pupils, or evidence of head trauma, the student needs to be evaluated by a licensed health professional immediately.
2. Neck: Is there any tenderness or pain on motion?	
3. Eyes: Are the pupils equal in size?	
4. Head: Are there any lacerations, bleeding, bumps, or bruises?	

Headaches: Potential Causes

Assessment	Plan
1. Acute onset headache	This may be associated with infectious illnesses, such as strep throat, colds, or influenza. May also be associated with lack of sleep, stress, dehydration, or not eating.
2. Acute recurrent headache	This may be migrainous. A student who presents with a severe headache should be sent home to be evaluated by their health care provider.
3. Chronic non-progressive headache (as a result of tension or stress)	This may cause dull, constant pain, commonly located around the forehead and temporal area. The student can often alleviate the pain with rest, dim lighting, a drink of water, a cool washcloth, and take an analgesic (for example; acetaminophen). Medication may require an authorized prescriber's order and parental consent depending on state law and school policy.

Sore Throat (Pharyngitis)

Infections of the throat may be caused by either viruses or bacteria, but the vast majority of infections are viral. Because it is not possible to know whether the infection is viral or bacterial by inspection, a referral for a throat culture may be necessary in order to identify an infection caused by bacteria, such as *Streptococcus*. An untreated streptococcal sore throat can lead to serious complications, such as rheumatic fever or nephritis. About 10 to 20 percent of children who present with sore throat have a *Streptococcus* infection (strep throat) as the cause of their pharyngitis. The typical incubation period for strep throat is one to three days. Viral infections of the throat usually last three to four days as part of a cold or upper respiratory infection. The following list of key questions and key physical examination components are commonly used to obtain subjective and objective information when assessing the student who complains of a sore throat:

Sore Throat: Questions (Subjective Data)

Question	Action
1. Name and age of student?	Obtain health record.

Sore Throat: Questions (Subjective Data)

Question	Action
2. How long has the sore throat been present? How severe is the discomfort?	Any sore throat that is characterized as very painful or has been present beyond 24 hours should be evaluated by a licensed health professional that same day.
3. Are there any associated symptoms, such as cough, runny nose, or itchy and/or watery eyes?	Sore throat associated with upper respiratory symptoms is likely to be caused by a virus. Sore throats of this nature may also be related to seasonal allergies.
4. Does the student have the following symptoms: headache, rash, chills, or abdominal pain?	Sore throat associated with these symptoms is more likely to be caused by bacteria.
5. Has the student had many sore throats or strep infections in the past?	If positive, the student should have a throat culture in order to rule out strep throat, a potentially serious infection.
6. Does the student have any serious chronic medical disorder, such as kidney disease, diabetes, or congenital heart disease?	If positive, the student should be evaluated by a licensed health professional that same day.
7. Has the student had recent contact with anyone who has had strep throat or impetigo (i.e., skin infection caused by <i>Streptococcus</i>)?	Sore throat following a recent contact with someone who had strep throat or impetigo warrants a throat culture in order to rule out <i>Streptococcus</i> as a cause of the pharyngitis.

Sore Throat: Physical Examination Components (Objective Data)

Action	Plan
1. Check the temperature.	If positive for elevated temperature and enlarged and tender glands with a red and pus-like throat, the student needs to be evaluated by a licensed health professional.
2. Neck: Are the glands in the neck swollen and/or tender?	
3. Mouth: Does the throat appear red? Are the tonsils enlarged? Is pus or exudate present on the throat or tonsils?	

Sore Throat: Potential Causes

Assessment	Plan
1. Viral infections	If there is no rash, fever, difficulty swallowing, swollen or tender glands, abdominal pain, or headache, the student most likely has a viral infection. The symptoms may be alleviated by taking an analgesic (for example; acetaminophen), gargling with weak, warm saltwater, and drinking fluids. Medication may require an authorized prescriber's order and parental consent depending on state law and school policy.
2. Bacterial infections	Sore throat associated with such symptoms as fever, difficulty swallowing, swollen and tender glands, abdominal pain, rash, or headache is more likely to be caused by bacterial infections. The student should have a throat culture performed. Usually the results are available within 24 to 48 hours. If positive, the student should be placed on antibiotics by the student's primary care provider. Students are considered not contagious after 24 hours of antibiotic therapy.

Abdominal Pain

Abdominal pain, usually classified as acute or recurrent, is a difficult complaint to assess. It can indicate a condition, such as appendicitis, that may require surgery. Other non-abdominal conditions (such as urinary tract infections or pneumonia) can also mimic acute or serious abdominal problems, such as appendicitis. Recurrent abdominal pain is also a challenge to diagnose since the student usually appears healthy but is complaining of severe pain. Chronic abdominal pain is classified as three or more episodes severe enough to interfere with activity occurring over a three-month period or longer. The etiology is usually unknown but may be psychosomatic in origin and associated with stress at home or in the classroom. The true incidence of an acute abdominal pain caused by appendicitis is estimated at between 7 and 12 percent; 10 to 12 percent of school-age children are affected by recurrent or chronic abdominal pain. The following list of key questions and key physical examination components are commonly used to obtain subjective and objective information when assessing the student who complains of abdominal pain:

Abdominal Pain: Questions (Subjective Data)

Question	Action
1. Name and age of student?	Obtain school health record.
2. Analyze the symptom. Ask the student to describe the pain, frequency, location, duration, if it radiates, and what makes it better or worse.	Inspect the area for any obvious recent injury. If pain appears severe and is interfering with activities, the student

3. Is this a new complaint? If not, how many times has the student complained of this?

should be referred to a licensed health professional immediately.

If this is a common complaint for this student, it may be indicative of stress-related illness and the student could stay in school.

4. Does the student have associated symptoms, such as nausea, vomiting, diarrhea, constipation, or decreased appetite?

If positive, these symptoms may indicate a viral infection but also may be indicative of an acute abdominal condition. Consult a licensed health professional immediately. Note that particularly in young children, abdominal pain may also be related to needing to use the restroom.

5. For girls: Is it associated with frequency or burning on urination? Is it associated with menses?

Urinary tract or vaginal infections need to be diagnosed and treated by a licensed health professional. If positive for the onset of menstrual period, rest, over-the-counter pain reliever (per school protocol or licensed prescriber's order, both with parental consent), and heat may be used to decrease pain and discomfort.

Abdominal Pain: Physical Examination Components (Objective Data)

Action	Plan
1. Check temperature and blood pressure.	If positive for temperature and other signs of severe pain, the student needs to be referred immediately to a licensed health professional to rule out appendicitis or other emergency condition.
2. Abdomen: Is pain localized? Does it radiate? Any signs of injury?	
3. Is student pale? Sweaty?	
4. Is mobility or activity severely restricted? Are there signs of guarding?	

Abdominal Pain: Potential Causes

Assessment	Plan
1. Acute abdominal pain	Appendicitis is the most common cause of acute abdominal pain.
2. Recurrent abdominal pain	Recurrent pain is associated with urinary tract infection, constipation, gastrointestinal viral infections, stress, and gynecological problems. Refer to a licensed health professional for evaluation.

General Malaise: “I Don’t Feel Well”

This complaint, frequently heard in school health offices, is vague and nonspecific and can indicate a wide variety of problems, from specific physical problems to psychosomatic or stress-related problems. School personnel need to obtain accurate information, since this complaint may not be the real reason the student is in the health office. The student may be using this complaint as a means of communicating an underlying problem to the school nurse or other school personnel. This assessment demands a thorough, skillful, and sensitive interview. The following list of key questions and key physical examination components are commonly used to obtain subjective and objective information when assessing the student who complains of a general malaise:

General Malaise: Questions (Subjective Data)

Question	Action
1. The most efficient way to collect information of a physical nature is to review the body systems. This includes a review of past and present illnesses and usually proceeds head to toe.	Differentiate between physical and psychological etiology.
2. Ask general questions: “Are you having any pain anywhere? Have you been sleeping? Any nausea, vomiting, diarrhea?”	If positive, follow up with more complete information on specific area.
3. Questions concerning family, home, school, and peers need to be open-ended and sensitive. “Has anything changed at home? How is school going?”	If positive, student might just need some “time out” in health office. Assess for further referral for counseling.

General Malaise: Physical Examination Components (Objective Data)

Action	Plan
1. Check temperature.	If positive, this may indicate nonspecific viral or bacterial disease. Refine assessment and refer for further evaluation.

General Malaise: Potential Causes

Assessment	Plan
1. Organic cause.	Vague, nonspecific complaints can still be indicative of physical injuries and illnesses. These need to be ruled out by careful history and data collection before the assumption is made that the complaint is stress related.
2. Psychosomatic or stress related.	Stress-related illness and chronic complaints warrant follow up and counseling by school guidance counselors, or referral to community services.

Resources

John, R. & Chewey, L. (2013). Common complaints. In J. Selekman (Ed.), *School nursing: A comprehensive text* (2nd ed., pp. 578-640). Philadelphia, PA: F. A. Davis Company.

Health Information Form Requirements

Authorization

[Code of Virginia, Section 22.1-270, Preschool Physical Examinations.](#) The *Code of Virginia* requires that parents or guardians of entering students shall complete a health information form, developed by the Departments of Education and Health, or developed by school divisions and approved by the Superintendent of Public Instruction.

Recommendations

Referral and Follow-Up Process. Any issues noted on the health information form may require referral or follow-up activities. The school nurse who is responsible should:

- Review the completed health information form.
- Identify health issues and/or health concerns that might necessitate evaluation for special education services.
- Provide appropriate referrals and follow up.
- Collaborate with parents/guardians and appropriate health care providers to ensure linkages between the school, home, and community.

Documentation

Health Information Form. The following “health information form (Part I)” is approved by the Superintendent of Public Instruction (school divisions can develop their own form, but it must be approved by the Superintendent of Public Instruction). (See *Code of Virginia*, § 22.1-270.)

- [Commonwealth of Virginia School Entrance Health Form MCH 213G \(Instructions\)](#)
- [Commonwealth of Virginia School Entrance Health Online Fillable Form \(MCH213G\)](#)
- <https://www.vdh.virginia.gov/school-age-health-and-forms/school-health-forms-and-action-plans/>

School Entrance Physical Examination Requirements

Authorization

[Code of Virginia, Section 22.1-270, Preschool physical examinations.](#) The *Code of Virginia* states that:

A. No pupil shall be admitted for the first time to any public kindergarten or elementary school in a school division unless such pupil shall furnish, prior to admission, (i) a report from a qualified licensed physician, or a licensed nurse practitioner or licensed physician assistant acting under the supervision of a licensed physician, of a comprehensive physical examination of a scope prescribed by the State Health Commissioner performed within the 12 months prior to the date such pupil first enters such public kindergarten or elementary school or (ii) records establishing that such pupil furnished such report upon prior admission to another school or school division and providing the information contained in such report.

If the pupil is a homeless child or youth as defined in § [22.1-3](#), and for that reason cannot furnish the report or records required by (i) or (ii) of this subsection, and the person seeking to enroll the pupil furnishes to the school division an affidavit so stating and also indicating that, to the best of his knowledge, such pupil is in good health and free from any communicable or contagious disease, the school division shall immediately refer the student to the local school division liaison, as described in the federal McKinney-Vento Homeless Education Assistance Improvements Act of 2001, as amended (42 U.S.C. § 11431 et seq.) (the Act), who shall, as soon as practicable, assist in obtaining the necessary physical examination by the county or city health department or other clinic or physician's office and shall immediately admit the pupil to school, as required by such Act.

B. The physician, or licensed nurse practitioner or licensed physician assistant acting under the supervision of a licensed physician, making a report of a physical examination required by this section shall, at the end of such report, summarize the abnormal physical findings, if any, and shall specifically state what, if any, conditions are found that would identify the child as handicapped.

C. Such physical examination report shall be placed in the child's health record at the school and shall be made available for review by any employee or official of the State Department of Health or any local health department at the request of such employee or official.

D. Such physical examination shall not be required of any child whose parent shall object on religious grounds and who shows no visual evidence of sickness, provided that such parent shall state in writing that, to the best of his knowledge, such child is in good health and free from any communicable or contagious disease.

E. The health departments of all of the counties and cities of the Commonwealth shall conduct such physical examinations for medically indigent children without charge upon request and may provide such examinations to others on such uniform basis as such departments may establish.

F. Parents of entering students shall complete a health information form which shall be distributed by the local school divisions. Such forms shall be developed and provided jointly by the Department of Education and Department of Health, or developed and provided by the school division and approved by the Superintendent of Public Instruction. Such forms shall be returnable within 15 days of receipt unless reasonable extensions have been granted by the superintendent or his designee.

Upon failure of the parent to complete such form within the extended time, the superintendent may send to the parent written notice of the date he intends to exclude the child from school; however, no child who is a homeless child or youth as defined in subdivision A 6 of §22.1-3 shall be excluded from school for such failure to complete such form.

Overview

A periodic physical examination is critically important for all children and adolescents and especially for those children who do not have primary care providers and ongoing monitoring of their growth and development. The physical examination is crucial for preventive, diagnostic, or corrective purposes. The objectives of a physical examination are to understand and follow up on health conditions that may adversely affect the student's well-being and ability to learn. While it is understood that the primary responsibility for a student's health care rests with the family, the school is responsible for the safety and well-being of students while they are in the school setting. Therefore, the family and the schools are in a partnership when it comes to the physical well-being of a child entrusted to the school division. Adequate and appropriate follow-up intervention is necessary to ensure that all school children have a periodic physical examination.

Recommendations

Procedure and Personnel. In some cases, the physical examination may be performed at school. Physical examinations completed in school should be done with parental consent; in the presence of an adult witness, preferably the same gender as the student, unless the student states otherwise⁶⁵; in a private setting; and with sufficient time allotted for an appraisal of both physical and mental health. Parents should be present, if possible. If the parent is present at the time of the physical examination, they should be apprised of all findings concerning the child's growth and development and the findings of the health appraisal. When the parent is not present written notification of the health care provider's findings is necessary.

Referral and Follow-Up Process. Any issues noted during the physical examination may require referral or follow-up activities. The school nurse should:

- Review the completed school entrance physical examination report.
- Identify health issues and/or physical, social-emotional, or developmental needs.
- Provide appropriate referrals and follow-up interventions to maximize the student's school readiness.
- Collaborate with parents/guardians, and appropriate health care providers to ensure linkages between the school, home, and community.

Documentation

School Entrance Physical Examination Form. Part III-Comprehensive Physical Examination Report of the Commonwealth of Virginia School Entrance Health Form constitutes the “scope” of a comprehensive physical examination prescribed by the State Health Commissioner. (Ref. *Code of Virginia*, § 22.1-270.)

School Health Forms and Action Plans – School-Age Health and Forms (below)

- [Commonwealth of Virginia School Entrance Health Form MCH 213G \(Instructions\)](#)
- [Commonwealth of Virginia School Entrance Health Online Fillable Form \(MCH213G\)](#)
- <https://www.vdh.virginia.gov/school-age-health-and-forms/school-health-forms-and-action-plans/>

Immunization Requirements

Authorization

[*Code of Virginia, Section 22.1-271.2, Immunization Requirements.*](#) The *Code of Virginia* requires that no student shall be admitted by a school unless at the time of admission the student or his parent submits documentary proof of immunization to the admitting official of the school or unless the student is exempted from immunization pursuant to subsection C or is a homeless child or youth as defined in subdivision A6 of [§22.1-3](#).

[*Code of Virginia, Section 22.1-271.1, Definitions.*](#) The *Code of Virginia*, for the purpose of § 22.1-271.2, defines the following terms: “admit” or “admission,” “admitting official,” “documentary proof,” “student,” “immunized” or “immunization,” and “school.”

[*Code of Virginia, Section 32.1-46, Immunization of Patients Against Certain Diseases.*](#)

[*Code of Virginia, Section 32.1-47, Exclusion From School of Children Not Immunized.*](#)

Minimum Requirements

Commonwealth of Virginia, State Board of Health (12VAC5-110): Regulations for the Immunization of School Children, Virginia Department of Health, Division of Immunization, defines immunization requirements for students attending school. The *Code of Virginia*, [§22.1-271.2](#), mandates the immunization requirements for all children attending school and licensed day care in Virginia.

Reference the current year, [Recommended Immunization Schedule for Children and Adolescents Aged 18 Years and Younger](#), United States, as approved by the Advisory Committee of Immunization Practices (ACIP).

Exceptions

The *Code of Virginia*, [§22.1-271.2](#), provides for exemptions from immunization requirements for religious and medical reasons, responsibilities of admitting officials to insure the immunization status of students, for the exclusion of students who are not in compliance with the immunization requirements, and responsibilities related to documentation of immunizations.

- **Medical Exemptions.** Medical exemptions are issued for a student with a medical contraindication to one or more vaccines. The parent or guardian must [present a statement on the Commonwealth of Virginia School Entrance Health Form \(MCH213G\)](#)

form from a licensed health professional or local health department official that the physical condition of the child is such that the administration of one or more of the required immunizing agents is contraindicated and whether the condition is permanent or temporary.

- **Religious Exemptions.** Religious exemptions are issued to student's parent/guardian by signing the Certificate of Religious Exemption form ([Form CRE-1](#)), an affidavit that must be notarized. If the parent maintains the need to continue the religious exemption during a documented school health emergency, the student will be excluded from school for his or her protection until the emergency is concluded.

Recommendations

Procedure and Personnel. To assure immunization compliance in assigned school(s), the school nurse should:

- Establish a system of documenting immunization compliance on the school health record.
- Issue special exemptions as the principal's designated official. To accomplish this, the school nurse should:
 - Issue special exemption certificates.
 - Maintain tickler file on all special exemption certificates issued.
 - Monitor status to assure legal compliance with the immunization law.
 - Document status on receipt of valid Certificate of Immunization.
 - Maintain a file of all students who are conditionally enrolled, and have a system for periodic follow up to ensure compliance.
 - Report to principal any students who fail to provide required documentation and must be suspended from school until this requirement is met.
 - Maintain liaison with state health department immunization representative.

Referral and Follow-Up Process. Representatives of the Virginia Department of Health are authorized to audit school records to ensure compliance with the regulation. A minimum of 10 percent of the state's public schools are selected from a random sample for annual audit; however, local health department staff will be conducting record reviews for a statistically valid local immunization audit.

Consultation and Technical Assistance. Although these guidelines are designed to cover most situations, school personnel need to refer to the [Virginia Department of Health, Division of](#)

[Immunization, School Requirements](#), to ensure that all students attending any public, private, or parochial school and all attendees of licensed child care centers in the Commonwealth are adequately immunized according to current recommendations, as appropriate for the age of the student. In addition, school personnel may contact either their local health department or the Virginia Department of Health, Division of Immunization, for further consultation or technical assistance.

Documentation

Recording Requirement. Every school must record each student's immunizations on the school immunization record, which is provided by the Virginia Department of Health and must be made part of the mandatory permanent student record. (See [Code of Virginia, § 22.1-271.2, E.](#))

Proof of Immunization. "Documentary proof" of immunization should be included on the following appropriately completed form.

- [Commonwealth of Virginia School Entrance Health Online Fillable Form \(MCH213G\)](#)
- For a new student transferring from an out-of-state school, any immunization record signed by a MD or RN, that contains the exact date (month/day/year) of administration of each of the required doses of vaccine when indicated, and complies fully with the requirements prescribed under Section 70 of the *Regulations for the Immunization of School Children* (12VAC5-110-70) are acceptable (Reference [12VAC5-110-100](#)). Questions regarding records should be directed to the local health department.

Reporting Requirement. Within 30 calendar days after the beginning of each school year or entrance of a student, each school admitting official shall file an immunization summary report with the local health department, using the most recent edition of the Student Immunization Status (SIS) Report form (Information and Instructions can be found via the [Student Immunization Survey Site](#)). (Reference [Code of Virginia, § 22.1-271.2, E.](#) and [12VAC5-110-90\(F\)](#)).

Compliance. Officials from the Virginia Department of Health and local health departments are authorized to inspect school immunization records (Reference [12VAC5-110-90\(G\)](#)). (A minimum of 10 percent of the state's public schools is selected from a random sample for annual audit (Reference *Code of Virginia* § 22.1-271.2 (E)). However, local health department staff will be conducting record reviews for a statistically valid local immunization audit.

Athletic Pre-Participation Physical Examination Requirements

Authorization

[Virginia High School League, Inc.](#) (VHSL). The VHSL requires that all high school students complete a pre-participation physical examination (PPE) in order to be eligible to represent their school in any VHSL interscholastic athletic contest. The purpose of this examination is to screen for life threatening health conditions and/or health conditions that may lead to injury or illness. In addition, the PPE provides information on the student's general health.⁶⁶ A separate examination and certification are required for each high school year and are valid from May 1 of the current year through June 30 of the succeeding year. The completed form must be on file in the Office of the Principal. The Medical Advisory Board of VHSL, Inc. is responsible for updating the Athletic Participation/Parental Consent/Physical Examination Form as needed in order to remain consistent with the most recent recommendations and guidelines pertaining to the health and well-being of adolescents.

Separate jurisdictions may choose to require middle school athletes participating in competitive sports, other than intra-mural sports, to submit a pre-participation physical. However, this is not a state requirement and is left up to the discretion of the particular locality. Middle schools that choose to require physical examinations may use this form or provide another form developed by the health care providers of their choice.

Recommendations

Procedure and Personnel. The athletic pre-participation physical examination is best performed by the student's primary health care provider. Oftentimes, adolescents only visit their health care provider for a sports physical. Therefore, students should be encouraged to have this evaluation performed by their primary health care provider where the assessment can be integrated with other age-appropriate anticipatory guidance and screening. The PPE should be completed at least six weeks before the beginning of the athletic season so that any additional recommended tests or consultations may be completed.⁶⁶

Referral and Follow-Up Process. The completed forms should be reviewed by the school nurse or other health professional to clarify questionable health information. The school nurse should track such referrals and collaborate with parents/guardians.

Documentation

Athletic Pre-Participation Physical Examination. Completed [Athletic Participation/Parental Consent/Physical Examination Form](#).

Resources

- American Academy of Pediatrics, Sports Medicine and Fitness
[Preparticipation Physical Evaluation](#)
- Virginia High School League, Inc.
[Handbook and Policy Manual](#)

The *Handbook* contains official information concerning League officers and administration, organization and membership, rules and regulations, and activities programs. Supplements to the *Handbook* are published regularly throughout the school year. The *Policy Manual* provides specific provisions related to various aspects of the *Handbook* and League programs. This handbook is updated annually.

Career & Technical Education Medical Assessment

Authorization

Career & Technical Education Program Health Requirements. Certain programs may have health requirements that were established to minimize transmission of communicable disease in the work setting. The following list provides examples of what might be required for some vocational programs:

Career & Technical Education Program Health Requirements		
Program	Health Requirements	Resources
Cosmetology	Annual Tuberculin skin test	Health Department Private Physician
Licensed Practical Nursing Emergency Medical Technical	Annual Tuberculin skin test Hepatitis B vaccine series MMR vaccine Tetanus vaccine	Health Department Private Physician
Horticulture	Tetanus vaccine	Health Department Private Physician
Dental Assistant	Annual Tuberculin skin test Hepatitis B vaccine series MMR vaccine Tetanus vaccine	Health Department Private Physician

Recommendations

Procedure and Personnel. Each school division should ascertain the requirements for its own programs; students should be counseled about these requirements and available community resources for meeting them.

Referral and Follow-Up Process. The completed forms should be reviewed by the school nurse or other health professional to clarify questionable health information. The school nurse should track such referrals and collaborate with parents/guardians.

Record Keeping and Documentation. It is recommended that documentation of counseling be maintained in the student's file.

Chapter 13: Population-Based Screening Programs

Population-based screening for health problems, an important component of a school health program, is designed to detect previously unrecognized conditions or pre-clinical illnesses. Early detection provides the opportunity for early intervention and remediation while limiting potential disability and negative impact on scholastic performance. The following guidelines⁶¹ are applicable to any screening program in either the school or community.

Assessment. The scope and nature of a screening program should be based on the documented health needs of the population served. These needs may have been identified by a state agency and may be mandated by statute or regulation, or they may be identified by local school or community health personnel, parents, students, or educators. Decisions should be based on the definition of the target population that is at risk for developing an illness or condition that is not likely to be detected unless the screening program is offered.

Planning. Careful planning is the key to an effective screening program. The time invested at the planning stage will make implementation easier and more accurate. The school nurse should play a major role in the planning phase and will need to spend the required time to develop a successful program.

The following activities and/or decisions should be addressed during the planning phase:

- Determine the purpose of the screening program.
- Define the population to be screened.
- Decide which screening procedure or test to use.
- Ensure that adequate resources are available for equipment and supplies; staff training; and staff time to conduct tests and retests, record results, interpret them to students and families, and conduct follow-up interventions.
- Determine referral criteria.
- Collaborate with members of the school health team, including community health providers, regarding the following issues: criteria used for referral for diagnosis and treatment, decisions regarding who will be treated, and what resources are available for follow-up interventions, especially for those who are uninsured.
- Plan the mechanics of the actual screening program, including determination of time required for screening, and designating screening personnel role responsibilities.
- Outline a time frame for additional/makeup/rescreening, referrals, and follow up.

- Decide how to include content regarding the disease or condition and screening procedure into the health education curriculum.
- Determine how to evaluate and report the results of the screening program.

Implementation. Implementation begins with the training of the screening personnel or arranging for training of staff (school nurses, health aides, physical education teachers, volunteers, etc.). In addition, implementation requires the following:

- Order supplies.
- Ensure that the equipment (e.g., audiometer, sphygmomanometer) is in good working order, and has been calibrated per the schedule recommended by the manufacturer ⁶⁷.
- Notify parents/guardians of screening.
- Recruit, orient, and train personnel and/or volunteers, if used.
- Arrange for space that is appropriate, quiet, and private.
- Perform the actual screening as planned. Document all test results on student health records.
- Re-screen students with borderline or questionable results (school nurse usually does this).
- Refer for follow-up care all those who fail to meet the criteria.
- Notify parent or guardian by letter and telephone call if appropriate.
- Notify medical provider by letter, usually via parent or guardian.
- Obtain reports from the medical provider or other related professionals, such as audiologists or optometrists regarding diagnosis, treatment, and follow-up care.
- Continue contact with parents or guardians, including home visits or telephone calls, until follow-up care is achieved.
- Communicate as needed with educational staff. Ensure confidential data handling.
- Attach follow-up medical reports to the health record.

Evaluation. Use evaluative outcome criteria that focus on the results of the program, measure behaviors, and give dates by which behaviors occur. Tally test data by grade; compare results to expected results based on national or state data. Finally, compare completed referrals to a set goal (e.g., “95% of referrals will be completed”). Work toward increasing the percentage of completed referrals.

Although screening does not substitute for a diagnostic evaluation, effective screening programs are likely to identify health problems that otherwise would not be identified until a later date, when treatment is less effective or more costly. In addition, referral and follow-up care after screening is a key component. Appropriate and timely follow up can lead to early diagnosis and prompt treatment of the problem before it becomes a disability and/or more costly to treat. Screening and follow-up interventions are essential roles of the school health program.

Waiver Procedure. Waivers for some types of screening are available in order to make local school health programs more relevant to the community. Contact local school division for procedures and waiver requests.

The following subsections identify and explain traditional student population health assessments that are typically used by health care providers in the school environment.

- [Blood Pressure Screening](#)
- [Dental Screening and Oral Health](#)
- [Early Periodic Screening, Diagnosis, and Treatment \(EPSDT\) Program, Medicaid \(FAMIS Plus\), and CHIP \(FAMIS\)](#)
- [Hearing Screening](#)
- [Height and Weight Screening](#)
- [Scoliosis Screening](#)
- [Speech and Language Screening](#)
- [Vision Screening](#)

Blood Pressure Screening

Authorization

No Specific Legal Mandate. There is no specific legal mandate to provide blood pressure screening. Blood pressure measurement should be included in the physical examination as part of the continuing care of the child, not as an isolated screening procedure. The school entry physical examination and the yearly athletic physical for high school athletes require documentation of a student's blood pressure.

Overview

Blood pressure assessment provides a physiological indicator of cardiovascular status. Hypertension (higher than normal blood pressure) in children is defined as persistent blood pressure elevation that is at or above the blood pressure of 95% of children at the same age and sex on initial screening on at least three back-to-back occurrences.⁶⁸ The detection of high blood pressure during childhood is of potential value in identifying those children who are at increased risk of primary hypertension (hypertension that develops without apparent cause) as adults and who might benefit from earlier intervention and follow-up care. Children older than ten years of age are more like to have primary hypertension.⁶⁸ Early identification of children with elevated blood pressures may make it possible to halt the hypertensive process and the development of complications. Proper diet, regular exercise, and avoidance of smoking are important in helping to maintain normal blood pressure.⁶⁸ The [American Academy of Pediatrics \(AAP\)](#) screening guidelines recommend blood pressure measurements annually in children between 3 and 21 years of age.

Recommendations

Procedure and Personnel. Trained health care personnel should follow standard practices for procedures for measuring blood pressure. Ideally, an accurate BP measurement should be taken after the student rests for 5 minutes, in a seated position, using an appropriately sized cuff covering 40% of the circumference of the student's middle right upper arm.⁶⁷ Interpretation of the measurement is made by consulting a table of normative pressures for the child's age. A current table of normative pressures, by age and gender, can be found through the National Institute of Health ([NIH](#)).

Referral and Follow-Up Process. All children with blood pressure readings inconsistent with norms for their age, weight, sex, and height should be referred to their health care provider for follow-up care. Every attempt should be made by school health personnel to work with parents/guardians, encouraging follow-up care with their health care provider and getting feedback on any changes that the health care provider recommends, in order that school personnel can make the appropriate educational adjustments.

If a student is identified as having concerning blood pressure measurements, the school nurse should work closely with the student's teachers in order to ensure any necessary adjustments are made in the classroom to provide the child with an optimum learning experience.

Documentation

Recording Recommendation. Blood pressure should be recorded as part of the annual physical examination or athletic physical. These forms can be found following the links below:

- [Commonwealth of Virginia School Entrance Health Form MCH 213G \(Instructions\)](#)
- [Commonwealth of Virginia School Entrance Health Online Fillable Form \(MCH213G\)](#)
- [Athletic Participation Parental Consent Physical Examination Form](#) (Note: This is a Virginia High School League form, not a VDH/VDOE form. Direct any questions regarding the use of this form to the [VHSL](#))
- [Cumulative Health Record, Virginia Department of Education \(Form LF.009\)](#)

Dental Screening and Oral Health

Authorization

No Specific Mandate. There is no specific legal mandate to provide dental screening in Virginia.

Overview

Dental screening is an opportunity to detect early dental or oral health problems in children. Screening is not a replacement for a complete examination in a dentist's office. However, dental screening can be an important component of an oral health program and an important element of a school health program.

Oral health is a critical aspect of an individual's overall health⁶⁹, contributing to their general wellness and affecting their quality of life. General physical health, appearance, speech, and interpersonal relations are all impacted by an individual's oral health. Addressing such issues as oral hygiene, the quality of dental care, community water fluoridation, and good nutrition and safety habits at a young age will help determine the quality of a person's oral health throughout their life. The American Academy of Pediatric Dentistry, the Academy of General Dentistry, the American Dental Association, and the American Academy of Pediatrics (AAP) recommend that a child's first dental visit in a dental home should occur no later than 1 year of age⁶⁹, with the frequency of subsequent visits determined by the dentist.

Schools have a unique opportunity to affect the oral/dental health of the community by providing:

- Dental screening⁶⁷ to all students.
- Dental health education⁶⁷, in an effort to create an awareness of the importance of good dental health and well-balanced nutritious meals as part of the school food service.

In addition, collaborating with the Virginia Department of Health, Division of Dental Health, and local health departments, schools can help to ensure:

- Dental care for children who might otherwise not receive treatment, such as fluoride and sealants as determined by dental experts.
- Fluoridation of the public water supply.
- Access to services, such as consultation and in-service training for teachers, school nurses, and interested community groups.

Children suffering with oral disease often are unable to concentrate on their schoolwork. They may be experiencing pain related to dental caries or infection and/or be unable to chew, resulting in decreased nutrition. Both of these conditions can severely limit the ability of a child

to focus in the classroom. Additionally, poor oral health can result in a speech defect, poor appearance, and permanent loss of teeth. Consequently, this impairment of a child's overall physical and emotional health can result in an inability to achieve their academic and social potential.

Recommendations

A school health program should include:

- Dental screening.
- Referrals for follow-up process.
- Dental health education.

Dental Screening. If children are to maintain optimum oral health, they should have a dental examination on a routine basis. Ideally, the examination should be done in the dentist's office. If this is not possible, then less comprehensive inspections or screenings can be done in the school setting. The screening should look for the presence of dental caries (tooth decay), periodontal disease (inflammation of the gums and supporting structures), malocclusion (irregularity of the teeth or jaw), and trauma from oral injuries. School nurses, using a tongue blade and adequate illumination (e.g., penlight) can detect tooth decay and gum problems (e.g., mild gingivitis).

Teachers can play an important role in promoting good dental care and oral health. They can identify children in the classroom who are in pain related to dental problems or a child with a speech defect that may be related to a dental problem and possibly expedite a referral. In addition, reinforcement of dental health education issues by teachers, including good daily oral hygiene and good nutritional and safety habits, may contribute to a decrease in the incidence of children with oral health problems.

Referral and Follow-Up Process. All children with obvious dental caries, mild gum disease, or complaint of oral pain related to possible infection or injury should be referred to their dentist for a more complete examination. Every attempt should be made by school health personnel to work with parents/guardians, encouraging follow-up care with the dentist and getting feedback on any changes that the dentist recommends, in order that school personnel can make the appropriate educational adjustments. As the referral process and forms may vary by school divisions and locations, please consult local school division policies and procedures.

Dental Education. Schools can promote good oral health and prevent oral problems by educating students and parents/guardians. Oral health education should focus on:

- Prevention of decay through proper methods of oral hygiene (e.g., brushing, flossing).
- Use of fluoride or fluoridated water.

- Good nutrition.
- Information on the dangers of all tobacco products, including chewing tobacco.
- The importance of using mouth guards in organized high body contact sports. The [National Federation of State High School Associations](#) mandates the use of mouth guards in football, field hockey, ice hockey, lacrosse and wrestling (for wrestlers wearing braces).
- Cautioning children about running, pushing, and shoving other children as fractures of teeth frequently occur at drinking fountains as a result of these activities.
- The dangers of poorly designed school play equipment. Schools and the community should work closely to provide safe play equipment for all children.

Resources. An effective dental screening and oral health education program require the availability and use of resources in the community. Local health departments, the Virginia Department of Medical Assistance Services, and the Virginia Department of Health, Division of Dental Health, provide resources for the children in Virginia. The following chart provides a summary of resources available from the health department and other local and state agencies.

Dental Screening and Oral Health Education Programs

Program	Resources Available
Health Departments	<ul style="list-style-type: none"> • Many local health departments provide dental care for pre-school and school-age children. Charges are on a sliding fee schedule based on family income. Children on free lunch are not charged. • Dental personnel of the local health departments are an excellent resource for consultation, in-service education, screenings, and dental education in the schools.
Department of Medical Assistance Services	<ul style="list-style-type: none"> • Dental care is available through private practitioners and local health departments for children eligible for Medicaid. Eligibility is based on income and other factors determined by the local department of social services. Check with the dentist before referring children for care to confirm that they accept Medicaid. • For additional information about the Smiles for Children program, please call DentaQuest at 1-888-912-3456.
Virginia Department of Health, Division of Dental Health	<ul style="list-style-type: none"> • Fluoridation of Public Water Supply—This is the best method available to prevent dental decay in a community. Funding is available through division to provide fluoridation. • The division will provide consultation on oral health topics and will provide in-service training for teachers and school nurses. Upon request, educational materials are also available on a limited basis.

Dental Screening and Oral Health Education Programs

Program	Resources Available
	<ul style="list-style-type: none"> • Dental Surveys and Screenings—The division will conduct dental screenings and perform epidemiological surveys to determine the dental needs of a school division in selected areas of the state. • For further information on any of these services or programs, please contact the Virginia Department of Health, Division of Dental Health
Local and State Dental and Dental Hygiene Societies	<ul style="list-style-type: none"> • Assistance may be obtained from local dental or dental hygiene societies or the Virginia Dental Association. Please contact one of the local dentist or hygienists in your community for assistance.

Documentation

Recording Recommendation. A record of the dental screening of each student can be kept by recording the results on the student's health record or the following form, [Cumulative Health Record, Virginia Department of Education \(Form LF.009, Rev. 10/07\)](#)

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medicaid (FAMIS Plus) and CHIP (FAMIS)

Overview

This subsection presents a brief summary of children’s Medicaid (called FAMIS Plus), the Children’s Health Insurance Program (called FAMIS) Virginia, and school health services, including the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Information in this section is from the [Virginia Department of Medical Assistance Services, Maternal and Child Health Program](#), unless otherwise noted.

Medicaid

Medicaid is a jointly funded, federal-state health insurance program for certain people with limited income and resources. The program was authorized by Congress as part of the Social Security Act Amendments of 1965 and became Title XIX of the Act. Medicaid is a health insurance program for certain low-income families with children; aged, blind or disabled people on Supplemental Security Income; certain low-income pregnant women and children; and people who have very high medical bills. Although there are broad federal requirements for Medicaid, each state designs and administers its own program, which creates substantial variation among state programs in terms of persons covered, types and scope of benefits offered, and the amount of payments for services. States have authority to:

- Establish eligibility standards.
- Determine what benefits and services to cover.
- Set payment rates.

Each state operates its Medicaid program in accordance with its State Plan for Medical Assistance, a document that describes the state’s basic eligibility, coverage, reimbursement and administrative policies. The State Plan must be approved by the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicaid program. CMS administers the Medicaid program with the assistance of Regional Offices located throughout the country. Each state’s State Plan is periodically updated to reflect changes in state policy or to conform to new federal requirements. Because states have flexibility in structuring their Medicaid programs, there are variations from state to state. All states, however, must cover these basic services: inpatient and outpatient hospital services; laboratory and X-ray services; skilled nursing and home health services; doctors’ services; family planning; and periodic health checkups, diagnosis and treatment for children. In Virginia, the Medicaid program for children is called FAMIS Plus. In 2014, children covered through Medicaid constituted the greatest percentage of those covered, with over 614,000 children receiving assistance.

Information about services provided through Medicaid (FAMIS Plus) and CHIP (FAMIS) can be found through [Cover Virginia](#). The [Virginia Department of Medical Assistance Services \(DMAS\)](#) is the agency that is directly responsible for the administration of the Medicaid program. Families may apply for coverage for their children on [Cover Virginia](#), by calling Toll Free (1-855-242-8282), or through their local Department of Social Services Office.

Children's Health Insurance Program (FAMIS)

The Federal Children's Health Insurance Program (CHIP) is another publicly-funded insurance program, separate from Medicaid. Together, Medicaid and CHIP provide health coverage to more than 43 million children, including half of all low-income children in the United States. The federal government sets minimum guidelines for Medicaid eligibility, but states can choose to expand coverage beyond the minimum threshold.

Virginia FAMIS. Virginia's Child Health Insurance Program, FAMIS, is designed to provide comprehensive health benefits for uninsured children (under 19 years of age) in families with household incomes below 200% of the federal poverty level (FPL) but do not qualify for Medicaid. Specific eligibility requirements and information can be found through [Cover Virginia](#), [Am I Eligible?](#) Enrolled children receive many of the health services provided to Medicaid recipients including inpatient and outpatient hospital care, well child care, physician's and surgical services, mental health services, laboratory and radiological health services, vaccinations, dental care, prescription drugs, and emergency care. FAMIS is administered by the Virginia Department of Medical Assistance Services. Families may apply for coverage for their children on [Cover Virginia](#), by calling Toll Free (1-855-242-8282), or through their local Department of Social Services Office. Additional information and resources for school personnel and families can be found through [Cover Virginia](#).

Medicaid and School Health Services. According to the Health Care Financing Administration's [Medicaid and School Health: A Technical Assistance Guide](#), school health services play an important role in the health care of adolescents and children. Whether implemented for children with special needs under the Individuals with Disabilities Education Act (IDEA), or for routine preventive care, on-going primary care and treatment in the form of a school-based or linked health clinic, school-centered programs are often able to provide medical care efficiently and easily without extended absences from school. Recognizing the important role school health services can play, the Medicaid program has been supportive of school-centered health care as an effective method of providing access to essential medical care to eligible children. Questions about Medicaid reimbursement for school services can be directed to the [Virginia Department of Education Office of Student and School Support](#).

Health Care Delivery System for Medicaid and FAMIS. In Virginia, most children enrolled in Medicaid and FAMIS receive their benefits through managed care organizations (MCO). Some children are initially enrolled in fee-for-service (FFS) until they choose, or are assigned to a MCO. Some however, remain in the FFS system. When providing or coordinating school health

services, it is important to know the child's Medicaid or FAMIS coverage and delivery system. This assures appropriate service authorizations are obtained, services are coordinated, and the school division can pursue the appropriate avenue for reimbursement, if applicable.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) is a comprehensive and preventive child health program for individuals under the age of 21. The EPSDT benefit serves all children in Medicaid and is limited to those FAMIS enrolled children who receive their care under FFS (not MCO). EPSDT includes periodic screening, vision, dental and hearing services. In addition, under the Social Security Act Section 1905(r)(5), states are required to provide any medically necessary health care services listed at section 1905(a) of the Social Security Act to correct and ameliorate physical and mental conditions even if the service is not included under the state's Medicaid plan. Virginia's EPSDT program goals are to keep children as healthy as possible by assuring that health and developmental concerns are diagnosed as early as possible, assuring that treatment is provided before problems become complex, and assuring that medically justified services are provided to treat or correct identified problems.⁷⁰ EPSDT is geared toward the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible.

Any caregiver or professional who interacts with the EPSDT enrollee may request the screening. EPSDT screenings are conducted by physicians or certified nurse practitioners and can occur during the following:⁷⁰

- **Periodic Screening** – Checkup that should occur at regular intervals. Virginia uses the American Academy of Pediatrics and Bright Futures guidelines to develop the Virginia EPSDT periodicity schedule.
- **Inter-periodic Screening** – unscheduled check-up or problem focused assessment that can happen at any time because of illness or a change in condition.

Required Components in EPSDT Screenings.⁷⁰

- Comprehensive unclothed physical exam
- Patient and family medical history
- Developmental Screening
- Laboratory services including mandatory lead testing at 12 months and 24 months
- Age appropriate immunizations

- Referral to a dentist at age 1
- Age appropriate anticipatory guidance/health counseling
- Referrals for medically necessary health and mental health treatment

School personnel, and in particular, school nurses are encouraged to learn about state and local resources available to assist families, as well as understanding and being able to identify those in need. School-based health services can represent an effective tool that can be used to bring more Medicaid-eligible children into preventive and appropriate follow-up care. In addition, schools present an opportunity for Medicaid outreach. Because schools are by definition “in the business of serving children,” they can be a catalyst for encouraging otherwise eligible Medicaid children to obtain primary and preventive services, as well as other necessary treatment services.

Resources

- Centers for Disease Control and Prevention
[National Health Initiatives, Strategies, and Action Plans](#)
- [The Center for Health and Healthcare in Schools](#)
- [Centers for Medicaid and Medicare Services](#)
- Medicaid.gov
[Virginia](#)
- [School Based Health Alliance](#)
- [Virginia Department of Medical Assistance Services](#)
 - [Virginia Medicaid Provider Portal](#)
 - [Cover Virginia](#)
 - [Maternal and Child Health Programs](#)
 - FAMIS
 - EPSDT
 - [Virginia EPSDT Periodicity Schedule](#)
 - Phone Numbers
 - Medicaid Provider Helpline --1-800-552-8627
 - Recipient Helpline – (804) 786-6145
 - Managed Care Helpline -- 1-800-643-2273
- Virginia Department of Social Services
[Medicaid Forms/Applications](#)

Hearing Screening

Authorization

[Code of Virginia, Section 22.1-273, Vision and hearing of student to be tested; exceptions.](#)

The *Code of Virginia* requires that within the time periods and at the grades provided in regulations promulgated by the Board of Education, the principal of each such school shall cause the hearing of the relevant students in the public schools to be tested, unless such students are students admitted for the first time to a public elementary school and have been so tested as part of the comprehensive physical examination required by §22.1-270; or the parents or guardians of such student object on religious grounds and the students show no obvious evidence of any defect or disease of the ears; or any such student has an Individualized Education Program or a Section 504 Plan that documents a defect of hearing or a disease of the ears and the principal determines that such a test would not identify any previously unknown defect of hearing or a disease of the ears.

[Code of Virginia, Section 22.1-214, Board to Prepare Special Education Program for Children with Disabilities.](#)

Excerpt:

The Board of Education shall prepare and supervise the implementation by each school division of a program of special education designed to educate and train children with disabilities between the ages defined in § [22.1-213](#) and may prepare and place in operation such program for such individuals of other ages. The program developed by the Board of Education shall be designed to ensure that all children with disabilities have available to them a free and appropriate education, including specially designed instruction to meet the unique needs of such children. The program shall require (i) that the hearing of each disabled child be tested prior to placement in a special education program and (ii) that a complete audiological assessment, including tests which will assess inner and middle ear functioning, be performed on each child who is hearing impaired or who fails the test required in clause (i).

Regulations. [Regulations Governing Special Education Programs for Children with Disabilities in Virginia.](#)

For specific regulations on the following sub-sections, use the above link to access the information:

8VAC20-81-30. Part III: Responsibilities of Local School Divisions and State-Operated Programs.

8VAC20-81-50. Child Find.

- C. Screening.
- D. Referrals.

Summary. *In Virginia, hearing screening is required as follows:*

- [Commonwealth of Virginia School Entrance Health Form MCH 213G \(Instructions\)](#)
- [Commonwealth of Virginia School Entrance Health Online Fillable Form \(MCH213G\)](#)
(See *Code of Virginia*, [§22.1-270](#).)
- *Grades 3, 7, and 10—unless tested as part of the School Entrance Health Form (See Code of Virginia, [§22.1-273](#).); or the parents or guardians of such student object on religious grounds and the students show no obvious evidence of any defect or disease of the ears; or any such student has an Individualized Education Program or a Section 504 Plan that documents a defect of hearing or a disease of the ears and the principal determines that such a test would not identify any previously unknown defect of hearing or a disease of the ears.*
- *All children within 60 administrative working days of initial enrollment in a public school (see [Regulations Governing Special Education Programs for Children with Disabilities in Virginia](#).)*
- *The hearing of each child with a disability shall be tested during the eligibility process prior to be placement in a special education program (see [Regulations Governing Special Education Programs for Children with Disabilities in Virginia](#).)*

Overview

The purpose of a school hearing screening program is to identify students with a hearing loss that may impact their intellectual, emotional, social, speech, and/or language development. The subtlety of a hearing loss may lead to a child's hearing loss being overlooked. The school's hearing screening program can play an important role in ensuring no student has a hearing loss that goes undetected and unmanaged, resulting in further developmental or academic delays. Even mild hearing losses may be educationally and medically significant. An undetected hearing loss may result in:^{61,71}

- A delay in speech and language skills.
- Language deficits, which may lead to learning problems and limited academic achievement.
- Difficulties in communication, which may lead to social isolation and poor self-concept, resulting in emotional or behavioral problems.
- A negative impact on the child's vocational and educational choices.

- Behavioral problems.

Most children with significant hearing loss are identified prior to school entry.⁶¹ Research indicates that the critical period for screening is birth to 3 years, as auditory stimuli during this period appear to be critical to development of speech and language skills. The incidence of children born with moderate, severe, or profound hearing loss in the U.S. is approximately three in every 1000 live births.⁷² Conductive hearing loss in pre-school and school-age children related to otitis media (middle ear infection) can also cause hearing loss, although it is typically temporary in nature. Due to this possibility and the incidence of childhood hearing loss that has not been detected, hearing screening in the school setting can prevent the negative impact any hearing loss might have on a child's ability to communicate effectively and achieve academically. Hearing screenings at older age levels are important to identify noise-induced hearing loss.

Screening Recommendations.

- The [American Academy of Pediatrics \(AAP\)](#) recommends objective hearing testing at school entry, ages 4, 5, 6, 8, 10, and once each during middle and high school at a minimum.
- The [American Academy of Audiology](#) recommends children be screened, at a minimum, during preschool, kindergarten, grades 1, 3, and 5, and either in grade 7 or 9.
- The [American Speech-Language-Hearing Association \(ASHA\)](#) recommends more frequent testing for children with additional risk factors.

History. A family and medical history of every child to be screened should be assessed for risk factors for hearing impairment. Whenever possible, parents should be asked about the auditory responsiveness and speech and language development of their child. Parental reports of impairment should be seriously evaluated. If this is not possible, when the results of the hearing screening indicate a problem or potential problem, the past medical history recorded on the school entrance physical examination should be evaluated for changes over time.

Recommendations

Procedure and Personnel. Each school division may set a policy, assigning the personnel responsible for completion of hearing screening. School nurses, speech-language pathologists and audiologists are qualified to conduct hearing screening programs. Certification programs for hearing screening are available for other personnel. Non-certified personnel responsible for the screening program should receive instruction in the proper techniques to be used. Training should be conducted by a currently licensed audiologist.⁷³ Personnel conducting the screening should give an explanation of the test procedure to the class as a group, and individually as needed, prior to the testing to assure that students understand the purpose and process. Individual screening is required as group screening is not valid. Care should be taken to choose

a site for the testing that is in the quietest part of a building. Environmental noise levels should be low enough to allow a person with normal hearing to easily hear the pure tone frequencies through the headphones. A soundproof room is preferable, if available.

Guidelines for Pure Tone Screening. The pure tone audiometer is used in school-based screening programs and must meet the standards for screening audiometers established by the American National Standards Institute (ANSI).⁷³ It should have the air conduction frequencies of 500, 1000, 2000, and 4000 Hertz. Proper handling of these machines is required, with at least yearly calibration, in order to ensure accurate readings. The following are general steps for using a pure tone audiometer for testing hearing:^{67,71,73,74}

1. The examiner should turn on the machine and listen to screening tones to assure that audiometer is properly functioning, making sure to listen to both right and left earphones. (The recommendation is that the individual responsible for the audiometer should listen to it each day to detect gross abnormalities.) If screening is being done throughout the day, leave the audiometer on to avoid having to wait for the machine to warm up.
2. Have the student sit down positioned so he/she cannot see the examiner operate the audiometer.
3. Give clear, concise instructions. For example, "You are going to wear earphones." "You will hear beeps. They will be quiet (soft) so you will have to listen carefully. Please indicate when you hear the beep by immediately raising your hand." "Please put your hand down when you no longer hear the beep. You will hear a louder sound first to let you hear clearly what you are listening for, then the sounds will be softer for testing."
4. Have the student remove glasses and large earrings. Be sure student is not chewing food, candy, or gum.
5. Place earphones on each ear (red earphone over student's right ear; blue earphone over student's left ear). Be sure that the earphones fit snugly and that nothing interferes with the passage of sound (remove hair from between earphone and ear).
6. Set the Hearing Threshold Level at 20 dBHL and the frequency at 1000 Hz. Note: If the location is too noisy to use 20 dBHL, a new location must be secured. Screening should never be conducted at intensities greater than 25 dBHL.
7. Present the tone 1000 Hz for one to two seconds. Right ear first. The tone may be presented twice to make sure the child hears the tone and understands what is supposed to be heard.
8. Proceed to 2000 Hz, 4000 Hz, then 1000 Hz, and on to 500 Hz.
9. Repeat the procedure in the left ear. Vary the length, tone, and pauses to prevent establishing a rhythm.
10. If the student fails to hear any tone, it may be repeated at the same level.

11. If the student fails to respond in either ear to one or more frequencies, repeat instructions, reposition the earphones, and rescreen the student within the same screening period.⁷³

Referral should be made if the second screening results are not improved. If the screening is part of the special education eligibility process, the school should be responsible for obtaining an audiological evaluation.

12. Record hearing screening results, per state and local policy, on student's permanent health record.
13. At the end of the school year record hearing screening results on the [Vision and Hearing Screening: Summary Report, Virginia Department of Education \(Rev. 1/08\)](#)

Guidelines for Tympanometry Screening.⁷³ A comprehensive hearing screening program includes tympanometry screening in addition to pure tone screening. Tympanometry screening should not replace pure tone screening. According to the American Academy of Audiology, tympanometry should be used as a second-stage screening method following failure of pure tone or otoacoustic emissions screening (OAE). Young child populations should be targeted for tympanometry screening. The tympanometry equipment should comply with ANSI standards. Rescreen with tympanometry after a defined period: after failing the immediate pure tone rescreening, and in 8-10 weeks for children failing pure tone or OAE screening and tympanometry.

Referral and Follow-Up Process. Parents of all students who do not perform satisfactorily on a hearing screening and subsequent re-test are notified by school health personnel. A repeat failure of the screening indicates that there is sufficient deviation from the norm in the results of the screening test to justify parental notification. Parents should be advised to have the child evaluated by an audiologist or by their health care provider. If the screening is part of the special education eligibility process, the school should be responsible for obtaining an audiological evaluation. Every attempt should be made by school health personnel to work with parents. Parents should be encouraged to follow up with their health care provider and get feedback on any changes that the health care provider feels need to be made in order that school personnel can make the appropriate educational adjustments.

If a student has been identified as having a hearing disability, speech-language pathologists, audiologists, and school nurses should work closely with classroom teachers to ensure any necessary adjustments are made in the classroom so that the student is provided with an optimum learning experience.

Students screened as part of a referral for special education must be referred back to the director of special education for an audiological evaluation.

Documentation

Recording Requirement. Every principal must keep a record of the testing of the hearing of the relevant students and must notify the parent or guardian, in writing, of any defect of hearing or disease of the ears found. (See [Code of Virginia § 22.1-273](#).)

Proof of Testing the Hearing of Pupils. A record of the testing of the hearing of each student can be kept by recording the results on the student's health record or the following form:

- [Cumulative Health Record, Virginia Department of Education \(Form LF.009, Rev. 10/07\)](#)

Reporting Requirement. Copies of the hearing testing report are to be preserved for use by the Superintendent of Public Instruction, as the Superintendent may require.

- Vision and Hearing Reports are summaries of screenings at grade levels KG, 3, 7, and 10 and for new students admitted to schools.
- Each school division will submit data through the Virginia Department of Education, Single Sign-on Web Server (SSWS) and submit by the end of the school year. Each school division has an SSWS Administrator that can provide access for reporting purposes.

Resources

- American Academy of Audiology
[Childhood Hearing Screening Guidelines](#)
- American Academy of Otolaryngology – Head and Neck Surgery
[Clinical Practice Guidelines](#)
- American Speech-Language-Hearing Association
[Childhood Hearing Screening Guidelines for Audiologic Screening](#)
- Massachusetts Department of Public Health
[Comprehensive School Health Guidelines](#)

Height and Weight Screening

Authorization

No Specific Mandate. There is no specific mandate for annual height and weight screenings in Virginia. However, height and weight measurements are a component of a complete physical examination and both are included in the comprehensive physical examination required for school entry into kindergarten or elementary school and the yearly physical examination for participation in competitive sports in the high school. (See previous subsections on School Entrance Physical Examination Requirements and Athletic Pre-Participation Physical Examination Requirements.)

Overview

Annual height and weight measurements provide a simple, effective method of identifying significant childhood health problems. Poor growth patterns can result from systemic disorders (e.g., malnutrition, intestinal conditions), psychosocial conditions (e.g., eating disorders), congenital disorders (e.g., Turner’s Syndrome, intrauterine growth retardation), or conditions of the endocrine system (e.g., hypothyroidism, growth hormone deficiency).⁶¹ In addition, yearly height and weight measurements can be used as an educational tool for parents, students, and school personnel by:

- Creating an awareness of the relationship between good nutrition and growth, and good health practices and growth.
- Stimulating interest in self-responsibility for an individual’s growth and development.

Major professional authorities - including the American Academy of Family Physicians (AAFP), the U.S. Preventive Service Task Force, and the American Academy of Pediatrics (AAP) - recommend yearly screenings of height and weight. The American Medical Association (AMA) recommends screening adolescents annually for eating disorders and obesity by measuring height and weight and by asking about body image and dieting patterns. The [CDC](#) and AAP recommend that all children and adolescents between ages 6 and 19 should be screened for obesity using BMI. The range of normal height and weight varies for each child, but general growth remains relatively constant. After rapid growth in the first two years of life, growth generally slows down to 2 to 2 1/2 inches per year until puberty (approximately 11 to 13 years). Growth dramatically increases during puberty and lasts about two years until sexual development is achieved. At this point, the child’s growth is nearly completed. Growth patterns should follow the normal growth curves of children the same age and sex and fall between the 5th and 95th percentile curves on a standardized growth chart.

Childhood overweight and obesity are becoming greater public health concerns, with the CDC reporting that 1 in 5 children and adolescents in the United States are affected by obesity.⁷⁵ Annual screening and review of BMI measurements, as well as trends, can be a valuable tool in early identification of students at risk for problems or in need of a referral. In addition to notifying students and parents of concerns, school nurses can provide education and basic nutrition counseling, as well as referrals to community resources, both for individuals, families, and the general school population.

Recommendations

Procedure and Personnel. Each school division should set a policy, assigning the personnel responsible for completion of annual height and weight screening. Classroom teachers, physical education teachers, school nurses, or parent volunteers given the responsibility for height and weight screening should receive instruction in proper techniques to be used. Applying appropriate measuring techniques and using well-calibrated equipment is essential. In addition, for accuracy, it may be necessary to take measurements more than once, particularly with young or uncooperative students. Furthermore, it is advantageous for one person to be responsible for taking heights and weights as measurements taken by different individuals may vary.

Growth can be charted on a standardized graph to have meaning to health care providers or recorded on the student's cumulative permanent health record.

Measurements should be interpreted within the context of the individual student's family and growth history. Although most height and weight screenings are done in large groups, it is important to provide privacy during the actual measurements. This will eliminate the potential for embarrassment and teasing. The individual doing the screening may also try to use this time as an opportunity to gain insight into a particular student's health concerns, acquire information about the student's nutritional and exercise habits, and address particular concerns the student might have.

Equipment. Equipment should include a beam balance scale with non-detachable weights⁶¹ or a calibrated electronic scale.⁶⁷ Ensure when using the electronic scale that the scale is "zeroed" before having the student step on. To measure height, use wall-mounted stadiometer or metal ruler (which is preferable to a non-stretchable tape measure) attached to a vertical, flat surface, such as a wall.⁶⁷ A right-angle headboard is also needed for lowering onto the student's head when taking the measurement. Once height and weight have been measured, nurses can use the CDC's [Children's BMI Tools for Schools](#) to calculate and track BMI for students, as well as provide education to students and parents.

Referral and Follow-Up Process.⁶¹ The school nurse is in an ideal position to ensure the early identification of students at risk for growth problems by providing appropriate assessments and referrals. The following conditions warrant a referral by the school nurse for follow-up care:

- Weight for height or for age is more than the 95th percentile.
- Weight for height, weight for age, or height for age is less than the 5th percentile.
- Student's growth pattern changes dramatically; for example, a student who has been consistently at the 50th percentile drops to the 10th percentile or rises to the 90th percentile.
- Students with BMI greater than the 85th percentile and less than the 95th percentile are considered overweight. Students with a BMI at or above the 95th percentile are considered obese. Students with a BMI less than the 5th percentile are considered underweight.⁶⁷

Documentation

The growth chart should become part of the student's permanent health record. Any indications for referral and follow-up care should be documented in the student's health record.

Scoliosis Screening

Authorization

[Code of Virginia § 22.1-273.1. Annual Screening for Scoliosis.](#)

The *Code of Virginia* requires that within the time periods and at the grades provided in regulations promulgated by the Board of Education, each school board shall provide parent educational information on scoliosis or implement a program of regular screening for scoliosis of the relevant students in the school, unless such students are students admitted for the first time to a public school and have been so tested as part of the comprehensive physical examination required by §22.1-270; or the parents or guardians of such students have indicated their preference that their students not participate in such screening.

Regulations. [Virginia Administrative Code \(VAC\).](#)

8VAC20-690-10. Definitions.

8VAC20-690-20. Scoliosis program.

8VAC20-690-30. Parent educational information.

8VAC20-690-40. Regular scoliosis screening.

8VAC20-690-50. Training required for personnel and volunteers.

Regulations. [Regulations Governing Special Education Programs for Children with Disabilities in Virginia.](#)

For specific regulations on the following sub-sections, use the above link to access the information:

8VAC20-81-30. Part III: Responsibilities of Local School Divisions and State Operated Programs.

8VAC20-81-50. Child Find.

C. Screening.

Summary. In Virginia, the provision of parent educational information on scoliosis or scoliosis screening is required as follows:

- [Commonwealth of Virginia School Entrance Health Form MCH 213G \(Instructions\)](#)
- [Commonwealth of Virginia School Entrance Health Online Fillable Form \(MCH213G\)](#)
(See *Code of Virginia*, [§22.1-270.](#))
- Grades 5 through 10-unless tested as part of the School Entrance Health Form (See *Code of Virginia*, [§22.1-270.](#))
- All students in grades 5 through 10 within 60 business days of the opening of school each year (see the [Virginia Administrative Code](#)).

- Or the parents of such students have indicated their preference that their students not participate in such screenings (see the [Virginia Administrative Code](#)).

Overview

Scoliosis is a lateral curvature of the spine⁶⁷ that impacts two to three percent of the population.⁷⁶ “Most are diagnosed with scoliosis between the ages of 10 and 15”.⁷⁶ If left untreated, scoliosis may progress causing spine deformity,⁷⁷ chronic back pain, impair heart and lung function, and affect self-esteem.⁷⁶ Early detection can prevent scoliosis from progressing as well as identifying those in need of treatment. The Scoliosis Research Society (SRS), American Academy of Orthopedic Surgeons (AAOS), Pediatric Orthopedic Society of North America (POSNA), and the American Academy of Pediatrics (AAP) position statement recommend the following:⁷⁷

Early diagnosis of scoliosis has potential benefits. The statement recommends that scoliosis screening programs screen girls twice (at ages 10 and 12 or grades 5 and 7), and boys once (at ages 13 or 14, or grades 8 or 9). Screening programs should include use of the forward bending test, scoliometer measurements, and screening personnel trained to identify potential spine deformity.

Conversely, the U.S. Preventive Services Taskforce (USPSTF) notes:⁷⁸

The USPSTF did not find good evidence on screening adolescents for idiopathic scoliosis and health outcomes. Nor did the USPSTF find good evidence on the detriment of screening and treatment. Hence, the USPSTF recommendation determined that there is inadequate evidence to assess the effective benefits and detriments on screening adolescents, 10 to 18 years of age, for idiopathic scoliosis.

Recommendations for the Provision of Parental Educational Information on Scoliosis

Procedure. If the school division implements a scoliosis program consisting of the provision of parental educational information on scoliosis, such information shall be provided to parents of students in grades 5 through 10 within 60 business days after the opening of school each year. Parental educational information shall include but not be limited to:

- definition of scoliosis
- description of how scoliosis is identified
- statement describing why it is important to screen for scoliosis
- description of the types of screening procedures
- description of potential treatments for scoliosis
- Information on where screening may be obtained (Reference 8VAC20-690-30)

Recommendations for Scoliosis Screening

Procedure and Personnel.^{61,67,79} If the school division implements a scoliosis program of regular scoliosis screening, school nurses should have the responsibility for organizing and implementing the scoliosis screening program collaboratively with physical education teachers for students in grades 5 through 10. This screening must be completed at least twice during the 6-year period, except those students entering the school division for the first time during the 10th grade who shall be screened once. If the school nurse is unavailable, screening can be done by other licensed health professionals (e.g., physicians, nurses, or physical therapists) who have been trained in scoliosis screening technique. All school personnel and volunteers participating in scoliosis screening should participate in a training session prior to screening. The school division should send a written notice to parents a minimum of 10 business days prior to screening that contains information indicating when the screening will occur, the purpose for the screening, that shall include the parent educational information required, a procedure for notifying the parents of students who are identified as having a possible spinal curvature, and a procedure for parents to opt out of the screening (Reference 8VAC20-690-40).

The screening program has two components: (1) an initial educational session held by the screener and (2) the screening itself. The educational session should include information on how the spine grows and develops, what scoliosis is, how it is detected, why it is important to screen, what the screening procedure will entail, and what will be done for those with positive findings. It is advisable to suggest to students that they wear their gym uniforms for the screening. Students should be advised that each screening takes approximately one to three minutes, depending on the examiner. The schedule for screening should be prepared in advance and coordinated with the various teachers.

Girls and boys are screened separately. An adult screener of the same gender as the student is preferable whenever possible. Student privacy must be respected at all times. The optimal view of the spine occurs when the back is bare. Therefore, girls are asked to wear halter-tops, or a bathing suit and boys will be asked to take off their shirts. Shoes must also be removed. Every student should be screened in each of the following positions:

1. **Front and Back View:** (The screener should be seated.) The student should stand erect first with front facing the screener and then face away from the screener, toes placed on the tape, feet together, knees straight, and weight evenly distributed on both feet. Arms should be at the sides and relaxed. Students should be encouraged to avoid slouching or standing at “attention.” Observe for:
 - High shoulder
 - Curved spine
 - Uneven shoulder blades
 - Uneven hips or waist
 - Uneven space between creases, arms, and body

2. **Right and Left Lateral View:** (The screener remains seated.) The student continues to stand erect but is directed to stand first with right side toward the screener, and then turn to stand with the left side toward the screener. Observe for:
 - Exaggerated roundness of upper back
 - Exaggerated arch in lower back

3. **Adams Forward Bend Test:** While the screener stands behind the student, instruct the student to bend forward at the waist until back is horizontal, feet 2-3 inches apart, knees straight, and toes even. Palms of the hands are held together, as if diving or facing each other, and arms hang down, and are relaxed. The head is down. Observe for:
 - Uneven shoulder blades
 - Prominent bump on one side of the back
 - Uneven hips
 - Curve in the spine

The data and results of the screening should be recorded as normal or using terms that describe any detected discrepancy (e.g., right shoulder higher than left; left arm-to-body distance greater than right) on the student’s health record.

Guidelines for Use of Scoliometer. The following are general steps for testing for scoliosis using a scoliometer.

1. Ask student to bend forward slowly, stopping when the shoulders are level with the hips. View the student from the back. For best view, the screener's eyes should be at the same level as the back. Note any rib elevation and/or symmetry in the flank (low back) area.
2. Before measuring with the scoliometer, adjust the height of the person's bending position to the level where the deformity of the spine is most pronounced. This position will vary from one person to another depending upon the location of the curvature. For example, a curve low in the lumbar spine will require that the person bend further forward than one which is present in the thoracic or upper spine.
3. Lay the scoliometer across the deformity at right angles to the body, with the "0" mark over the top of the spinous process. Let the scoliometer rest gently on the skin, do not push down. Read the number of degrees of rotation.
Note: If there is asymmetry in both the upper and lower back, two scoliometer readings will be necessary. The curves will almost always go in opposite directions, with the one in the thoracic spine usually to the right and the other in the lumbar spine usually to the left.
4. The screening examination is considered positive if the reading on the scoliometer is 7 degrees or more at any level of the spine.⁷⁸ Lesser degrees of rotation may or may not indicate a mild degree of scoliosis. In such cases re-screening is recommended within three to six months.⁶⁷

Referral and Follow-Up Process. All children with positive findings should be scheduled for re-screening. To avoid the possibility of unnecessary referral, all students with positive findings for any part of the screening should be re-screened at a separate session by someone other than the original screener.

If a positive finding is confirmed by another person who does the re-screening, the family should be contacted and advised that the student be examined by their health care provider. Emphasize that this is not an emergency. The school health professional responsible for notifying the parents should explain the significance of the screening without causing undue anxiety and apprehension. Every attempt should be made by school health personnel to work with parents. Parents should be encouraged to schedule a follow-up evaluation with their health care provider and obtain feedback on any changes that the health care provider recommends, in order that school personnel can make the appropriate educational adjustments.

If a student has been identified as having scoliosis, school nurses should work closely with classroom teachers to ensure any necessary adjustments are made in the classroom to provide the child with an optimum learning experience.

Documentation

Recording Recommendation. A record of the scoliosis screening of each student can be kept on the student's permanent health record or by recording the results on the following form:

- [Cumulative Health Record, Virginia Department of Education \(Form LF.009, Rev. 10/07\)](#)

Reporting Recommendation. If copies of the scoliosis screening results are to be preserved for local administrative purposes, the following form can be used to preserve summaries of scoliosis screenings for each school division:

- [Scoliosis Report, Virginia Department of Education \(Rev. 4/08\)](#)

Resources

- [National Scoliosis Foundation](#) - Information and resources for students, parents, and educators, as well as resources for school nurses who need training or assistance with scoliosis screening.
- [Scoliosis Research Society](#)
- Texas Scottish Rite Hospital for Children [Scoliosis Screening](#) – Information and videos on how to screen for scoliosis

Speech and Language Screening

Authorization

[Code of Virginia, Section 22.1-214, Board to Prepare Special Education Program for Children with Disabilities.](#)

Excerpt:

The Board of Education shall prepare and supervise the implementation by each school division of a program of special education designed to educate and train children with disabilities between the ages defined in [§22.1-213](#) and may prepare and place in operation such program for such individuals of other ages. The program developed by the Board of Education shall be designed to ensure that all children with disabilities have available to them a free and appropriate education, including specially designed instruction to meet the unique needs of such children. The program shall require (i) that the hearing of each disabled child be tested prior to placement in a special education program and (ii) that a complete audiological assessment, including tests which will assess inner and middle ear functioning, be performed on each child who is hearing impaired or who fails the test required in clause (i).

Regulations. [Regulations Governing Special Education Programs for Children with Disabilities in Virginia.](#)

Overview

The purpose of screening in the area of speech and language is to identify students who may have a speech-language deficit. As a result of the screening, students may be referred for a special education eligibility assessment or the speech-language pathologist may consult with the teacher or parents regarding the student's speech-language skills.

Recommendations

Personnel and Procedure. The local education agency (LEA) may determine who is responsible for the speech-language screenings. Recommended practice would indicate that screening of early childhood and elementary students should be done by a speech-language pathologist or under that person's supervision and that the screening of middle and high school students be completed by the speech-language pathologist, teacher, guidance counselor, or school nurse. If the LEA designates someone other than the speech pathologist to implement speech-language screening at the middle or high school level, in-service training by the speech-language pathologist should be conducted.

Pathology Services. Speech/language pathology includes:⁸⁰

1. Identification of children with speech/language impairments.
2. Appraisal and diagnosis of the specific speech/language impairment.
3. Referral for medical or other professional attention necessary for the habitation of speech or language impairments.
4. Provisions of speech/language services for the prevention or habitation of communication impairments.
5. Counseling and guidance for parents, children, and teachers regarding speech and/or language impairments.

Referral and Follow-Up Process. Documentation of testing of children unable to successfully complete the speech and language screenings according to the established criteria should be forwarded to the director of special education or the director's designee.

Screening Instruments. There are a number of commercially available screening instruments. Sample informal screening tools are included on the following pages. Regardless of the instruments used, local norms should be established to determine the validity of the screening instrument for that population. Please contact the speech-language pathologist(s) serving the LEA for further information on screening instruments.

Recording Recommendation. A record of the speech and language screenings of each student can be kept by recording the results on the following form:

- [Cumulative Health Record, Virginia Department of Education \(Form LF.009, Rev. 10/07\)](#)

Resources

For guidelines on services in the schools, sample speech-language screening forms, and additional references, please see the [Speech-Language Pathology Services In Schools: Guidelines for Best Practice \(Revised 2018\)](#), from the Virginia Department of Education.

Vision Screening

Authorization

[Code of Virginia, Section 22.1-273, Vision and Hearing of Student to be Tested; Exceptions.](#)

The *Code of Virginia* requires that the principal of each public elementary school, middle school and high school shall cause the vision of students enrolled in kindergarten, grade two or three, grade seven and ten to be tested, unless: any student is admitted for the first time to a public elementary school (kindergarten, grade 2 or 3), or any such student (in grade 7 and 10) produces a written record of a comprehensive eye examination performed within the preceding 24 months; the parents or guardians of such students object on religious grounds and the students show no obvious evidence of any defect or disease of the eyes; or any such student has an individualized education program or a Section 504 plan that documents a defect of vision or a disease of the eyes and the principal determines that such a test would not identify any previously unknown defect of vision or a disease of the eyes.

Vision screening may be conducted at any time during the school year; however, the scheduling of such screenings shall be completed within 60 administrative working days of the school year. The *Code* defines the “comprehensive vision program” that incorporates the quality-controlled requirements for vision screening. Vision screening may be conducted by a “qualified nonprofit vision health organization”, defined in the *Code*, that uses a digital photoscreening method following a comprehensive vision program or other methods that comply with DOE requirements.

[Code of Virginia, Section 22.1-214, Board to Prepare Special Education Program for Children with Disabilities.](#)

Regulations. [Regulations Governing Special Education Programs for Children with Disabilities in Virginia.](#)

For specific regulations on the following sub-sections, use the above link to access the information:

- 8VAC20-81-30. Part III: Responsibilities of Local School Divisions and State-Operated Programs.
 - Identification, Evaluation, and Eligibility.
 - 8VAC20-81-50. Child Find.
 - C. Screening.

Individual school divisions with the available resources may choose to expand the vision screening program based on the current research that suggests that all children, beginning in the newborn period, benefit from age appropriate vision screening. Early identification of conditions that interfere with vision is important, because visual stimuli are critical to the development of normal vision.

Summary. *In Virginia, vision screening is required as follows:*

- [Commonwealth of Virginia School Entrance Health Form MCH 213G \(Instructions\)](#)
- [Commonwealth of Virginia School Entrance Health Online Fillable Form](#)
(See *Code of Virginia*, [§22.1-270](#).)
- *Grades K, 2 or 3, 7, and 10*—unless any student is admitted for the first time to a public elementary school (kindergarten, grade 2 or 3), or any such student (in grade 7 and 10) produces a written record of a comprehensive eye examination performed within the preceding 24 months; the parents or guardians of such students object on religious grounds and the students show no obvious evidence of any defect or disease of the eyes; or any such student has an individualized education program or a Section 504 plan that documents a defect of vision or a disease of the eyes and the principal determines that such a test would not identify any previously unknown defect of vision or a disease of the eyes.
- The scheduling of vision screening shall be completed within 60 administrative working days of the school year. Screening may be conducted at anytime during the school year.

Overview

Visual acuity develops swiftly from newborn age maturing “to adult levels of 20/20 vision when the child is 5 to 6 years of age”.⁸¹ Vision screening and eye examination are essential for detecting visual impairment.⁸² Conditions that lead to visual abnormalities may lead to inadequate school performance⁸² and prevent students from obtaining maximum benefits from their educational experience. Undetected impairments of the visual process can lead to permanent loss of vision in the affected eye, loss of depth perception, decreased integration of visual and motor skills, potential decrease in learning ability, and problems in school adjustment.^{67,82, 83}

Visual acuity testing should take place as soon as the child is old enough to cooperate with an eye exam, typically around age 3.^{67,82} Vision screening guidelines have been endorsed by the American Academy of Pediatrics (AAP), the American Association for Pediatric Ophthalmology and Strabismus (AAPOS), and the American Academy of Ophthalmology (AAO) for use by all pediatric vision screening professionals (including physicians, nurses, educational institutions,

and public health departments) to standardize the process of vision screening and to detect children with vision impairments who might be overlooked. School screening programs generally focus on visual distance acuity and can include screening for near vision, color discrimination, ocular muscle imbalance, and depth perception (binocularity or stereopsis).⁶⁷ All children should receive a complete eye examination, including testing for ocular alignment, by their health care provider or an eye specialist.⁸²

A history of vision or eye problems, family history of vision or eye problems, and parental concerns about a child's visual functioning are all important to the complete assessment of a child's vision.⁸³

Recording Recommendation. All vision screening results completed in the school should be recorded on the student's permanent health record or the [Cumulative Health Record, Virginia Department of Education \(Form LF.009, Rev. 10/07\)](#)

Recommendations

Procedure and Personnel. Each school division may set a policy, assigning the personnel responsible for completion of vision screening. Classroom teachers, physical education teachers, school nurses, or parent volunteers given the responsibility for vision screening should receive instruction in the proper techniques to be used.⁶⁷ In addition, personnel should understand that vision screening is designed *only* to identify students who may need further attention.⁸⁴ It is not for the purpose of diagnosis. No attempt should be made by screening personnel when contacting the parents of a student who does not meet the screening criteria to provide a diagnosis. Personnel conducting the screening should explain the test procedure to the class as a group, and individually as needed, prior to the testing to assure that students understand the purpose and the process. Confidentiality needs to be maintained; therefore, students should be screened in a private setting.

Testing Procedures for Assessing Visual Acuity.

In 2019, a Vision Advisory Council representing vision specialists, school nurses, and a representative from the Virginia Department of Education convened to revise the current vision screening process in schools, and to identify best practices for vision screening in school age children [Reference [Code of Virginia §22.1-273\(2\)](#)]. The Vision Advisory Council concurred that the use of digital photoscreening devices were acceptable alternatives to the traditional methods of vision screening using the Snellen Eye Chart. These devices should be operated according to manufacturers' guidelines. Generally, the manufacturers or representatives provide training to personnel using these devices to conduct vision screening assessment. Some benefits of this method of screening are time efficiency, ease of screening, and high predictive value. Additionally, digital photoscreening is useful for children who cannot engage in optotype (eye chart) based vision screening.

Traditional testing procedures for assessing visual acuity in children include several eye charts (or optotypes).^{67,85} These include the Sloan Letters Chart (currently the gold standard), HOTV, LEA Symbols Chart, and Snellen Letters Chart. The Snellen Charts, while most commonly used in schools, are not standardized and have unequal spacing. The Tumbling E Chart is no longer recommended as it was determined that directionality skills are needed to respond correctly, and it was testing cognitive ability as well as vision which are not developed until age 8. The use of poorly designed charts can lead to over- or under-referral of children with visual deficits. For younger children who have not yet learned their letters, the HOTV and LEA charts can be used, with the LEA symbols being preferred. Stereoscopic vision screening machines, such as the Titmus vision tester, are no longer recommended.

Guidelines for Use of Eye Chart.⁶⁷ Visual acuity may be tested at 10 or 20 feet, depending on the chart used. For young students, a distance of 10 feet may result in better compliance due to closer interaction with the screener. Care should be taken to select a room for testing that is without distractions and that has diffuse lighting and is without glare, to make sure the student stands at the appropriate distance from the chart (the distance may be marked off with a piece of masking tape or paper feet placed at the measured distance), and that the student does not “peek” with the eye that is covered and not being tested. Directions for use of an eye chart vary based on the chart being used. The screener should carefully review screening procedures for the specific chart that is used. The following are general steps for using an eye chart for testing visual acuity:

1. Each eye is tested separately. Tell the student to keep both eyes open during testing. Test the right eye first by covering the left eye with an occluder, a card, or paper cup. Note: A student who has corrective eyeglasses should be screened wearing the glasses. However, eyeglasses prescribed for use while reading should not be worn when distance acuity is being tested.
2. Instruct the student to read the letter to which you point. (Pointing should be done below the symbol or letter.) Note: With younger students, start with a large line to assure that the student understands the directions.
3. If a student fails the practice line, move up the chart to the next larger line. If the student fails this line, continue up the chart until a line is found that the student can pass. Then move down the chart again until the student fails to read a line. To pass a line, a student must identify greater than half of the symbols or letters on the line correctly. Repeat the above procedure covering the right eye. Pass for a visual acuity of 20/40 in either eye for students 4-5 years of age (48 to 59 months), and 20/30 (or a 20/32 line) for other students (60 months and older).⁸⁵

4. Record results. Arrange a second screening for those students who did not pass within two weeks to one month. Referral should be made if the second screening results are not improved. In addition, record the name of the test administered.
5. Record screening results, per state and local policy, on student's permanent health record.
6. Results should be recorded on the [Vision and Hearing Screening: Summary Report, Virginia Department of Education \(Rev. 1/08\)](#).

Vision results are written and spoken of as one number over another (e.g., 20/20). The figures refer to the distance at which a standard object can be recognized. The top number refers to the number of feet from the eye chart, and the lower number refers to the line of the chart the person is able to read. A person who is nearsighted (myopia) may only be able to recognize at 20 feet an object that a person with perfect vision (20/20) can recognize at 100 feet. In this case, the results would be recorded as 20/100.

Testing Procedures for Assessing Color Discrimination.⁶⁷ Ideally, screening for color deficiency is recommended in preschool or early kindergarten because of educational or vocational implications. There is no treatment. The [Ishihara Color Test](#) is the recommended test and comes with instructions with which the screener should be familiar before beginning the testing. A room with adequate lighting should always be used.

Referral and Follow-Up Process. Parents of all students who do not perform satisfactorily on a vision screening and subsequent re-test (within two weeks to one month) should be notified by school health personnel. A referral means *only* that there is sufficient deviation in the student's visual condition to justify a more complete examination by a qualified eye specialist. Every attempt should be made by school health personnel to work with parents, encouraging follow-up care with their health care provider and getting feedback on any changes that the health care provider recommends, in order that school personnel can make the appropriate educational adjustments.

If a student has been identified as having a visual impairment, school nurses should work closely with classroom teachers to ensure any necessary adjustments are made in the classroom so that the student is provided with an optimum learning experience.

Documentation

Recording Requirement. Every principal must keep a record of the testing of vision of the relevant students and must notify the parent or guardian, in writing, of any defect of vision or disease of the eyes found. (See *Code of Virginia*, § [22.1-273](#).)

Proof of Testing the Sight of Pupils. A record of the testing of vision of each student can be kept by recording the results on the following form:

- [Cumulative Health Record, Virginia Department of Education \(Form LF.009, Rev. 10/07\)](#)

Reporting Requirement. Copies of vision testing report are to be preserved for use by the Superintendent of Publication Instruction, as the Superintendent may require. (See *Code of Virginia*, § [22.1-273](#).)

- Vision screening data is to be submitted at the end of the school year to school administrators and to the Virginia Department of Education.
- Vision screening data will be compiled by grade levels (KG, 2 or 3, 7, and 10), and summaries submitted by schools to the Single Sign-on Web Server (SSWS). This secure website can be accessed with permission from the SSWS Administrator for each school division and uploaded to the SSWS, *Vision and Hearing Survey*.

Resources

Resources are available to provide information on vision screenings, screening procedures, vouchers and educational materials.

- American Academy of Pediatrics
[Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition](#)
- American Association for Pediatric Ophthalmology and Strabismus
[Resources for School Nurses](#)
- National Association of School Nurses
[Tools & Resources: Vision](#)
- [Prevent Blindness](#)
- U.S. Preventive Services Task Force
[Vision Screening Recommendations](#)

Chapter 14: Implementing Special Education - Students with Special Needs

According to the [National Survey of Children with Special Health Needs](#), published in June 2013, 15.1% of U.S. children, or 11.2 million children, have special health care needs, and 23.0 percent of households with children include at least one child with a special health care need. These rates represent a slight increase from the percentages reported in 2005-2006, which, in turn, represented an increase from 2001. The increases in numbers of children is possibly a result of more children having special needs, though it is equally possible that children's conditions are more likely to be diagnosed, due to increased access to medical care, or growing awareness of these conditions on the part of parents and physicians, or that the changes in the composition of the sample affected the likelihood that children with special health care needs would be identified by the survey. Determination of a child's need and eligibility for services at the earliest possible time leads to better educational outcomes for the child. School nurses and other school health personnel are involved in identifying and serving students with special needs.

Historical Perspective: Key Federal Legislation

Listed below are summaries of some key special education federal laws and acronyms of special education.

Early Education for Handicapped Children Program of 1970. In 1970, Congress passed the Early Education for Handicapped Children Program, providing seed money for the development and operation of experimental, demonstration, and outreach preschool and early intervention programs for handicapped children. This was the federal government's first major effort in early intervention.

[Rehabilitation Act of 1973 \(Public Law 93-112\)](#). The Rehabilitation Act of 1973 prohibits discrimination on the basis of disability in programs conducted by federal agencies, in programs receiving federal financial assistance, in federal employment, and in the employment practices of federal contractors. The standards for determining employment discrimination under the Rehabilitation Act are the same as those used in Title I of the Americans with Disabilities Act of 1990.

- **Section 504.** Section 504 of the 1973 Rehabilitation Act is the basic civil rights legislation prohibiting discrimination against persons with "handicapping conditions" in programs that receive federal funds. This includes public schools.
- **Handicapping Condition.** The definition of "handicapping condition" in Section 504 is: a handicapped student is one who has a physical or mental impairment

that substantially limits one or more life activities (such as working, eating, dressing, breathing). The Office of Civil Rights, which oversees enforcement of the statute, has determined that this may include drug and alcohol addiction, attention deficit disorder, AIDS, hospitalization due to depression, and other conditions not typically qualifying under special education. Federal special education funds cannot be used to comply with 504.⁸⁶

Education Amendments of 1974 (Public Law 93-380). In 1974, to assure appropriate education opportunities for children with special needs, Congress passed the Education Amendments of 1974, which guarantees due process and provision of education in the least restrictive environment.

Education for All Handicapped Children Act of 1975 (Public Law 94-142). In 1975, Congress passed a law called the Education for All Handicapped Children Act (EHA). This law established legal standards and requirements for the education provided to children with disabilities. This law required all states to provide a “Free, appropriate public education” to school-age children with handicaps in the “least restrictive environment.”

- **Section 619.** Section 619 of the EHA provided incentives to states to serve handicapped children ages 3 to 5.
- **Handicapped Children.** Under this law, “handicapped children” were defined as those who are mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, other health impaired, or who have specific learning disabilities, and who by reason of these handicaps require special education and related services.
- **Related Services.** Under this law, “related services,” which included school health-related services, were among those services that must be provided to sustain these children’s attendance. These services are described in P. L. 94-142 and include, among others, school health services; physical, occupational, and language therapy; modification of classroom schedules; and if necessary, actual physical alterations of the school.
- **Least Restrictive Environment.** To the extent possible (given the nature and severity of the child’s handicap), the child should be educated in the regular classroom with peers who are not handicapped.

Note: The EHA was to be re-enacted every 4 years, resulting in numerous changes in the Act over the intervening two decades.

Public Law 98-199. In 1983, believing that it was time to encourage states to expand services to preschool children, infants, and toddlers with handicaps, Congress passed P.L. 98-109. That legislation set aside money for planning, development, and implementation grants dealing with the preschool populations - allowing states to apply for grants to provide services to disabled children age birth through 3 years. In the first quarter of 1985, 20 states received such grants.

[Education of the Handicapped Act Amendments of 1986 \(Public Law 99-457\)](#). In 1986, Congress enacted P. L. 99-457, the Education of the Handicapped Act Amendments of 1986. This legislation amended the Education of All Handicapped Children Act (EHA) to, among other things, replace the preschool grants program (Part B, Section 619) and create a new early intervention program for infants and toddlers (Part H). The least restrictive environment concept was continued.

- **Part B, Section 619.** Replaced the preschool grants program authorized by P.L. 94-142 with a new program (Part B, Section 619) for children with disabilities, ages 3 through 5.
- **Children with Disabilities.** Under this law, the term “handicapped children” was replaced with “children with disabilities.” This term means mentally retarded, hard of hearing, deaf, speech or language impaired, visually handicapped, severely emotionally disturbed, orthopedically impaired, or other health impaired, or children with specific learning disabilities, who by reason thereof require special education and related services. (20 U.S.C. § 1401 [a].)
- **Infant and Toddlers Program.** Created a new state grant program (Part H) to encourage states to plan, develop, and implement early intervention services to infants and toddlers with developmental delay and their families. States participating in the Part H program were permitted five years (1988-1993) to develop programs to provide appropriate services to eligible children and their families.
- **Infants and Toddlers with Disabilities.** Under this law, the term “infants and toddlers with disabilities” is defined as children from birth through age 2 who required early intervention services because they (a) are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive development, physical development, language and speech development, psychosocial development, or self-help skills, or (b) have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. (20 U.S.C. § 1472.)

[Individuals with Disabilities Education Act of 1990 \(Public Law 101-476\)](#). In October 1990, Congress passed P.L. 101-476, which reauthorized the Education for All Handicapped Children Act (EHA), Parts C through G, through fiscal year 1994, changed the name to the Individuals with Disabilities Education Act (IDEA), and made minor changes to Parts B and H. There were some changes in the definition categories for special education and related services, including new categories of traumatic brain injury, developmental delay, and autism. Additional services, such as transition and assistive technology, were added.

[**Americans with Disabilities Act of 1990 \(Public Law 101-336\)**](#). The Americans with Disabilities Act (ADA) was signed into law on July 26, 1990. The ADA prohibits discrimination on the basis of disability in employment, programs and services provided by state and local governments, goods and services provided by private companies, and in commercial facilities. The ADA protects every person who either has, used to have, or is treated as having a physical or mental disability that substantially limits one or more major life activity. Individuals who have serious contagious and non-contagious diseases - such as HIV/AIDS, cancer, epilepsy or tuberculosis—are also covered under the auspices of ADA. The ADA extends the coverage of Section 504 of the Rehabilitation Act of 1973.

- **Public Schools.** The ADA accords persons with disabilities meaningful access to programs and facilities of public schools, as well as most business. It requires employer to make “reasonable accommodation” for disabled persons to enable them to perform the job.⁸⁷

[**Individuals with Disabilities Education Act Amendments of 1997 \(Public Law 105-17\)**](#). The Individuals with Disabilities Education Act Amendments of 1997 (IDEA 97) were signed into law on June 4, 1997, with final implementing regulations released March 12, 1999. The new law consists of four parts: Part A - General Provisions, Part B - Assistance for Education of All Children with Disabilities, Part C - Infants and Toddlers with Disabilities (formerly Part H), and Part D—National Activities to Improve Education of Children with Disabilities.

- **Children with Disabilities.** Under this law, the term “children with disabilities” is defined as those children evaluated in accordance with the federal special education regulations as having mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, specific learning disabilities, deaf-blindness, or multiple disabilities, and who, because of those impairments, need special education and related services.
- **Related Services.** Under this law, “related services” are defined as follows: transportation, and such developmental, corrective, and other supportive services— including speech language pathology and audiology, psychological services, physical and occupational therapy, recreation (including therapeutic recreation and social work services), and medical and counseling services (including rehabilitation counseling), except that such medical services shall be for diagnostic and evaluation purposes only—that may be required to assist a child with a disability to benefit from special education. (IDEA, 20 U.S.C. 1401 [17].) The term also includes school health services, social work services in the schools, and parent counseling and training. (34 C.F.R. 300.1 3[a].)

[Individuals with Disabilities Education Improvement Act of 2004 \(Public Law 108-446\)](#).⁸⁸ The reauthorization and major updates to IDEA were signed into law on December 3, 2004 and effective on July 1, 2005, with changes primarily focused on academic accountability for student and school performance. completed within a year. These changes were based findings from the 2002 President’s Commission on Excellence in Special Education which recommended special education reforms based on academic results for students, early intervention, parental choice, and paperwork reduction. Notable changes to the IDEA include:

- **Identification of Learning Disabilities:** The addition of language that allows local education agencies (LEAs) to eliminate the IQ-Achievement discrepancy requirement and changes to how states can determine the presence of a specific learning disability. The law provided state and local education agencies flexibility in their process for identification, and prohibited states from establishing a standard statewide identification process. Rather, agencies are encouraged to utilize research-based models that can be adapted to specific needs and collaborate with LEAs to determine consistent identification criteria.
- **Unique Circumstances:** Schools will now be allowed to consider any unique circumstances on a case-by-case basis when determining whether to order a change in placement for a child with a disability who violates a code of student conduct.
- **Manifestation Determination:** The amendments continue manifestation but with some changes:
 - The law authorizes schools to order, for children with disabilities who violate student conduct codes, changes of placement to an appropriate interim educational setting, another setting, or suspension, for up to ten school days, to the same extent as would apply to a non-disabled student, without making a manifestation determination.
 - The plan maintains the manifestation determination with modifications intended to simplify the process, as well as the exception for cases involving guns, bombs, drugs, or serious bodily injury (as defined in criminal code).
 - Manifestation determinations must be conducted within 10 school days of a disciplinary decision that results in a change of placement.
 - If the child’s conduct is determined to be a manifestation of their disability the IEP team must: (1) conduct a functional behavioral assessment and implement a behavioral intervention plan, if the LEA has not done so; or (2) review an existing behavioral intervention plan and modify it to address the behavior; and (3) except in cases involving weapons, drugs, or infliction of serious bodily injury, return the child to the placement from which the child was removed, unless the parent and

- LEA agree to a change of placement as part of the modification of the behavioral intervention plan.
- IDEA 2004 authorizes schools, upon determining that the violation was not a manifestation of the child's disability, to apply the same disciplinary procedures as for a child without a disability, provided that FAPE requirements are met, with the option of providing such FAPE in an interim alternative educational setting.
 - In cases involving weapons or drugs, or when a child has committed serious bodily injury, a school will be authorized to remove the child from the regular classroom setting for up to 45 school days, regardless of whether the child's behavior was a manifestation of disability.
- **Reevaluations:** New language clarifies the requirements for reevaluations and place limitations on their frequency. The bill states that a reevaluation shall occur not more frequently than once a year, unless the parent and the LEA agree otherwise; and at least every 3 years unless the parent and the LEA agree that a reevaluation is unnecessary.
 - **Early Intervening Services:** The law now places a greater emphasis on the use of pre-referral services to minimize over-identification and prevent unnecessary referrals to special education.
 - **Over-identification and Disproportionality:** States are now required to keep track of numbers of minority students being identified for special education, the amount of time spent in general education settings, and the number of discipline referrals, they will also be required to provide “comprehensive, coordinated, early-intervention programs” for children in groups that are determined to be overrepresented.
 - **Notable IEP Changes:**
 - Individualized Education Programs (IEPs) must contain measurable annual goals and a description of how the child's progress will be measured and reported.
 - Team members may be excused from an IEP meeting if no modifications are being made to that member's area of curriculum or service; or if the member provides input prior to the meeting on a modification to be made.
 - Changes to IEPs can be made without convening the IEP team if both the school district and parent agree.
 - Minor changes to IEPs can be made in a conference call or by letter providing that team members agree on this format.

- Requirements to make provisions for transition planning has been changed from age 14 to 16, with language added regarding transition from services.
 - Demonstration states will be permitted, among other changes, to allow school districts to offer the option of three-year IEPs to parents.
- **Accountability:** The new law revised requirements for academic achievement and functional performance of children with disabilities to conform IDEA to the State and LEA accountability system established under the NCLB Act, along with new requirements for reporting disaggregated data.
- **Personnel Standards:** The new legislation eliminated the use of emergency, temporary and provisional certification for related service providers, and allows states greater authority to determine professional qualifications in schools.
- **Child Medication:** New language prohibits schools from requiring a child to obtain a prescription for a substance covered by the Controlled Substances Act (21 U.S.C. 1801 et seq.) as a condition of attending school, receiving an evaluation under subsection (a) or (c) of section 614, or receiving services.
- **[2006 IDEA Part B Final Regulations](#)**.⁸⁹ Published on August 14, 2006, these regulations address the recruitment, training, and education of personnel, removing limitations and setting standards to ensure staff are appropriately prepared for their roles. Additionally, schools may now use up to 15 percent of the Part B funds it receives to develop and implement coordinated, early intervening services for children who have not been identified as eligible, but who need additional academic and behavioral support. Changes were also made regarding the Individualized Education Plan (IEP), including revising definitions and terminology, state requirements, team meetings and participation, considerations and related services for IEP development, IEP amendment, discussion of the rights of a child with a medical or surgically implanted device, and necessity or ethnic considerations and cultural competence.
- **[2008 IDEA Part B Supplemental Final Regulations](#)**.⁹⁰ Published on December 1, 2008 and effective on December 31, 2008, the regulations address the following: parental consent for continued special education and related services, non-attorney representation in due process hearings, State monitoring, technical assistance, and enforcement; allocation of funds, and positive efforts to employ and advance in employment individuals with disabilities.
- **[2011 IDEA Part C Final Regulations](#)**.⁹¹ These regulations were published on September 28, 2011. The final Part C rules reflect changes in IDEA 2004 which include changing to job requirements and training, the addition of State Early Hearing Detection and Intervention under the realm of Child Find efforts, redefine terms used in the Individualized Family Service Plan (IFSP), as well as outlining guidance and standards for the IFSP, the inclusion of language regulating services provided and access to services be culturally competent (to

include assessment in the native language, when appropriate), and requirements that states can opt to provide early intervention services to children beginning at 3 years of age until the children enter, or are eligible to enter, kindergarten or elementary school.

- [**2013 IDEA Part B Final Regulations**](#).⁹² On February 14, 2013, the IDEA Part B final regulations were published, and took effect on March 18, 2013. These regulations outline changes in the requirements in 34 CFR 300.154(d) related to parental consent to access public benefits or insurance. Previously, public agencies were required to obtain parental consent each time access to public benefits or insurance was sought. Public agencies are now required to obtain a one-time written consent and provide written notification, before accessing the child's or the parent's public benefits or insurance for the first time, and annually. These regulations protect family rights, ensuring parents are informed on their rights and protections, while also reducing the burden on public agencies in terms of paperwork and simplified implementation.

[**Americans with Disabilities Act Amendments Act of 2008 \(Public Law 110-325\)**](#).⁹³ The Amendments Act was passed on September 2008 and effective January 1, 2009, partially to supersede Supreme Court decisions that had too narrowly interpreted the ADA's definition of a disability. This also includes a conforming amendment to the Rehabilitation Act of 1973 that affects the meaning of disability in Section 504. 29 U.S.C. § 705(20)(B). All persons covered by Section 504 or Title II are protected from discrimination under the general nondiscrimination regulatory provisions implementing these statutes, which cover program and physical accessibility requirements, as well as protection against retaliation and harassment. 28 C.F.R. pt. 35; 34 C.F.R. §§ 104.4, 104.21-23, 104.61 (incorporating 34 C.F.R. § 100.7(e)). Significant changes include:

- Students who previously may not have been determined to have a disability under Section 504 and Title II may now in fact be found to have a disability and should now be considered.
- A revision in how the term "disability" is to be interpreted. Congress directed that the definition of disability shall be construed broadly and that the determination of whether an individual has a disability should not demand extensive analysis.
- School districts may no longer consider the effects of mitigating measures when making a disability determination, they remain relevant in evaluating student needs. An evaluation must take place for any individual who, because of a disability, "needs or is believed to need" special education or related services, if as a result of the evaluation, it is determined that the student does not need special education or related services, the district is not required to provide aids or services.

- If a parent or guardian of a child with an impairment believes that the child may be a student with a disability and therefore requires services that he or she is not currently receiving in school, the parent or guardian can ask the school district to evaluate or reevaluate the child pursuant to the requirements of the Section 504 regulation.
- If a child is receiving special education or related services that the parent or guardian believes are inadequate, the parent or guardian can request changes to the educational placement. If agreement cannot be reached, the parent or guardian may invoke the procedural safeguards set forth in 34 C.F.R. § 104.36 to address the child's needs and current educational placement.

Subsections

The following subsections provide guidance on implementing key legislation and regulations.

- [Implementing IDEA](#)
- [Implementing Part C of IDEA](#)
- [Implementing Section 504 of the Rehabilitation Act](#)
- [Special Education Health Assessment](#)
- [The Role of the School Nurse](#)

Implementing IDEA

Authorization

Individuals with Disabilities Education Act (IDEA). The IDEA requires public schools to make available to all eligible children with disabilities a free appropriate public education in the least restrictive environment, appropriate to their individual needs. The Individuals with Disabilities Education Act Amendments of 1997 (Public Law 105-17) were signed into law on June 4, 1997. Subsequent amendments were published in 2004, with federal regulations published in 2006, 2008, 2011, and 2013.

Code of Virginia Section 22.1-213. Definitions (special education program for children with disabilities). The *Code of Virginia*, § 22.1-213 defines “children with disabilities” as those persons:

(i) who are age two to 21, inclusive, having reached the age of two by the date specified in § 22.1-254, (ii) who have intellectual disability or serious emotional disturbance, or are physically disabled, speech impaired, hearing impaired, visually impaired, or multiple disabled, or are otherwise health impaired including those who have autism spectrum disorder or a specific learning disability or are otherwise disabled as defined by the Board of Education and (iii) who because of such impairments need special education.

Code of Virginia § 22.1-214, Board to Prepare Special Education Program for Children With Disabilities.

The *Code of Virginia* requires that the Board of Education shall prepare and supervise the implementation by each school division of a program of special education designed to educate and train children with disabilities between the ages defined in § 22.1-213 and may prepare and place in operation such program for such individuals of other ages. The program developed by the Board of Education shall be designed to ensure that all children with disabilities have available to them a free and appropriate education, including specially designed instruction to meet the unique needs of such children. The program shall require (i) that the hearing of each disabled child be tested prior to placement in a special education program and (ii) that a complete audiological assessment, including tests which will assess inner and middle ear functioning, be performed on each child who is hearing impaired or who fails the test required in clause (i). The school boards of the several school divisions, the Department for the Blind and Vision Impaired, the Department for the Deaf and Hard-of-Hearing, the Department of Health and other state and local agencies which can or may be able to assist in providing educational and related services shall assist and cooperate with the Board of Education in the development of such program.

Regulations. The Board of Education has established regulations governing the implementation of special education and related services for students with disabilities in Virginia. [Regulations Governing Special Education Programs for Children with Disabilities in Virginia](#) (2010).

Definitions. Key general definitions from *Regulations Governing Special Education Programs for Children with Disabilities in Virginia* (2010), Virginia Department of Education are included in the following chart:

General Definitions of Terms Associated with Special Education	
Term	Definition
Child with a Disability	“Child with a disability” means a child evaluated in accordance with the provisions of this chapter as having an intellectual disability, a hearing impairment (including deafness), a speech or language impairment, a visual impairment (including blindness), a serious emotional disability (referred to in this part as “emotional disability”), an orthopedic impairment, autism, traumatic brain injury, another health impairment, a specific learning disability, deaf-blindness, or multiple disabilities who, by reason thereof, needs special education and related services.
Age of Eligibility	means all eligible children with disabilities who have not graduated with a standard or advanced studies high school diploma who, because of such disabilities, are in need of special education and related services, and whose second birthday falls on or before September 30, and who have not reached their 22nd birthday on or before September 30 (two to 21, inclusive) in accordance with the Code of Virginia. A child with a disability whose 22nd birthday is after September 30 remains eligible for the remainder of the school year.
Free, Appropriate Public Education (FAPE)	means special education and related services that: <ol style="list-style-type: none"> 1. Are provided at public expense, under public supervision and direction, and without charge 2. Meet the standards of the Virginia Board of Education 3. Include an appropriate preschool, elementary school, middle school or secondary school education in Virginia 4. Are provided in conformity with an individualized education program that meets the requirements of this chapter.
Individualized Education Program (IEP)	means a written statement for a child with a disability that is developed, reviewed, and revised in a team meeting in accordance with this chapter. The IEP specifies the individual educational needs of the child and what special education and related services are necessary to meet the child’s educational needs.

Process and Procedures for Implementing IDEA

The following information reflects the IDEA Amendments of 2004, federal regulations published in 2006, 2008, 2011, 2013, and the [Regulations Governing Special Education Programs for Children with Disabilities in Virginia](#) (2010).

Child Find. Public awareness responsibilities of local school divisions include:

- Conducting a public awareness campaign annually that involves parents and community members in child find and community awareness campaign.
- Maintaining an active and continuing child find program to identify, locate, and evaluate children birth through 21, who are in need of special education and related services.

Screening. Each local school division is responsible for establishing and maintaining screening. Refer to the section on “Population-Based Screening” for specific screening information.

1. Hearing and vision.
2. Scoliosis.
3. Speech, language, and voice.
4. Vision and hearing.
5. Fine and gross motor function.

Child Study. Formal committee established in each school to review records and performance of students referred through a screening process or by another source and to decide what course of action is indicated. The committee may be termed “Instructional Support Team,” “Teacher Assistance Team”, “School-Based Team” or other similar terminology. The school nurse may be a part of this committee.

Evaluation. Procedures used to determine whether a child has a disability under IDEA. Each local school division shall have established policies and procedures related to the evaluation of referred students. Policies and procedures include parental consent, confidentiality, written notification, nondiscriminatory testing, qualified personnel, and notification of parental rights. A team of individuals, including the parents, determines what will be assessed. These may include health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities. Virginia law requires hearing screening for all students evaluated for special education. This is typically accomplished through the assessment of components that are contained in the following chart.

Assessment Components of Suspected Disability	
Component	Description
Educational	Written report describing current educational performance and identifying instructional strengths and weaknesses in academic skills and language performance.
Medical	Written report from a licensed physician indicating general medical history and any medical/health problems that may impede learning.

Assessment Components of Suspected Disability

Component	Description
Sociocultural	Written report from a qualified visiting teacher or school social worker that describes family history, structure, and dynamics; developmental and health history; and social/adaptive behavior in the home, school, and community. The information is obtained through interviews with parents or primary caretakers in addition to use of other social appraisal methods.
Psychological	Written report from a qualified psychologist based on the use of a battery of appropriate instruments that shall include individual intelligence test(s) and psycho-educational tests.
Developmental	Written report of assessment of how the child functions in the major areas of development (such as cognition, motor, social/adaptive behavior, perceptions, and communications), where required in the regulations for assessing the specified handicapping conditions.
Other	Where indicated (e.g., audiological, speech-language). All assessments must be provided in written format and must be conducted by qualified personnel. To be qualified, professionals must meet any applicable licensing requirements.

Eligibility. A committee made up of persons representing the disciplines providing the assessments and the special educator administrator or designee shall determine if the student has a disability under IDEA and if the student requires special education and related services. The school nurse may be a part of this committee. A written summary of its deliberations and findings is prepared, and if the child is found to be eligible, the summary is forwarded to the IEP committee.

Individualized Education Program (IEP). A written program for each child with a disability that is developed by a committee consisting of a representative of the local school division who is qualified to provide or supervise the provision of special education, the child's teacher (general and special education), the child's parents, the child (if appropriate), and other individuals at the discretion of the parents (may include an advocate) or local school division (may include a member of the evaluation team or related service provider). The school nurse may be a part of the committee and will perform an important role in the development of goals, objectives, and services for students with special health needs. The written plan must include the following components:

- A statement of the child's present level of academic achievement and functional performance.

- A statement of measurable annual goals, including academic and functional goals.
- If determined appropriate by the IEP team, as outlined in subdivision F2 of this section, a description of benchmarks or short-term objectives.
- A statement of the special education and related services and supplementary aids and services, based on peer-reviewed research to the extent practicable, to be provided for the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided to enable the child.
- An explanation of the extent, if any, to which the child will not participate with children without disabilities in the regular class and in the activities as described in the Regulations.
- Specific information concerning state and division-wide assessments shall be included (see Regulations for detailed information).
- The projected dates (month, day, and year) for the beginning of the services and modifications and the anticipated frequency, location, and duration of those services and modifications.
- A statement of: a. How the child's progress toward the annual goals will be measured; and b. When periodic reports on the progress the child is making toward meeting the annual goals will be provided; for example, through the use of quarterly or other periodic reports, concurrent with the issuance of report cards, and at least as often as parents are informed of the progress of their children without disabilities.
- Statement regarding the plan for initial and secondary transition services.
- Beginning at least one year before a student reaches the age of majority, the student's IEP shall include a statement that the student and parent(s) have been informed of the rights under this chapter, if any, that will transfer to the student on reaching the age of majority.

The parent shall be given a copy of the IEP and information regarding due process procedural safeguards that stipulate their rights as parents of the student with a disability. The IEP should be revised at least annually.

Instruction. Instruction is provided according to the terms of the IEP.

Placement. Educational placement is based on the child's IEP, is determined at least annually, and occurs as close as possible to the child's home in the least restrictive environment. Unless indicated otherwise by the IEP, the child is educated in the school that the child would attend if nondisabled. Alternative placements follow a continuum, including integrated service delivery

with general education, special classes, special schools, home instruction, instruction in hospitals or institutions, or residential placement.

Annual Review. Each local educational agency shall ensure that the IEP team reviews the child's IEP periodically, but not less than annually, to determine whether the annual goals are being achieved and to revise its provisions, as appropriate. A reevaluation is conducted at least every three years.

Implementing Part C of IDEA

Authorization

Individuals with Disabilities Education Act (IDEA). The IDEA was amended in 1986 with legislation designed to help states establish a statewide, comprehensive system of early intervention services for infants and young children with special needs and their families. Part H of this legislation, P.L. 99-457, mandated services for children beginning at age three with the option to provide services for children who were developmentally delayed or at risk for developmental delays from birth through the second year of life. This bill established a national policy on early intervention that provided assistance to states to build systems of service delivery and recognized the unique role of families in the development of their young child with disabilities. Virginia opted to participate in the optional early intervention program for infants and toddlers from birth through age 2. Virginia had required special education for children, beginning at age 2, since prior to the first passage of Federal legislation in 1975. The IDEA Amendment in 1997, reauthorized the infant and toddler program and renamed the program in Part C. In 2004, additional amendments were introduced, with changes to the process and implementation. Subsequent changes and amendments were made in 2011.

Implementation of Part C

Goals. The goals of the Part C program include:

1. To develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with, or at-risk for, disabilities, and their families.
2. To facilitate the coordination of payment for early intervention services from federal, state, local, and private sources.
3. To enhance states' capacity to provide quality early intervention services and expand and improve existing services.

Early Intervention.⁹⁴ The term early intervention services means developmental services that are provided under public supervision, are provided at no cost except where Federal or State law provides for a system of payments by families, including a schedule of sliding fees, meet the standards of the State in which the services are provided, including the requirements of this part, and are designed to meet the developmental needs of an infant or toddler with a disability, as identified by the individualized family service plan team, in any 1 or more of the following areas:

- Physical development
- Cognitive development
- Communication development

- Social or emotional development; or
- Adaptive development

Services include:

- Family training, counseling, and home visits
- Special instruction
- Speech-language pathology and audiology services, and sign language and cued language services
- Occupational therapy
- Physical therapy
- Psychological services
- Service coordination services
- Medical services only for diagnostic or evaluation purposes
- Early identification, screening, and assessment services
- Health services necessary to enable the infant or toddler to benefit from the other early intervention services
- Social work services
- Vision services
- Assistive technology devices and assistive technology services
- Transportation and related costs that are necessary to enable an infant or toddler and the infant's or toddler's family to receive another service described in this paragraph

State Agency Authority

The [Virginia Department of Behavioral Health and Developmental Services](#) (DBHDS) has been designated as Virginia's lead agency for Part C. A state-level interagency council ([Virginia Interagency Coordinating Council - VICC](#)) meets to advise and assist the lead agency in performing its responsibilities. VICC members are appointed by the governor and include a representative from the major state agencies that are engaged in providing services to young children with disabilities, parent representatives, and community members. There are 40 Local Interagency Coordinating Councils (LICCs) across the Commonwealth. These LICCs typically are composed of representatives from the local school division, community services board, health department, social services department, parents, and direct care providers.

Implementing Section 504 of the Rehabilitation Act

Definitions

Section 504.^{95, 96} [Section 504 of the Rehabilitation Act of 1973](#) (29.U.S.C. 701 et. Seq.) is a federal law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to employers, organizations, programs and activities that receive federal financial assistance. Organizations receiving federal financial assistance include public school divisions, institutions of higher education, and other local and state education agencies. Section 504 forbids organizations and employers from excluding or denying individuals with disabilities an equal opportunity to receive program benefits and services. It defines the rights of individuals with disabilities to participate in, and have access to, program benefits and services.

Qualified Person. A qualified person with disabilities under Section 504 covers a broader population than the definition of a child with a disability under IDEA. A qualified handicapped individual under Section 504 is any person who meets one or more of the following criteria:⁹⁶

- Has a physical or mental impairment that substantially limits one or more major life activities.
- Has a record of such an impairment.
- Is regarded as having such an impairment.

Physical or Mental Impairment.⁹⁶ Physical or mental impairment is defined as: any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine; or any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The regulatory provision does not set forth an exhaustive list of specific diseases and conditions that may constitute physical or mental impairments because of the difficulty of ensuring the comprehensiveness of such a list.

Major Life Activities.⁹⁶ Major life activities means functions such as, but not limited to, caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Record of Impairment.⁹⁷ Record of disability means that the individual has a history of or has been classified as having a mental or physical impairment that substantially limits one or more major life activities.

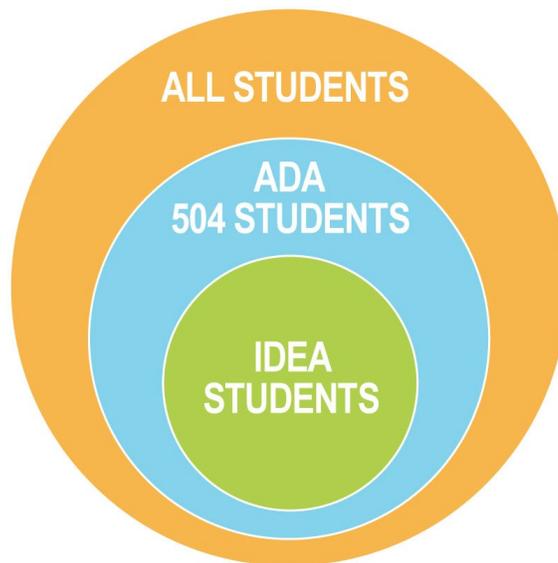
Regarded as Having an Impairment.⁹⁷ Regarded as having a disability means:

- Has a physical or mental impairment that does not substantially limit major life activities, but is treated as constituting such limitation.
- Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment.
- Has none of the impairments defined in the previous section “Physical or Mental Impairment” but is treated by a recipient as having such an impairment.

Similarities and Differences Between Section 504 and IDEA

Some students with disabilities may not qualify for special education and services under IDEA but may qualify for services under Section 504. Figure 3 compares eligibility under IDEA and Section 504.

Figure 3. IDEA and 504 Eligible Student Population Comparisons
 Reprinted with permission from [Success for Students with Hearing Loss](#)



IDEA/504 STUDENTS	SECTION 504 STUDENTS ONLY
Students are qualified under one or more of 13 IDEA disabling condition categories. Specially designed individualized education programs (IEP) are planned for each student by IEP Teams.	Due to substantial mental or physical impairments that limit one or more of the student’s major life activities, special accommodations to the student’s general education program are required. A 504 accommodation plan is designed for each student according to individual need.

	<p>Examples of potential 504 handicapping conditions <u>not typically covered</u> under IDEA are:</p> <ul style="list-style-type: none"> • Communicable diseases—HIV, Tuberculosis. • Medical conditions— asthma, allergies, diabetes, heart disease. • Temporary medical conditions due to illness or accident. • Attention Deficit Disorders (ADD, ADHD). • Behavioral difficulties. • Drug/alcohol addiction. • Other conditions.
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All students who are eligible (disabled) under the IDEA are also considered to be disabled and, therefore, protected under Section 504. Some students who are not eligible for IDEA services are deemed disabled under Section 504. The IDEA defines as eligible only students who have certain specified types of disabilities and who, because of one of those conditions, needs special education. Section 504, on the other hand, protects all students with disabilities, defined as those having any physical or mental impairment that substantially limits one or more major life activities. Section 504 covers all students who meet this definition, even if they do not meet the IDEA criteria for having a disability and requiring special education. Application of this definition would pertain to a student who has juvenile arthritis but who is not eligible for special education and related services through IDEA. Such a student has a health impairment and is disabled for the purposes of Section 504, if their condition substantially limits their ability to function at school. Accommodations and related services and aids must be provided for the student to benefit from free and appropriate public education. The school division must evaluate the student and, if qualified under Section 504, must develop and implement a plan for the delivery of all needed services.

The following resources further outline the differences between IDEA and Section 504 coverage and eligibility:

- [Understood.org: The Difference Between IEPs and 504 Plans](#)
- [IDEA and 504 Comparison Chart](#)
- [Disability Rights Education & Defense Fund: A Comparison of ADA, IDEA, and Section 504](#)

- Determining Student Need: [IDEA/504 Flow Chart](#)

Process for Implementation of Section 504 Protections/Services

The following information reflects Section 504 of the Rehabilitation Act of 1973, the [U.S. Department of Education Protecting Students with Disabilities, CASE, Student Access Section 504 Procedures Checklist](#), and the [VDOE Power Point Section 504: Keys to Implementation in Virginia Schools](#).

Referral. The first step of the process is referral. Students falling under the auspices of Section 504 generally are those who meet one or more of the following descriptions:

- Are experiencing academic difficulty (below grade level performance), and it is suspected that the health condition is or will adversely affect classroom functioning.
- Need medically related adaptations to perform in a general education classroom placement.
- Need or may need homebound instruction on an intermittent basis due to medical condition.

The school principal is generally the central figure in any process involving special services for students assigned to the school. It is the responsibility of all staff (e.g., secretaries, teachers, visiting teachers, health professionals, psychologists, and other support personnel) to immediately make the principal aware of any student who may need 504 services. Parents may also refer their children or request services. Every effort should be made to review health information on all students when they enroll.

Screening. The school division may elect to have either a centralized committee or a school-based building screening committee. The committee may consist of principal/designee, student's general education teacher(s), specialist(s), school nurse, licensed nurse practitioner, public health nurse, parents and/or referring source, and any other persons deemed necessary. As a member of this committee, the school nurse may assist in determining whether a complete comprehensive assessment and/or any single or multiple assessment is necessary in order to make a determination of the child's needs. The school nurse may recommend that the screening committee request additional information, reports or records, and classroom observation or intervention.

The 504 evaluation may consist of the following written components:

- Medical.
- Psychological.

- Educational.
- Socio-cultural.
- Others as appropriate to the student's suspected disability; for example, an audiological may be requested to determine a student's eligibility for hearing impairment services.

Evaluation. Procedures should be developed for this evaluation that ensure the following:

- Evaluation materials are appropriate for intended use.
- Evaluators are properly trained.
- Evaluation materials used should test relevant areas of educational need and not merely IQ.
- Selection and administration of tests should accommodate sensory, manual, and speaking deficiencies.

Eligibility. A committee to determine 504 eligibility may consist of the following individuals: director of special services, school psychologist, school social worker, school nurse, educational diagnostician, representative from the referring school, student, family member, and individuals representing the assessment components as required. Each school division will determine the membership based on local needs. The school nurse may be a part of this committee when necessary. The purpose of the eligibility meeting is to determine whether or not there is a disability condition.

Section 504 Evaluation Committee. The Section 504 Evaluation Committee is responsible for determining the following:

- Whether the student has a disability.
- The type of disability.
- The effect of any disability on the student in the school setting.

The 504 Plan. A Section 504 Accommodation Plan must be developed to incorporate the services that the student needs in the educational setting. The school nurse may assist in developing the components of the 504 Accommodation Plan related to health issues.

Special Education Health Assessment

Overview

An important component of the special education assessment is a complete medical history and physical examination. The school nurse may play an integral part by taking the medical history. A complete physical examination should be performed by a licensed physician or licensed nurse practitioner (directly supervised by a physician).

Health History ⁹⁸

School Nurse's Role in Medical/Health History. Obtaining a complete medical history is the most important aspect of a health examination. For younger children, the parents are the primary informants. However, a child not accompanied by a parent is unlikely to be able to provide answers to some of the questions posed by the school nurse. The school nurse should use professional judgment to determine which questions are appropriate to ask of a child and which questions will need to be deferred for a later interview with a parent. If the nurse completes the health history, it should be reviewed by the examiner prior to medical assessment.

Setting. The school nurse responsible for completing a health history must be cognizant of the importance of this interview in establishing communication and rapport with the student. In addition, this first step is key in setting up a successful physical assessment. The interview should be conducted in a room that is private, bright, and nonthreatening. The school nurse should define the scope of the interview, assure complete confidentiality, and tailor communication strategies to the age and developmental level of the student being interviewed. If a parent is present, the school nurse must inform the parent of the relevance of the information they are about to give as well as who has access to the information the parent and student share with the school nurse. The school nurse may already have access to identifying data about a particular student (e.g., name, nickname, parents' names, home phone, and so forth). If the school nurse does not have this information, or is unable to obtain it from the student, the nurse should follow up with a parent after the interview.

Health History Categories. The categories the school nurse should address when taking a health history include:

Past Medical History. Past medical history includes:

- General state of health, including appetite, recent weight losses or gains, fatigue, and stresses.
- Birth history (if a parent is present). Birth history is especially important if the child is younger than 2 years of age or is experiencing developmental or neurological problems. Questions should relate to significant prenatal history,

birth complications, and neonatal history (e.g., respiratory distress, cyanosis, jaundice, seizures, poor feeding, patterns of sleeping).

- Previous illnesses, operations, or injuries, including:
 1. Dates of hospitalizations.
 2. Reasons for hospitalizations.
 3. Accidents, specifically head injuries. (It is important to inquire about a history of fainting spells.)
- Chronic illnesses, such as asthma, seizure disorders, cardiac disease, and diabetes.
- Current medications, including prescription and non-prescription drugs, dose, frequency, and duration of use.
- Allergies, including the agent (e.g., environment, medication).
- Immunization status.
- Developmental disabilities or other disabilities.

Growth and Development.

- Physical development, including height and weight (when indicated, approximate height and weight at 1, 2, 5, and 10 years of age and tooth eruption/loss should be obtained).
- Developmental history, including developmental milestones (e.g., ages at which child rolled over, sat alone, crawled, walked, spoke first words, spoke first sentences, and dressed without help). Note: For children already participating in school, academic achievement may be included in this section.
- Social history, including issues relating to:
 1. Temperament (e.g., congeniality, aggressiveness, withdrawal): Children and adolescents should be asked if they ever feel sad or down; if yes, they should be asked if they have ever thought of killing themselves.
 2. Attention span.
 3. Adjustment to school, including school absences and relationship to peers (in and out of school).
 4. Tobacco, alcohol, and drug use.
 5. Relationships with family members.
 6. Toileting habits (where appropriate).

Review of Systems. Review of systems includes inquiry as to the student's or parent's understanding of the child's general health status. Areas to be addressed include:

1. General health status
2. Skin
3. Head and neck
4. Ears
5. Eyes
6. Face and nose
7. Thorax and lungs
8. Cardiovascular
9. Abdominal
10. Genitourinary/reproductive
11. Musculoskeletal
12. Neurologic

Physical Examination ⁹⁸

A complete physical examination should be performed by a licensed physician or licensed nurse practitioner (directly supervised by a physician). The health care provider should address the following areas during the physical examination:

- **General appearance, demeanor, and cooperation.**
- **Pulse, respiration, and blood pressure.**
- **Height, weight, and nutritional status.**
- **Posture, gait, flexibility (assessment for scoliosis at appropriate age).**
- **Eyes and vision.**
- **Nose, mouth, teeth, throat, and neck.**
- **Chest and lungs.**
- **Heart.**
- **Abdomen.**
- **Genitalia, hernia, pubertal status (Tanner stage).**
- **Extremities (tone and range of motion).**
- **Behavior and mental status.**

Referral and Follow-Up Process. School nurses and health care providers involved in the interviewing and examination of students may identify medical and non-medical issues requiring follow-up interventions. Effective follow up requires a knowledge of community health resources and good communication between school health personnel, parents, health professionals, and community agencies.

Documentation

The entire special education assessment is confidential. Any information should be documented in the student's record. The record is the responsibility of the director of special education or pupil personnel services. A copy of the medical/health history must be available for the school nurse.

Role of the School Nurse

Overview

School nurses serve a critical role in the special education process as an essential member of the multidisciplinary education team, identifying children who may be eligible for services through IDEA and Section 504.⁹⁹ They can access the student's physical and functional health status, recommend health-related accommodations/services that assist students to access the educational program, and participate in the planning, implementation, and evaluation of IEPs and Section 504 Accommodation Plans.⁹⁹ Nurses have a unique perspective to be able to understand the medical and educational components, and can serve as a resource for the parents, and an advocate for the student with special health needs.¹⁰⁰

It is responsibility of the nurse to understand the federal and state laws and that provide protections for students with disabilities,⁹⁹ and to identify the resources and community referrals available to assist students who qualify for services under IDEA and/or Section 504. As the health care expert in the school setting, the school nurse has the essential body of knowledge and experience to identify health-related barriers to learning, and the accommodations needed for the students with disabilities to access their education.⁹⁹

Resources

For additional information on the role of the nurse in the IDEA, 504, and Special Education processes, refer to the following:

- 2009 National Alliance for Medicaid in Education
["Lock In" Your Team: The Role of the School Nurse in Special Education](#)
- American Academy of Pediatrics, Council on School Health
[Role of the School Nurse in Providing School Health Services](#)
- Maryland State School Health Guideline
[Role of the School Nurse in Implementing Section 504 and Individualized Education Program Services](#)
- National Association of School Nurses
[Position Statement: Section 504 and the Individuals with Disabilities Education Improvement Act – the Role of the School Nurse](#)

Chapter 15: General Guidelines for Administering Medication in School

Information in this section is taken from the Virginia Department of Education [Manual for the Medication Training Manual for Unlicensed School Personnel](#) and the Virginia Department of Health [Guidelines for Healthcare Procedures in Schools \(2017\)](#).

Overview

Administering prescriptive and over-the-counter medication during school hours is a complex issue. In order for many students with chronic illnesses or disabilities to remain in school, they must receive medication. However, administering medication in school has the potential for many problems, such as storage problems, who will administer the medication, side effects, and emergency situations which may arise. Medication must be administered under the safest possible conditions. The following guidelines are intended to assist school divisions in developing a policy for administering medication to students at school.

Prior to Administering Medication

Prior to administering any prescriptive medication, the following three items should be addressed:

1. Authorization for medication
2. Labeling for the medication
3. Parental consent

NOTE: Policies for over-the-counter medications vary greatly from one school division to another. **Refer to the local school division for policies for over-the-counter medications.**

Medication Authorization. The use of all prescriptive medications should be authorized in writing by a licensed prescriber, which includes physicians, dentists, physician assistants, or licensed nurse practitioners. The written authorization should include the following information:

- Student's name
- Licensed prescriber's name, telephone number, and signature
- Date prescription written
- Name of the medication
- Dosage
- Time of day to be given

- Anticipated length of treatment
- Diagnosis or reason the medication is needed (unless reason should remain confidential).
- Serious reactions that the student might experience
- Any serious reactions that may occur if the medication is not administered
- Special handling instructions

Any changes in the original medication authorization require a new written authorization and a corresponding change in the prescription label. Faxed authorizations may be acceptable as long as there is a signed parental consent for the medications authorized by fax. Changes in medications communicated via the telephone should be taken only under extreme or urgent circumstances, and only be a licensed registered nurse. The telephone authorization for changes in medications should be recorded on the student's record and be a one-time-order only. A telephone authorization (verbal order) should be followed by a written and signed order from the licensed prescriber within 48 hours.¹⁰¹

Medication authorizations should be received on a standardized authorization form. However, authorizations on stationary or prescription pads from the licensed prescriber are acceptable and should be attached to the medication authorization form. Medication authorizations and parental consent must be renewed annually.

Parental Consent. In addition to the authorization for administering medication, parental consent must be obtained before a medication is given to a student. For each medication, the parental consent should include the following information:

- Student's name
- Parent's name
- Parent's emergency/daytime phone number
- Statement of parental consent
- Date of consent
- Allergies
- Name of the medication (if not on medication authorization form)
- Reason for the medication (if not on medication authorization form)
- Duration of treatment (if not on medication authorization form)

Medication Labeling. The final area that should be addressed prior to administering medication is labeling. The medication must be in its original container before it is given to a student, regardless of whether it is a prescription or over-the-counter medication. The pharmacist can divide the medication into two containers - one for home and one for school. The original container should be labeled with the student's name, name of medication, directions for dosage, route for administration, frequency to be administered, the licensed prescriber's name, pharmacy contact information, date the prescription was filled, and expiration date.¹⁰²

Medications in plastic bags or other non-original containers are not acceptable.

Administering Medication

School Staff. The school nurses should assume responsibility for administration of medication to students. In schools where school nurses are not available on a daily basis, the principal should assume the responsibility for designating school staff to administer medication to students. If someone other than the school nurse is to give the medication, the nurse must provide training in the administration of the medication to that designated person. Refer to the Virginia Department of Education's [Manual for the Training of Public School Employees in the Administration of Medication](#) for additional guidance. The initial dose of any new medication should be given at home. It is recommended that the principal or school nurse ensure that:

- Medication is given correctly and documented appropriately.
- The appropriate forms are completed prior to giving a medication to include authorization and parental consent.
- The medication is properly labeled and stored properly in a secure, safe place.

Documentation of Administering Medication. When medication is brought to school, the amount of medication in the container should be documented (e.g., the number of capsules or the volume of liquid). Each time a medication is administered a record should be kept of who administered it (initials may be used as long as a complete signature that corresponds with the person's initials is noted on the record), to whom it was given, the name of the medication, the time it was given, the dose given, the manner in which it was delivered (e.g., by mouth, in ear), the effect of the medication, and any side effects or reactions. Any changes in the type, dosage, or the time a medication is to be given should be accompanied by a new medication authorization/parent consent form, and a newly labeled medication container from the pharmacy.

Storage of Medications. Medications should be kept in an appropriately labeled container which is locked and secured in a designated space (e.g., a locked box stored within a locked cabinet). It is recommended that only a 30-day supply of a controlled substance be kept at school at any given time. Keys must be kept in a secure location accessible only to those employees who have been designated and trained to administer medication to students. A listing of authorized staff should be maintained by the principal and updated routinely. Keys to

the medication storage area should never leave the school grounds. Arrangements need to be made for medications requiring refrigeration.

Parents/Guardian. Prior to administering a medication at school, the parents should:

1. Provide the school with a written authorization from the licensed prescriber that includes the following information: the student's name, name of the medication, dosage, time to be given, method by which it is to be given, name of the licensed prescriber, date of the prescription, expected duration of administration of the medication, and most importantly, possible toxic effects and side effects. For any changes in medication, the parents must provide a written authorization signed by the licensed prescriber.
2. Provide the medication in a properly labeled container.
3. Provide a completed parental consent form.
4. Administer the first dose of any new medication at home.
5. Transportation of medication to school is the responsibility of the parent.

Unused medication should be picked up by parents within one week of the expiration date or the date that the medication is no longer required. After one week, the medication should be destroyed by the school nurse, principal, or the principal's designee. Medication given on a daily basis throughout the year should be destroyed if not picked up by the parent, per school division policy. It is advisable that the destruction of the medication be witnessed by another person. Document the name and amount of the medication that is destroyed.

Student Self-Administration of Medications

Some school divisions allow student self-administration of medication under special circumstances with a healthcare provider order and under the supervision of the school nurse, principal or the principal's designee. School divisions that allow student self-administration of medication should include the following information in their policy for student self-administration of medication:

- Demonstration of capability for self-administration of the medication.
- Safe storage and appropriate use of the medication.
- The need for a medication order stating that the student is qualified and/or able to self-administer the medication.
- Parental consent for student self-administration.
- Physician authorization to self-carry and administer medication.
- Notification of appropriate team members (such as teachers, principals, support persons) of all student self-testing or self-administration of medication.

- Training for staff to be appropriately prepared for working with the student.
- Recognition that self-administration of medication is a privilege that can be taken away if medication policies are abused or ignored.
- Expectation of reporting medication use to school health personnel.

Some school divisions that allow student self-administration of medication use a “medication pass” system. Each student who is allowed to self-administer medication receives a pass that states the student’s name, the name of the medication that the student can self-administer, date issued, who issued the pass, when the pass expires (e.g., seven days, end of school year), when it is to be taken (as needed, on a schedule), and any monitoring that is required. The student should carry the pass at all times. It should be noted that the guidelines listed previously for prescription and over-the-counter medication should be followed with medication that is self-administered.

Field Trips

Medication given on field trips must be administered according to the same policies for administering medication in the school. These include:

- Administering medication according to the prescribed directions.
- Administering the medication from the original container or a correctly labeled container prepared in advance by the school nurse (see excerpt below for labeling instructions).
- Properly documenting medication administration.

All medications must be kept secure throughout the field trip. Controlled substances, such as Ritalin, may require special handling because of their potential value (as street drugs). It is generally not advisable to send an entire bottle of prescription medication on a field trip when only one day’s dose will be administered. In Virginia, only licensed medical professionals, such as registered and licensed practical nurses, may repackage medications for a one-day field trip as discussed below.

At least one day prior to a field trip, the person who administers the medication should be made aware of the event so that arrangements can be made to meet the student’s needs for medication. More notice may be required if the nurse is not in the school every day. It is the responsibility of the appropriately trained school employee (e.g., school nurse, teacher, health assistant) to administer medication to students on field trips. Persons who are not employees (or contracted employees) who accompany students on field trips—such as parents and chaperones—should not administer medication to students, except where such persons administer medication to their own child. Children cannot be excluded from a field trip because of a disability or a medical need. Parents may be requested to attend the field trip to assist with

student needs, but if unavailable, the school division must provide necessary accommodations for health care services at the same level the student required while in the school building.¹⁰²

Emergency contact information and the number for Poison Control (1-800-222- 1222) should be provided to staff administering medications on a field trip, in case a problem arises. Forms documenting administration and any unused medications must be returned to the school health office once the staff and students return to school.

NOTE: The following clarification of the term, “administer” medication was set forth in [Guidance Document:110-18 Interpretation of "Administer" to Include Preparation for Administration](#), adopted by the Board of Pharmacy on June 11, 1998, the Board of Nursing concurred on July 21, 1998, and revised September 29, 2015:

If the advance preparation, as performed by a person licensed to dispense or administer drugs, is to assist in the administration of medication to students during a single-day field trip, such advance preparation shall not be made prior to the last working day before the day of the field trip and shall not exceed a one-day supply. Any packaging used in such advance preparation shall include the student’s name and any other appropriate student identifier; physician’s name; drug name and strength, and quantity; and appropriate directions for administration. For any field trip which is longer than one day in length, a student’s prescription medication should be provided by the student’s parent or guardian in a properly labeled prescription vial which has been dispensed from a pharmacy and, for oral medications, which contains only the quantity needed for the duration of the field trip.

Emergency Medications

Written policies should be available for any emergency medication that is administered to students. Emergency medications require a written authorization by the medical healthcare provider and the written permission of the parent/guardian. In some school divisions, standing orders may be provided by the identified prescriber for emergency medications to be used in specified circumstances for students and/or staff. The school nurse should prepare an Individualized Health Care Plan and an Emergency Care Plan for each student who has an order for an emergency medication. Training and supervision of unlicensed staff designated to administer these medications is a function of the school nurse. Examples of emergency medications include:¹⁰²

- Epinephrine
- Rectal diazepam
- Glucagon
- Albuterol nebulizers and inhalers

Epinephrine Protocol

To be used in conjunction with a healthcare provider order in an EMERGENCY situation.

Information in this section is adapted from [Virginia Department of Health, Recognition and Treatment of Anaphylaxis in the School Setting](#) and protocol developed by Susan Werner, Chairperson Culpeper County School Health Advisory Committee.

Epinephrine (also known as “adrenaline”) is the drug of choice used to treat and reverse the symptoms of anaphylaxis by constricting blood vessels and raising blood pressure, relaxing the bronchial muscles and reducing tissue swelling. Epinephrine is a prescribed medication and is administered by injection, either intramuscularly by an auto-injector or intramuscularly by syringe.

Epinephrine should be administered promptly at the first sign of anaphylaxis. It is safer to administer epinephrine than to delay treatment for anaphylaxis. The sooner anaphylaxis is treated, the greater the person’s chance for surviving the reaction. Epinephrine is fast acting, but its effects last only 5-15 minutes; therefore, a second dose of epinephrine may be required if symptoms continue.

Anaphylaxis is a severe systemic allergic reaction, resulting from exposure to an allergen that is rapid in onset and can cause death. Common symptoms of anaphylaxis include:

- Sudden difficulty breathing
- Wheezing
- Hives
- Generalized flushing
- Itching, or redness of the skin
- Swelling of the throat, lips, tongue
- Tightness/change of voice
- Difficulty swallowing
- Tingling sensation, itching, or metallic taste in mouth
- Feeling of apprehension, agitation

Anaphylaxis is one type of allergic reaction, in which the immune system responds to otherwise harmless substances from the environment (called “allergens”). A variety of allergens can provoke anaphylaxis, but the most common culprits are food, insect venom, medications, and latex. Unlike other allergic reactions, however, anaphylaxis is potentially lethal and can kill in a matter of minutes. Anaphylaxis typically begins within minutes or even seconds of exposure, and can rapidly progress to cause airway constriction, skin and intestinal irritation, and altered

heart rhythms. Without treatment, in severe cases, it can result in complete airway obstruction, shock, and death. Initial emergency treatment is the administration of injectable epinephrine (also known as “adrenaline”) coupled with immediate summoning of emergency medical personnel and emergency transportation to the hospital. Appropriate, timely treatment can totally reverse anaphylaxis and return a child or adult to their prior state of health.

Two dosages of epinephrine are available—0.3 ml and 0.15 ml of 1:1000 epinephrine (i.e., single dose of epipen). Epinephrine should be administered in the prescribed dosage subcutaneously as directed on epipen directions.

At the same time as the epinephrine is given, assisting personnel should activate the 911 system for transportation of the student to the hospital emergency room, and alert them that epinephrine has been given. Parents should be also be notified, as soon as possible.

Epinephrine Accessibility in School

[Anaphylaxis in the School Setting Guidelines](#)

§ [22.1-274.2 \(C\)](#) of the *Code of Virginia*, to ensure the accessibility of epinephrine at all times by individuals trained to administer this life-saving drug when needed during regular school hours. This legislation directs local school board policies to require that at least one school nurse, employee of the school board, employee of a local governing body, or employee of a local health department who is authorized by a prescriber and trained in the administration of epinephrine has the means to access at all times during regular school hours any such epinephrine that is stored in a locked or otherwise generally inaccessible container or area.

Epinephrine is an injectable emergency medication that is given to individuals experiencing life-threatening signs of anaphylaxis or allergic reaction. A delay in administration of this medication by only a few minutes can have serious consequences. Quick access to areas where epinephrine is stored (e.g., rooms, storage units, or drawers) is imperative for those personnel trained in the administration of this medication and the recovery of individuals receiving this life saving medication.

Albuterol Protocol

To be used in conjunction with a health care provider/local health director order in an EMERGENCY situation.

Asthma is a chronic lung disease that causes airway inflammation. Inflamed airways are particularly sensitive and tend to overreact to certain “triggers.” Triggers can include numerous physical, chemical, and pharmacologic agents, such as allergens, viral infections, cold air, and exercise. When the airways react to a trigger, three physiologic processes happen:

1. Bronchospasm, contraction or squeezing of the involuntary muscle surrounding the airway
2. Inflammation and edema (swelling) of the mucous membranes of the airways

Bronchospasm, edema, and increased mucus narrow the airway and result in less air getting into and out of the lungs thereby causing wheezing, coughing, chest tightness, and/or difficulty breathing. Wheezing is a high-pitched whistling or squeaky sound that can be made when air moves through narrowed airways. These symptoms can be mild or moderate and affect activity levels, or they can be severe and life threatening. Therefore, persons caring for a student with asthma need knowledge and skill to assess and support the student.

Treating Asthma Attacks

The most common symptoms of asthma are coughing, wheezing, chest tightness, and shortness of breath. Symptoms may occur after physical exercise or at any time. Other symptoms include having less energy than usual, tightening of neck muscles with breathing, sucking in of the chest with each breath (retractions), and grayish, cyanotic tint to nail beds and lips. Children may have difficulty talking or become anxious when they have an asthma attack. Very young children may complain of stomach aches, headaches, or scratchy throats when their asthma is worsening.

During an asthma attack, do not leave the student unattended, it is important to stay calm, have the student sit in a comfortable position, and follow the instructions on the student’s [Emergency Asthma Action Plan](#) if one has been provided to the school by the parent/guardian. It is extremely important for a student diagnosed with asthma to have a **written** plan in place outlining how to manage the student’s asthma on a daily basis and what to do in an emergency. If a student does not have an Asthma Action Plan, schools should follow their school division’s plan for undesignated stock albuterol use and refer the student to their healthcare provider for follow up care.

Albuterol Accessibility in Schools

In 2021, the General Assembly passed [HB2019](#) (McQuinn) , which amended and reenacted [8.01-225](#), [22.1-274.2](#) , and [54.1-3408](#) of the Code of Virginia, relating to public elementary and secondary schools; possession and administration of undesignated stock albuterol inhalers and valved holding chambers. This legislation becomes effective on **January 1, 2022**.

This legislation requires schools to possess and administer undesignated stock albuterol metered dose inhalers (MDI) and valved holding chambers to **any student** experiencing respiratory distress. The purpose of the administration of school undesignated stock emergency albuterol is to reduce the amount of time children spend away from the classroom and to make schools safer for all children. After completion of training and with a standing order from the local health department director for undesignated stock albuterol, school nurses, unlicensed assistive personnel (UAP) and non-medical personnel are authorized to administer albuterol to a student believed to be experiencing or about to experience an asthmatic crisis.

The Virginia Department of Education provides guidance, resources and training for school staff to assist students experiencing respiratory distress symptoms. The [Guidelines for Managing Asthma in Virginia Schools](#), and the Use of Undesignated Stock Albuterol in Schools Manual includes model policy and best practices for the administration of undesignated stock albuterol for students while in school and can be found on the Virginia Department of Education [School Health Services](#) webpage.

Administering Medication

Emergency, Quick Relief, or Rescue Medications work very quickly and are used to open the airways in asthma attacks. They are usually bronchodilators and work by relaxing the muscles surrounding the airways so that the airways open and allow the child to breathe easier. Albuterol (Proventil, Ventolin) is an example of a common bronchodilator. Quick relief medications often are delivered through metered dose inhalers (MDI) and usually work for about four hours.

The administration of undesignated stock albuterol may be used in the following situations:

- If the student has a current Asthma Action Plan supplied to the school by the parent/guardian, but does not have their prescribed medication available: School staff should use the medical care plan provided by the healthcare provider for the student and the school's supply of undesignated stock albuterol inhaler with valved holding chamber.
- If there is no Asthma Action Plan from a healthcare provider for the student and the student is having difficulty breathing: School staff use the school's standing order and the school's supply of undesignated stock albuterol inhaler with valved holding chamber.

Authorization/Parental Consent for Administering Medication

Sample forms for medication authorization, parent authorization, and student self-administration can be found in Appendix D in *the [Medication Training Manual for Unlicensed School Personnel](#)* and in Appendix A of the [Guidelines for Healthcare Procedures in Schools](#).

Before adapting any of the sample forms, please refer to local school board policies and regulations regarding medications and the code of conduct.

Procedure for Administering Medication

Information in this section is taken from the Virginia Department of Education *Manual for the Training of Public School Employees in the Administration of Medication (2012)* and Hockenberry, M.J., Wilson, D. & Rodgers, C.C. (Eds.)(2019). *Wong's nursing care of infants and children* (pp.708-724). St. Louis: Elsevier.

Procedure	Points to Remember
General Procedure	
1. Wash hands.	
2. Assemble: equipment, medication, container for administering (if applicable)	
3. Review the medication authorization, medication label, and parental consent for administering medication.	<i>The first dose of any new medication should be given at home.</i>
4. Review Health Care Plan for documentation of any student-specific techniques that are recommended for administering the medication.	<i>Prior to administering medication, it is essential that the method used for giving the medication at home be known. This method should be followed in the school setting.</i>
5. Remove medication from storage area. Compare label on medication container with medication authorization. Ensure that the dosage, time given, student's name, and licensed prescriber's name on the medication label is identical to the medication authorization. Read the label 3 times before administering the medication.	<i>Helps to ensure that the right medication is given to the right student.</i>
6. Prepare medication. An accurate means for measuring the medication should be readily available. Liquid medication may be poured into a measuring cup with metric markings, a hollow handled medicine spoon with metric markings, or pulled up into a syringe. A tablet or capsule may be placed in a cup.	<p><i>The person preparing the medication should be the person giving the medication.</i></p> <p><i>All pediatric liquid oral medicines should be measured and administered in millileters only, not teaspoons or other non-metric units, to ensure accurate dosing.</i></p>
7. Place remaining medication back into the designated storage area.	

Procedure	Points to Remember
8. Explain the procedure to the student at his/her level of understanding. Encourage the student to participate as much as possible.	<i>By encouraging the student to assist in the procedure, the caregiver is helping the student achieve maximum self-care skills.</i>
Oral Medications	
<p>1. Positioning for special situations:</p> <p><u>Small students at infant developmental level:</u></p> <ul style="list-style-type: none"> • Hold student in the cradle position. • Stabilize student's head against your body. • Hold student's arm with your free arm. • Press on student's chin to open mouth. <p><u>Large student at infant developmental level</u></p> <ul style="list-style-type: none"> • Allow student to remain in wheelchair. • Support student's head against your body. • Press on student's chin to open mouth. <p><u>Students with tongue thrust</u></p> <ul style="list-style-type: none"> • Medications may need to be rescued from the student's lips or chin and re-administered. 	<p><i>When holding or supporting the student, it is important that the student is relaxed to prevent choking.</i></p> <p><i>A relaxed position may be achieved by flexing the student's neck, rounding the shoulders, and positioning the student in a slightly forward or flexed position.</i></p>
2. Administering medication:	
<p><u>Dropper</u></p> <ul style="list-style-type: none"> • Squirt medication to the back and side of the student's mouth in small amounts. 	
<p><u>Syringe</u></p> <ul style="list-style-type: none"> • Place syringe to the back and side of the student's mouth. • Give the medication slowly in small amounts, allowing the student to swallow. 	
<p><u>Nipple</u></p> <ul style="list-style-type: none"> • Pour medication into the nipple after it has been measured. Allow the student to suck the medication from the nipple. Follow the medication with water. 	

Procedure	Points to Remember
<p><u>Medicine Cup</u></p> <ul style="list-style-type: none"> Place the medication in the cup. If the student is capable of drinking the medication without help, allow him/her to do so; if the student is unable to hold the cup, then hold the cup and allow the student to drink the medication. 	
<p><u>Tablets</u></p> <ul style="list-style-type: none"> If the student is able to swallow a tablet, place it on the middle of the tongue, then student can swallow tablet with juice or water. Tablets that may be chewed or crushed and placed in a fruit syrup or applesauce. Unscored tablets should not be divided. If medication authorization requires unscored tablet to be divided, please consult with pharmacist prior to dividing the medication. Do not force a student to take a tablet if he/she resists because of the potential for aspiration. 	<p><i>NOTE: Helpful tips for teaching students how to swallow can be found at http://www.pillswallowing.com</i></p> <p><i>It is important to check with pharmacist to see if drug action will be affected by crushing the medication.</i></p> <p><i>Division of unscored tablets may adversely affect their absorption by the body.</i></p> <p><i>Check with parents to determine how the medication is given at home.</i></p>
<p><u>Capsules</u></p> <ul style="list-style-type: none"> Place the capsule on the back of the tongue and have the student swallow lots of fluid. Some capsules may be opened and sprinkled on a spoonful of food. Check with pharmacist to see if this can be done. 	<p><i>Many medications are designed to be time-released. It is important not to disrupt this formulation because it affects the absorption of the medication and may cause potential harm to the student.</i></p>
<p>3. Before student leaves your presence, make sure that he/she has received and swallowed all of the medication.</p>	<p><i>Students may hold medication in their mouth and spit it out at a later time.</i></p>
<p>Nose Drops</p>	
<p>1. For young children/developmentally young children, cradle student in your arms, stabilizing head with arm, and tilt student's head slightly back OR place student's head over a pillow.</p>	<p><i>The lowered position is necessary when the student can not sniff the medication.</i></p>
<p>2. Squeeze prescribed drops into each nostril. Student should remain in position for 1 minute to</p>	

Procedure	Points to Remember
allow the nasal medication to come into contact with the nasal surfaces.	
3. Older students may give their own medication, if they are able to sniff the medication.	
Ear Drops	
1. Place student in prone or supine position and tilt student's head away from affected ear. Pull pinna (outer edge of ear) upwards and back in students older than 3 years of age.	
2. Instill eardrops as ordered into the student's ear.	
3. Student should maintain this position for a few minutes. Then place a small piece of cotton ball into the ear canal.	<i>Keeps medication from flowing out of the ear.</i>
Eye Drops or Ointment	
1. Place student in a supine position (lying down on his/her back).	
2. Drops - Pull lower eyelid down and out to form a cup. Drop solution into the cup. Close eye gently and attempt to keep eye closed for a few moments.	<i>Avoid touching dropper to eye to avoid contamination of the medication.</i>
3. Ointment - Pull lower eyelid down, apply ointment along edge of lower eyelid from the nose side of the eyelid to the opposite side.	<i>Avoid touching tip of medication container to the eye to avoid contamination of the medication.</i>
Rectal Medications	
1. Place student in side-lying or prone position (on his/her stomach)	
2. Lubricate suppository with water-soluble gel.	
3. Using a gloved hand or finger cot, gently insert the suppository into the rectum beyond both rectal sphincters. Hold buttocks together for 5 to 10 minutes.	<i>It is important that privacy be provided.</i> <i>Prevents quick expulsion of the medication so that the medication has adequate time to be absorbed.</i>

Procedure	Points to Remember
Enzyme Replacement Therapy (Used with students with cystic fibrosis to provide pancreatic enzymes.)	
1. Enzymes should be given prior to a meal or snack.	<i>Pancreatic enzymes aid in digestion and absorption of food; therefore, they should be given prior to eating.</i>
2. Microspheres or microtablets should not be crushed or chewed.	<i>Enzymes should dissolve in the higher pH environment of the intestines rather than the mouth. The enzymes are coated with an enteric coating that prevents the enzyme from being dissolved till it reaches the intestine. If the coating is disrupted by crushing or chewing, the enzyme will not dissolve in the proper place.</i>
3. For infants and small children, the capsules should be broken open and mixed with a lower pH food, such as applesauce.	
4. Document medication given, time given, amount given, how it was given, who gave it, and the student's name. Also, document any problems or side effects.	<i>Notify parents and/or physician of any problems or side effects.</i>

Possible Problems	
Observations	Reason/Action
Incomplete dose of medication	<i>If the student spits or vomits the medication, consult with the healthcare provider before re-administering the dose. Investigate why the student spit or vomited. Perhaps a smaller portion of medication may be given at more frequent times, or medication may be mixed with juice to make it more palatable.</i>
Incorrect medication	<i>Notify parents and physician immediately with name of medication and dosage given. Follow physician's orders.</i>

Medication not given	<i>Report immediately to parents and/or physician. Determine when medication should be given next.</i>
Choking	<i>Stop giving medication immediately. When student begins to breathe regularly and has completely recovered, medication can be given. If the student does not recover and is believed to have an obstructed airway, perform the Heimlich Maneuver, activate the emergency medical system, and begin CPR as indicated.</i>
Response to medication	<i>Any side effects should be reported to the parents. If the student has an allergic reaction, the medication should be discontinued.</i>

Resources

- American Academy of Pediatrics
 - [Policy Statement – Guidance on the Administration of Medication in School](#)
- American Diabetes Association
 - [Safe at School](#)
- Cystic Fibrosis Foundation
 - [CF at School](#)
 - [CF Clinical Care Guidelines](#)
- National Association of School Nurses
 - [Medication Administration in the School Setting](#)

Chapter 16: Infectious Disease Control

Authorization

Code of Virginia. The following include information related to infectious disease control:

- [Section 32.1-39. Surveillance and Investigation.](#)
- [Section 22.1-272. Contagious and Infectious Diseases.](#)
- [Sections 22.1-271.1. Definitions. and 22.1-271.2. Immunization Requirements.](#)
- [Section 32.1-47. Exclusion From School of Children Not Immunized.](#)
- [Section 22.1-271.3. Guidelines for School Attendance for Children Infected with Human Immunodeficiency Virus; School Personnel Training Required; Notification of School Personnel in Certain Cases.](#)

A list of reportable diseases, which are subject to control under isolation and quarantine regulations and general reporting duties, is available via the Virginia Department of Health, [Virginia Reportable Disease List.](#)

Overview

Communicable disease is an illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host. These diseases can pose serious problems for school health programs, causing staff and student discomfort and absences, which can interfere with academic performance. This section is intended to provide school health services personnel with a ready source of information on managing the control of communicable diseases in the school setting. However, it should only be used as guidance and is not intended to replace more inclusive textbooks, regulations and legal requirements, or state and local policies, or be a therapeutic guide, but to be a source of basic information on which initial action can be taken.

Definitions

The following resources used to outline the technical meanings of terms used in this section:

- Arsonson, S.S., and Shope. T.R. (2016). *Managing infectious diseases in child care and schools: A quick reference guide* (4th ed.). Elk Grove: American Academy of Pediatrics.
- Columbia University
 - [Glossary of Epidemiology Terms](#)
- Northwest Center for Public Health Practice
 - [Epidemiology Glossary](#)
- UCLA School of Public Health
 - [Definitions](#)

Agent: A microorganism, chemical, type of radiation, or other factor whose presence, excessive presence, or (in deficiency diseases) relative absence can cause disease or damage to the human body.

Carrier: A person who carries a specific disease-causing organism within his or her body, has no symptoms of disease, and can spread the disease to others.

Case: In epidemiology, a countable instance in the population, or study group, of a particular disease, health disorder, or condition under investigation. It can also refer to an individual with the particular disease.

Communicable disease: A disease caused by a microorganism (e.g. bacterium, virus, fungus, parasite) that can be transmitted from person to person via an infected body fluid or respiratory spray, with or without an intermediary agent (e.g. tick, mosquito) or environmental object (e.g. table surface). Many communicable diseases are reportable to the local health authority. (Synonym: infectious disease.)

Communicable period: The period of time during which an infected host (person) remains capable of passing along the infective agent (for example, a virus).

Contact: Exposure to a source of an infection, or a person so exposed.

Contagious: Capable of being transmitted from one person to another by contact or close proximity.

Contamination: The presence of infectious microorganisms in or on the body, environmental surfaces, articles of clothing, or food or water.

Epidemic: The occurrence of more cases of a disease than expected in a given area or among a specific group of people over a particular period of time.

Host: A person or organism that can be infected by an agent that causes disease.

Inapparent infection: The presence of infection in a host without recognizable clinical signs or symptoms. Inapparent infections are identifiable only by laboratory means such as a blood test or by the development of positive reactivity to specific skin tests.

Incubation period: Time between exposure to an infectious microorganism and beginning of symptoms.

Infection: A condition caused by the multiplication of an infectious agent in the body.

Infectivity: The ability of an infectious agent to cause infection, measured as the proportion of people who become infected after being exposed to the infectious agent.

Infestation: Common usage of this term refers to parasites (e.g. lice, scabies) living on or in the body.

Organism: Living things. Often used as a general term for germs (e.g. bacteria, viruses, fungi, parasites) that can cause disease.

Patient or sick person: A person who is ill.

Report of a disease: An official report notifying an appropriate authority of the occurrence of specified communicable or other disease in humans or animals.

Reservoir: The habitat in which an infectious agent normally lives, grows, and multiplies; reservoirs include humans, animals, and the environment.

Transmission of infectious agents: The passing of an infectious organism or germ from person to person. These mechanisms are as follows:

1. **Direct Transmission:** Direct and essentially immediate transfer of infectious agents to a receptive portal of entry through which human or animal infection may take place. This may be by **direct contact** (e.g., touching, biting, kissing, sexual intercourse) or by **direct projection** (droplet spread) of droplet spray onto the conjunctiva or onto the mucous membranes of the eye, nose, or mouth during sneezing, coughing, spitting, singing, or talking (usually limited to a distance of about 1 meter or less).
2. **Indirect Transmission:**
 - a. Vehicle-borne—Contaminated inanimate materials or objects (fomites) such as toys, handkerchiefs, soiled clothes, bedding, cooking or eating utensils, surgical instruments or dressings; water, food, milk, and biological products including blood, serum, plasma, tissues or organs; or any substance serving as an intermediate means by which an infectious agent is transported and introduced into a susceptible host through a suitable portal of entry. The agent may or may not have multiplied or developed in or on the vehicle before being transmitted.
 - b. Vector-borne—(i) Mechanical: Includes simple mechanical carriage by a crawling or flying insect through soiling of its feet or proboscis, or by passage of organisms through its gastrointestinal tract. This does not require multiplication or development of the organism. (ii) Biological: Propagation (multiplication), cyclic development, or a combination of these (cyclopropagative) is required before the arthropod can transmit the infective form of the agent to humans. An incubation period

(extrinsic) is required following infection before the arthropod becomes **infective**. The infectious agent may be passed vertically to succeeding generations (**transovarian transmission**); **transstadial transmission** indicates its passage from one stage of life cycle to another, as nymph to adult. Transmission may be by injection of salivary gland fluid during biting, or by regurgitation or deposition on the skin of feces or other material capable of penetrating through the bite wound or through an area of trauma from scratching or rubbing. This transmission is by an infected nonvertebrate host and not simple mechanical carriage by a vector as a vehicle. However, an arthropod in either role is termed a **vector**.

3. **Airborne:** The dissemination of microbial aerosols to a suitable portal of entry, usually the respiratory tract. Microbial aerosols are suspensions of particles in the air consisting partially or wholly of microorganisms. They may remain suspended in the air for long periods of time, some retaining and others losing infectivity or virulence. Particles in the 1 to 5 particulate matter (PM) range are easily drawn into the alveoli of the lungs and may be retained there. Not considered as airborne are droplets and other large particles that promptly settle out (see Direct transmission, above).
 - a. **Droplet nuclei** - Usually the small residues that result from evaporation of fluid from droplets emitted by an infected host (see above). They may also be created purposely by a variety of atomizing devices, or accidentally as in microbiology laboratories or in abattoirs, rendering plants or autopsy rooms. They usually remain suspended in the air for long periods of time.
 - b. **Dust** - The small particles of widely varying size that may arise from soil (as, e.g., fungus spores separated from dry soil by wind or mechanical agitation), clothes, bedding or contaminated floors.

Infectious Disease Control Measures

Infectious disease control measures in school include:

- Requiring certain immunizations.
- Identifying children who have communicable diseases.
- Preventing illnesses from spreading.
- Temporarily excluding some children who are ill.
- Reporting illnesses regulated by Virginia Department of Health.
- Being prepared by having policies, procedures, and trained personnel.

Resources

- Virginia Department of Health, [*Office of Epidemiology*](#)
 - [*Division of Disease Prevention*](#)
 - [*Division of Surveillance and Investigation*](#)
 - [*Division of Immunization*](#)
 - [*Disease Fact Sheets*](#)
 - [*Communicable Disease Reference Chart for School Personnel*](#)
 - [*Virginia Reportable Disease List*](#)
 - [*Regulations for Disease Reporting and Control*](#)

- Control of Communicable Diseases Manual
David L. Heymann, Editor
20th Edition, 2014
American Public Health Association
To order, visit the [APHA Store](#)

The information presented below is a composite of information and recommendations from the following references:

- American Academy of Otolaryngology
 - [*Head and Neck Surgery: Patient Health Information*](#)

- American Academy of Pediatrics
 - [*2018 Red Book, Report of the Committee on Infectious Diseases \(31st Edition\)*](#)

- Aronson, S.S., and Shope, T.R. (2016). *Managing infectious disease in child care and schools: A quick reference guide* (4th ed.). Elk Grove Village: American Academy of Pediatrics.

- [*Centers for Disease Control and Prevention: Diseases and Conditions*](#)

- Heymann, D.L. (Ed.). (2014). *Control of communicable diseases manual* (20th ed.). Washington, D.C.: American Public Health Association.

- [*The Merck Manuals: Professional Version*](#)

- Massachusetts Department of Health
 - [*Comprehensive School Health Manual*](#)

- [Virginia Department of Health, Office of Epidemiology](#)

The following subsections provide guidance or overviews for specific modes of disease transmission, including preventive recommendations.

- [Prevention Guidelines for Diseases Spread Through Direct Skin Contact](#)
- [Prevention Guidelines for Diseases Spread Through the Intestinal Tract](#)
- [Prevention Guidelines for Diseases Spread Through the Respiratory Tract](#)
- [Prevention Guidelines for Diseases Spread During Sexual Activity](#)
- [Prevention Guidelines for Sports-Related Infectious Diseases](#)

Prevention Guidelines for Diseases Spread Through Direct Skin Contact

Overview

Communicable infectious diseases that are usually spread through direct skin contact, including those commonly known as head lice, impetigo, pink-eye, scabies, and ringworm, can be spread from person to person by direct or indirect transfer of the disease-causing organism (infectious agent). Organisms that cause such diseases include bacteria, parasites, and fungi.

Direct transmission of the organisms can occur by direct contact with an infected or infested person (e.g., direct skin-to-skin contact, immediate contact with infected lesions or discharges). Indirect transmission of the organism can occur, though usually to a lesser extent, through contaminated inanimate materials or objects (e.g., shared clothing, headgear, or shower stalls). For some of the diseases, it is possible to transmit the organism through other modes (e.g., autoinfection, airborne spread). These diseases are common and, when treated, are not serious. Because students constantly touch the people around them and their surroundings, these diseases are easily spread among students and staff.

Listed below are some examples of how the disease-causing organisms can be transmitted:

- A student's arm has sores with discharge. During interaction, this discharge gets on another individual's arm and into a cut or scratch.
- A hat belonging to a student with head lice is used by another student. A louse from the hat crawls onto the head of the second student.
- A student with runny eyes rubs them with his or her hands before picking up a book, pen, or pencil, contaminating them with eye discharge. Other students become infected by picking up those objects and then rubbing their own eyes with contaminated hands.

School Exclusion Guidelines

Refer to Part VII, Universal Precautions and Infectious Diseases, for disease-specific information.

Recommendations

1. Follow hand washing and cleanliness guidelines that include:
 - a. Making sure staff and students thoroughly wash their hands after contact with any possible infected areas.
 - b. Using liquid soap dispensers whenever possible.
 - c. Always using disposable tissues or towels for wiping and washing.
 - d. Never using the same tissue or towel from more than one student.
 - e. Disposing of used tissues and paper towels in a lined and covered container that is kept away from food and materials.
2. Washing or vacuuming frequently used surfaces (e.g., tables, counters, furniture, and floors) daily.
3. Do not permit students to share personal items, such as combs, brushes, hats, or clothing.
4. Provide adequate individual areas for students to keep their outer clothing items, such as coats, hats, scarves, and mittens.
5. Wash and cover sores, cuts, and scrapes promptly, and keep infected eyes wiped dry.
6. Report rashes, sores, runny eyes, and severe itching to a student's parents so they may contact their health care provider for diagnosis and appropriate treatment.

Prevention Guidelines for Diseases Spread Through the Intestinal Tract

Overview

Communicable infectious diseases that are usually spread through the intestinal tract, including those commonly known as *Campylobacter*, *Giardia*, Hepatitis A, Hepatitis E, pinworms, Rotavirus, *Salmonella*, and *Shigella*, can be spread from person to person by direct or indirect transfer of the disease-causing organism (infectious agent). Organisms that cause such diseases include bacteria, viruses, and parasites.

Direct transmission of the organisms, for most of the diseases, can occur by hand-to-mouth transfer of the organism from the stool of an infected person (i.e., fecal-oral route), especially in institutions and day care centers. Indirect transmission of the organisms can occur, though usually to a lesser extent for some of the diseases, through contaminated inanimate materials or objects (e.g., ingestion of organism in food, unpasteurized milk, water). For some of the diseases, it is possible to transfer the organisms through other modes (e.g., contact with an infected pet, possibly fecal-respiratory route). Some organisms, such as *Campylobacter* and *Salmonella* bacteria, must be ingested in large quantities to cause illness.

Because students and staff who have intestinal tract diseases do not always feel sick or have diarrhea, the best method for preventing spread of disease is to have a constant prevention program in place. In the school setting, this program should include hand washing before preparing or eating food and after using the bathroom. All school bathrooms should have adequate supplies of soap, running water, paper towels, and toilet paper. Laboratory tests are the only means of confirming the presence of this type of organism in a particular stool and may be performed as part of an effort to control an outbreak of disease.

School Exclusion Guidelines

1. When students or staff have uncontrolled diarrhea and fever or vomiting (or have severe or bloody diarrhea) or if diarrhea cannot be contained by diapers (in those students using them), they should be excluded from school until their fever or diarrhea are gone and they have been treated as determined by a health care provider.
2. When students or staff have mild diarrhea but are not sick, special precautions should be taken or they should be excluded from school.
3. When students or staff who do not prepare food or feed students are found to have infectious diarrheal germs in their stool (positive stool cultures) but have no diarrhea or illness symptoms, special precautions should be taken but they should not be excluded from school. (If necessary, make sure they receive appropriate management from a

health care provider.) During outbreaks a negative stool culture may be required before returning to school.

4. When staff who normally prepare food or feed children have positive stool cultures, do not permit them to prepare food or feed students until they have one negative stool culture taken 48 hours after medication is completed, if antibiotics are used. During outbreaks, two consecutive negative stool cultures may be required.

Refer to Part VII, Universal Precautions and Infectious Diseases, for disease-specific information.

Return Guidelines

Excluded students and staff may come back to school after treatment and when severe diarrhea is gone. During outbreaks, negative stool cultures may be required before excluded students and staff may come back to school.

Recommendations

1. Strictly enforce proper handwashing after using the bathroom, diapering, and before preparing or eating food. Handwashing is the best way to prevent spread of infectious diseases caused by organisms that are transmitted by the fecal-oral route.
2. Pay attention to environmental cleaning and sanitation.
3. Keep track of the number of cases of diarrhea.
4. If there is an increase in the number of cases expected in the school, call the local health department for guidelines on additional precautionary measures to be taken to ensure the protection of students and staff from further spread of illness.

Prevention Guidelines for Diseases Spread Through the Respiratory Tract

Overview

Communicable infectious diseases that are usually spread through the respiratory tract, including those commonly known as chickenpox, common cold, flu, measles, bacterial meningitis, tuberculosis, and whooping cough, can be spread from person to person by direct, indirect, or airborne transfer of the disease-causing organism (infectious agent). Organisms that cause such diseases include bacteria and viruses. When a person infected with such a disease coughs, sneezes, blows their nose, sings, or talks (usually limited to about 1 meter) they can produce infected droplets (large infected particles that settle out of the air) or infected airborne particles (microbial aerosols that do not settle out of the air for a long time).

Direct transmission of the organisms can occur by direct contact with the mucous membranes of the infected person (e.g. touching or kissing) or direct projection (spray) of the droplets onto the eye, nose, or mouth. Indirect transmission of the organisms can occur, for most of the diseases, by hands and articles (e.g., handkerchiefs, toys, pencils, books, desks) freshly soiled by droplets, discharges from nose and throat, or secretions from lesions of an infected person—the organisms are transmitted by contaminated hands carrying organisms to the mucous membranes of the eye or nose. Furthermore, transmission of the organisms can occur by inhalation of airborne particles.

Diseases spread through the respiratory tract can be mild (e.g., viral colds) or life-threatening (e.g., bacterial meningitis). People who are infected with such diseases and do not wash their hands after touching their eyes, nose, or mouth increase the likelihood of spreading the disease by contaminating articles with discharges from their respiratory tract. The organisms can easily be transferred to others through those contaminated articles. In addition, people who are infected with respiratory disease and do not cover their mouths and nose when coughing or sneezing can increase the likelihood of airborne spread, which can predominate among crowded populations in enclosed spaces (e.g., school buses).

School Exclusion Guidelines

1. Most children will not need to be excluded from school for mild respiratory tract illnesses, because transmission is likely to have occurred before symptoms developed in the child or is a result of contact with children with asymptomatic infection.
2. Exclusion from school of children with respiratory tract symptoms that are due to common cold, croup, bronchitis, pneumonia, sinusitis, and/or otitis media probably will not decrease the spread of infection.

3. Separation from other children is indicated when one or more of the following conditions exist:
 - a. The illness has a specific cause that requires exclusion or treatment prior to returning to school as outlined under the discussion of the specific illness.
 - b. It interferes with the child's ability to concentrate and limits the child's comfortable participation in school activities.
 - c. Results in a need for care from staff members that compromises the health and safety of other children.

Refer to Part VII, Universal Precautions and Infectious Diseases, for disease-specific information.

Recommendations

1. Hand washing and other hygiene practices are essential to decreasing the spread of all respiratory tract diseases. Students and staff should be encouraged to wash their hands after wiping or blowing their noses; after contact with any nose, throat, or eye secretions, and before preparing or eating food.
2. A supply of tissues should be available in each classroom. Encourage children to cough or sneeze into a tissue and away from other people. It is best to cover a cough or sneeze with a disposable tissue and then perform good hand hygiene. Children should be taught to direct a sudden cough or sneeze to an empty space on the floor or use an elbow or shoulder as a barrier.
3. Tissues should be properly disposed of and hand washing should follow. Dispose of tissues contaminated with nose, throat, or eye discharges in a step-can with a plastic liner. Keep soiled tissues away from food and other classroom materials.
4. Discourage the sharing of food.
5. Surface areas, toys, and other inanimate materials and objects shared by children in the classroom should be properly cleaned.

NOTE: Aspirin (or products containing salicylate) should *never* be administered to children for fever control of any viral illness, but particularly if influenza or chickenpox is suspected. There is an association with Reye's syndrome (vomiting, liver problems, and/or coma) and the use of aspirin in the treatment of these types of illnesses.

Prevention Guidelines for Diseases Spread During Sexual Activity

Overview

Sexually Transmitted Diseases (STDs) refer to a group of preventable diseases that are spread from person to person during sexual activity. This term includes such conditions as AIDS and HIV infection, chlamydia, crabs (pubic lice), genital warts, gonorrhea, hepatitis B (HBV), genital herpes, syphilis, and vaginitis (yeast infections, trichomoniasis). The organisms that cause an STD can be spread during oral (mouth), anal, or vaginal sexual activity; some can also be spread via skin-to-skin contact with an infected partner's genital area—not just through intercourse. A pregnant woman can also pass an infection to her baby. Left untreated, some STDs can cause serious long-term health problems.

Symptoms. The symptoms, transmission, and treatment of STDs are specific for each disease. However, listed below are some of the symptoms that might indicate that a person is infected with an STD:

Females

- Any odor or unusual discharge (fluid) that comes from vagina.
- Itching or burning around vagina.
- Pain during sex.
- Bleeding other than during menstrual period.
- Pain in the lower abdominal area that does not go away.
- Left untreated, some STDs can cause Pelvic Inflammatory Disease (PID)—a very serious condition. PID can develop when untreated infections spread further into the reproductive organs. Symptoms are usually serious and, left untreated, can cause sterility.

Males

- A discharge or drip (fluid) from penis.
- Pain or soreness in the area of testicles.

Males and Females

- Pain or burning with urination.
- Any blisters, sores, ulcers, bumps, or warts on or around sex organs or anus.

- Any burning, itching, swelling, or redness on or around sex organs.
- Persistent flu-like symptoms, such as tiredness, fever, aches, chills, night sweats, weight loss, or diarrhea.

NOTE: Sometimes a person may not have ANY symptoms whatsoever but might still have an STD.

Treatment

Physicians can identify and treat STDs. In addition, most local health departments have special clinics just for STDs.

School Exclusion Guidelines

Refer to Part VII, Universal Precautions and Infectious Diseases, for disease-specific information.

Recommendations

1. The only guaranteed method of prevention of STD infection is abstinence. The following recommendations for those who are sexually active include:
 - a. Having a monogamous relationship with one uninfected partner. If the partner is not monogamous, the other partner can get a STD.
 - b. The best protection for a sexually active person is to use a latex condom every time that person has any sexual contact or intercourse. Condom use has been proven to reduce the risk of STD transmission.

Prevention Guidelines for Sports-Related Infectious Diseases

Communicable Diseases

The spread of communicable infectious diseases among students in the school setting is a problem shared by all educational institutions. Contact in the classroom, cafeteria, or schoolyard can facilitate the spread of infectious diseases. In addition to the exposures that students face in these common situations, student athletes may contract or spread infectious diseases while participating in sporting activities. Teachers, coaches, and athletic staff, school/team physicians, school nurses, and others responsible for the health and safety of athletes need to be aware of the infectious disease spread that can occur during training, competition, or even during physical education class activities.

Risk of Exposure. There may be risk of exposure for the individual athlete, the team, and spectators. Transmission of infectious diseases in sports settings usually occurs via direct contact, the fecal-oral route, common-source exposure, or airborne and/or droplet spread. In some cases, disease transmission is unavoidable due to infectiousness before symptoms become apparent. In other cases, the spread of disease occurs as a result of many people congregating together or sharing water bottles or other eating/drinking utensils. The following chart lists some infectious diseases that have occurred due to sports-related activities:

Sports-Related Infectious Diseases		
Disease	Mode of Transmission	Sports Involved
Herpes simplex virus (HSV), (<i>herpes gladiatorum</i>) <i>Staphylococcus aureus</i> Group A streptococci, fungi	Direct contact	Wrestling, rugby, basketball, football
Enteroviruses (coxsackievirus, echoviruses)	Common-source or fecal-oral	Team sports
<i>Pseudomonas aeruginosa</i>	Common-source	Swimming
Meningococcal illnesses	Saliva exchange	Team sports
Measles	Airborne or droplet	Tournaments involving gymnastics, basketball, wrestling, other indoor sports

School Exclusion Guidelines

Refer to Part VII, Universal Precautions and Infectious Diseases, for disease-specific information.

Recommendations. Some concern has been raised about the possibility of sports-related transmission of blood-borne pathogens. Team physicians, trainers, school nurses, physical education teachers, and others involved with the health of the student athlete should not only be able to recognize and manage acute problems but should also institute policies for the prevention of disease transmission. These policies are adapted from the National Federation of State High School Sports Associations [General Guidelines for Sports Hygiene, Skin Infections, and Communicable Diseases](#).¹⁰³

1. In order to decrease transmission of diseases spread by mucous membrane contact or the fecal-oral route, coaches, trainers, and physical education instructors should be educated about the need to prevent exposures of athletes sharing water bottles and pails during sports-related activities.
2. Students diagnosed with skin infections should be cautioned about their participation in sports involving close physical contact. Players with open lesions that cannot be covered should not be permitted to participate in sports where they could transmit disease to others.
3. All athletic equipment in contact with student's skin or secretions should be routinely cleaned after use. This would include, but not be limited to, gymnastic and wrestling mats, mouth guards, and other protective equipment. Sanitizing of mats with a dilute bleach solution (1 tablespoon bleach to 1 quart of water) and airing of mats is also recommended as a standard precaution.
4. All students must be vaccinated against communicable diseases as described in Part VI, Chapter 28, *School and Daycare Minimum Immunization Requirements*.
5. When airborne diseases occur, a mechanism should be in place to inform everyone exposed, including athletes, staff, and spectators.
6. Athletes with symptoms of an infectious disease should not be permitted to participate in sports activities until they have been evaluated by their health care provider and are no longer infectious.
7. Public health officials should be immediately notified of a case or suspected case of a reportable disease in an athlete. Timely reporting of even a suspected case of an infectious disease may help to prevent further spread among athletes, spectators, and the community.

Chapter 17: Other School Health Services

In addition to health assessments, population screening, services associated with the students with special needs, and medication administration, school divisions may offer a variety of health services. A few services that are typically offered by school divisions in Virginia have been selected and highlighted in this section. The following subsections contain information on other health services that may be offered by school divisions.

- [Managing Illnesses/Injuries, and Crises](#)
- [Referring to Child Protective Services](#)
- [Home Visits](#)
- [Nursing Liaison Services to Homebound Students](#)
- [Students Requiring Specialized Health Care Procedures](#)

Managing Illnesses, Injuries, and Crises

Each school is responsible for the safety and well-being of students, staff, and visitors during school hours on school property, and during school-sponsored activities. Schools and their staff must be ready to manage first aid emergencies, disasters, and crises that occur in the school or impact the school from outside. It is important that schools have written procedures and policies for managing first aid emergencies, disasters, and crises. In addition, the school and staff need to have the knowledge of the policies and procedures so that they can handle these situations competently.

Authorization

- [Code of Virginia, Section 54.1-2969, Authority to Consent to Surgical and Medical Treatment of Certain Minors.](#)
- [Code of Virginia, Section 8.01-225, Persons Rendering Emergency Care, Obstetrical Services, Exempt From Liability.](#)
- [Code of Virginia, Section 22.1-274 E, School Health Services.](#)
- [Code of Virginia, Section 22.1-279.8, School Safety Audits and School Crisis, Emergency Management, and Medical Emergency Response Plans Required.](#)

Managing Illnesses and Injuries

The information presented below is adapted from the following publications:

- Aronson, S.S., and Shope, T.R. (2016). *Managing infectious disease in child care and schools: A quick reference guide* (4th ed). Elk Grove Village: American Academy of Pediatrics.
- Selekman, J. (2013). *School nursing: A comprehensive text* (2nd ed). Philadelphia: F.A. Davis Company.
- Virginia Department of Health
 - [First Aid Guide for Child Care and School Emergencies \(2015\)](#)

Many minor injuries and illnesses occur in students and staff during the course of the school day. Students, employees, and visitors may have medical emergencies at school or off the school premises (e.g., on the school bus or field trips). Students with chronic health problems or disabilities often are at greater risk for injury, illness, or extreme medical emergencies. Selected

school personnel should be able to provide first aid in emergencies, know how to perform cardiopulmonary resuscitation (CPR), use an automated external defibrillator (AED), and administer Glucagon and Epinephrine. Timely and appropriate administration of first aid and basic life supporting measures can save lives and minimize disability.

Standing Orders and Nursing Protocols. Standing orders and nursing protocols are helpful in meeting the health needs of school children. Both standing orders and nursing protocols help in the management of medical issues and are useful in the school setting. Standing orders and nursing protocols help to insure convenience, consistency, completeness, and continued learning. Additionally, health professionals can use the standing order to defend their actions. Standing orders and nursing protocols serve as the primary guidelines for health care providers at all levels of expertise (e.g., registered nurses, licensed practical nurses, and unlicensed healthcare providers).

Standing orders (i.e., *general orders*) refer to those orders, rules, or regulations that have been determined by a licensed prescribing healthcare provider and are used by other health professionals in carrying out medical procedures. They apply to any student for whom the order may be applicable and must be based on federal/state laws and regulations and local school policy. Standing orders are used to provide the school nurse or nurse practitioner with specific orders of treatment for specific medical issues such as epinephrine in life threatening, allergic reactions (anaphylaxis), or acetaminophen for fever, headaches, sprains, or menstrual cramps.

When legally sanctioned and indicated for the safety of the student body, a standing order may also be used to provide school personnel other than nurses with instructions for action and treatment on a specific medical emergency. A standing order for personnel who are not health professionals must be more detailed and provide more direction. The school division is responsible for seeing that school staff have sufficient training in emergency techniques to carry out the standing order. The registered nurse and the school's physician or medical advisor should review standing orders on an annual basis and revise as necessary. Examples of standing orders can be reviewed for reference in the [New Mexico School Health Manual](#).

Student-specific treatment orders (i.e., *specific orders*) for known health issues are written by the individual student's licensed prescribing health care provider in consultation with the student's parents and school nurse, and are part of the student's individualized healthcare plan (IHP). Standing orders for the general student body do not supplant medical orders for individual students. Permission from the student's parent(s)/guardian(s) must be acquired for implementing either of the two types of orders: *standing orders* or *specific treatment orders*.

Nursing protocols are explicit or general operational guidelines that describe steps to be taken in the nursing management of specific health issues. In contrast to standing orders, protocols usually include strategies for obtaining relevant historical data and significant physical findings as well as plans of action. Nursing protocols are used to enhance standardization of care and thoroughness of service throughout the school division. Standardized nursing routines direct the health care of children at school. Some are based on accepted nursing practice, as outlined

by each state's Nursing Practice Act. (See [Virginia Nurse Practice Act](#).) These are most appropriately used in circumstances in which the outcome of care given can be predicted with considerable accuracy and provide guidelines for the observation of a medical condition, its management, referral and recommendations to the student, the student's parent(s)/guardian(s), and school staff. A typical protocol describes the physical characteristics of a medical issue, states what the nurse should do, and recommends follow-up. Nursing protocols can be utilized in sports programs, in screening programs, and in the management of specific health issues or complaints. The degree to which protocols are used depends upon the school division's responsibility for providing health care services. It is imperative that nursing protocols reflect the level of training of the school's health care personnel.

Protocols for nurse practitioners may include guidelines for in-depth clinical assessment and management of a wide range of primary health care issues, but call for referral to a pediatrician or other specialist when indicated.

Protocols for the registered nurse (RN) involve guidelines for the clinical assessment and management of routine primary health issues. Referral is made to the school nurse practitioner, physician, or other health care provider when in-depth assessment and management are indicated.

Protocols developed for the licensed practical nurse (LPN) and unlicensed healthcare personnel (UAP) must be much more specific and emphasize information gathering and early referral to a registered nurse or other appropriate health professional. Protocols can be written by the registered nurse (in consultation with the student's parents and health care provider) for use by the classroom teacher in the event that a set of symptoms, medical complications, or other issues occur. This type of protocol would provide the classroom teacher with specific guidelines for managing a child with a known health issue until professional help was available.

Samples nursing protocols to be used as guidance are available through the [New York State Center for School Health](#) in the form of Emergency Care Plans (ECPs) and Individualized Health Plans (IHPs).

First Aid. First aid involves the administration of emergency assistance to individuals who have been injured or otherwise disabled, prior to the arrival of a physician or transportation to a hospital or a physician's office. First aid should never be the substitution for definitive medical care.

- Please refer to the latest edition of the flipbook, [First Aid Guide for Child Care and School Emergencies](#), published by the Virginia Department of Health, for guidance on administering immediate and temporary care to an ill or injured person. It contains practical, step-by-step instructions that describe what to do when caring for an injured or ill individual. The flipbook is designed for use by teachers, school nurses, clinic aides, and other staff members who are responsible for the health and safety of students and others in the school setting.
- The flipbook, [First Aid Guide for Child Care and School Emergencies](#), should be posted in a place that is easily accessible to all staff members. It is recommended that all staff become familiar with the contents of the flipbook prior to handling an emergency.

Written Procedures. Each school division should have written procedures for managing emergencies involving students, school personnel, and visitors. The school division staff should be knowledgeable about the emergency management procedures. The school is responsible for the safety and well-being of students, staff, and visitors during school hours on school property and during school-sponsored activities. Therefore, local school division policies should address:

- Preventive measures to limit injuries.
- Policies to define what action will be taken when a serious injury or medical emergency occurs.
- Facilities and supplies to accommodate basic first aid and care of ill or injured students, staff members, or visitors.

For additional information, please refer to *Code of Virginia*, [§ 54.1-2969, Authority to consent to surgical and medical treatment of certain minors](#), and for *Code of Virginia*, [§ 8.01-225, Persons rendering emergency care, obstetrical services, exempt from liability](#).

Procedures

1. Prior to an emergency:
 - a. The most recent edition of the flipbook, [First Aid Guide for Child Care and School Emergencies](#) *should* be readily available in the school health office (i.e., school clinic) of each school building. This guide contains a comprehensive listing of first aid measures needed to manage student, school personnel, and visitor emergencies.
 - b. An emergency information card system for students should be maintained in the school health office. A similar system for staff members should be maintained following local school division policies.
 - c. Each school should have contingency plans for emergencies that include staff certified in cardiopulmonary resuscitation (CPR)/use of an

automated external defibrillator (AED), as well as administration of Glucagon and Epinephrine.

- d. The *Code of Virginia*, [§22.1-274](#), requires that:

Each school board shall ensure that in school buildings with an instructional and administrative staff of 10 or more (i) at least three employees have current certification or training in emergency first aid, cardiopulmonary resuscitation, and the use of an automated external defibrillator and (ii) if one or more students diagnosed as having diabetes attend such school, at least two employees have been trained in the administration of insulin and glucagon. In school buildings with an instructional and administrative staff of fewer than 10, school boards shall ensure that (a) at least two employees have current certification or training in emergency first aid, cardiopulmonary resuscitation, and the use of an automated external defibrillator and (b) if one or more students diagnosed as having diabetes attend such school, at least one employee has been trained in the administration of insulin and glucagon. "Employee" includes any person employed by a local health department who is assigned to the public school pursuant to an agreement between the local health department and the school board. When a registered nurse, nurse practitioner, physician, or physician assistant is present, no employee who is not a registered nurse, nurse practitioner, physician, or physician assistant shall assist with the administration of insulin or administer glucagon.

2. When an emergency occurs:

- a. Reference the Virginia Department of Health, [First Aid Guide for Child Care and School Emergencies](#), for guidance on administering immediate and temporary care to an injured or ill individual.
- b. Parents/guardians of students should be notified of all emergencies/injuries so that further observation/follow-up care can be provided at home.
- c. Injuries should be carefully documented to preclude misinformation and to provide an accurate recording of events prior to the injury and the subsequent administration of first aid.
- d. The teacher or other staff member who is responsible for the student at the time an injury occurs should complete and file an injury report according to local school division policies.
- e. Staff members sustaining work-related injuries should follow the appropriate guidelines for Worker's Compensation Insurance.

3. Ongoing Evaluation:

- a. The *Code of Virginia*, [§22.1-279.8](#), requires an assessment of the safety conditions in each public school to:

(i) identify and, if necessary, develop solutions for physical safety concerns, including building security issues and (ii) identify and evaluate any patterns of student safety concerns occurring on school property or at school-sponsored events. Solutions and responses shall include recommendations for structural adjustments, changes in school safety procedures, and revisions to the school board's standards for student conduct.

- b. *School nurses should have knowledge of the school safety audit process and are encouraged to participate as part of the audit team.*
- c. *School nurses should audit injury reports to identify areas of high risk in the school, including causative factors, and submit a report of findings to the principal for corrective action.*
- d. *School nurses should supplement the curriculum with classroom health lessons and individual health counseling as necessary, based on information derived from environmental monitoring and/or review of injury reports.*

Extreme Emergencies

- All school personnel should be able to identify members of the response team and initiate the local school division's established system of triage for extreme medical emergencies.
- In extreme emergencies, the school principal or his/her designee may make arrangements for immediate hospitalization of injured or ill students, contacting parents/guardians in advance, if possible.
- The school nurse and/or other designated school personnel, with the emergency information card, should accompany the student to the hospital and remain until the parent/guardian assumes responsibility.

Chronically Ill. Individual health plans for chronically ill students should address potential emergency situations based on each student's health condition and provide precise instructions/healthcare provider's orders for specific treatments in certain defined emergency circumstances. Local school division policies for managing school emergencies should be reviewed and approved by a consulting physician (e.g., school physician, private physician, local health department medical director or physician, school health advisory board).

Report Forms. Please see Appendix C for a sample Student Injury Report.

Managing Crises

The following information is taken from: [*Resource Guide: Crisis Management and Emergency Response in Virginia Schools*](#), a publication of the Virginia Department of Education. This manual provides detailed information on sample policies, guidance on roles and procedures, training and education, communication, and planning for crisis management in the school system.

Effective Crisis Management. A crisis can occur at any time whether or not schools have a plan and it is unlikely that any school will escape the necessity of responding to a significant crisis. A crisis can impact a single building or the entire school division, depending on the nature of the crisis. Establishing a Crisis Management Plan anticipates potential problems and establishes a coordinated response to minimize school community stress and disruption.

Events of recent years, including the terrorist attack of September 11, 2001, violence and attacks on school grounds, and hurricanes and flooding in the Gulf Coast, have greatly contributed to the development of knowledge around preparing for and responding to emergencies. Described below are common emergency management concepts and frameworks that school administrators need to understand as they approach crisis planning and management:

1. Crisis Planning Cycle
 - a. Prevention/Mitigation Phase
 - b. Preparedness Phase
 - c. Response Phase
 - d. Recovery Phase
2. Multi-Hazard Comprehensive Planning
 - a. In school crisis planning, consideration should be given also to:
 - i. Physical and environmental risks
 - ii. Social and emotional well-being of students, faculty, and staff
 - iii. School culture and climate.
3. National Incident Management System (NIMS)
 - a. The six key components of NIMS are:
 - i. Command and Management
 - ii. Preparedness
 - iii. Resource Management

- iv. Communications and Information Management
 - v. Supporting Technologies
 - vi. Ongoing Management and Maintenance
4. Incident Command System (ICS)
 - a. School staff members need to be familiar with their local jurisdiction's ICS to avoid any confusion when responding to a critical incident. It is a good idea to identify in advance a liaison officer for the school; this is typically the principal. There is a clear chain of command among law enforcement, emergency personnel of the fire department, and paramedics. It is very important for school leaders to meet them ahead of time and learn about their ICS so that the school can become a functioning member of the ICS team.
 5. Framework for Crisis Management Planning
 - a. Pre-incident Identification/Intervention
 - b. Non-Emergency Crisis Response
 - c. Critical Incident Response

Regardless of which framework a division or school adopts, effective crisis management is critical. *Crisis management* is that part of a school division's approach to school safety that focuses more narrowly on a time-limited, problem-focused intervention to identify, confront, and resolve the crisis, restore equilibrium, and support appropriate adaptive responses. The essential elements of crisis management in schools include the following:

- **Policy and Leadership.** Provides both a foundation and a framework for action. The chances of effectively managing a crisis are increased with a division level plan and individual building plans that operate within the framework of the division plan but are tailored to the conditions and resources of the individual school. Leadership is necessary to ensure effective implementation of plans and maintenance or preparedness.
- **The Crisis Response Team.** A school Crisis Response Team can be a highly effective organizational unit for dealing with a variety of crises. Such teams can operate at three levels: (1) individual school building, (2) central office, and (3) community. Well-functioning teams at each level provide a network that can support action whenever crises arise.
- **The School Crisis Management Plan.** A school that is *prepared* before a crisis occurs will be much more likely to manage students and staff effectively.
- **Communications.** When a crisis occurs, effective communication is essential—within the school and the school division, with parents and the community at

large, and with the media. Effective communication can speed the restoration of equilibrium; poor communication can make a bad situation much worse.

- **Training and Maintenance.** Preparation for and response to crises rely on people understanding policies and procedures and knowing what they are to do. These are achieved through *training*. Maintaining preparedness is an ongoing process that involves debriefing following crises, periodic review and updating, and ongoing training.

Policy and Leadership. Policy provides both a foundation and a framework for crisis management. Leadership, however, is necessary to ensure effective implementation and maintenance of preparedness.

School division policies typically include the following elements:

- A definition of “crisis.”
- A requirement that each school establish a crisis management team and develop a crisis management plan.
- Specifications for membership of the crisis management team, usually including provision for accessing, in the event of crisis, additional resources from within the school division and/or community.
- Specifications for issues to be addressed in each school’s crisis management plan, usually including designation of chain of command, development of protocols for management of specific types of crises, coordination of communications, provisions for support services, staff in-service training, and periodic review of the plan.

Leadership at the central office includes developing a division plan as a management plan. The following are key principles for effective crisis planning:

- Effective crisis planning begins with leadership at the top.
- Crisis plans should not be developed in a vacuum.
- Schools and divisions should open the channels of communication well before a crisis.
- Crisis plans should be developed in partnership with other community groups, including law enforcement, fire safety officials, emergency medical services, as well as health and mental health professionals.
- A common vocabulary is necessary.
- Schools should tailor division crisis plans to meet individual school needs.
- Plan for the diverse needs of children and staff.

- Include all types of schools where appropriate.
- Provide teachers and staff with ready access to the plan so that they can understand its components and act on them.
- Training and practice are essential for the successful implementation of crisis plans.

Leadership of the principal at the individual school level is crucial for effective crisis management. As the highest-level executive in the school, the principal bears responsibility for all decision and activities. The following are key actions of the principal for crisis preparation:

- Review division-wide policies related to crisis and emergency management, including any interagency agreements. Gain a clear understanding of the channels of communication, lines of authority, and roles and responsibilities of both school division and community agency personnel.
- Establish a school crisis team and work with them to develop a school crisis plan within the framework of division policy and tailored to the school's unique needs.
- Establish a clear chain of command within your school. Clearly designate who is in charge in case of an emergency when you are away from the school.
- Make a point of meeting, in advance of an emergency community public safety personnel who will respond to an emergency at your school. Consult with them in developing your school's plan and maintain the collaborative relationships.
- Become thoroughly familiar with the school building and grounds, including the mechanical infrastructure.
- Ensure that all staff members understand the school's crisis management plan and particularly their specific responsibilities in the event of an emergency.
- Prepare students to assume an appropriate role by enlisting their vigilance and conducting practice drills.
- Communicate the school's crisis management plan to parents and the community at large.

Establishing the Crisis Response Team. The process of developing and maintaining an emergency management plan is complex; therefore, before a plan is developed, division crisis response teams and individual school crisis response teams should be assembled. These teams are composed of a variety of professionals with expertise in emergency management (e.g., police, fire and emergency medical services personnel) and include community partners (e.g., public and mental health professionals) and school-based staff (e.g., facilities and cafeteria

managers, nurses, disability specialists, counselors, teachers and administrators). Partner agreements, or memoranda of understanding, should be created by the school and school division crisis response teams to clearly delineate team members' roles and responsibilities.

Crisis response teams are typically responsible for:

- Establishing relationships with community partners.
- Coordinating vulnerability assessments.
- Developing training activities and conducting exercises to support and improve the emergency management plan.
- Establishing and enforcing a school and school division's emergency management plans.
- Guiding and supporting the development of individual schools' crisis response teams.

The crisis network should include a **building-level team** in each school. The school-level crisis management team (CMT) is led by the principal with an alternate designated to act in the principal's absence. The membership of each school's CMT should consist of an immediately accessible core group of school personnel who have the knowledge and skills to handle an emergency situation. Selecting a wide range of members for the CMT will ensure the various aspects of crisis planning can be accomplished. In addition to teachers, the team may include guidance counselor(s), the school nurse, school psychologist and/or school social worker, school secretary, and custodian/building engineer. School resource officers also often serve on school crisis response teams. When school resource officers are assigned to a school, they should be consulted in the development of the school's crisis management plan and involved in response to any crisis involving a violation of law or threat to public safety. The school level crisis response team typically has responsibility for the following:

- Establishing a written protocol for dealing with specific types of crises.
- Establishing a systematic approach for identifying, referring, and intervening with students identified as at-risk for suicide or posing a threat to others.
- Orienting staff to procedures and training to fulfill designated roles, including conducting tabletop simulations and practice drills.
- Providing information to students, staff, and community on crisis management referral procedures.
- Providing assistance during a crisis in accordance with designated roles and providing follow-up activities.
- Conducting debriefing at the conclusion of each crisis episode to critique the effectiveness of the building's Crisis Management Plan.

- Conducting periodic reviews and updating of the Crisis Management Plan and conducting related updated staff training.

In addition to a building-level team in each school building, the crisis network should include a **school division central-office team**. This central-office crisis team typically includes the Superintendent and Senior Management officials from the following areas: Community Relations, Facilities and Operational Support, Finance/Human Resources, Technology/Information Services, Transportation, Instruction, and Student Services. It might also include consultants outside the school system. The central-office crisis team responsibilities can include:

- Overseeing and coordinating the building-level teams.
- Authorizing resources for areas where they are most needed.
- Collecting and disseminating educational materials to schools for training crisis team members and faculty.
- Establishing a central library of materials on violence, suicide, and other crisis management issues for use by faculty, staff, and students.
- Conducting mock crisis events to test the crisis management procedures.
- Evaluating response to crises with a report to the Superintendent and a plan for follow-up.
- Establishing a community support team and encouraging input and support from its members.

Furthermore, in addition to the building-level and central-office level crisis teams, the crisis network should include a **community support network**. This network should include representatives from the community and government agencies. Additionally, it may include personnel from mental health and law enforcement agencies, emergency medical personnel, and specialized resources, such as domestic violence shelters, rape, runaway, and victim's advocacy services. Schools should maintain periodic contact with community agencies and organizations and invite them to participate in meetings with school Crisis Management Teams.

Developing the School Crisis Management Plan. When setting up a Crisis Management Plan, the following actions should be taken:

1. Decide who will be in charge during the crisis.
2. Select the School Crisis Management Team (CMT).
3. Develop clear and consistent policies and procedures.
4. Provide training for the CMT.
5. Establish a law enforcement liaison.
6. Establish a media liaison and identify suitable facilities where reporters can work, and news conferences can be held.

7. Establish a working relationship with community health agencies and other resources groups.
8. Set up “phone trees” and a contact system (text message, email, phone)
9. Plan to make space available for community meetings and for outside service providers involved in crisis management.
10. Develop necessary forms and information sheets.
11. Develop a plan for emergency coverage of classes.
12. Establish a code to alert staff.
13. Develop a collection of readings.
14. Have a school attorney review crisis response procedures and forms.
15. Hold a practice “crisis alert” session.
16. Hold an annual in-service meeting on general crisis intervention.

School Communications. Communication is a critical part of crisis management. School staff members and students must be told what is happening and what to do. Parents of students and families of staff members must be informed about the situation, including the status of their child or family member. Timely contact with law enforcement and other emergency services is necessary for effective response. School Board members must be kept informed and updated information must be transmitted to central office and to other affected schools. The press must be informed and kept updated. Additionally, groups that are part of the school community (e.g., PTA, school health advisory board) can assist with getting accurate information into the community. Guidance on dealing with rumors, using technology for communication, voice and hand signals, using code messages, and sample communication announcements are presented in [*Resource Guide: Crisis Management and Emergency Response in Virginia Schools*](#), Virginia Department of Education.

Training and Maintaining Preparedness. A crisis management plan cannot be implemented properly unless staff members know what the plan is and what is expected of them in the event of an emergency. In addition to staff training, it is important for students to know (and practice) emergency procedures. School-based training should be provided to all personnel, including instructional, custodial, and food service employees, nurses, bus drivers, substitute teachers, temporary employees, and volunteers. Inviting parent leaders (e.g., PTA officers) should be considered - they have important roles in communicating with other parents and in helping restore equilibrium in the event of a major crisis. The training should include practice scenarios. A mock disaster drill coordinated with local emergency preparedness groups may also be conducted.

Training and in-service activities should be designed to meet three distinct needs:

1. How to prevent certain types of emergencies.
2. How to respond when emergencies occur.

3. How to deal with the aftermath of an emergency.

Quick Guide to Crisis Management. The following samples of guidelines and checklists for the management of specific types of crises are presented in [Resource Guide: Crisis Management and Emergency Response in Virginia Schools](#):

- Basic Response Procedures
 - Evacuation
 - Lockdown
 - Shelter-in-Place
- Non-Emergency Events Affecting Schools
 - Deaths
 - Perceived Crises
 - Suicides
- Medical/Health Emergencies
 - Medical Emergencies – When to call 911
 - General Emergency Procedures for Injury or Illness
 - Allergic Reaction
 - Asthma
 - Diabetes
 - Heat Stroke/Heat Exhaustion
 - Poisoning and Overdose
 - Seizure
 - Stabbing and Gunshot Injuries
- Critical Incidents at or Affecting Schools
 - Bio-Hazard Threats
 - Bomb
 - Bomb Threat
 - Bus/Auto Accidents on Trips Away From the School Division
 - Chemical Spill
 - Disaster
 - Disaster Preventing Dismissal
 - Explosion/Threat of Explosion

- Fire
- Hazardous Materials
- Hostage Armed/Dangerous Situations
- Intruder/Trespasser
- Kidnapping
- Shootings/Woundings/Attacks
- Weapons Situation
- Weather Emergencies/Disasters
 - Earthquake
 - Hurricane
 - Lightning
 - Tornado
- New Challenges in Crises Planning
 - Terrorism
 - Pandemic Flu

Resources

- [Federal Emergency Management Agency \(FEMA\)](#)
 - [National Association of School Nurses](#)
 - [Disaster Preparedness](#)
- [National School Safety Center](#)
- U.S. Department of Education
 - [Office of Safe and Healthy Students](#)
- Virginia Department of Criminal Justice Services
 - [Crime Prevention Center](#)
 - [Virginia Center for School and Campus Safety](#)
- Virginia Department of Education
 - [Safe and Drug-Free Schools Act](#)
- [Virginia Department of Emergency Management](#)
- Virginia Department of Health, Office of Family Health Services
 - [Division of Prevention and Health Promotion](#)

Referring to Child Protective Services

Authorization

[Code of Virginia, Section 63.2-100, Definitions.](#) The *Code of Virginia*, defines an “Abused or neglected child” as any child less than 18 years of age:

1. *Whose parents or other person responsible for his care creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon such child a physical or mental injury by other than accidental means, or creates a substantial risk of death, disfigurement, or impairment of bodily or mental functions, including, but not limited to, a child who is with his parent or other person responsible for his care either (i) during the manufacture or attempted manufacture of a Schedule I or II controlled substance, or (ii) during the unlawful sale of such substance by that child's parents or other person responsible for his care, where such manufacture, or attempted manufacture or unlawful sale would constitute a felony violation of § [18.2-248](#);*
2. *Whose parents or other person responsible for his care neglects or refuses to provide care necessary for his health. However, no child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall for that reason alone be considered to be an abused or neglected child. Further, a decision by parents who have legal authority for the child or, in the absence of parents with legal authority for the child, any person with legal authority for the child, who refuses a particular medical treatment for a child with a life-threatening condition shall not be deemed a refusal to provide necessary care if (i) such decision is made jointly by the parents or other person with legal authority and the child; (ii) the child has reached 14 years of age and is sufficiently mature to have an informed opinion on the subject of his medical treatment; (iii) the parents or other person with legal authority and the child have considered alternative treatment options; and (iv) the parents or other person with legal authority and the child believe in good faith that such decision is in the child's best interest. Nothing in this subdivision shall be construed to limit the provisions of § [16.1-278.4](#);*
3. *Whose parents or other person responsible for his care abandons such child;*
4. *Whose parents or other person responsible for his care commits or allows to be committed any act of sexual exploitation or any sexual act upon a child in violation of the law;*
5. *Who is without parental care or guardianship caused by the unreasonable absence or the mental or physical incapacity of the child's parent, guardian, legal custodian or other person standing in loco parentis; or*
6. *Whose parents or other person responsible for his care creates a substantial risk of physical or mental injury by knowingly leaving the child alone in the same dwelling, including an apartment as defined in § [55-79.2](#), with a person to whom the child is not related by blood or marriage and who the parent or other person responsible for his care knows has been convicted of an offense against a minor for which registration is required as a violent sexual offender pursuant to § [9.1-902](#).*

[*Code of Virginia, Section 63.2-1509. Requirement that Certain Injuries Be Reported by Physicians, Nurses, Teachers, etc.; Penalty for Failure to Report.*](#)

[*Code of Virginia, Section 63.2-1510. Complaints by Others of Certain Injuries to Children.*](#)

[*Code of Virginia, Section 63.2-1512 Immunity of Person Making Report, Etc., From Liability.*](#)

[*Code of Virginia, Section 63.2-1518. Authority to Talk to Child or Sibling.*](#)

[*Code of Virginia, Section 63.2-1520. Photographs and X-Rays of Child; Use as Evidence.*](#)

[*Code of Virginia, Section 63.2-1507. Cooperation by State Entities.*](#)

Certain situations have not been considered abuse/neglect by the courts. These include:

1. Failure to provide immunizations to children. ([§32.1-46](#) of the *Code of Virginia* requires that parents/guardians immunize their children at designated intervals. However, not immunizing a child does not constitute abuse or neglect under Virginia statutes.)
2. Parental substance abuse where there is no demonstrated adverse impact on the care of the child, is not reportable to Child Protective Services (CPS). However, chronic parental substance abuse where the child's health or safety has been neglected or endangered is reportable to CPS.
3. Virginia law requires the use of seat belts. The intent of the law is to protect children from serious injury in the event of an accident. However, this is a civil law, with designated fines and penalties, to be implemented by law enforcement authorities.

Information in this section is taken from the Virginia Department of Social Services [*A Guide for Mandated Reporters in Recognizing and Reporting Child Abuse and Neglect*](#), and [*Recognizing and Reporting Child Abuse and Neglect in Virginia: A Guide for School Employees*](#).

Overview

School personnel are in a unique position to assist children who may be victims of abuse/neglect. The day-to-day contact teachers and other school staff have with students provide the opportunity for immediate and ongoing assessment of children who may be in need of assistance.

For this reason, it is important for all school personnel to be familiar with:

- Reasons for abuse, types of abuse, and those at particular risk for abuse.
- The legal responsibilities for reporting actual proof of or suspicion of abuse.
- The method for reporting (including that which is specific to the particular school division where the individual is employed).
- Resources available for the individual reporting the abuse and the individual being subjected to the abuse.

Causes of Abuse and Neglect

Child abuse and neglect are universal problems that occur across economic, cultural, and ethnic lines. Research indicates that there are circumstances that increase the likelihood abuse and neglect may occur in some families. It is important to remember that the abuser is not always a parent and can be any childcare provider, teacher, foster parent, or anyone responsible for the care of a child. Circumstances that may predispose a person to abuse and neglect include:

- A parent or individual who may have been abused or neglected as a child may continue this pattern when raising his or her own children.
- Increase in stress in life, including marital, financial, and employment difficulty.
- Substance abuse in the home.
- Parents and childcare providers who lack the skill and knowledge for the role.
- Individual's inability to tolerate frustration and inability to control the impulse to act.
- Families and individuals who feel isolated from family, friends, and community.

Operational Definitions of Abuse

Physical Abuse. Physical abuse is defined as any act, whether intentional or not, that causes harm to a child. Intentional physical injury usually is related to severe corporal punishment; however, physical abuse ranges from minor cuts and bruises to severe neurologic trauma and death.

Physical Neglect. Physical neglect occurs when caretakers do not provide for a child's physical survival needs (including adequate food, clothing, shelter, hygiene, supervision, and medical and dental care) to the extent that the child's health or safety is endangered.

Sexual Abuse. Sexual abuse is defined as acts of sexual assault or sexual exploitation of minors. This category includes a wide spectrum of activities and may occur only once in a child's life or may be a long-term situation of sexual abuse or exploitation. Specifically, sexual abuse includes the following sexual acts: incest, rape, intercourse, oral-genital contact, fondling, sexual propositions or enticement, indecent exposure, child pornography, and child prostitution.

Sexual abuse is most commonly carried out by someone a child knows and does not always involve violence. Males and females, infants and adolescents are all subject to sexual abuse. The abuser may be an adult or another child.

Emotional Maltreatment. Emotional maltreatment is a pattern of acts by the child's caretaker that results in psychological or emotional harm to the child's physical health and development. Patterns of emotional maltreatment include rejection, intimidation, ignoring, ridiculing, or isolation.

Assessing for Signs of Abuse and Neglect

The following are guidelines for school personnel in an overall assessment of suspected child abuse:

Physical Abuse/Neglect. A significant factor in distinguishing whether an injury is unintentional or as the result of abuse is an inconsistency between the history of an injury and the injury itself. When considering a physical injury consider the information that is summarized in the chart on the following page.

Type of Information and Rationale Used to Distinguish Unintentional Injuries from Those That Result from Abuse

Information	Rationale
Location of the injury	Children are more likely to sustain unintentional injuries on the knees, elbows, shins, and forehead. Injuries located on non-protuberant areas (such as the back, thighs, genital area, buttocks, back of the legs or face) are more likely the result of intentional injury.
Number and frequency of injuries	Unless a child has been in a serious accident, he/she is unlikely to have a number of injuries concurrently nor is it likely that the injuries would be at various stages of healing.
Size and shape of the injury	Unintentional injuries rarely have a defined shape. Intentional injuries, such as burns (e.g., from cigarettes, immersion in hot liquids, burns from irons, and ropes) or other objects (e.g., sticks, belts, hairbrushes, and human bite marks), will have a definitive, definable appearance.
Description of how the injury occurred	Unintentional injuries, when described by a child, generally have a reasonable explanation and one that is consistent with the appearance of the injury. Descriptions of injuries by a child that are inconsistent with the presentation are cause for suspicion.
Consistency of injury with the child's developmental capability	A child presenting with an injury that he/she is developmentally or physically incapable of causing (e.g., child is too small to generate a force sufficient to create that type of injury) should be considered for intentional abuse by their child caretaker.
Behavioral indicators of physical abuse/neglect	School personnel should also observe children for behaviors that may result from intentional physical abuse/neglect by a child's caretaker. Examples include: wariness of physical contact and/or adult contact, apprehension when another child cries, fear of his/her parent(s), stated fear of going home or crying when it is time to go, exhibits behavior extremes, aggressiveness or withdrawal, complains of soreness or moves uncomfortably, wears clothes inappropriate for weather to cover injuries, reluctant to change clothes, report of an injury inflicted by a parent, and may be a chronic runaway.

Mental Abuse/Neglect. There are a variety of behaviors a child may exhibit as a result of mental abuse/neglect. It is important when assessing for this type of abuse to examine specific behaviors of a child as well as develop an overall picture of the child's ability to interact and communicate with children and other adults. When assessing a child for mental abuse/neglect, it is important to place the behavior within the context of the child's developmental, emotional,

and physical age. The following chart lists particular behaviors and interaction styles that may be indicators of mental abuse or neglect:

Behaviors and Interaction Styles That May be Indicators of Mental Abuse or Neglect

Behavior	Example
Habit Disorders	<ul style="list-style-type: none"> • Biting. • Sucking. • Rocking. • Enuresis. • Over- or under-eating without physical cause.
Conduct Disorders	<ul style="list-style-type: none"> • Withdrawal. • Antisocial behavior, such as destructiveness, cruelty, and stealing.
Neurotic Traits	<ul style="list-style-type: none"> • Sleep disorders. • Speech disorders. • Inhibition of play.
Others	<ul style="list-style-type: none"> • Psychoneurotic traits. • Overly compliant, passive, and undemanding. • Extremely aggressive, demanding, or angry behavior. • Over-adaptive behaviors that are either inappropriately adult or infantile. • Delays in physical, emotional, and intellectual development. • Attempts at suicide. • Frequent comments and behavior suggesting low self-esteem.

Sexual Abuse. A child that has been a victim of sexual abuse - whether it is a single incident or a long-term pattern of sexual abuse - is unlikely to reveal this information directly to anyone. More than likely, a child will send signals to those around him/her that something is wrong. School personnel need to be attuned to the type of clues that may indicate a child is in a sexually abusive situation. The signs may be physical, emotional, and or reflected in developmentally inappropriate behavior by the child. The information below has been divided into two age groups: the younger child and the older child. The information of potential signs of sexual abuse is by no means a complete list of the possible behaviors a child might exhibit when involved in a sexual abuse/neglect situation. School personnel may refer to this list as a guideline for further exploration and to classify behaviors they might be seeing in a child. It is strongly recommended that school personnel become familiar with available resources.

Young Child. A young child (i.e., toddlers, preschoolers, early elementary school-age) may have difficulty verbalizing their fears and concerns as well as the actual sexual abuse to which they are being subjected. This is especially true for children with disabilities. The following chart

summarizes behavioral and physical signs that may be indicators of sexual abuse in the young child.

Signs That May Indicate Sexual Abuse in the Young Child

Type of Sign	Sign
Behavioral	<ul style="list-style-type: none"> • Reports sexual abuse. • Sleep disturbances, such as fear of falling asleep and nightmares. • Sudden changes in behavior and/or regressive behavior. • Excessive masturbation. • Detailed and age-inappropriate understanding and verbalization of sexual behavior. • Highly sexualized play. • Inappropriate behavior with peers and adults that is seductive in nature. • Appears threatened or afraid of physical contact.
Physical	<ul style="list-style-type: none"> • Stomachaches. • Dysuria (painful urination) or enuresis (involuntary urination after the age at which bladder control should have been established). • Encopresis (involuntary soiling with feces after the age at which control of defecation should have been established). • Complaints of genital irritation, laceration, abrasion, bleeding, discharge, or infection. (Venereal disease should be considered in children with anal or genital infection, discharge, or irritation.) • A gagging response, sore throat, or mouth or throat lesions (as the result of oral-genital contact). • Other signs of physical abuse.

Older Child. Older children may be able to verbalize and label what is happening to them in a sexually abusive situation; however, feelings of embarrassment, humiliation, guilt, a sense of responsibility, and fear may prevent them from talking with anyone. In fact, like young children, signs of sexual abuse in older children may emerge in regressive or sudden behavioral changes, physical signs of injury, or withdrawal. The following chart summarizes behavioral and physical signs that may be indicators of sexual abuse in the older child.

Signs That May Indicate Sexual Abuse in the Older Child

Type of Sign	Sign
Behavioral	<ul style="list-style-type: none"> • Reports sexual abuse. • Poor relationships with peers. This may take the form of withdrawal from established relationships; an inability to establish new relationships; aggressive, violent, or sexually promiscuous behavior. • Poor self-esteem. • General feelings of shame or guilt.

Signs That May Indicate Sexual Abuse in the Older Child

Type of Sign	Sign
	<ul style="list-style-type: none"> • Eating disorders (bulimia and anorexia). • Excessive concern about homosexuality (especially boys). • Deterioration in academic performance. • Role reversal with parent and overly concerned about younger sibling(s). • Running away. • Alcohol and/or abuse. • Moderate to severe anxiety or depression.
Physical	<ul style="list-style-type: none"> • Attempts at suicide. • Unexplained vaginal discharge, pregnancy, and/or venereal disease. • Bruises and/or bleeding of external genital, vaginal, or anal areas and inner thighs. • Gagging response, sore throat, or mouth or throat lesions (as the result of oral-genital contact). • Difficulty sitting or walking. • Other signs of physical abuse.

Other Information. Other information about the child and their family is important to incorporate into an evaluation of possible sexual abuse of a child. In a family where there is a history of the following, a suspicion of sexual abuse may be warranted: abuse of the child or other children; alcoholism or known substance abuse; isolation of the family as a whole; overly restrictive control by a father of his female children; expectations by parents that children act more like adults; or vague reports by a parent that their child may have been sexually abused by a stranger or a member of their family.

Inappropriate Sexual Activity Between Children. There are situations in which children sexually abuse other children. These are not situations in which the activity is considered to be the normal sexual curiosity that is developmentally appropriate. These are situations in which (1) a child is the victim of another child, (2) violence may be a component, (3) there is a lack of adult supervision that enables this activity to take place, (4) a child is in a caretaker role of another child, and (5) it is possible that the child inflicting the abuse may be a victim of abuse themselves. These situations must be examined carefully. Children who abuse and victimize other children need to be referred for evaluation. Children 12 years and older engaging in repetitive sexual abuse and violence against other children should be referred to law enforcement for court supervision and services.

Reporting Abuse/Neglect

Who Makes the Report. Anyone may report abuse or neglect; however, under Virginia law, certain professionals are required to report when they suspect that a child is an abused or neglected child. These professionals include:

- Persons licensed to practice medicine or any of the healing arts.
- Hospital residents or interns.
- Persons employed in the nursing profession.
- Social workers.
- Eligibility workers in a local department of social services.
- Probation officers.
- Teachers or other persons employed in a public or private school, kindergarten, or nursery school.
- Persons providing full- or part-time child care for pay on a regular basis.
- Law enforcement officers.
- Mental health professionals.
- Mediators; certified to receive court referrals.
- Professional staff persons employed by a public or private hospital, institution, or facility in which children are placed.
- Persons 18 years or older associated with or employed by any public or private organization responsible for the care, custody, and control of children.
- Volunteer Court Appointed Special Advocates (CASA).
- Persons employed by public or private institutions of higher education other than attorneys employed by institutions of higher education as it relates to information gained in the course of providing legal representation to a client.
- Athletic coaches, directors or other persons 18 years of age or older, employed by or volunteering with a private sports organization or team.
- Administrators or employees, 18 years of age or older, of public or private day camps, youth centers and youth recreation programs.
- Any person 18 years of age or older, who has received training approved by the Department of Social Services for the purposes of recognizing and reporting child abuse and neglect.

This reporting requirement shall not apply to any regular minister, priest, rabbi, imam, or duly accredited practitioner of any religious organization or denomination usually referred to as a church as it relates to (i) information required by the doctrine of the religious organization or denomination to be kept in a confidential manner or (ii) information that would be subject to § [8.01-400](#) or [19.2-271.3](#) if offered as evidence in court.

Suspicion of Abuse/Neglect. The law does not require the professional to have proof or be convinced abuse or neglect has taken place. Suspicion is all that is needed. The *Code of Virginia*,

§ [63.2-1512](#), provides protection from criminal and civil liability to persons reporting abuse/neglect and/or participating in judicial proceedings related to a report of abuse/neglect unless the report has been made with malicious intent or bad faith. The reporter must make available to the local Department of Social Services all information that is the basis for the suspicion. This can include confidential information about the child/family that is contained in the school record. Note that under the *Code of Virginia*, § [63.2-1509](#), any person required to file a report pursuant to this section who fails to do so as soon as possible, but not longer than 24 hours after having reason to suspect a reportable offense of child abuse or neglect, shall be fined not more than \$500 for the first failure and for any subsequent failures not less than \$1,000. In cases evidencing acts of rape, sodomy, or object sexual penetration as defined in Article 7 (§ [18.2-61](#) et seq.) of Chapter 4 of Title 18.2, a person who knowingly and intentionally fails to make the report required pursuant to this section shall be guilty of a Class 1 misdemeanor.

How and to Whom the Report is Made. The law makes allowances for “chain of command” reporting. The school division or school can establish a policy that states that a person (possibly a classroom teacher or school nurse) who suspects that a child is abused or neglected can report their suspicion to a designated person in the school, who in turn reports the matter to the local Department of Social Services. The chain of command must respond immediately with a report of suspected child abuse. It is suggested that each school/school division develop a plan for reporting child abuse and identify the contact person(s) for the local Department of Social Services.

The *Code of Virginia*, § [63.2-1507](#), requires all law enforcement departments, other state and local departments, agencies, authorities, and institutions to cooperate with each local Department of Social Services in the detection and prevention of child abuse. Reports can be made to the local Department of Social Services during working hours or to the State Child Abuse/Neglect Hotline in Richmond (1-800-552-7096). The hotline operates 24 hours a day, year round. Information received on the hotline is forwarded to the appropriate locality for investigation. Reports can be made anonymously. Documentation is completed according to school/school division policy. It is suggested that as part of the school/school divisions’ plan for reporting child abuse, appropriate forms for documentation be developed.

What Information Should be Provided. When making a report of suspected abuse/neglect have the following information available:

- The name, address, and telephone number of the child and parents or other person(s) responsible for the child’s care.
- The child’s birth date, age, sex, and race.
- Names and ages of other people who live with the child and their relationship to the child.
- Whether or not there is a family member who can protect the child.

- Name, address, and telephone number of the suspected abuser and his/her relationship to the child.
- Nature and extent of the abuse/neglect, including any knowledge of prior maltreatment of the child or siblings.
- Any special language needs of the family.
- Any child or adult developmental issues.
- Whether the child has a disability and the ways in which the disability affects the child's functioning and care.
- As much information as possible about the incident involving the child, especially where, when, and who was present.
- Any other pertinent information that the school may have available.
- Reporting person's name, address, and phone number.

When describing an injury (e.g., cut, mark, bruise) be as specific as possible:

- Note the exact location on the body.
- Note the size of the mark—estimate in inches or in relation to a common object (e.g., size of a quarter, size of an egg, shape of an iron).
- Note the color of the injury. Injuries often change color with the passage of time. The colors can range from red to black to purple to green and yellow. Note the presence of bruising in multiple areas that may be in various stages of healing.
- In general, relate exactly what the child said in his/her own words. Be careful not to interpret what the child said.

Interviewing the Child

- Make sure the child is comfortable. Remain calm and reassuring. Do not rush. If the interviewer reacts with shock, anger, or disgust at what the child tells, the child may interpret that he/she is at fault and has done something wrong and may be unwilling to reveal further information.
- Put the child at ease by sitting near him/her, not behind a desk. Be sure to use a room that is private, and free from interruptions.
- Assure the child they are not in trouble and have done nothing wrong.
- Attempt to gain pertinent information, using open-ended questions.
- Be careful not to plant ideas or interpretations of what happened in the child's mind.

- Explain the purpose of the interviews in language appropriate to the child’s developmental level.
- Let the child know the interviewer will be talking to someone who will try to help him or her, without making any promises to the child that cannot be kept.

What Happens After a Report is Made

Many times, school personnel are unaware of what occurs after a report is made and may not understand why what appears to be an “obvious” situation cannot be investigated. There are specific criteria that must be met for the local Department of Social Services to proceed with an investigation once they receive the information. The criteria are:

- The child must be under 18 years of age at the time of the report.
- The alleged abuser was in a caretaker role (a caretaker is anyone, including a teenager, sibling, or adult, who is responsible for that child).
- The alleged abuse or neglect meets the definition of abuse or neglect as defined by the CPS Program.
- The local agency has jurisdiction to respond to the report.

If the report is not accepted for CPS response, the local agency will advise the reporter which validity criteria are not met. In addition, the local agency may contact local law enforcement to report possible criminal violations even if the report is not valid for CPS.

If a decision is made not to respond, and you disagree, you may further discuss your concerns with the CPS supervisor. When a case is not appropriate for CPS, you may seek consultation with the local agency for suggestions or guidance in dealing with the family.

When a report of suspected child abuse or neglect is made, CPS must determine if the report is valid for a CPS response. If the report is determined to be valid, the CPS worker will conduct either a family assessment or an investigation.

How an Investigation of Abuse/Neglect is Conducted

After a report is accepted for investigation, the CPS worker will assess the immediate safety needs of the child, identify protective and other service needs of the family, and assess risk of future harm. The social worker investigating the allegations tries to interview a child in a neutral setting, such as a school. The *Code of Virginia*, § [63.2-1518](#), gives the Child Protective Services social worker the authority to interview the child and any siblings without the prior consent of the parent/guardian. The child and siblings may be interviewed without the presence of the parent, guardian, school personnel or any other individual standing in loco parentis. Additionally, the *Code of Virginia*, § [63.2-1520](#), allows the social worker to take photographs of the child without the consent of the parent/guardian. The investigative worker will also talk with the alleged abuser/neglecter, the parents/guardians (if different) and any

other individual who may have information about the child's care related to the allegations—such as a doctor, teacher, and neighbors.

The CPS worker will complete the CPS investigation within 45-60 days of the report. There are two possible findings:

- “Founded” - The investigation reveals by a preponderance of evidence that abuse or neglect has occurred.
- “Unfounded” - The investigation reveals insufficient evidence that abuse or neglect occurred. This finding does not necessarily mean that abuse or neglect did not occur, but that the evidence was not sufficient for a founded disposition.

The local agency will inform you if your report is being accepted for a CPS response. At the conclusion of the CPS response, the local agency can tell you that either the investigation was unfounded or that the local agency took necessary action. Due to federal and state laws concerning the release of child protective services (CPS) information, the CPS worker is restricted in the information that can be given to individuals other than the alleged abuser, alleged victim, or victim's guardian if not the child's parent. If you are not contacted by the CPS worker within 45-60 days of the date of the report, and you wish to learn the outcome of the investigation or family assessment, you may call the worker assigned to the case or the supervisor.

If a Report of Suspected Child Abuse or Neglect is Not Accepted by Child Protective Services

If the criteria for investigation are not met, Child Protective Services will not pursue the report. When CPS does not investigate a report, it usually means that the situation does not meet the legal definition of abuse/neglect, law enforcement has the responsibility to investigate, or that a different type of service can more effectively address the family's problems. If the person reporting the abuse disagrees with the decision not to pursue the investigation, then the school personnel responsible for the reporting of abuse/neglect situations may discuss their concerns with the CPS supervisor. If the situation is labeled “unfounded,” it does not mean that the family may not be having problems. It just means that according to the law and the Department of Social Services policy the situation cannot be labeled as abusive/neglectful. The social worker may recommend a course of action, including other community-based services available (e.g., mental health treatment, substance abuse services, court services, and shelter care).

The school may be instrumental in providing assistance to the family to prevent the abuse or neglect of children. Such prevention programs may be in the form of support groups and educational programs as well as students utilizing the many programs developed for awareness and education of family problems and situations.

Professionals who have had unsatisfactory reporting experiences in the past may be reluctant to report a second case of abuse/neglect to the local Department of Social Services. It is possible that the experience the professional had may have been unsatisfactory and that they may have developed a distrust of the system for investigating abuse/neglect situations, feeling that nothing will be done again. Professionals must keep in mind that they are legally bound to report a case of suspected child. In addition, if the incident is not reported nothing will be done. Abused and neglected children cannot be protected unless they are first identified, and the key to identification is reporting.

Resources

- [Virginia Department of Social Services](#)
Child and Protective Services
[A Guide for Mandated Reporters in Recognizing and Reporting Child Abuse and Neglect](#)

Home Visits

Authority

Regulations. Some regulations that govern the delivery of services to students may require the use of home visits for students who are confined for periods of time that prevent normal school attendance. Refer to the following:

- Virginia Board of Education. [Regulations Establishing Standards for Accrediting Public Schools in Virginia.](#)
- Virginia Department of Education. [Regulations Governing Special Education Programs for Children with Disabilities in Virginia.](#)

Overview

Home visits made by members of the interdisciplinary team offer an excellent opportunity to foster communication between school and home. Advantages include:

- Convenience for the family.
- Option for those families unwilling or unable to travel.
- Family control of the setting and the potential for active participation in meeting the student's health needs.
- The opportunity to gain a more accurate assessment of the student's family structure and behavior in the natural environment.
- The opportunity to make observations of the home environment and to identify both barriers and support for reaching family health promotion goals.

Recommendations

Home Visit Objectives. During home visits, school health personnel can:

- Establish rapport with the student's family support system.
- Assess family strengths and needs, including limitations and barriers to the student's achievements, the student's need for community health resources, and the student's behavior and reactions to home situations.
- In partnership with the family, plan school health services that promote and support family goals to maximize functional capabilities, including the student's self-care, independence, and future school attendance.
- Provide for family/student participation in health promotion, maintenance, and restoration, including providing information needed to make decisions and choices about using health care resources.

- Assist the family/student in the process of accessing community resources and setting up appointments.

Procedures for a Home Visit. In preparing for the home visit, school health personnel should:

- Review available school and health records prior to home visit.
- Review current health care plans.
- Identify objectives for the visit.
- Contact student's health care provider, when appropriate, for questions and/or concerns.
- Plan time of visits to optimize safety and effectiveness.
- Make an appointment in advance of the visit.
- Log in and out at school office, noting the telephone number and address of the home to be visited, time of departure, and expected return.
- Wear identification (e.g., name badge).
- Avoid going alone to neighborhoods known to be dangerous.

During the home visit, school health personnel should:

- Explain purpose of the visit.
- Observe the home and surrounding environment, significant sociocultural influences, and interaction of family members.
- Identify health care needs/problems, based on subjective and objective data, and involve the family members in the process.
- List problems in order of importance in accordance with family perceptions.
- Discuss alternative solutions and available community resources.
- Make referrals as necessary to appropriate health care providers.
- Assist in the development of a plan for the appropriate interventions(s) and establish a time to evaluate the effectiveness of the plan.
- Assist the family in contacting local resources and services in the community.
- Share the plan with appropriate persons involved in the health care of the student.

After the home visit, school health personnel should record and document:

- Subjective and objective data, problems identified, and plan of action including timeline for achieving planned interventions.
- Future plans and recommendations for home visits.

Resources

- American Nurses Association & National Association of School Nurses. (2017). *School nursing: Scope and standards of practice* (3rd. ed). Silver Spring: American Nurses Association & National Association of School Nurses.
- Stanhope, M. and Lancaster, J. (2013). *Foundations of nursing in the community: Community oriented practice* (4th. ed). St. Louis: Mosby/Elsevier.

Nursing Liaison Services to Homebound Students

Authority

Regulations

- Virginia Board of Education. [Regulations Establishing Standards for Accrediting Public Schools in Virginia.](#)
- Virginia Department of Education. [Regulations Governing Special Education Programs for Children with Disabilities in Virginia.](#)

Overview

Students with acute and chronic illnesses, severe injuries, medically high-risk pregnancies, or recovering from surgery may require periods of homebound instruction. Though medical/nursing care will be provided by the private medical provider or a community agency, the school nurse may serve as a liaison between the school, family, and medical provider in the student's transition planning from homebound status to school attendance. School nurses recognize that a student's extended absence from school contributes to desocialization, isolation, and potential dropout of students, especially those who have a chronic illness, severe injury, or are pregnant.

School nurses coordinate care delivery and provide appropriate case management to support the student's transition from homebound to school attendance.

Recommendations

Procedure. The following procedure is recommended for school nurse visits to homebound students:

1. When homebound instruction is deemed necessary, the school nurse will be notified by the appropriate school personnel.
2. The school nurse contacts the family and student through telephone calls and home visits to assist the family in the utilization of appropriate community health care services.
3. The school nurse interprets medical information for school personnel and assists the student in making the transition from hospital and/or home to school.
4. Frequently it will be necessary to have a written individualized healthcare plan (IHP) that has been implemented prior to the student's return to school. The IHP should be developed by the registered nurse (RN), in collaboration with the school health

team, consisting of the parents, student, physician, school administrator, classroom teacher, homebound teacher and other appropriate personnel. The IHP should be shared with all persons who interact with the student at school.

Resources

- American Nurses Association & National Association of School Nurses. (2017). *School nursing: Scope and standards of practice* (3rd. ed). Silver Spring: American Nurses Association & National Association of School Nurses.
- [Virginia Department of Education Homebound Instructional Services Guidelines](#)

Students Requiring Specialized Health Care Procedures

Resource. The Virginia Department of Health [Guidelines for Health Care Procedures in Schools](#) is a resource document for school and public health personnel. The manual is intended to enhance the educational process by providing guidance to school administrators, school nurses, teachers, and other staff members on the care of students with special health care needs. It presents up-to-date, practical health information and recommendations for developing local programs and policies related the health care services to be provided for these students.

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PART IV: HEALTH EDUCATION

This section presents general guidelines for use in planning and implementing *school health education*, a component of a school health program, and a component in the Centers for Disease Control and Prevention's (CDC) Whole School, Whole Community, Whole Child (WSCC) model. Information includes relevant State of Virginia Codes, policies, and recommendations for addressing high-risk behaviors and providing education and interventions for healthy lifestyle choices.

Chapter 18: [Implementing Health Education in a School Health Program](#)

Chapter 19: [Planning Health Education Programs](#)

- Healthy Eating and Nutrition
- Mental and Emotional Health
- Personal Health and Wellness
- Physical Activity
- School Safety and Unintentional Injury Prevention
- School Violence and Prevention
- Tobacco Use
- Alcohol and Other Drug Use and Abuse
- Sexual Health

Chapter 18: Implementing Health Education in a School Health Program

Authorization

[Code of Virginia, Section 22.1-207, Physical and Health Education](#)

[Code of Virginia, Section 22.1-207.1, Family Life Education](#)

Overview

Definition. Although a universally accepted definition of the term “school health education” has not been adopted, *Health Is Academic: A Guide to Coordinated School Health Programs* presents the following definition:

Comprehensive school health education: Classroom instruction that addresses the physical, mental, emotional, and social dimensions of health; develops health knowledge, attitudes, and skills; and is tailored to each age level. Designated to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors.¹⁰⁴

The Centers for Disease Control and Prevention’s (CDC) *Youth Risk Behavior Surveillance System* (YRBSS) monitors the following six health-risk behaviors that contribute to the leading causes of death and disability among youth and adults:¹⁰⁵

- Behaviors that contribute to unintentional injuries and violence
- Sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection
- Alcohol and other drug use
- Tobacco use
- Unhealthy dietary behaviors
- Inadequate physical activity

Leading national education organizations recognize the close relationship between health and education, as well as the need to foster health and well-being within the educational environment for all students. Research has shown that school health programs can reduce the prevalence of health-risk behaviors among young people and have a positive affect the following selected measures of academic achievement:

- *Educational measures*, including educational attainment, graduation rates, class grades, and performance on standardized rates.

- *Educational behaviors*, including student attendance, dropout rates, behavioral problems at school, and degree of involvement in school activities, such as homework and extracurricular pursuits.
- *Student attitudes*, including those toward school, such as aspirations for postsecondary education and feelings about safety on school property, and personal attitudes, such as self-esteem and locus of control.

While the benefits of health education in schools are well documented, it is worth noting that the efficacy is dependent on certain factors, such as teacher training, comprehensiveness of the health program, time available for instruction, involvement, and community support.¹⁰⁶ In addition, sequential school health education programs for K-12 students have been found to be more effective in changing health-related risk behaviors than occasional programs on single health topics.¹⁰⁷

National Health Education Standards

Joint Committee for National School Health Education Standards. To assist schools in developing and evaluating comprehensive health education programs, the Joint Committee for National School Health Education Standards (NHES) has developed guidelines for school health standards, last revised in 2007. The committee was sponsored by the American Cancer Society and composed of representatives from the American Public Health Association, the American School Health Association, and SHAPE America (Society of Health and Physical Educators).

The committee's goal was to assess the need for school health education and create a framework for local school boards to use in determining content of the health curriculum in their communities. The guidelines serve to challenge schools and communities to continue their efforts towards excellence in health education. There are eight standards that promote health literacy, which is the capacity of individuals to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways that enhance health.¹⁰⁸

Description of the Standards. Each of these standards is correlated with the ten traditional health education content areas and the six categories of health-related risk behaviors identified by the Centers for Disease Control and Prevention (CDC). The NHES are written expectations for what students should know and be able to do by grades 2, 5, 8, and 12 to promote personal, family, and community health. The standards provide a framework for curriculum development and selection, instruction, and student assessment in health education. In addition, the standards identify the support needed at the local, state, and national levels, and the support needed within the school and the community, and through institutions of higher education curricula, to successfully implement quality health education.

Standards.¹⁰⁸ The standards and rationale are outlined below. For specific performance indicators by grade level, follow the links below:

- **[Standard 1:](#)** Students will comprehend concepts related to health promotion and disease prevention to enhance health.

Rationale: The acquisition of basic health concepts and functional health knowledge provides a foundation for promoting health-enhancing behaviors among youth. This standard includes essential concepts that are based on established health behavior theories and models. Concepts that focus on both health promotion and risk reduction are included in the performance indicators.

- **[Standard 2:](#)** Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.

Rationale: Health is affected by a variety of positive and negative influences within society. This standard focuses on identifying and understanding the diverse internal and external factors that influence health practices and behaviors among youth, including personal values, beliefs, and perceived norms.

- **[Standard 3:](#)** Students will demonstrate the ability to access valid information, products, and services to enhance health.

Rationale: Access to valid health information and health-promoting products and services is critical in the prevention, early detection, and treatment of health problems. This standard focuses on how to identify and access valid health resources and to reject unproven sources. Application of the skills of analysis, comparison, and evaluation of health resources empowers students to achieve health literacy.

- **[Standard 4:](#)** Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.

Rationale: Effective communication enhances personal, family, and community health. This standard focuses on how responsible individuals use verbal and non-verbal skills to develop and maintain healthy personal relationships. The ability to organize and to convey information and feelings is the basis for strengthening interpersonal interactions and reducing or avoiding conflict.

- **[Standard 5:](#)** Students will demonstrate the ability to use decision-making skills to enhance health.

Rationale: Decision-making skills are needed to identify, implement, and sustain health-enhancing behaviors. This standard includes the essential steps that are needed to make healthy decisions as prescribed in the performance indicators. When applied to health issues, the decision-making process enables individuals to collaborate with others to improve their quality of life.

- **[Standard 6:](#)** Students will demonstrate the ability to use goal-setting skills to enhance health.

Rationale: Goal-setting skills are essential to help students identify, adopt, and maintain healthy behaviors. This standard includes the critical steps that are needed to achieve both short-term and long-term health goals. These skills make it possible for individuals to have aspirations and plans for the future.

- **Standard 7:** Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.

Rationale: Research confirms that practicing health-enhancing behaviors can contribute to a positive quality of life. In addition, many diseases and injuries can be prevented by reducing harmful and risk-taking behaviors. This standard promotes the acceptance of personal responsibility for health and encourages the practice of healthy behaviors.

- **Standard 8:** Students will demonstrate the ability to advocate for personal, family, and community health.

Rationale: Advocacy skills help students promote healthy norms and healthy behaviors. This standard helps students develop important skills to target their health-enhancing messages and to encourage others to adopt healthy behaviors.

Chapter 19: Planning Health Education Programs

Overview

According to the CDC, health education provides students with opportunities to acquire the knowledge, attitudes, and skills necessary for making health-promoting decisions, achieving health literacy, adopting health-enhancing behaviors, and promoting the health of others. Comprehensive school health education includes courses of study for students in pre-K through grade 12 that address a variety of topics such as alcohol and other drug use and abuse, healthy eating/nutrition, mental and emotional health, personal health and wellness, physical activity, safety and injury prevention, sexual health, tobacco use, and violence prevention. Health education curricula should address the [National Health Education Standards \(NHES\)](#) and incorporate the CDC's [Characteristics of an Effective Health Education Curriculum](#).

Assessment

To determine what type of programs to offer within the health education component of a school health program, data should be gathered on student knowledge, skill, attitudes, and health-related risk behaviors to decide the priority areas in which to offer the program. Please refer to Part I, Chapter 3, *Developing a Program: Infrastructure and Planning Process Steps*, for additional guidance and information on Assessment.

School Health Education Program Characteristics

According to research and field experts, all health education programs should incorporate these characteristics to maximize outcomes:¹⁰⁹

1. Focuses on clear health goals and related behavioral outcomes.
2. Is research-based and theory-driven.
3. Addresses individual values, attitudes, and beliefs.
4. Addresses individual and group norms that support health-enhancing behaviors.
5. Focuses on reinforcing protective factors and increasing perceptions of personal risk and harmfulness of engaging in specific unhealthy practices and behaviors.
6. Addresses social pressures and influences.
7. Builds personal competence, social competence, and self-efficacy by addressing skills.
8. Provides functional health knowledge that is basic, accurate, and directly contributes to health-promoting decisions and behaviors.

9. Uses strategies designed to personalize information and engage students.
10. Provides age-appropriate and developmentally-appropriate information, learning strategies, teaching methods, and materials.
11. Incorporates learning strategies, teaching methods, and materials that are culturally inclusive.
12. Provides adequate time for instruction and learning.
13. Provides opportunities to reinforce skills and positive health behaviors.
14. Provides opportunities to make positive connections with influential others.
15. Includes teacher information and plans for professional development and training that enhance effectiveness of instruction and student learning.

Effective Methods of Instruction

The most effective methods of health education are student-centered approaches, hands-on activities, cooperative learning techniques, and activities that include problem-solving and peer instruction to help students develop skills in decision-making, communication, setting goals, resistance to peer pressure, and stress management.^{110, 111} As with other instructional areas, the teacher should promote parental involvement by sending materials home, involving parents in classroom activities, and creating assignments that involve parents.

Resources

[Healthy People 2020](#) may serve as a reference for general health education program and intervention planning and development. In addition, each subsection provides an overview of the pertinent health and safety topics for the target group, as well as ideas for education, resources, and preventive care. The targeted outcomes and recommended population-based interventions are a useful resource for program development.

- [Adolescent Health](#)
- [Early and Middle Childhood](#)
- [Educational and Community-Based Programs](#)
- [Tools and Resources](#)

Subsections

The following subsections contain information for use in planning school health education programs that will motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors.

- [Healthy Eating and Nutrition](#)
- [Mental and Emotional Health](#)
- [Personal Health and Wellness](#)
- [Physical Activity](#)
- [School Safety and Unintentional Injury Prevention](#)
- [School Violence and Prevention](#)
- [Tobacco Use](#)
- [Alcohol and Other Drug Use and Abuse](#)
- [Sexual Health](#)

Healthy Eating and Nutrition

Authorization

[Code of Virginia, Section 22.1-207, Physical and Health Education](#)

[Code of Virginia, Section 22.1-207.3, School Breakfast Program](#)

[Code of Virginia, Section 22.1-207.4, Nutritional Guidelines for Competitive Foods](#)

Information on additional state regulations, federal regulations, and memoranda can be found via the [Virginia Department of Education, Office of School Nutrition Programs](#).

Overview

Studies show that well-nourished students are better prepared to learn. Schools help provide a healthy environment through nutritious meals, healthy snacks and opportunities for physical education and nutrition education. Through school nutrition programs, 112 million lunches, 55 million breakfasts and 900,000 afterschool snacks are served on a typical day in Virginia public schools.¹¹²

Definition. Although a universally accepted definition of the term “school nutrition services” has not been adopted, *Health Is Academic: A Guide to Coordinated School Health Programs* presents the following definition:¹¹³

School Nutrition Services: Integration of nutritious, affordable, and appealing meals; nutrition education; and an environment that promotes healthy eating behaviors for all children. Designed to maximize each child’s education and health potential for a lifetime.

Services Provided. As reported in *Health Is Academic: A Guide to Coordinated School Health Programs*, school food and nutrition services vary significantly among schools. This variation depends on the perceived needs, resources, and priorities of schools and communities. Information on the federal programs available can be found through the Virginia Department of Education’s [Programs, Promotions, & Initiatives: U.S. Department of Agriculture Programs](#). School food and nutrition services can be categorized as follows:¹¹⁴

- Federally supported, nonprofit school lunches, breakfasts, and snacks, including those for students with special health care needs.
- For-profit food programs, including snack bars, school stores, vending machines, à la

carte items sold in school cafeterias, and special functions for students or staff.

- Nutrition education activities integrated with classroom instruction.
- Nutrition screening, assessments, and referral.
- Food service provided for non-school populations, including childcare, Head Start, elderly feeding, summer feeding, and contract services that meet the needs of local communities.

Recommendations

[Centers for Disease Control and Prevention’s School Health Guidelines to Promote Healthy Eating and Physical Activity](#). These guidelines identify strategies most likely to be effective in promoting lifelong healthy eating among young people. The guidelines were developed by Centers for Disease Control and Prevention (CDC) staff in collaboration with experts from other federal agencies, state agencies, universities, voluntary organizations, and professional associations.

The new guidelines synthesize the scientific evidence and best practices during 1995–2009 and combine healthy eating and physical activity into one set of evidence-based guidelines for schools serving students in grades K through 12; other educational programs within schools, such as prekindergarten, might also be able to apply these guidelines in their settings. Each of the nine guidelines listed below is accompanied by a series of strategies for school implementation.

1. Use a Coordinated Approach to Develop, Implement, and Evaluate Healthy Eating and Physical Activity Policies and Practices
2. Establish School Environments that Support Healthy Eating and Physical Activity
3. Provide a Quality School Meal Program and Ensure that Students Have Only Appealing, Healthy Food and Beverage Choices Offered Outside of the School Meal Program
4. Implement a Comprehensive Physical Activity Program with Quality Physical Education as the Cornerstone
5. Implement Health Education that Provides Students with the Knowledge, Attitudes, Skills, and Experiences Needed for Healthy Eating and Physical Activity
6. Provide Students with Health, Mental Health, and Social Services to Address Healthy Eating, Physical Activity, and Related Chronic Disease Prevention
7. Partner with Families and Community Members in the Development and Implementation of Healthy Eating and Physical Activity Policies, Practices, and Programs
8. Provide a School Employee Wellness Program that Includes Healthy Eating and Physical Activity Services for All School Staff Members

9. Employ Qualified Persons, and Provide Professional Development Opportunities for Physical Education, Health Education, Nutrition Services, and Health, Mental Health, and Social Services Staff Members, as well as Staff Members Who Supervise Recess, Cafeteria Time, and Out-Of-School–Time Programs

Healthy Hunger-Free Kids Act. Improving child nutrition is the focal point of the Healthy, Hunger-Free Kids Act of 2010. The legislation authorizes funding and sets policy for USDA's core child nutrition programs: The National School Lunch Program, the School Breakfast Program, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the Summer Food Service Program, and the Child and Adult Care Food Program. The Healthy, Hunger-Free Kids Act allows USDA, for the first time in over 30 years, opportunity to make real reforms to the school lunch and breakfast programs by improving the critical nutrition and hunger safety net for millions of children. The new standards align school meals with the latest nutrition science and the real-world circumstances of America's schools.¹¹⁵ Key items related to the schools, program expansion and application process include:

- Expands the Afterschool Meal Program to all 50 states.
- Creates a new option that will allow schools in high-poverty areas to offer free meals to all students without collecting paper applications, which will expand access to more children and reduce administrative burdens on schools.
- Eliminates the “letter method,” which requires families to return a letter to the school to establish eligibility.
- Makes foster children automatically eligible for free meals, eliminating the need to complete paper applications for school meal benefits.
- Gives the Secretary of Agriculture the authority to establish national nutrition standards for all foods sold on the school campus throughout the school day.
- Provides \$5 million annually in mandatory funding for farm-to-school programs starting October 1, 2012.
- Strengthens Local School Wellness Policies by updating the requirements of the policies, and requiring opportunities for public input, transparency, and an implementation plan.
- Allows only lower-fat milk options to be served, as recommended in the Dietary Guidelines.
- Ensures that water is available free of charge during the meal service.
- Subject to available appropriations, grants could be used to establish or expand school breakfast programs, with priority going to schools with 75 percent free and reduced-price eligible students.
- Requires a review of local policies on meal charges and the provision of alternate meals (i.e. cold cheese sandwich) to children who are without funds to purchase a meal.

- Requires school districts to gradually increase their “paid” lunch charges until the revenue per lunch matches the federal free reimbursement level.

A complete summary is available through the [U.S. Department of Agriculture, Food and Nutrition Service](#); additional information on the Healthy Hunger-Free Kids Act including updated policy memos can be found at the [USDA's Food and Nutrition Service: School Meals](#).

Handouts

Many of the resources listed below have handouts that can be distributed to teachers, staff, parents, and students to promote healthy nutrition and increase awareness. Below are links to some that may be particularly helpful and may serve as additional resources.

- [Breakfast in the Classroom - Facts, sample menus, and guidance on program implementation.](#)
- [Eat Right: Academic Success](#) - Fact sheets for parents, educators, and administrators about the impact of nutrition on academic success.
- [Eat Right: Healthy Schools, It's a Team Effort](#) - Fact sheet and resources emphasizing the collaboration needed to achieve a healthy school environment.
- [Eat Right: Promote School Wellness](#) - Provides links to child-focused nutrition and health websites, as well as ideas for collaborative work with school staff and community involvement.
- [National School Lunch Program Fact Sheet](#) - Answers questions regarding the basics of the program, eligibility, and nutritional requirements.
- [School Breakfast Program Fact Sheet](#) - Answers questions regarding the basics of the program, eligibility, and nutritional requirements.

Resources

NATIONAL HEALTHY EATING/NUTRITION RESOURCE LIST

- [Action for Healthy Kids: Tools for Schools](#) - Interactive website that provides a framework for improving the health of students and the school environment. Program and intervention ideas are provided based on the area of the school and includes ideas for school, families and community involvement.
- [American Cancer Society](#) - Encourages a proactive approach to cancer prevention through healthy lifestyle choices. Includes resources on general health and wellness, fitness, nutrition, and cancer screening guidelines.
- American Academy of Pediatrics - [Bright Futures Nutrition 4th Edition and Pocket Guide](#) - Focuses on health promotion and disease prevention for infants, children, adolescents, and families. It promotes positive attitudes toward nutrition and offers guidance on choosing healthful foods. *Available for download by section or for purchase by the AAP.*
- [Academy of Nutrition and Dietetics](#) - Sections of interest are those dedicated “For Kids” and “For Parents”. Each provides recipes, articles on concerning health/nutrition topics, and resources and ideas for how to improve the nutrition of the overall family.
- [School Nutrition Services](#) - Promote optimal food habits and nutritional status of the population with special emphasis on children through direction and leadership for quality practice, education, and research. Provides support and education on nutrition in the school setting with ideas for programs and interventions, research, and resources.
- [Nutrition Education Resources and Websites](#) - List of resources and websites for specific topics within the broader scope of healthy nutrition in the school setting.
- [American Heart Association](#) - Provides information for caregivers, educators, and families on how to get healthy, stay healthy, and prevent various cardiovascular conditions.
- Centers for Disease Control and Prevention: [Division of Nutrition, Physical Activity, and Obesity](#) - Provides evidence-based guidance for schools on how to implement policies and practices that effectively promote healthy choices and behaviors among youth.
- Healthy People 2020: [Nutrition and Weight Status](#) - Provides an overview on the importance of healthy eating and nutrition and the impact of food choices on weight and potential long-term health issues. Objectives are outlined, and a list and assessment of resources and interventions is provided.

- [International Food Information Council Foundation](#) - Provides continuing education for professionals, recipes, and information on a variety of food and nutrition related that could be used during research and development of programs.
- Let's Move: [Eat Healthy](#) - Offers parents and caregivers the tools, support and information they need to make healthier choices while instilling healthy eating habits in children that will last a lifetime.
- [National Cancer Institute](#) - Provides information for caregivers, educators, and families on adopting healthy lifestyles, cancer prevention, and information related to cancer screening, treatment, and associated challenges. The sub-section on cancer prevention includes specific information on food and nutrition choices.
- [Institute of Child Nutrition](#) - A federally funded national center dedicated to applied research, education and training, and technical assistance for child nutrition programs. Provides accurate, reliable information, offers face-to-face and on-site training seminars and online courses designed to support the professional development of child nutrition program and child care personnel.
- [School Nutrition Association](#) – Provides information on current legislation and policy, professional education, resources for school personnel, and current news and research.
- U.S. Department of Agriculture
 - [Food and Nutrition Information Center](#) – Provides resources on diet, nutrition, wellness, and as well as nutrition and food related issues and health concerns. Also available is information on nutrition assistance programs, current research, and professional resources
 - [Team Nutrition](#) – Team Nutrition is an initiative of the USDA Food and Nutrition Service to support the Child Nutrition Programs through training and technical assistance for foodservice, nutrition education for children and their caregivers, and school and community support for healthy eating and physical activity.
 - [My Plate](#) – Interactive website outlining the five food groups that are the building blocks for a healthy diet using a familiar image – a place setting for a meal. Users can access information on each food group, trackers, information on weight loss and activity, as well as educational resources and handouts.

VIRGINIA HEALTHY EATING/NUTRITION RESOURCE LIST

- [Northern Virginia Healthy Kids Coalition](#) - A community-wide campaign to promote healthy lifestyles for children in Northern Virginia. Tools and resources include handouts, interventions, community partnerships and ideas, current research, and tool kits aimed at various professional and community groups.
- Virginia Department of Education: [School Nutrition Programs](#) – Provides guidance and assistance to school divisions in developing effective and comprehensive nutrition services that result in children making educated, healthful choices.
- Virginia Department of Health: [Chronic Disease Prevention and Health Promotion Collaborative](#) - [A collection of resources for health, wellness, and nutrition that may be useful for program and intervention development.](#)
- [Healthy Eating and Active Living Program](#) – provides residents of Virginia with information, tools and resources for promoting healthy eating and access to proper nutrition options; and encourages an active lifestyle and healthy behaviors.
- Virginia Tech University: Department of Human Nutrition, Foods and Exercise
- [Virginia Cooperative Extension](#) - Extension is a joint program of Virginia Tech, Virginia State University, the U.S. Department of Agriculture, and state and local governments. The section on food & health is of particular use for school nurses and personnel, providing several resources, information, and guidance in program development.
- [Virginia Academy of Nutrition and Dietetics](#) – Provides professional and consumer resources, information on advocacy and current legislation, and the ability to locate local professionals who may be available for networking/consultation, partnership, or special education sessions in the schools.

Mental and Emotional Health

Authorization

[Code of Virginia, Section 22.1-207, Physical and Health Education](#)

[Virginia Administrative Code, Section 8VAC20-620-10, School Guidance and Counseling Services](#)

Overview

It is estimated that in the United States, more than 20% of children and adolescents meet the criteria for a diagnosis of a mental health disorder.¹¹⁶ Mental health is more than just the absence of disease, even though the term is commonly used in reference to mental illness. Although mental health and mental illness are related, they represent different psychological states. There is emerging evidence that positive mental health is associated with improved health outcomes.¹¹⁷

The Centers for Disease Control and Prevention defines mental health and mental illness:¹¹⁷

Mental health “includes our emotional, psychological, and social well-being. It affects how we think, feel, and act.” Mental health determines how we cope with normal stresses of life, interact with others, and make healthful choices.

Mental illness “are conditions that affect a person’s thinking, feeling, mood or behavior, such as depression, anxiety, bipolar disorder, or schizophrenia. Such conditions may be occasional or long-lasting (chronic) and affect someone’s ability to relate to others and function each day.”

Mental Health Indicators.¹¹⁶ Research has identified several domains of mental health, represented by the following indicators:

- Emotional well-being such as perceived life satisfaction, happiness, cheerfulness, peacefulness.
- Psychological well-being such as self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one’s environment, spirituality, self-direction, and positive relationships.
- Social well-being, social acceptance, beliefs in the potential of people and society as a whole, personal self-worth, and usefulness to society, sense of community.

Clinical Signs and Symptoms^{116,118}

School nurses may encounter students with a variety of mental health disorders that include, but are not limited to, attention deficit hyperactivity disorders, anxiety disorders, conduct disorders, depression, bipolar disorders, eating disorders, affective (mood) disorders, panic disorders, psychotic disorders, tic disorders, and substance abuse.

Symptoms vary greatly between specific illnesses, but may include:

- Noteworthy changes in behavior (from loud to quiet, extroverted to introverted, and vice versa)
- Mood changes
- Acting inappropriately for their age
- Inability to cope with daily life or problems
- Increased school absences
- Excessive complaints regarding physical ailments
- Changes in sleeping or eating patterns
- Frequent (and often sudden) outbursts of anger
- Withdrawn, anti-social behavior, and/or lack of interest in friends or activities
- Defiance of authority figures, disobedience
- Talk of death or self-harm
- Perseverance on weight, intense fear on gaining weight
- Changes in academic performance
- Excessive worrying and/or anxiety
- Secretive behavior
- Frequent nightmares
- Aggressive behavior, including bullying and teasing others
- Takes unnecessary risks
- Hearing/seeing things that aren't there

School nurses may notice that students present to the clinic with increasing frequency, and often with vague or non-specific complaints. Particularly in young children, who have difficulty naming and expressing their emotions, they may instead report feelings of nausea, headaches, or general malaise. It is often the accumulation of these complaints over time, when other physical ailments have been ruled out, that might lead a nurse to suspect the presence of a

mental or emotional distress or illness. Therefore, it is paramount that nurses document all clinic visits and complaints (as required by law), including those for complaints related to mental and emotional health, so that the record can be reviewed for patterns or changes over a period of time.

Recommendations

School nurses promote students' physical well-being and overall healthy behaviors. They support student success and nurture positive behavioral health by using a systematic approach to healthy social, and emotional development that strengthens students, families, schools, and communities.¹¹⁸ This includes education and role modeling to children and adolescents about positive self-esteem, tolerance, diversity, resiliency behaviors and protective buffers, help-seeking behaviors, anti-bullying programs, antiviolence programs, and suicide prevention programs. Additionally, school nurses are vital component of the school community, promoting positive mental health outcomes in students through evidence-based programs and education. They work in collaboration with school personnel, community health care professionals, students and families, in the assessment, identification, intervention, referral, and follow-up of children in need of mental health services and are uniquely qualified to identify students with potential mental health problems.¹¹⁸ School nurses, in collaboration with other school personnel, can also work to develop programs and interventions aimed at interpersonal conflict resolution and non-violent response techniques to better educate and prepare students to deal with challenging emotional situations.¹¹⁹ "These prevention and intervention services support the mental, behavioral, and social-emotional health of students and promote success in the learning process. Services include psychological, psychoeducational, and psychosocial assessments; direct and indirect interventions to address psychological, academic, and social barriers to learning, such as individual or group counseling and consultation; and referrals to school and community support services as needed."¹²⁰

Legislation mandates that schools provide school counseling and support services, and school nurses can play a vital role in this – working to help students address issues with self-efficacy and self-sufficiency regarding healthcare needs, sleep and/or eating problems, weight management, and medication management.¹¹⁹ Nurses may work with students, families, medical caregivers and school personnel to help develop a plan for management of the student's treatment both in and out of the school setting. This includes development and implementation of 504 plans, the health portion of the Special Education Individual Education Plan (IEP), and the Individualized Healthcare Plan (IHP).¹¹⁸ Using these same tools, the school nurse can assist in the re-entry of students into the school environment following homebound instruction or hospitalization and serve as a liaison between community mental health providers, the family, and school personnel.¹¹⁸ School nurses provide critical case management of students to ensure that compliance with treatment continues as long as necessary.

Students often view school nurses as trusted individuals, and clinics as a safe place; thus, students may seek out the nurse when they have a health care concern to discuss.¹¹⁶ It is

important to maintain student confidentiality and trust, while recognizing limitations both ethically and legally. Situations may include: the student expresses thoughts of harm (self or others),¹¹⁶ divulging a situation that mandates reporting to Child Protective Services (CPS), or expressing concerns that might indicate a need for a mental health evaluation and/or treatment. Finally, the nurse should be cognizant of students that may be in need of treatment and care beyond the scope of the clinic, and should have a knowledge and understanding of resources (school and community) available for referral.

Resources

- [American Academy of Pediatrics: Bright Futures](#) - Provides health and education professionals with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the *Bright Futures Guidelines*. Resources include presentations, handouts, educational materials, and current research.
- Centers for Disease Control and Prevention
 - [Mental Health](#) – Provides an overview on mental health, data and statistics, resources, and links to publications and related CDC sites.
- [Commonwealth of Virginia: Commission on Youth](#) – Evidenced-based best practices, legislation, and publications for professionals regarding mental health treatment and care for children.
- [National Institute of Mental Health](#) – Provides an overview of mental health and detailed information on specific conditions, education and support services, outreach, and current research in the field.
- Virginia Department of Education: Student and School Support
 - [School Counseling & Guidance](#) – State website on the standards and regulations of school counseling, and resources on career, academic, and personal development. Information is useful for school personnel in understanding the role of the counselor, how to collaborate, and appropriate times for a referral.
 - [Student and Family Services](#) – List of programs and resources are available to assist families in partnering with their local public school to support and improve teaching and learning.

Personal Health and Wellness

Authorization

[Code of Virginia, Section 22.1-207, Physical and Health Education](#)

Overview

Personal health and wellness are important topics to cover in health education for all grade levels. Specific areas should be tailored to meet the needs of the audience and consideration should be given to age, issues identified by staff, teachers, the community, parents and the school district, as well as student identified areas of interest.

- Bicycle/Pedestrian Safety
- Dental/Oral Care
- Feeling Safe and Connected to Friends, Family, and Community
- General Good Health and Safety Practices
- Handwashing
- Healthy Sleep Habits
- Peer Pressure
- Personal Hygiene/Grooming
- Sun Protection/Skin Care

Recommendations

Since topics vary, there is no one guideline or set of recommendations available. A number of resources are listed below by topic. Check with the local health department, school health services, and school staff for additional community-specific references, special programs, and potential guest speakers.

Resources

Bicycle/Pedestrian Safety.

- [National Center for Safe Routes to School](#) – Offers resources and education for implementing school and community activities encouraging walking/biking to school safely, school and community personnel information, ideas for funding, as well as national data and statistics.

- National Highway Traffic Safety Administration - Provides materials for children, parents, and school personnel related to commuting via bicycle, and as a pedestrian with an emphasis on safety and proper etiquette.
 - [Bicycles](#)
 - [Pedestrian Safety](#)

Dental/Oral Care.

- [American Academy of Pediatrics: Children’s Oral Health](#) – Educational materials and training for professionals, as well as links to additional resources for developing programs and interventions for students.
- American Dental Association – Provides education and evidence-based practice for health professionals to encourage and promote dental hygiene and proper care in the community and schools.
 - [Public Programs](#)
- [American Dental Association: National Children’s Dental Health Month](#)
- [American Academy of Pediatrics: Bright Futures](#) - Provides home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the *Bright Futures Guidelines*. Resources include presentations, handouts, educational materials, and current research.
- HealthyPeople.gov: Healthy People 2020
 - [Oral Health](#) - Provides an overview of disease and injury related to the mouth, teeth, and gums. Discusses the importance of prevention and health promotion and provides information on the long-term health risks and complications, education, and additional resources.

Feeling Safe and Connected to Friends, Family, and Community.

- Centers for Disease Control and Prevention
 - [Adolescent and School Health: Protective Factors](#) – Information and resources on protective factors for students in school and how to improve these as a means of improving overall health.
- KidsHealth.org – Resources for parents, children, teens, and educators providing practical information and support about a variety of health-related topics. Includes handouts for use, ideas for interventions and programs, and links to additional resources.

- [Feelings](#)
- [Kids Health in the Classroom](#) (see each age group for specific information)
- [School & Family Life](#)
- [National School Climate Center](#) – Helps school integrate social and emotional learning with academic instruction. Provides teachers, staff, students and parents with guidelines, programs, and services available that support the whole school model.

General Good Health and Safety Practices.

- American Academy of Pediatrics
 - [HealthyChildren.org](#) - Aimed at parents, this website discusses the current trends among teens, provides data and statistics on general health and good hygiene practice, provides educational materials and interventions.
- Centers for Disease Control and Prevention
 - [BAM! Body and Mind](#) – Primarily aimed at children and teens, with sections for parents and teachers. Covers a variety of health, hygiene, and safety topics.
- [KidsHealth.org](#) - Resources for parents, children, teens and educators providing practical information and support about a variety of health-related topics. Includes handouts for use, ideas for interventions and programs, and links to additional resources.
 - [Kids Health in the Classroom](#) (see each age group for specific information)
- [Northern Virginia Healthy Kids Coalition](#) - Community-wide campaign to promote healthy lifestyles for children in Northern Virginia. Offers ideas and tools provided to help incorporate health and positive messages into daily life, school programs, and community events.

Handwashing.

- Centers for Disease Control and Prevention
 - [Handwashing: Clean Hands Save Lives](#) – List of training and educational resources for the school, community, and families, related to handwashing and hygiene.
- KidsHealth.org - Resources for parents, children, teens, and educators providing practical information and support about a variety of health-related topics.
 - [Why Do I Need to Wash My Hands?](#)
- NSF International
 - [Scrub Club](#) – Cartoon and video-based programs, interventions, and activities aimed at helping children understand the importance of good hygiene. Provides

demonstrations, explanations of germs and diseases, and encourages healthy habits.

Healthy Sleep Habits.

- Cleveland Clinic
 - [Healthy Sleep Habits for Children](#) – Information on pediatric sleep disorders and common concerns, as well as tips and resources for parents and educators based on age.
- KidsHealth.org - Resources for parents, children, teens, and educators providing practical information and support about a variety of health-related topics.
 - [Kids Health in the Classroom \(see each age group for specific information\)](#)
 - [What Sleep Is and Why all Kids Need It](#)
- National Sleep Foundation
 - [Children and Sleep](#) – Overview of sleep patterns, concerns, and health by ages. A good resource for parents, educators and school personnel.

Peer Pressure.

- [The Cool Spot](#) – Focuses on peer pressure as it relates to alcohol. Aimed at teens, with good information for educators, school personnel, and parents as well.
- KidsHealth.org - Resources for parents, children, teens, and educators providing practical information and support about a variety of health-related topics.
 - [Kids Health in the Classroom](#) (see each age group for specific information)
- Teacher Vision
 - [Putting a Positive Spin on Peer Pressure](#) – Article aimed at helping teachers understand, address, and reduce peer pressure in the school setting.

Personal Hygiene/Grooming.

- Centers for Disease Control and Prevention
 - [Hygiene Etiquette & Practice](#) – Links to hygiene and etiquette practices broken down by topics. Good resource to provide information to parents and students on a non-medical level.
- KidsHealth.org - Resources for parents, children, teens, and educators providing practical information and support about a variety of health-related topics.
 - [Hygiene Basics](#)
 - [Kids Health in the Classroom](#) (see each age group for specific information)

- Menstrual Supplies – Code of Virginia, section § 22.1-6.1. Menstrual Supplies availability; legislation which requires each school board to make menstrual supplies available at all times and at no cost to students in accessible locations, as deemed appropriate, in each elementary school. The legislation further requires each school board to make menstrual supplies available at all times and at no cost to students in the bathrooms of each middle and high school in the local school division. Elementary schools are required to keep menstrual supplies such as pads or tampons in a location where they are readily available if needed. Examples of possible accessible locations include bathrooms and school nurse office or clinic. Middle and high school settings are required to keep tampons or pads in the bathrooms of each school building so students can have timely access to these free personal care products as needed during the school year. [School Health Services Website](#)

Sun Protection/Skin Care.

Sunscreen Protocol

Code of Virginia, section § 22.1-274.5. Topical sunscreen which permits public elementary or secondary schools students to possess or use topical sunscreen, in its original packaging on a school bus, on school property, or at a school-sponsored event without a note or prescription from a licensed healthcare provider. The sunscreen must be approved by the Food and Drug Administration (FDA) for nonprescription use for the purpose of limiting damage to skin caused by exposure to ultraviolet light.

This legislation allows students to self-carry and apply FDA approved sunscreen products on the school bus, on school property or during school events. This is a change from previous guidelines which required a note from the parent or healthcare provider in order for a student to use or apply sunscreen products while at school. [School Health Services Website](#)

- American Academy of Dermatology
 - [Kids and Sun Safety](#) – Information on community programs, the basics of skin care/cancer and sun prevention, plus programs, resources, and handouts for parents, schools, and children.
- Centers for Disease Control and Prevention
 - [Skin Cancer: How Can I Protect My Children From the Sun?](#) – Basics of sun protection and skin care for parents and children.
- Environmental Protection Agency
 - [The SunWise School Program Guide](#)– Educational resources and information for parents, children, and health educators on sun and proper sun protection.

- [Sun Safety for Kids](#) – Videos, information, school policies and additional resources aimed at schools, parents, and children. Provides a good mix of programs for various age levels.

Physical Activity

Authorization

[Code of Virginia, Section 22.1-207, Physical and Health Education](#)

[Physical Education Standards of Learning](#)

Overview ¹²¹

Regular physical activity promotes health and fitness. The health benefits of physical activity include building and maintaining healthy bones and muscles; reducing the risk of developing chronic diseases; and decreasing feelings of depression and anxiety. Additionally, physical activity contributes to psychological well-being influencing a student’s academic and classroom performance through increased focus and concentration, improved behavior, and academic achievement. Over time, physical inactivity (along with other lifestyle factors such as poor diet) can lead to overweight and obesity, which in turn increase one’s risk for diabetes, high blood pressure, high cholesterol, arthritis, and poor health status.

Definition. The U.S. Department of Health and Human Services *Physical Activity Guidelines for Americans, 2nd Edition*, defines:¹²¹

Physical Activity: Any bodily movement produced by the contraction of skeletal muscle that increases energy expenditure above a basal level. In these Guidelines, physical activity generally refers to the subset of physical activity that enhances health.

Although a universally accepted definition of the term “physical education” has not been adopted, *Health Is Academic: A Guide to Coordinated School Health Programs* presents the following definition.¹²²

Physical Education: Planned, sequential instruction that promotes lifelong physical activity. Designed to develop basic movement skills, sports skills, and physical fitness as well as to enhance mental, social, and emotional abilities.

Objectives for Physical Education Program. The National Standards for Physical Education define what a student should know and be able to do as result of a quality physical education program. The standards are outlined below and can be used to develop or update curricula,

programs and interventions.¹²³ For students with disabilities, there are [Adapted Physical Education National Standards](#):

- **Standard 1** - The physically literate individual demonstrates competency in a variety of motor skills and movement patterns.
- **Standard 2** - The physically literate individual applies knowledge of concepts, principles, strategies and tactics related to movement and performance.
- **Standard 3** - The physically literate individual demonstrates the knowledge and skills to achieve and maintain a health-enhancing level of physical activity and fitness.
- **Standard 4** - The physically literate individual exhibits responsible personal and social behavior that respects self and others.
- **Standard 5** - The physically literate individual recognizes the value of physical activity for health, enjoyment, challenge, self-expression and/or social interaction.

It is important to remember that physical education is an academic subject and provides students the opportunity to learn knowledge and gain skills needed to establish and maintain physically active lifestyles throughout childhood and adolescence and into adulthood. Quality physical education should meet the needs of all students, be an enjoyable experience for all students, keep students active for most of class time, teach self-management, teach skills to maximize movement proficiency, and emphasize knowledge and skills for a lifetime of physical activity. A well-designed and implemented program can increase student participation in physical activity, increase physical fitness, and enhance student knowledge and skills about why and how they should be physically active.

Recommendations

[Comprehensive School Physical Activity Program \(CSPAP\)](#).¹²⁴ A CSPAP is a multi-component approach developed in partnership by the Centers for Disease Control and Prevention and SHAPE America. It provides school districts and schools guidance for how to implement a program for students to be physically active, meet the nationally recommended 60 minutes of physical activity each day, and develop the knowledge, skills, and confidence to be physically active for a lifetime. Quality physical education programs should include physical activity before, during, and after school, staff involvement, and family and community engagement. The goals of CSPAP are:

- To provide a variety of school-based physical activities to enable all students to participate in 60 minutes of moderate-to-vigorous physical activity each day.
- To provide coordination among the CSPAP components to maximize understanding, application, and practice of the knowledge and skills learned in physical education so that all students will be fully physically educated and well equipped for a lifetime of physical activity.

Resources

NATIONAL PHYSICAL ACTIVITY INFORMATION RESOURCE LIST

- Action for Healthy Kids
 - [Tools for Schools](#)
- [American Academy of Pediatrics: Bright Futures](#) - Provides home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the *Bright Futures Guidelines*. Resources include presentations, handouts, educational materials, and current research.
- Centers for Disease Control and Prevention
 - [Adolescent and School Health: Nutrition, Physical Activity, & Obesity](#)
- HealthyPeople.gov: Healthy People 2020
 - [Physical Activity](#)
- KidsHealth.org - Resources for parents, children, teens and educators providing practical information and support about a variety of health-related topics.
 - [Kids Health in the Classroom](#) (see each age group for specific information)
- [SHAPE America](#) – Organization of professionals involved in school-based health, physical education, and physical activity dedicated to teaching and promoting a healthy, active lifestyle. Provides resources for educators and the public, as well as develops guidelines and standards for programs and interventions.

VIRGINIA PHYSICAL ACTIVITY INFORMATION RESOURCE LIST

- [Northern Virginia Healthy Kids Coalition](#) - A community-wide campaign to promote healthy lifestyles for children in Northern Virginia. Tools and resources include handouts, interventions, community partnerships and ideas, current research, and tool kits aimed at various professional and community groups.
- Virginia Department of Education
 - [Instruction: Physical Education](#) – List of resources and organizations that can be used to develop guidelines and implement education and activity interventions in schools.

- [School Nutrition: Best Practices](#) - Provides a means for school divisions to research and share information about successful programs and local efforts to improve the well-being of students and promote healthy lifestyles.
- Virginia Department of Health
 - [Healthy Eating and Active Living Program](#) – Aimed at preventing obesity and chronic diseases by providing Virginians with information, tools and resources for promoting healthy eating and access to proper nutrition options and encouraging and reinforcing active lifestyles and behaviors.
- Virginia Tech University
 - Department of Human Nutrition, Foods and Exercise
 - [Virginia Cooperative Extension](#) - A joint program of Virginia Tech, Virginia State University, the U.S. Department of Agriculture, and state and local governments. The section on food & health is of particular use for school nurses and personnel, providing several resources, information, and guidance in program development.

School Safety and Unintentional Injury Prevention

Authorization

[Code of Virginia, Section 22.1-207, Physical and Health Education](#)

[Code of Virginia, Section 22.1-279.8, School Safety Audits, and School Crisis, Emergency Management, and Medical Emergency Response Plans Required](#)

Overview

According to the Children’s Safety Network, unintentional injuries and violence are the leading causes of death, injury, and hospital for children under 18 in Virginia.¹²⁵ Between 10 and 25% of these injuries occur in and around schools.¹²⁶ Injuries are one of the most frequent conditions cared for by school health personnel. Most injuries are minor in nature and can be treated in the clinic. However, the nurse should be aware of repeat injuries, or clusters of similar injuries and circumstances that could be remediated to prevent further injuries.

Prevention Strategies

School Role. Prevention of injuries in the school environment is a responsibility shared by all school and clinic personnel. Strategies include “regular review of school injury reports and close monitoring of causes of injuries, development of school safety policies, drafting a comprehensive injury prevention plan, and establishment of a school safety committee to deal with both unintentional and intentional injuries.”¹²⁷ School-based implementation of a quality, age-appropriate injury prevention curriculum will provide children with the knowledge and skills they need to make safer choices and to avoid injury at school, at home and in the community. Motor vehicle, bike and pedestrian safety, fire and burn, choking, drowning, poisoning and fall prevention; gun safety; and violence prevention are all areas that can be addressed. Community resources (e.g. police, fire, health care providers, and other safety educators) are readily available and can complement school-based injury prevention. Schools should provide adequate-supervision and ensure age-appropriate activities and use of age-appropriate equipment to minimize the potential for injuries.

Examples. The following is a list of prevention strategies for school injuries, which focus on environmental changes.^{126,127}

- **Removal of Physical Hazards**
 - Glass in doors.
 - Asphalt under playground equipment.
 - Bleachers on playing field lines.
 - Uneven surfaces (holes or ruts) on playing fields.

- **Maintenance of Equipment and Facilities**
 - Protective guards on shop equipment.
 - Playground equipment in good repair.
 - Working smoke and carbon monoxide detectors.
 - Active grounds maintenance committee.
 - Routine inspection and maintenance of equipment and facilities.
- **Addition of Safety Features and Equipment**
 - Padded mats on concrete gym equipment.
 - Use of helmets and mouth guards during sports.
 - Locks on roof doors.
 - Metal detectors.
 - Increased lighting.
 - Storage for student belongings.
 - Low shrubbery at blind corners of buildings.
- **Enforced Policies and Regulations**
 - Collection and review of injury report forms by a designated staff person.
 - Completion of a school safety audit.
 - Development of school-wide safety policies based on injury reports.
 - Development of injury response and emergency treatment protocol for school staff.
 - Enforcement of rules, especially for sports and recreational activities.
 - Monthly safety checks of school premises, including recreational areas.
 - Identification of clear policies for injuries in the absence of medical personnel or athletic trainer on site.
- **Modification of Behaviors**
 - Education of staff on hazards and prevention.
 - Education of staff on completing injury report forms and their usefulness for prevention.
 - Training of coaches, gym teachers and other school personnel in emergency first aid, CPR, and AED use.
 - Increased supervision of students during recess and recreational time.

- Curriculum activities for students oriented to safety education on school grounds (and training of children to make safer choices and avoid injury at school, at home, and in the community).

Documentation

Please refer to Appendix C, *Risk Management of Accidents and Incidents in the School Setting*, for information on the Incident, Accident, and Injury Forms, and a copy of the Henrico County Schools Student Injury Report Form. For specific guidance on documentation of student accidents and injuries, please refer to local division policies and procedures.

Resources

Please refer to the comprehensive lists of national and state resources at the end of the next subsection.

School Violence and Prevention

Authorization

[Code of Virginia, Section 22.1-207, Physical and Health Education](#)

[Code of Virginia, Section 22.1-279.8, School Safety Audits, and School Crisis, Emergency Management, and Medical Emergency Response Plans Required](#)

Overview

School violence is considered to be a subset of youth violence. The Centers for Disease Control and Prevention (CDC) defines youth violence as “the intentional use of physical force or power to threaten or harm others by young people ages 10-24”.¹²⁸ School violence can occur going to or from school, on school property, going to or from a school-sponsored activity, or during a school-sponsored activity.¹²⁹ The CDC’s Youth Risk Behavior Survey (YRBS) reports “8.5% of high school students had been in a physical fight on school property one or more times during the 12 months before the survey”.¹²⁹

Violent behaviors may include the following:¹²⁹

- Fighting (examples: punching, slapping, kicking)
- Bullying
- Weapon use
- Cyberbullying
- Gang violence

[The Code of Virginia, § 22.1-279.3:1, Reports of certain acts to school authorities](#), requires that:

Reports shall be made to the division superintendent and to the principal or his designee on all incidents involving (i) the assault or assault and battery, without bodily injury, of any person on a school bus, on school property, or at a school-sponsored activity; (ii) the assault and battery that results in bodily injury, sexual assault, death, shooting, stabbing, cutting, or wounding of any person, or stalking of any person as described in § 18.2-60.3, on a school bus, on school property, or at a school-sponsored activity; (iii) any conduct involving alcohol, marijuana, a controlled substance, imitation controlled substance, or an anabolic steroid on a school bus, on school property, or at a school-sponsored activity, including the theft or attempted theft of student prescription medications; (iv) any threats against school personnel while on a school bus, on school property or at a school-sponsored activity; (v) the illegal carrying of a firearm, as defined in § 22.1-277.07, onto school property; (vi) any illegal conduct involving firebombs, explosive materials or devices, or hoax explosive devices, as defined in § 18.2-85, or explosive or incendiary devices, as defined in § 18.2-433.1, or chemical bombs, as described in § 18.2-87.1, on a school bus, on school property, or at a school-sponsored activity; (vii) any threats or false threats to bomb, as described in § 18.2-83, made

against school personnel or involving school property or school buses; or (viii) the arrest of any student for an incident occurring on a school bus, on school property, or at a school-sponsored activity, including the charge therefor.

Prevention

School violence represents a threat to not only an individual, but to the safe learning environment within the school community. It can cause physical, mental, and emotional harm to those involved, and that impact may be felt for years to come. Often, those who are perpetrating the violence are seeking attention and in need of assistance. The individual may be experiencing violence, abuse, or neglect at home, or feel alienated and without a support network, expressing their anger and frustration through violence. If a student is identified as expressing a desire to cause harm or commit a violent act, school administrators, counseling staff, and the parents should be notified immediately. It is imperative that every threat is taken seriously, and that appropriate action taken.

School violence is preventable. School nurses can partner with students, parents, administrators, and school personnel, as well as those in the community to help understand and address the concerns. Each school and community can work together in assessing the school climate for violence potential and/or signs of violence;¹³⁰ thus, identifying interventions that can be directed towards individuals or small groups, relationships between various groups at school, or focused on the entire community.

Documentation

Please refer Appendix C, *Risk Management of Accidents and Incidents in the School Setting*, for information on the Incident, Accident, and Injury Forms and a copy of the Henrico County Schools Student Injury Report Form. For specific guidance on documentation of student accidents and injuries, please refer to local division policies and procedures.

Resources

NATIONAL VIOLENCE AND PREVENTION INFORMATION RESOURCE LIST

- [American Academy of Pediatrics: Bright Futures](#) - Provides home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the *Bright Futures Guidelines*.
- [Promoting Safety and Injury Prevention](#)

- [Center for Safe Schools](#) – Offers creative and effective solutions to problems that disrupt the educational process and affect school safety. Provides training and technical assistance for program development and implementation.
- Centers for Disease Control and Prevention
 - [Safe Youth, Safe Schools](#)
 - [School Violence: Prevention](#) -Prevent injuries and death caused by violence through monitoring, research, program development and implementation, and evaluation of programs and interventions for efficacy.
- [National School Safety Center](#) – Serves as an advocate for safe, secure, and peaceful school and as a catalyst for the prevention of school crime and violence. Provides school communities with information, resources, consultation and training.
- The School Superintendents Association
 - [Safe and Secure Schools](#) – Outlines the basics principles of school safety, as well as providing education, resources, and programs to promote and enhance safety in the school setting.
- U.S. Department of Education
 - Office of Elementary and Secondary Education
 - [Office of Safe and Healthy Students](#) – Goal is to provide information and education to enhance the culture of safe and supportive schools; health, mental health, environmental health, and physical education; drug and violence prevention; character and civic education.
 - [Early Warning, Timely Response: A Guide to Safe Schools](#)
[Creating Safe and Drug-Free Schools: An Action Guide](#)
[Conflict Resolution Education](#)
- U.S. Department of Health and Human Services
 - [StopBullying.gov](#) - Provides information from various government agencies on what bullying is, what cyberbullying is, who is at risk, and to prevent and respond to bullying.
- U.S. Department of Justice, Office of Justice Programs
 - [National Crime Prevention Council](#) - Offers tools that schools and communities can use to learn crime prevention strategies, engage community members, and coordinate with local agencies.
 - [Safer Schools](#)

- UCLA, Department of Psychology
 - Center for Mental Health in Schools
[School Mental Health Project](#) – Provides an overview of mental health, current issues, and ongoing topics of discussion. Materials are available for download, as well as links to additional resources, trainings, and guides for program and policy development.
- University of Colorado at Boulder, Institute of Behavioral Science
[Center for the Study and Prevention of Violence](#) - Provides assistance to groups committed to understanding and preventing violence, particularly adolescent violence. Provides information to the public, as well as technical assistance to those working in violence prevention.

VIRGINIA VIOLENCE AND PREVENTION INFORMATION RESOURCE LIST

- University of Virginia, Curry School of Education
 - [Youth Violence Project](#) – An initiative through the University that studies violence and violent behavior in youth and has developed programs and interventions aimed at reduction and prevention.
- Virginia Department of Criminal Justice Services
 - [Virginia Center for School and Campus Safety](#) – Serves as a resource and referral center for Virginia school divisions, collecting and disseminating information on topics such as school safety initiatives and school safety data.
- Virginia Department of Education
 - Student & School Support
 - [Division & School Safety](#) – Provides resources to assist school divisions and communities in sustaining safe school environments. Addresses program planning and implementation.
- Virginia Department of Health
 - [Office of Family Health Services, Violence Prevention](#)

Tobacco Use

Authorization

[Code of Virginia, Section 22.1-207, Physical and Health Education](#)

[Code of Virginia, Section 32.1-73.8, Youth Health Risk Behavior Survey](#)

Overview

According to the Campaign for Tobacco-Free Kids, every day more than 2,800 kids in the United States try their first cigarette and there are more than 250,000 new underage daily smokers each year.¹³¹ Because adolescence is a critical period of growth and development, exposure to nicotine may have lasting, adverse consequences on brain development. Short term consequences include bad breath, irritated eyes and throat and increased heartbeat and blood pressure, and the impact on health long term can lead to respiratory problems, reduced immune function, increased illness, tooth decay, gum disease and pre-cancerous gene mutations.¹³²

Recommendations

[Centers for Disease Control and Prevention's Guidelines for Preventing Tobacco Use and Addiction](#). The guidelines were developed by Centers for Disease Control and Prevention (CDC) staff in collaboration with experts from other federal agencies, state agencies, universities, voluntary organizations, and professional associations. They identify strategies most likely to be effective in preventing tobacco use and addiction among young people. When choosing or designing a program, school programs should take in account the following:

- Have proven effective in preventing tobacco use.
- Provide prevention education during the years when the risk of becoming addicted to tobacco is greatest.
- Provide a tobacco-free environment that establishes non-use of tobacco as a norm and offers opportunities for positive role modeling.
- Can help prevent the use of other drugs, especially if the program addresses the use of these substances.¹³³

The guidelines have seven specific recommendations that are effective in preventing youth tobacco use, and will ensure the greatest impact, as outlined below:

1. Develop and enforce a school policy on tobacco use.
2. Provide instruction about the short- and long-term negative physiologic and social consequences of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills.
3. Provide tobacco-use prevention education in kindergarten through 12th grade; this instruction should be especially intensive in junior high or middle school and should be reinforced in high school.
4. Provide program-specific training for teachers.
5. Involve parents or families in support of school-based programs to prevent tobacco use.
6. Support cessation efforts among students and all school staff who use tobacco.
7. Assess the tobacco-use prevention program at regular intervals.

As with all school-based interventions, it is important to review local data and statistics. Identification of the population's readiness to learn, knowledge, and needs, as well as local resources, is critical to effective implementation and positive impact.

Resources

For sample programs and interventions, as well as research on design and implementation, visit the following websites:

- [National Cancer Institute: Research-tested Intervention Programs \(RTIPs\)](#) - A searchable database of cancer control interventions and program materials and is designed to provide program planners and public health practitioners easy and immediate access to research-tested materials.
- [SAMHSA National Center of Excellence for Tobacco-Free Recovery \(National Center-TFR\)](#)- Mobilize stakeholders to develop and implement a state-wide action plan to reduce the high prevalence rate of tobacco use by persons with mental and/or substance use disorders.

For additional resources, including handouts, visit the following:

- [Campaign for Tobacco-Free Kids](#) – Focuses on advocating for public policies that prevent children and adolescents from smoking, providing resources to help people stop smoking, and reducing health risks of the population through a reduction in second-hand smoke exposure.

- [Fact Sheets](#) – Handouts for students, parents, school personnel, and the community focusing on the issues of tobacco use in youth.
- HealthyPeople.gov: Healthy People 2020
 - [Tobacco Use](#) - Provides an overview of tobacco use particularly among children and adolescents. Discusses the importance of prevention and reduction and provides information on the long-term health risks and complications, education, and additional resources.
- Centers for Disease Control and Prevention: Adolescent and School Health
 - [Youth Tobacco Prevention](#)
 - [Youth Risk Behavior Surveillance System \(YRBSS\)](#) - A national school-based survey that monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults, including tobacco use.
- Virginia Department of Education
 - [Federal Programs: Safe & Drug Free School Act Toolkit](#) - Resources for school personal to providence guidance on program development and implementation, as well as community collaboration.
- Virginia Department of Health, Office of Family Health Services
 - [Tobacco Control Program \(TCP\)](#)

E-cigarette or Vaping Use

Overview

In 2018, the [Surgeon General declared that e-cigarette use has become an epidemic among U.S. youth](#), with one in five high school students reporting current e-cigarette use. Most e-cigarettes contain nicotine, an addictive chemical that affects learning, memory and attention. The liquid can contain: nicotine, tetrahydrocannabinol (THC) and cannabinoid (CBD) oils, and other substances, flavorings, and additives. THC is the psychoactive mind –altering compounds of marijuana that produces the “high.” THC use has been associated with a wide range of health effects, particularly with prolonged frequent use. The best way to avoid potentially harmful effects is to not use THC-containing e-cigarette, or vaping, products. Other harmful chemicals might also be present in these products and full ingredient lists are not usually available.

Due to a growing public health concern, VDH is requiring physicians to immediately report suspect cases of severe lung injury due to vaping to the [local health department](#). This directive is consistent with the Code of Virginia ([32.1-36](#) and [32.1-37](#)) and Board of Health Regulations ([12 VAC 5-90-80](#)), that require physicians immediately report unusual events of public health concern to the local health department. This concerning outbreak of severe lung injury is an additional reminder of the importance of preventing both tobacco and e-cigarette use, particularly among youth.

Recommendations

[Per the Centers for Disease Control and Prevention \(CDC\)](#),

[CDC Information E-Cigarettes](#)

The guidelines were developed by Centers for Disease Control and Prevention (CDC) staff in collaboration with experts from other federal agencies, state agencies, universities, voluntary organizations, and professional associations. They identify strategies most likely to be effective in preventing use and addiction among young people. When choosing or designing a program, school programs should take in account the following:

- Have proven effective in preventing e-cigarette use.
- Provide prevention education during the years when the risk of becoming addicted to

nicotine and THC is the greatest.

- Provide a vaping-free environment and offer opportunities for positive role modeling.

The guidelines have seven specific recommendations that are effective in preventing youth use of e-cigarette or vaping, and will ensure the greatest impact, as outlined below:

1. Develop and enforce a school policy on use of e-cigarette or vaping.
2. Provide instruction about the short- and long-term negative physiologic and social consequences of vaping, social influences on vaping, peer norms regarding vaping, and refusal skills.
3. Provide vaping prevention education in kindergarten through 12th grade; this instruction should be especially intensive in junior high or middle school and should be reinforced in high school.
4. Provide program-specific training for teachers.
5. Involve parents or families in support of school-based programs to prevent use of e-cigarettes.
6. Support vaping cessation efforts among students and all school staff.
7. Assess vaping prevention programs at regular intervals.

As with all school-based interventions, it is important to review local data and statistics. Identification of the population's readiness to learn, knowledge, and needs, as well as local resources, is critical to effective implementation and positive impact.

5 Key Actions School Nurses Can Take Now

1. Maintain a high index of suspicion for e-cigarette associated lung injury.
 - Ask students who report e-cigarette use or vaping within the last 90 days about signs and symptoms of respiratory illness. Ask students with signs and symptoms of respiratory illness about e-cigarette use or vaping within the last 90 days.
 - Asking only about "smoking" is not sufficient because e-cigarette users might not consider themselves smokers. E-cigarettes are known by many different names, including "e-cigs," "e-hookahs," "mods," "vape pens," "vapes," and "tanks." Using an e-cigarette is often called "vaping" or "JUULing." An "E-cigarette 101" video tutorial is available [on CDC's outbreak website](#).
2. Immediately report suspect cases of lung injury of unclear etiology and a history of e-cigarette or vaping product use within the past 90 days to your [local health department](#)

•

3. Review CDC guidance about patient management.
 - Information about collecting a patient history, diagnosis, and treatment is in [CDC's Health Alert Network \(HAN\) Advisory](#) and CDC's outbreak website.
 - With the upcoming flu season, it is critical to also consider respiratory infections in patients presenting with respiratory symptoms and a history of e-cigarette use.
4. Educate students.
 - The best way to avoid the harmful effects of e-cigarette products and tobacco products is to not use them. E-cigarette products should never be used by youth, young adults, pregnant women, or adults who do not currently use tobacco products.
 - People who use e-cigarette products should not buy products off the street and should not modify products or add any substances that are not intended by the manufacturer.
 - People who use e-cigarette products should monitor themselves for symptoms (e.g., cough, shortness of breath, chest pain, nausea, vomiting, abdominal pain, fever) and promptly seek medical attention if they develop symptoms.
 - Tobacco smokers attempting to quit should use evidence-based treatments, including counseling and FDA-approved medications, rather than e-cigarettes.
5. If help is needed to quit tobacco products, including e-cigarettes, contact a health care provider.

Resources

For sample programs and interventions, as well as research on design and implementation, visit the following websites:

1. www.QuitNow.net/Virginia - Focuses on help needed to quit tobacco products, including e-cigarettes. Free cessation counseling may be obtained by contacting the VDH quitline at 1-800-QUIT NOW (1-800-784-8669).
2. rethinkvape.org - Resource parents, educators and health professionals. General information about vaping, research findings, education materials, and offers resources.
3. [Reducing-Vaping-Among-Youth-and-Young-Adults](#) - This guide supports health care providers, systems, and communities seeking to prevent vaping. It describes relevant research findings, examines emerging and best practices, identifies knowledge gaps and implementation challenges, and offers useful resources.

4. [Get the facts about electronic cigarettes, their health effects and the risks of using e-cigarettes](#) – CDC Resources for School Nurses, parents and school personnel including program materials, current literature and suggestions for references that can be used in planning, development, and implementation.

6. [What’s the Bottom Line on the Risks of E-cigarettes for Kids, Teens, and Young Adults?](#) – CDC Resources for parents, School Nurses and School Personnel including program materials, current literature and suggestions for references that can be used in planning, development, and implementation.

Alcohol and Other Drug Use and Abuse

Authorization

[Code of Virginia, Section 22.1-207, Physical and Health Education](#)

[Code of Virginia, Section 32.1-73.8, Youth Health Risk Behavior Survey](#)

[Code of Virginia, Section 22.1-206, Instructions Concerning Drugs, Alcohol, and Substance Abuse](#)

Regulations of the Virginia Board of Education. [Rules Governing Instructions Concerning Drugs and Substance Abuse, 8 VAC20-310-10. Health education program.](#)

Excerpt:

The Board of Education recognizes that the illegal and inappropriate use of certain substances constitutes a hazard to the development of students. Elementary and secondary schools shall include in the health education program instruction in drugs and abuse.

Therefore, the public schools of the Commonwealth shall:

1. Be concerned with education and prevention in all areas of substance use and abuse.
2. Establish and maintain a realistic, meaningful substance abuse prevention and education program that shall be developed and incorporated in the total education program.
3. Establish and maintain an ongoing in-service substance abuse prevention program for all school personnel.
4. Cooperate with government and approved private agencies involved with health of students relating to the abuse of substances.
5. Encourage and support pupil-run organizations and activities that will develop a positive peer influence in the area of substance abuse.
6. Create a climate whereby students may seek and receive counseling about substance abuse and related problems without fear of reprisal.

Overview

Data from the [National Survey on Drug Use and Health \(NSDUH\)](#), demonstrates that approximately 11.2% of Americans aged 12 or older were current users of illicit drugs: reporting use of an illicit drug in the past month. The [2017 Centers for Disease Control and Prevention \(CDC\) Youth Risk Behavior Survey \(YRBS\)](#) report indicated that nationwide 60.4% of students had had at least one drink of alcohol on at least 1 day during their life, and 15.5% of students younger than 13 had their first drink of alcohol. In addition, the [2017 CDC YRBS](#) report indicated that 35.6% of students younger than 13 had used marijuana one or more times during their life.

Alcohol and drugs can cause significantly impaired judgment, lack of focus, and an inability to concentrate. They can also increase the incidence of a variety of aggressive acts, including domestic violence and sexual assault. Long term effects can vary depending on the substance but may include permanent damage to vital organs such as the brain, heart, pancreas and liver, a weakened immune system, and an increased risk of developing cancers.¹³⁴

Commonly Used and Abused Substances. Information on the most common drugs and substances, along with effects and health risks, can be found at [The National Institute of Drug Abuse](#) and [Partnership for Drug-Free Kids](#).

Recommendations

The most important factor in development and implementation is to tailor the programs and interventions to the needs of the community. The age, development, and skill level of the audience should also be considered. Data suggests that early intervention, prior to high school is most effective, as rates of substance abuse increase significantly during the high school years.¹³⁵

The National Institute on Drug Abuse (NIDA) has identified [16 key principles](#) to consider for program development and intervention, based on identified risk, type of program, and planned delivery. The principles are outlined in brief below. Additional information and resources can be found using the above link.¹³⁶ Note that these are designed for drug abuse prevention, but the ideas can be applied to any program focusing on alcohol and/or substance abuse prevention:

- **Principle 1** - Prevention programs should enhance protective factors and reverse or reduce risk factors.
- **Principle 2** - Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs (e.g., tobacco or alcohol); the use of illegal drugs (e.g., marijuana or heroin); and the inappropriate use of legally obtained substances (e.g., inhalants), prescription medications, or over-the-counter drugs.

- **Principle 3** - Prevention programs should address the type of drug abuse problem in the local community, target modifiable risk factors, and strengthen identified protective factors.
- **Principle 4** - Prevention programs should be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness.
- **Principle 5** - Family-based prevention programs should enhance family bonding and relationships and include parenting skills; practice in developing, discussing, and enforcing family policies on substance abuse; and training in drug education and information.
- **Principle 6** - Prevention programs can be designed to intervene as early as preschool to address risk factors for drug abuse, such as aggressive behavior, poor social skills, and academic difficulties.
- **Principle 7** - Prevention programs for elementary school children should target improving academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure, and school dropout. Education should focus on the following skills: self-control, emotional awareness, communication, social problem-solving, and academic support, especially in reading.
- **Principle 8** - Prevention programs for middle or junior high and high school students should increase academic and social competence with the following skills: study habits and academic support, communication, peer relationships, self-efficacy and assertiveness, drug resistance skills, reinforcement of anti-drug attitudes, and strengthening of personal commitments against drug abuse.
- **Principle 9** - Prevention programs aimed at general populations at key transition points, such as the transition to middle school, can produce beneficial effects even among high-risk families and children.
- **Principle 10** - Community prevention programs that combine two or more effective programs, such as family-based and school-based programs, can be more effective than a single program alone.
- **Principle 11** - Community prevention programs reaching populations in multiple settings—for example, schools, clubs, faith-based organizations, and the media—are most effective when they present consistent, community-wide messages in each setting.
- **Principle 12** - When communities adapt programs to match their needs, community norms, or differing cultural requirements, they should retain core elements of the original research-based intervention which include: Structure (how the program is organized and constructed), Content (the information, skills, and strategies of the program), and Delivery (how the program is adapted, implemented, and evaluated).

- **Principle 13** - Prevention programs should be long-term with repeated interventions (i.e., booster programs) to reinforce the original prevention goals.
- **Principle 14** - Prevention programs should include teacher training on good classroom management practices, such as rewarding appropriate student behavior.
- **Principle 15** - Prevention programs are most effective when they employ interactive techniques, such as peer discussion groups and parent role-playing, that allow for active involvement in learning about drug abuse and reinforcing skills.
- **Principle 16** - Research-based prevention programs can be cost-effective.

Resources

While there are no national standardized guidelines on health education for prevention of alcohol and substance abuse, several national organizations have developed guidelines and suggested instructional interventions to address risky behaviors, peer pressure, and preventative education.

NATIONAL ALCOHOL AND DRUG USE/ABUSE RESOURCE LIST

- Centers for Disease Control and Prevention
 - [Alcohol and Other Drug Abuse](#) – Provides links to current data and statistics, as well as resources and reference material for educational programs, program and intervention development and implementation.
 - [Youth Risk Behavior Surveillance System \(YRBSS\)](#) – A national school-based survey that monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults, including drug and alcohol use.
- HealthyChildren.org – Aimed at parents, this website discusses the current trends among teens, provides data and statistics on use and abuse, and discusses peer pressure, as well as provides educational materials and interventions.
 - [Ages & Stages: Substance Abuse](#)
- HealthyPeople.gov: Healthy People 2020
 - [Substance Abuse](#) - Provides an overview of alcohol and drug use particularly among children and adolescents. Discusses the importance of prevention and reduction and provides information on the long-term health risks and complications, education, and additional resources.

- [National Association of School Nurses](#) – Resource for School Nurses providing position statements, articles and current literature, and suggestions for references and resources that can be used in planning, development, and implementation.
 - [Drugs of Abuse](#)
- [SAMHSA’s Evidence-based Practices and Resource Center](#) – A searchable online center of substance abuse and mental health interventions. Developed to help the public learn more about available evidence-based interventions.

VIRGINIA ALCOHOL AND DRUG USE/ABUSE RESOURCE LIST

- Student & School Support, Prevention Strategies & Programs
- [Drug & Alcohol Abuse](#) – A collaborative effort with other state agencies to provide resources and strategies for school to support drug and alcohol education and prevention interventions.
- [Virginia Association of Community Services Boards \(VACSBs\)](#)
Community Services Boards (CSBs) throughout Virginia engage in Community-Based Prevention Planning, which involves identification of community risk and protective factors and of community resources. The [Virginia Department of Behavioral Health & Developmental Services](#) maintains a current list of community service boards.
- Virginia Department of Education
 - [Federal Programs: Safe & Drug Free School Act Toolkit](#) – Resources for school personal to provide guidance on program development and implementation, as well as community collaboration.
- [Virginia Department of Health](#) - For district specific programs and education, contact the Health Educator of the local health department.
- Virginia Office of the Attorney General
 - [Virginia Rules: Teens Learn & Live the Law](#) – Designed especially for teens, Virginia Rules provide information about the laws in Virginia with specific emphasis on how they apply to teens in their day-to-day lives.

Sexual Health

Authorization

[Code of Virginia, Section 22.1-207, Physical and Health Education](#)

[Code of Virginia, Section 22.1-207.1, Family Life Education](#)

[Code of Virginia, Section 22.1-207.1:1, Family Life Education; certain curricula and Standards of Learning](#)

[Board of Education Guidelines and Standards of Learning for Virginia Public Schools: Family Life Education](#)

Overview

Research has shown that early sexual behavior may lead unintended consequences such as teen pregnancy, sexually transmitted infections, and HIV infection/AIDS. Among U.S. high school students in 2013: ¹³⁷

- 40% had ever had sexual intercourse
- 30% had had sexual intercourse during the previous 3 months, and, of these
- 46% did not use a condom the last time they had sex
- 10% had had sex with four or more people during their life

To reduce risky sexual behavior practices and related health problems among youth, schools and school nurses can help young people adopt lifelong attitudes and behaviors that support their health and well-being—including behaviors that reduce their risk for HIV, other STDs, and unintended pregnancy. This can be achieved in part through development and implementation of education programs and targeted interventions.

Recommendations

It is the position of the National Association of School Nurses that age-appropriate health education about sexual health should be included as part of a comprehensive school health education program and be accessible to all students in schools. While parents and families serve as the primary source of education about sexual health, the school nurse also plays a vital role. School nurses should utilize evidence-based strategies in the development and implementation of instructional programs that educate students on prevention of unintended pregnancies and sexually transmitted infections including HIV, and that promote healthy sexual development.¹³⁸

Resources

NATIONAL SEXUAL HEALTH RESOURCE LIST

Although there are no national guidelines on health education for this topic, guidelines have been developed by some national organizations, as well as suggested instructional procedures to address sexual behaviors that lead to teen pregnancy or sexually transmitted diseases or infections, including HIV infection. A few resources are listed below:

- [Advocates for Youth Advocates for Children and Youth](#) - Champions efforts that help young people make informed and responsible decisions about their reproductive and sexual health. Encourages a more positive and realistic approach to adolescent sexual health through the three core values of rights, respect, and responsibility.
- [American School Health Association](#) – Professional resource with education for school professionals, articles, and current advocacy work in the area of sexual health and education.
- Centers for Disease Control and Prevention
 - [Adolescent and School Health: Sexual Risk Behaviors Can Lead to HIV, STDs, & Teen Pregnancy Prevention](#) – An overview of current data and statistics, guidance and support for programs and interventions, as well as resources and educational materials.
- HealthyPeople.gov: Healthy People 2020
 - [Sexually Transmitted Diseases](#) - Provides an overview of the biology of sexually transmitted diseases, the importance of prevention, the diseases and emerging issues. In addition, information is available on the long-term health risks and complications, education, and additional resources.

VIRGINIA SEXUAL HEALTH RESOURCE LIST

- Virginia Department of Education
 - Instruction: [Family Life Education](#) - Virginia's standards for family life education provide a comprehensive, sequential K-12 curriculum. They include age-appropriate instruction in family living and community relationships, abstinence education, the value of postponing sexual activity, the benefits of adoption as a

positive choice in the event of an unwanted pregnancy, human sexuality and human reproduction.

- Virginia Department of Health
 - [Abstinence Education Program](#) - The program targets youth ages 10 through 14 and youth to avoid risky behaviors by choosing abstinence. Strategies include peer-to-peer education, in-school education, parent education and community forums. These healthy life skills may include distinguishing between healthy and unhealthy relationships, understanding sexually transmitted infections, setting goals, positive decision-making, and character building.
- For district specific programs and education please contact the Health Educator of the [local health department](#).

End Notes

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PART V: HEALTHFUL ENVIRONMENT

This section presents general guidelines for use in planning and implementing a *healthful school environment*, a component of a school health program. It focuses on the physical environment, including related codes, standards, and recommendations for addressing the physical climate of the school.

Chapter 20: [Introduction to a Healthful Environment](#)

Chapter 21: [Building and Environmental Standards](#)

- Safety and Security
- Hazard Communication
- School Nutrition Programs
- Indoor Air Quality
- Asbestos
- Radon
- Lead
- Underground Storage Tanks in Schools
- Pesticides
- Toxic Art Supplies

Chapter 22: [Laboratory, Industrial, and Vocational Hazards](#)

- Facilities
- Ventilation
- Equipment and Supplies
- Storage and Handling of Toxic or Hazardous Materials

Chapter 23: [Health and Safety Recommendations](#)

- Playground Safety
- Toilets, Lavatories, Drinking Fountains, and Bathing Facilities
- Animals in School
- Lighting
- Swimming Pools/Therapy Pools
- School Maintenance and Sanitation
- Sewage Disposal
- Refuse Disposal
- Recycling

Chapter 24: [Technology Related Health Concerns](#)

- Hazards from Video Display Terminals
- Photocopier Equipment and Other Machines
- Radiation Producing Devices

Chapter 20: Introduction to a Healthful Environment

Authorization

The following governmental agencies are associated with the school health environment:

[Virginia Department of Education](#). [Office of School Nutrition Programs](#), within the Virginia Department of Education, requires compliance with its regulations governing the operation of food service programs.

[Virginia Department of Health](#). The Virginia Board of Health has established standards for food service establishments, which are administered by the local health department. The operation of a food service facility in a school requires a permit from the local health department. These minimum standards cover all aspects of food sanitation, sources of food, food protection, health and cleanliness of personnel, design and construction, installation and cleanliness of equipment and utensils, water supply, plumbing and sewage disposal, toilet and hand-washing facilities, vermin control, garbage and rubbish handling and disposal, lighting and ventilation, dressing rooms, and housekeeping. A minimum of one inspection by the local health department per year is required.

Overview

Definition. Although a universally accepted definition of the term “healthful school environment” has not been adopted, *Health Is Academic: A Guide to Coordinated School Health Programs* presents the following definition:¹³⁹

Healthy School Environment: The physical, emotional, and social climate of the school. Designed to provide a safe physical plant, as well as a healthy and supportive environment that fosters learning.

A safe and healthful physical school environment includes the school building(s) and contents, school land location as well as surrounding area, school equipment, appropriate physical learning conditions, and an environment that meets privacy needs.¹⁴⁰ Through a safe and healthful school environment, students and staff are protected from injury, disease, or adverse conditions that are associated with known risk factors. A positive school environment is considered key to healthy relationships in the school.

The following section provides an outline to begin an assessment of the school environment. When assessing the school environment, local, state, and federal codes, and appropriate standards should be reviewed, along with any applicable Superintendent’s Memoranda issued by the Superintendent of Public Instruction. This section includes codes, standards, references,

resources, and some assessment tools that may help in gathering information about a school's environment. The section is not comprehensive; however, it provides the tools necessary to begin the process.

Topic-specific resources are listed at the end of each of the following subsections. For additional information about school health environment policies, procedures, and related student/staff training, please contact the school division's maintenance and operation unit or contact the following state agencies:

- Virginia Department of Education
 - [Student & School Support: Facility Construction & Maintenance](#): Provides leadership and technical services to Virginia public school facilities in the areas of facility planning, building guidelines, energy efficiency and high performance school buildings, construction cost data, construction project submission, facility conferences and training, school safety, playground safety, facility studies, and resources and information.
 - [Safety & Crisis Management: Division & School Safety: Provides resources to assist school divisions and communities in sustaining safe school environments.](#) Addresses planning and implementation in the categories of prevention, protection, mitigation, response, and recovery.

- Virginia Department of Health
 - [Environmental Health Services](#): Focuses on public health protection through preventing the transmission of disease through food, milk, shellfish, water and sewage, and to work in partnership with other agencies to protect the environment.

Chapter 21: Building and Environmental Standards

Authorization

In Virginia, the responsibility for establishing and enforcing minimal building and environmental standards for school buildings is shared by two state agencies: the [Virginia Department of Housing and Community Development](#) and [Virginia Department of Education](#). These agencies depend on local health, fire, and building inspection staff to approve school facilities as being in conformance with applicable state codes and regulations.

- **Virginia Department of Housing and Community Development.** The Virginia Board of Housing and Community Development is responsible for the Virginia [Uniform Statewide Building Code \(USBC\)](#) explained in the [Code of Virginia](#).
- **Virginia Department of Education.** The Virginia Department of Education is responsible for ensuring that the building meets the [Guidelines for School Facilities in Virginia's Public Schools](#).
- **Fire Marshal.** The local or state fire marshal establishes regulations requiring local inspections with regard to fire hazards. Local building inspectors are responsible for the local inspections and for approving school buildings within their municipality.
- **Building Requirements.** The school plant and accessory buildings should be maintained in good repair and in a clean sanitary condition. In the absence of more stringent applicable construction codes or related standards, the most current edition of the [Virginia Uniform Statewide Building Code: 2015 Virginia Construction Code \(USBC, Part I\)](#) should be used as a guideline for the construction or alteration of school buildings. (Note: For information on maintenance standards, refer to the [2015 Virginia Maintenance Code \(USBC, Part III\)](#)).

Subsections

The following subsections highlight building and environmental standards that may be of particular interest to schools.

- [Safety and Security](#)
- [Hazard Communication Standards](#)
- [School Nutrition Programs](#)
- [Indoor Air Quality](#)
- [Asbestos](#)
- [Radon](#)
- [Lead](#)
- [Underground Storage Tanks in Schools](#)
- [Pesticides](#)
- [Toxic Art Supplies](#)

Safety and Security

Authorization

[Code of Virginia, Section 22.1-279.8, School Safety Audits and School Crisis, Emergency Management, and Medical Emergency Response Plans Required](#)

Excerpt:

Each local school board shall require all schools under its supervisory control to annually conduct school safety audits as defined in this section and consistent with such list.

"School safety audit" means a written assessment of the safety conditions in each public school to (i) identify and, if necessary, develop solutions for physical safety concerns, including building security issues and (ii) identify and evaluate any patterns of student safety concerns occurring on school property or at school-sponsored events. Solutions and responses shall include recommendations for structural adjustments, changes in school safety procedures, and revisions to the school board's standards for student conduct.

School Safety Audit. Beginning in 2005, the Virginia Center for School and Campus Safety (VCSCS) has been tasked with collecting, analyzing, and disseminating various school safety data. To complete this task, the VCSCS developed five components to incorporate into the school safety audit. Each component of the safety audit was developed to provide schools with extensive knowledge about their schools' environment and safety.

1. [Virginia School Safety Survey](#). An annual, web-based survey, which assesses school safety conditions in all public, K-12 schools. The division Superintendent must review these surveys annually and certify the review to the VCSCS.
2. **Division Level Survey.** In addition to the annual school survey, every three years, or as needed, school divisions around the Commonwealth are also surveyed on division level policy changes and practices.
3. [Virginia Crisis Management Plan Review and Certification](#). By August 31st of each year, school division Superintendents are required to certify to the VCSCS that their school board has reviewed the written school crisis, emergency management, and medical emergency response plans for each school it supervises. Additionally, schools must provide a copy of said plans to the local chief law enforcement officer, local fire chief, local chief emergency medical services official, and local emergency management official.
4. [Virginia Secondary School Climate Survey](#). The VCSCS, in partnership with the University of Virginia's Curry School of Education, and the Virginia Department of Education survey students and staff in Virginia regarding the climate of their schools. Alternating between

grades 7 and 8 and grades 9-12, the survey provides schools with a report detailing their student and staff perception of rules and discipline, student-staff relationships, student engagement, and the extent of bullying and teasing at school.

5. [School Safety Inspection Checklist](#). Each school division Superintendent must certify to the VCSCS that all schools in their division have completed a Safety Inspection Checklist every three years.

Additionally, there are several other requirements placed upon Virginia schools to ensure a safe environment.

- [Safety Audit Committee](#). Each division Superintendent must establish a committee, including representatives of parents, teachers, law enforcement, emergency services, community services boards, and judicial and public safety personnel, to review all components of the safety audit and submit any needed plans for improving school safety to the Superintendent and local school board.
- [Emergency Manager](#). Every school division in Virginia must designate an emergency manager. The Emergency Manager position has the potential to be an important partner to first responders and to be instrumental in maintaining school safety. Suggested responsibilities for the position include, but are not limited to, assisting in the evaluation, implementation, and coordination of physical security improvements, communicating with local law enforcement and school personnel in monitoring and surveying local security needs, ensuring the sharing of safety and emergency plans, etc.
- [Threat Assessment Teams](#). Local school boards in Virginia must establish policies and procedures for the establishment of threat assessment teams. In addition, the school division superintendent must establish a threat assessment team for each school in the division (a team may serve more than one school). The team provides guidance to students, faculty, and staff regarding the recognition of threatening or aberrant behavior that may result in a threat to the community, identify members of the school community to whom threatening behavior will be reported, and implement the policies established by the school board. In addition, the team must also report to the Superintendent upon a preliminary determination that an individual poses a threat of violence to themselves or others.
- [Lock-down Drills](#). Every school in Virginia must conduct two lock-down drills per school year.

Overview

As crime rates rise, an increasing number of school divisions are incorporating environmental crime prevention features in the design of new buildings. In addition, school divisions are trying to redesign existing architecture to reflect the principles of environmental crime prevention. Traditionally, security concerns have been given a low priority in the building process. Until the late 1960s, when the federal government took an interest in crime prevention in urban housing,

few serious attempts were made to develop a workable philosophy for controlling crime through architectural planning and design. In the early 1970s, several studies financed through the Law Enforcement Assistance Administration and the Department of Housing and Urban Development demonstrated that architectural design could be used effectively to influence crime rates in housing developments. These studies showed that by combining security hardware, psychology, and site design, a physical environment could be developed that would, by its very nature, discourage crime.

Crime Prevention Through Environmental Design (CPTED) in Schools

Crime Prevention Through Environmental Design. Crime Prevention Through Environmental Design, or CPTED (pronounced “sep-ted”), creates a defensive environment both from a physical and a psychological aspect. The goal of CPTED is the reduction of opportunities for crime to occur. This reduction is achieved by employing physical design features that discourage crime, while at the same time encouraging legitimate use of the environment. The features include defensible space, surveillance, lighting, and landscaping, which offer protection without resorting to the prison camp approach to security.

CPTED strategies are often linked with other community-based crime prevention strategies, such as problem-oriented policing, which emphasizes tailoring crime prevention strategies to solve specific problems. As with other types of community-based crime prevention programs, CPTED is made up of multiple elements or approaches and can be used by various stakeholders within and outside of the criminal justice system. CPTED strategies address quality of life issues by attempting to deter criminal activity, increase overall safety for citizens, and reduce citizen fear of crime.

Recommendations

Every school shall conduct an annual school safety audit. One particular aspect of the annual school safety audit that addresses the importance of CPTED strategies is the [School Safety Inspection Checklist](#). The *2016 School Safety Inspection Checklist for Virginia Public Schools*¹⁴¹ is built upon the knowledge and training of crime prevention experts using criminal behaviors and fields of science included in the philosophy of Crime Prevention Through Environmental Design (CPTED). Each school or school system should recognize their own unique challenges and address priorities accordingly. Recommendations for Best Practices included in this document are general in nature. The unique construction, access and egress of the school being examined, must be taken into account to ensure compliance with all applicable fire statutes and other building codes. It is with this concern in mind that [§22.1-279.8](#) was amended to mandate that schools establish a school safety audit committee which includes representatives from various emergency services disciplines.

The purpose of this checklist is to identify vulnerabilities and offer a foundation upon which to build a safer learning environment. The recommendations contained in this report are intended to reduce the opportunity for crime and related problems. Should any of the recommendations be in conflict with the Fire Protection Code or other ordinances and codes, the *Code of Virginia* shall take precedence.

As part of the school safety inspection, personnel should gather crime statistics on all reported school incidents available from their local law enforcement agency for analysis. School discipline data should also be used. This information identifies areas of vulnerability in planning, classroom assignment and location, allows for examination of causative factors, and guides the development of possible solutions. Trends or patterns of crime can be included in the team's report. Areas included in the inspection-¹⁴¹

- Exterior
- Traffic and Parking Lot Safety
- Interior

Resources

For additional information, contact the [Virginia Department of Education, Division & School Safety](#).

Hazard Communication

Authorization

Virginia Occupational Safety and Health (VOSH) Standards for Hazard Communication, 1910.1200. The VOSH Standards for Hazard Communication requires employers to maintain and implement a written hazard communications policy if hazardous chemicals are used or stored. This standard was adopted from the Federal OSHA Standard ([29 CFR part 1910](#)) as Virginia Law.

[Hazard Communication: Small Entity Compliance Guide for Employers That Use Hazardous Materials](#). In addition, revisions to the Hazard Communications Standards (HCS) by the Occupational Health and Safety Administration (OSHA) became effective January 1, 2013 and were adopted by VOSH.

Overview

The purpose of the hazard communication standards is to ensure that the hazards of all chemicals produced or imported are evaluated and that information concerning their hazards is transmitted to employers and employees so they can recognize the hazards of chemicals used and stored and undertake appropriate protective measures. Such chemicals may include, but are not limited to, those used in science laboratories and vocational educational centers.

Recommendations

OSHA identified six steps employers that have hazardous chemicals in the workplace should take when implementing a hazard communication program. The information is summarized below, see [OSHA Fact Sheet: Steps to an Effective Hazard Communication Program for Employers That Use Hazardous Chemicals](#) for detailed descriptions.¹⁴²

1. Learn the Standard/Identify Responsible Staff.
 - a. Obtain a copy of OSHA's Hazard Communication Standard.
 - b. Become familiar with its provisions.
 - c. Make sure that someone has primary responsibility for coordinating implementation.
 - d. Identify staff for particular activities (e.g., training). It is important that you become familiar with these provisions to determine what is needed for compliance in your workplace. In order to ensure that you have an effective hazard communication program, and address all of the necessary components, responsibility for implementation of hazard communication should be assigned to someone to coordinate.

2. Prepare and Implement a Written Hazard Communication Program
 - a. Prepare a written plan to indicate how hazard communication will be addressed in your facility.
 - b. Prepare a list or inventory of all hazardous chemicals in the workplace. The written program must indicate how you will address the requirements of paragraphs (f) labels and other forms of warning; (g) safety data sheets (SDS); and (h) employee information and training, in your workplace. The written program also requires employers to maintain a list of the hazardous chemicals known to be present in the workplace. Using the product identifier (e.g., product name, common name, or chemical name) to prepare the list will make it easier for you to track the status of SDSs and labels of a particular hazardous chemical. Remember, the product identifier must be the same name that appears on the label and SDS of the hazardous chemical.
3. Ensure Containers are Labeled
 - a. Keep labels on shipped containers.
 - b. Label workplace containers where required. Chemical manufacturers and importers are required to provide labels on shipped containers with the following information: product identifier, signal word, pictograms, hazard statements, precautionary statements, and the name, address and phone number of the responsible party. Therefore, when an employer receives a hazardous chemical from a supplier, all of this information will be located together on the label; however, additional information may also appear. As the employer, you are required to ensure that containers in the workplace are labeled. Any container of hazardous chemicals in the workplace must at a minimum include the product identifier and general information concerning the hazards of the chemical.
4. Maintain Safety Data Sheets (SDSs)
 - a. Maintain safety data sheets for each hazardous chemical in the workplace.
 - b. Ensure that safety data sheets are readily accessible to employees. Safety data sheets are the source of detailed information on a particular hazardous chemical. Employers must maintain copies of SDSs for all hazardous chemicals present in their workplaces. If you do not receive an SDS from your supplier automatically, you must request one. You also must ensure that SDSs are readily accessible to workers when they are in their work areas during their work shifts. If SDSs are supplied electronically, there must be an adequate back-up system in place in the event of a power outage, equipment failure, or other emergency involving the primary electronic system. In addition, the employer must ensure that workers are trained on how to use the system to access SDSs and are able to obtain hard copies of the SDSs. In the event of a medical emergency, hard copy SDSs must be immediately available to medical personnel.

5. Inform and Train Employees

- a. Train employees on the hazardous chemicals in their work area before initial assignment, and when new hazards are introduced.
- b. Include the requirements of the standard, hazards of chemicals, appropriate protective measures, and where and how to obtain additional information. Paragraph (h) of the HCS requires that employers train employees on the hazardous chemicals in their work area before their initial assignment and when new hazards are introduced into the work area, and this training must be conducted in a manner and language that employees can understand. Workers must understand they are exposed to hazardous chemicals. They must know that labels and safety data sheets can provide them with information on the hazards of a chemical, and these items should be consulted when needed. In addition, workers must have a general understanding of what information is provided on labels and SDSs, and how to access them. They must also be aware of the protective measures available in their workplace, how to use or implement these measures, and whom they should contact if an issue arises.

6. Evaluate and Reassess Your Program

- a. Review your hazard communication program periodically to make sure that it is still working and meeting its objectives.
- b. Revise your program as appropriate to address changed conditions in the workplace (e.g., new chemicals, new hazards, etc.). Although the HCS does not require you to evaluate and reassess your hazard communication program, it must remain current and relevant for you and your employees.

Resources

- U.S. Department of Labor
- [Occupational Safety & Health Administration: Hazard Communication](#): Provides guidance on regulations and enforcement related to safety communication in the workplace. Information on labeling and safety data sheets is available along with statistics, training, and publications.
- For more information, contact the [Virginia Department of Labor and Industry \(VDOLI\)](#) or the VDOLI regional field offices:
 - [Abingdon Field Office](#)
Abingdon, Virginia
Phone: (276) 676-5465

- [Central Region](#)
Richmond, Virginia
Phone: (804) 371-3104
- [Lynchburg Field Office](#)
Lynchburg, Virginia
Phone: (434) 385-0806
- [Main Street Centre](#)
Richmond, Virginia
Phone: (804) 371-2327
- [Northern Virginia Region](#)
Manassas, Virginia
Phone: (703) 392-0900
- [Southwest Region](#)
Roanoke, Virginia
Phone: (540) 562-3580
- [Tidewater Region](#)
Norfolk, Virginia
Phone: (757) 455-0891
- [Verona Field Office](#)
Verona, Virginia
Phone: (540) 248-9280

School Nutrition Programs

Authorization

Regulations. All food operations must be conducted in accordance with the requirements of the [Virginia Regulations Governing Restaurants](#), which are promulgated by the Virginia Department of Health.

Health Department. The local health department provides oversight through periodic, unannounced inspections.

Overview

Many foods are ideal media for the growth of microorganisms, including pathogenic bacteria. Contamination with pathogenic bacteria combined with mishandling or temperature abuse will result in infectious levels of bacteria or toxin production and subsequent foodborne illness outbreaks. Food sanitation is particularly important in a school food service program, since the food is usually prepared to be served to a large number of students at one time.

Food service operations in the schools of the Commonwealth must be carried out in a manner that will prevent the occurrence of food-borne illness, a major public health issue. Using basic principles of food protection, suitable equipment, and sanitary food practices can reduce the incidence of such illness. Food may be prepared at the school or off-site and transported to the school. Nutrition and food services in the schools are provided by the Virginia Department of Education, [Office of School Nutrition Programs](#).

Guidelines for Food Service Personnel ¹⁴³

Food Service Personnel. Food service personnel must be in good physical health and be free of symptoms of communicable diseases (see the [Virginia Reportable Disease List](#)), open or infected cuts, burns, sores, or skin conditions that may contribute to the contamination of food. The food service manager should be able to recognize such conditions in the staff and exclude them from working in direct contact with food.

Training. Training of food service personnel is not required but is offered by the local health department and local cooperative extension agencies.

Hand Washing. Food service personnel must have clean hands at all times and should not wear rings or other jewelry on their hands. Hands must be washed with soap and hot running water after using the toilet, coughing, sneezing, using a handkerchief, handling any object that may contaminate food, and between other operational functions and before returning to food preparation or handling functions.

Guidelines for Food Handling.

- Fingers should be kept out of the mouth and away from the hair, face, and nose.
- Workers must not eat or drink or use tobacco products in food areas.
- Plastic gloves are primarily suited for a continual food handling function.
- If used, workers must change gloves when switching from one operation to another.
- The use of gloves is not a substitute for proper hand washing.
- When food service workers change from a nonfood handling function to a food-handling function or from handling raw foods, they must still wash their hands before using gloves.
- Foodservice workers must also wear clean clothes and keep their hair secured with a hairnet, hat, or fastener.

Food Preparation and Storage

Ensuring Proper Food Temperature. Adequate equipment must be provided and maintained to ensure proper temperatures for food during storage, preparation, and service, as well as for the sanitation of dishware, tableware, and utensils. There must be a sufficient number of thermometers to monitor these temperatures constantly, and there must be test kits for monitoring the strength of the required sanitizing agents.

Food Transportation and Storage. If food is transported from one facility to another, adequate holding temperatures must be maintained at all times. Potentially hazardous foods must be either below 42°F or above 134° F at all times. The schools must have the facilities to maintain appropriate temperatures during storage, transportation, and service. It is important that the food and the food establishment be protected from contamination by insects and rodents, by the use of screens and other protective devices.

Resources

- Virginia Department of Health
 - [Food and General Environmental Services](#): Programs include food safety, milk safety, bedding & upholstery, childhood lead prevention, campground regulation and hotel & pool surveillance. Information is provided on each of these programs as well as links to additional resources.
- For additional information, please contact the [local health department](#).

Indoor Air Quality

Authorization

[Code of Virginia, Section 15.2-2824, Prohibitions on smoking generally; penalty for violation](#)

Excerpt: Prohibitions on smoking generally; penalty for violation. Prohibits smoking as follows:

in (ii) public school buses; (iii) the interior of any public elementary, intermediate, and secondary school; (iv) hospital emergency rooms; (v) local or district health departments; (vi) polling rooms; (vii) indoor service lines and cashier lines; (viii) public restrooms in any building owned or leased by the Commonwealth or any agency thereof; (ix) the interior of a child day center licensed pursuant to [§ 63.2-1701](#) that is not also used for residential purposes; however, this prohibition shall not apply to any area of a building not utilized by a child day center, unless otherwise prohibited by this chapter; and (x) public restrooms of health care facilities.

Overview ¹⁴⁴

Most people are aware that outdoor air pollution can damage their health, but many do not know that indoor air pollution can also cause harm. Studies by the Environmental Protection Agency (EPA) on human exposure to air pollutants indicate that indoor levels of pollutants may be 2 to 5 times, and occasionally more than 100 times, higher than outdoor levels. These levels of indoor air pollutants are of particular concern because it is estimated that most people spend about 90 percent of their time indoors. Comparative risk studies performed by EPA and its Science Advisory Board have consistently ranked indoor air pollution among the top five environmental risks to the public.

Consequences of Indoor Air Problems.¹⁴⁵ Failure to prevent indoor air problems, or failure to act promptly, can have such consequences as:

- Impact student and staff learning environment, attendance, comfort, and performance. Reduce productivity of teachers, staff, and students due to discomfort, sickness, or absenteeism.
- Faster deterioration and reduced efficiency of the school's physical plant and equipment. Increase the chance that schools will have to be closed due to high incidence of illness.
- An unplanned, costly, temporary move for affected occupants may be required.
- Straining relationships among school administration, parents, and staff.
- Create negative publicity that could damage a school's or administration's reputation and effectiveness.
- Impact community trust.

- Create liability problems.

Indoor air problems can be subtle and do not always produce easily recognized impacts on health, well-being of occupants, or the deterioration of the physical plant. Symptoms, such as headache, fatigue, shortness of breath, sinus congestion, coughing, sneezing, dizziness, nausea, and irritation of the eye, nose, throat and skin, are not necessarily due to air quality deficiencies, but may also be caused by other factors - poor lighting, stress, noise, and more. Due to varying sensitivities among school occupants, IAQ problems may affect a group of people or just one individual, and may affect people in different ways. The smaller bodies of children require increased rate of respiration, therefore the toxic load is increased in young children. For these reasons, proper maintenance of indoor air is more than a quality issue – it includes safety and good management of our investment in the students, staff, and facilities.

With regards to IAQ, there are aspects that are unique to schools. Unlike other buildings, managing schools involves the combined responsibility for public funds and child safety issues. These can instigate strong reactions from concerned parents and the general community. Issues to consider include:

- Occupants are close together, with the typical school having approximately four times as many occupants as office buildings for the same amount of floor space.
- Budgets are tight, with maintenance often receiving the largest cut during budget reductions.
- The presence of a variety of pollutant sources, including art and science supplies, industrial and vocational arts, home economic classes, and gyms.
- A large number of heating, ventilating, and air-conditioning equipment place an added strain on maintenance staff.
- Concentrated diesel exhaust exposure due to school buses. (Students, staff, and vehicles congregate at the same places at the same time of day, increasing exposure to vehicle emissions.) Long, daily school bus rides may contribute to elevated exposure to diesel exhaust for many students.
- As schools add space, the operation and maintenance of each addition are often different.
- Schools sometimes use rooms, portable classrooms, or buildings that were not originally designed to service the unique requirements of schools.

Factors Affecting Indoor Air Quality (IAQ)¹⁴⁵

Over the past 40 or 50 years, exposure to indoor air pollutants has increased due to a variety of factors, including the construction of more tightly sealed buildings, reduced ventilation rates to save energy, the use of synthetic building materials and furnishings, and the unrestricted use of chemically-formulated personal care products, pesticides, and housekeeping supplies, including air fresheners. During this time, the number of children with asthma has increased, and these children, along with adults in the school buildings suffering from asthma and respiratory conditions, are more vulnerable to the factors affecting IAQ. In addition, such decisions as delaying maintenance to save money can lead to problems from sources and ventilation. There are three factors that should be considered with respect to indoor air quality:

- Temperature and humidity.
- Sources of indoor air pollutants.
- Airflow patterns and ventilation.

Temperature and Humidity. Dry, hot air in winter removes moisture from skin and mucous membranes. Closing of windows to outside air increases the bacterial and viral load in a poorly ventilated room. In summer, hot and humid air prevents a person's body from cooling off - the body tends to react by overheating. Stagnant, humid air in closed rooms causes all types of mold to flourish.

Although specific temperatures are not mandated by regulation in Virginia, it is recommended that heating and cooling systems be properly maintained and capable of providing room temperatures recommended by the local school division. The building or room occupants should be able to control the temperature in accordance with weather and occupancy changes.

Sources of Indoor Air Pollutants.¹⁴⁵ Indoor air contaminants can begin within the building or be drawn in from outdoors. If pollutant sources are not controlled IAQ problems can occur, even if the HVAC system is working properly. Air pollutants consist of numerous particles, fibers, mists, molds, bacteria, gases, pollen, and animal dander. In addition to the number of potential pollutants, indoor air pollutant levels can vary within the school building or even a single classroom. Pollutants can also vary with time, such as only once each week when floor stripping is done, or be continuous, such as when fungi are growing in the HVAC system.

The typical sources of indoor air pollutants are outlined in the table below:

OUTDOOR SOURCES	BUILDING EQUIPMENT	COMPONENTS/ FURNISHINGS	OTHER POTENTIAL INDOOR SOURCES
<p>Polluted Outdoor Air</p> <ul style="list-style-type: none"> • Pollen, dust, mold spores • Industrial emissions • Vehicle and non-road engine emissions (cars, buses, trucks, lawn and garden equipment) <p>Nearby Sources</p> <ul style="list-style-type: none"> • Loading docks • Odors from dumpsters • Unsanitary debris or building exhausts near outdoor air intakes <p>Underground Sources</p> <ul style="list-style-type: none"> • Radon • Pesticides • Leakage from underground storage tanks 	<p>HVAC Equipment</p> <ul style="list-style-type: none"> • Mold growth in drip pans, ductwork, coils, and humidifiers • Improper venting of combustion products • Dust or debris in ductwork <p>Non-HVAC Equipment</p> <ul style="list-style-type: none"> • Emissions from office equipment (volatile organic compounds (VOCs) and ozone) • Emissions from shop, lab, and cleaning equipment 	<p>Components</p> <ul style="list-style-type: none"> • Mold growth on or in soiled or water-damaged materials • Dry drain traps that allow the passage of sewer gas • Materials containing VOCs, inorganic compounds, or damaged asbestos • Materials that produce particles (dust) <p>Furnishings</p> <ul style="list-style-type: none"> • Emissions from new furnishings and floorings • Mold growth on or in soiled or water-damaged furnishings 	<ul style="list-style-type: none"> • Science laboratory supplies • Vocational art supplies • Copy/print areas • Food prep areas • Smoking lounges • Cleaning materials • Emissions from trash • Pesticides • Odors and VOCs from paint, chalk, adhesives • Occupants with communicable diseases • Dry-erase markers and similar pens • Insects and other pests • Personal care products • Stored gasoline and lawn and garden equipment

Airflow Patterns and Ventilation.¹⁴⁵ Airflow patterns in buildings are caused by mechanical ventilation systems, human activity, and natural effects, such as wind. Air pressure differences created by these forces move airborne pollutants from areas of higher pressure to areas of lower pressure through any available openings in building walls, ceilings, floors, doors, windows, and HVAC systems.

An inflated balloon is an example of this driving force. As long as the opening to the balloon is kept shut, no air will flow, but when open, air will move from inside (area of higher pressure) to the outside (area of lower pressure). Even if the opening is small, air will move until the pressures inside and outside are equal.

Determining if There is an IAQ Problem

Diagnosing symptoms that relate to IAQ can be difficult. Acute (short-term) symptoms of IAQ problems typically are vague and similar to those from colds, allergies, fatigue, or influenza. There are clues, however, that can serve as indicators of potential indoor air problems:

- The symptoms are widespread within a class or within the school, potentially indicating a ventilation problem.
- The symptoms disappear when the students or staff leave the school building for the day.
- The onset is sudden after some change at school, such as painting or pesticide application.
- Persons with allergies, asthma, or chemical sensitivities have reactions indoors but not outdoors.
- A doctor has diagnosed a student or staff member as having an indoor air-related illness.

All of these symptoms, however, may also be caused by other factors and are not necessarily due to air quality problems. Such environmental stressors as improper lighting, noise, vibration, overcrowding, and psychosocial problems (such as job or home stress) can produce symptoms that are similar to those associated with poor air quality but require different solutions.

However, a lack of symptoms does not mean that the quality of the air within the school is acceptable. Symptoms from long-term health effects, such as lung cancer due to radon, may not be present for many years. For this reason, schools should establish a preventive indoor air program to minimize exposure of students and staff to indoor air pollutants.

Technical Solutions for IAQ Management

The following seven areas are identified by the [EPA's Indoor Air Quality Tools for Schools](#) as the most common issues that schools need to address to effectively manage IAQ risks.

Provide Quality HVAC.

- Inspect HVAC systems regularly and establish a maintenance plan.
- Change filters regularly and ensure condensate pans are draining.
- Provide outdoor air ventilation according to [ASHRAE Standard 62.1-2010](#) or local codes.
- Clean air supply diffusers, return registers and outside air intakes.
- Keep unit ventilators clear of books, papers and other items.
- Use the [Ventilation Checklist](#) from the *IAQ Tools for Schools Action Kit*.
- Garbage receptacles or bags must not be placed in rooms where HVAC equipment is located.

Control Moisture and Mold.

- Conduct routine moisture inspections.
- Establish a mold prevention and remediation plan.
- Maintain indoor humidity levels between 30 and 60 percent.
- Address moisture problems promptly. Dry wet areas within 24 to 48 hours.
- Review EPA's [Mold Remediation in Schools and Large Buildings](#) to learn about mold growth in schools and how it can be managed.

Integrated Pest Management (IPM).

- Inspect and monitor school environments for pests.
- Establish an IPM plan.
- Use spot treatments and baits rather than broad pesticide applications.
- Communicate with occupants prior to pesticide use.
- Mark indoor and outdoor areas treated with pesticides.
- Use the [IPM Checklist](#) from the *IAQ Tools for Schools Action Kit*.

Cleaning and Maintenance.

- Conduct routine inspections of school environments.
- Develop a preventive maintenance plan.
- Train cleaning and maintenance staff on IAQ protocols.
- Clean all mechanical ventilation equipment with appropriate materials on a regular schedule.
- Ensure [Safety Data Sheets \(SDSs\)](#), are available to all staff.
- Clean and remove dust with a damp cloth.
- Vacuum using high-efficiency filters.
- Limit use of room deodorizers.
- Remove furniture or screens that block the intended airflow.
- Set up specific guidance for reporting all leaks, water, or storm damage.

Smart Materials Selection.

- Maintain products inventory.
- Develop [low-emitting products](#) purchasing and use policies.
- Use only [formaldehyde-free](#) materials.
- Use only low-toxicity and low-emitting paint.
- Select products based on product rating systems.
- Use the least toxic cleaners possible — only those approved by the school district.

Aggressive Source Control.

- Conduct regular building walkthrough inspections and use the EPA's [Background Information for Walkthrough Inspection Checklist](#) and [Walkthrough Inspection Checklist](#).
- Test for radon and mitigate as necessary. Refer to the [IAQ Reference Guide, Appendix G - Radon](#) for specific information.
- Implement a hazardous materials plan that addresses use, labeling, storage and disposal.
- Establish a [school chemical management and inventory plan](#).
- Implement comprehensive tobacco-free school policies.

- Establish an [Idling Reduction Campaign](#).
- Use walk-off mats at building entrances.
- Conduct pollutant-releasing activities when school is unoccupied.

Energy Efficiency.

- Integrate Energy Management Solutions.
- Protect IAQ during energy efficiency upgrades and building renovations.
- Conduct regular HVAC maintenance and tune-ups.
- Install programmable thermostats.
- Consider performing post-construction commissioning for HVAC systems.
- Control moisture in building assemblies, mechanical systems and occupied spaces.

Resources

- Environmental Protection Agency
 - [IAQ in Schools](#): A resource dedicated to improving air quality in schools. Includes framework for interventions, tools for assessment, tips on remediation of issues, prevention strategies, building guidelines, and education tools for school personnel.
 - [The IAQ Tools for Schools Action Kit](#)
- Additional information on IAQ is available by contacting the Regional EPA office or by calling (800) 438-4318.
- Occupational Safety and Health Administration
 - [Indoor Air Quality](#): Provides workers and employers useful, up-to-date information to identify, correct, and prevent IAQ problems. A special section on specifically addressing schools is included.

Asbestos

Authorization

Asbestos Hazard Emergency Response Act. In 1986, the U.S. Congress passed the [Asbestos Hazard Emergency Response Act \(AHERA\)](#) to protect school children and school employees from exposure to asbestos in school buildings, which was most recently updated in 2009. The AHERA rule requires public school districts and private not-for-profit schools to inspect all school buildings for asbestos, to develop plans to manage asbestos in schools, and to carry out the rules in a timely fashion. Schools are required to inform parents and staff about the presence of asbestos in the school. A copy of the survey report must be available both at the School Board's administrative offices and in each school identifying the location of asbestos containing materials in the school.¹⁴⁶ OSHA standards mandate training and specific work practices for any school employees who disturb asbestos or perform housekeeping in schools that have asbestos present.

Asbestos Coordinator. In Virginia and nationally, the asbestos coordinator in each school division ensures that AHERA is properly carried out. The Virginia Department of Professional and Occupational Regulation (DPOR) sets standards for state accreditation of personnel involved in asbestos management or abatement in school buildings.¹⁴² The Virginia Department of Labor and Industry (DOLI) enforces the OSHA standards that govern work with asbestos.

Asbestos Licensing Board. Inspectors and other designated asbestos professionals must be licensed by the Board for Asbestos, Lead, and Home Inspectors within the DPOR.

Overview

Description. Asbestos is a mineral found in certain types of rock formation. It takes the form of small fibers that are usually invisible to the naked eye. Because the fibers are so small and light, they can remain in the air for many hours if they are released from asbestos-containing material, increasing the danger of being inhaled.¹⁴⁷

Asbestos Containing Materials. EPA estimates there are asbestos-containing materials in most of the nation's primary, secondary and charter schools. Asbestos is most commonly used in schools as insulation and in building materials. It has also been used in floor and ceiling tile, cement asbestos pipe, corrugated paper pipe wrap, acoustical and decorative insulation, pipe and boiler insulation, and spray-applied fireproofing.¹⁴⁷

Health Risk. Intact and undisturbed asbestos materials generally do not pose a health risk. However, asbestos fibers can cause serious health problems when, due to damage or deterioration over time (e.g., cracking, tearing, or crumbling), they release harmful fibers. If the fibers become airborne and are inhaled, they can disrupt normal lung function, and lead to diseases such as asbestosis, lung cancer, and mesothelioma. These diseases do not develop

immediately after inhalation of asbestos fibers - it may be twenty years or more before symptoms become apparent. The more asbestos fibers a person inhales, the greater the risk is of developing an asbestos-related disease.¹⁴⁷

Resources

- The Code of Federal Regulations related to asbestos-containing materials in schools; asbestos worker protection; and prohibition of the manufacture of certain asbestos products can be found via the [EPA](#).
- For more information, contact the school division's Asbestos Coordinator local or the Director of Facilities at: [Virginia Department of Education Facilities Construction & Maintenance](#).

Radon

Authorization

[Code of Virginia, Section 22.1-138 B, Minimum Standards for Public School Buildings](#)

Overview

Description.¹⁴⁸ Radon is a naturally occurring radioactive gas that seeps into buildings from the surrounding soil and, in some cases, accumulates in ground water that supplies wells. The primary source of harmful exposure to radon is from breathing air that contains elevated levels of radon gas. The risk from radon in water is the result of breathing radon released into the air due to household water use, such as showering. A person cannot see, taste, or smell radon. In fact, the only way to discover if high levels of radon are present is through testing.

Risks Associated with Radon.¹⁴⁸ Radon gas decays into radioactive particles that can be trapped in a person's lungs when a person breathes. As these particles break down, they release small bursts of energy. This can damage lung tissue and lead to lung cancer over the course of a person's lifetime. An individual's risk of getting lung cancer from radon depends mostly on three factors: (1) the level of radon, (2) the duration of exposure, and (3) their smoking habits.

EPA. The U.S. Environmental Protection Agency (EPA) and other major national and international scientific organizations have concluded that radon is a human carcinogen and a serious environmental health problem. Indoor radon is second only to smoking as the leading cause of lung cancer, causing approximately 21,000 lung cancer deaths a year in the United States, about 700 of which are estimated to occur in Virginia.¹⁴⁹

A nationwide survey of radon levels in schools surmises that approximately one in five has at least one classroom with a short-term radon level above the action level of 4pCi/L (picocuries per liter)-the level at which EPA recommends schools take action to reduce the radon level.¹⁴⁸

Recommendations

School Testing for Radon. Testing for radon is simple and relatively inexpensive. The EPA has published guidance that is available free to schools¹⁴⁸, and the [Virginia Department of Health Office of Radiological Health](#) is available to provide technical guidance and advice to school personnel on radon testing and mitigation (see Resources below). The basic elements of testing are:¹⁴⁸

- Test all frequently used rooms on and below the ground level.
- Conduct tests in the cooler months of the year.
- Follow the testing and mitigation standards for schools.

If a school identifies elevated radiation levels, the problem can be corrected. Proven techniques are available that will lower radon levels and lower risks of lung cancer from radon exposure.¹⁴⁸

Resources

For more information, visit the websites listed below.

- Virginia Department of Health
 - [Office of Radiological Health](#): The Office of Radiological Health Program is responsible for protecting the public health and safety from unnecessary radiation from a diversity of sources that spans a wide spectrum of applications in the healing arts, research and educational institutions, and industry. The regulation and emergency response involving sources of radiation require a staff with multi-disciplinary skills and extensive training.
- United States Environmental Protection Agency
 - [EPA/Radon Hotlines and Information Resources](#): Search frequently asked questions or submit your own question. The database also provides information on any of our topic areas, for example, Asthma, IAQ Tools for Schools, Mold, Smoke-free Homes, IAQ Design Tools for Schools, and General Indoor Air Quality Issues.
 - [Radon: Publications and Resources](#): A listing of available publications and resources to provide additional information on radon for parents, students, families, educators, and school personnel.
 - [Radon in Schools](#)

Lead

Authorization

No mandates for school inspections.

Overview

Risks.¹⁵⁰ Lead in the school environment may pose a health threat to children up to 6 years of age. Once in the body, lead is very slow to leave the system. It can damage the brain and central nervous system of children, interfering permanently with their learning abilities and physical growth. Children are at high risk because their brain cells are still developing, and even low levels of lead can interfere with normal brain development. There is no safe level of lead for children.¹⁵¹

Sources of Lead.¹⁵¹ School officials should be concerned about the existence of lead in paint, dust, air, water, soil, and food. Additional sources of lead include art activities such as stained glass and pottery, some cosmetics and folk medicine, some children's toys and learning tools, some artificial turf, as well as emissions from industrial processes in auto shops and technical training centers.

LEAD-BASED PAINT

Overview.¹⁵⁰ Lead-based paint was banned for use in residences and child-care facilities in 1978. Since it was not banned for steel structures, some steel structural components in schools constructed after 1978 may contain lead-based paint if they were delivered to the school construction site pre-painted.

Recommendations.¹⁵⁰

- Primary concern should be to identify and remediate or abate any lead-based paint exposure hazards from areas of the school occupied by children under age 6.
- Document all areas where lead-based paint exists so that future renovation and remodeling work can be planned with appropriate precautions to avoid scraping, burning, or open dry-sanding of lead-based paint. Only Virginia Department of Professional and Occupational Regulation (DPOR) licensed certified lead-based paint risk assessors, and abatement contractors, or EPA certified renovation, repair and painting contractors shall be utilized for these activities.

Resources. For more information, contact the [Virginia Department of Professional and Occupational Regulation](#) at (804) 367-8500.

SOIL

Overview.¹⁵¹ Lead occurs naturally in soil, which also collects lead from the air and other sources. Soil near roads and parking lots may be high in lead content due to a settling of particulates from the years of leaded gasoline exhaust emissions, old buildings where deteriorated paint contaminates the soil, as well as industrial sources such as lead battery factories.

Recommendations

- Steps should be taken to avoid direct exposure of children aged 6 or under to soil contaminated with lead.
- Bare soil areas of playgrounds use by preschoolers should be tested and covered if found to exceed the EPA recommended level of 400 parts per million.¹⁵² Appropriate coverings include mulch, sand, or a cultivated grass cover to reduce exposure to bare soil.
- Children should always wash their hands after playing outside and especially before eating.

PLAYGROUND EQUIPMENT

Overview. Testing by the [U.S. Consumer Product Safety Commission](#) and some state and local jurisdictions has shown that school, park, and community playgrounds across the country may have playground equipment that presents a potential lead-paint poisoning hazard for young children aged 6 and under. The equipment was painted with lead paint and, over time, the paint has deteriorated into chips and dust containing lead. Young children who put their hands on the equipment while playing and then put their hands in their mouths can ingest the lead paint chips and dust. Older playgrounds with lead-based paints should be identified and a strategy to control lead paint exposure should be developed. Playground managers should consult the October 1996 report, CPSC Staff Recommendations for Identifying and Controlling Lead Paint on Public Playground Equipment, while ensuring that all paints and other similar finishes meet the current CPSC regulation.¹⁵³

Recommendations. Please refer to the [U. S. Consumer Product Safety Commission Public Playground Safety Handbook](#) for additional information and management recommendations.

WATER

Overview. Lead is rarely found in source water, but enters tap water through corrosion of plumbing materials. Although drinking water is rarely the sole cause of lead poisoning, it can increase a person's total lead exposure. Lead dissolved in water cannot be seen, tasted, or smelled.¹⁵⁴

Schools built before 1986 were more likely to have lead in their plumbing. Lead is no longer used in plumbing; however, it can still get into drinking water from old water pipes that contain lead, and until January 2014, small amounts of lead were allowed in plumbing fixtures.¹⁵¹ Because lead concentrations can change as water moves through a distribution system, the best way to know if a school or child care facility might have high levels of lead in its drinking water is by testing the water in that school or child care facility. Testing facilitates an evaluation of the plumbing and helps target remediation. It is a key first step in understanding the problem, if there is one, and designing an appropriate response.¹⁵⁵

Recommendations.¹⁵⁶ The United States Environmental Protection Agency Office of Ground Water and Drinking Water manual, [*3Ts for Reducing Lead in Drinking Water in Schools and Child Care Facilities*](#), serves as a resource to assist schools and child care facilities to implement a voluntary program for reducing lead in drinking water. Three key steps in this approach include:

- **Training-** school and child care officials to raise awareness of the 3Ts program and summarize the potential causes and health effects of lead in drinking water.
- **Testing-** drinking water in schools and child care facilities to identify potential lead problems.
- **Taking Action-** to reduce lead in drinking water.

“There is no federal law requiring testing of drinking water in schools and child care facilities, except for schools and child care facilities that own and/or operate their own public water supply and are thus regulated under the Safe Drinking Water Act (SDWA). Some states, tribes, and local jurisdictions have established their own laws, regulations, or guidance for testing drinking water lead levels in schools and/or child care facilities. School and child care facilities should reach out to their state to find out what laws or regulations may apply to them.”¹⁵⁶

Resources

- United States Environmental Protection Agency (EPA) Office of Ground Water and Drinking Water- [*3Ts for Reducing Lead in Drinking Water in Schools and Child Care Facilities*](#)
- [Safe Drinking Water Act \(SDWA\)](#)
- Virginia Department of Health Office of Drinking Water
 - [Schools and Child Care Facilities](#)

LEAD SCREENING

Childhood lead poisoning is preventable. Virginia performs “targeted” testing per CDC recommendations, as all children are not at high-risk for lead poisoning. The Virginia Department of Health provides guidance for testing Virginia children for lead exposure. [Virginia Guidelines](#). All children enrolled in Medicaid are required to be tested at 1 and 2 years of age. To determine if screening is necessary based on risk factors for other children, follow the guidelines below.¹⁵⁷

Other Risk Factors for Children. A careful history regarding possible lead exposure should be taken at each routine visit. Blood lead levels shall be obtained in children at ages 1 and 2 if they meet ANY one of the criteria noted in the box below. In addition, children ages 3-5 years of age who have not previously been tested, and meet ANY one of the following criteria or experienced a change since testing that has resulted in an increased risk shall also be tested:

- Eligible for or receiving benefits from Medicaid or WIC?
- Living in or regularly visiting a house or day care center facility built before 1960.
- Living in or regularly visiting a house built before 1978 with peeling or chipping paint or recent (within the last 6 months), ongoing or planned renovation.
- Living with or regularly visiting housing in which one or more persons have evidence of lead exposure.
- Living with an adult whose job or hobby involves exposure to lead.
- Living near an active lead smelter, battery recycling plant, or other industry likely to release lead.
- The child’s parent or guardian requests the child’s blood be tested due to any suspected exposure.
- Recent refugee, immigrant, or child adopted from outside of the U.S.

Resources

- [Centers for Disease Control and Protection: Lead](#): A national resource on current data and statistics concerning lead/lead exposure, tools and training, prevention tips, and the lead poisoning prevention program.
- [Environmental Protection Agency: Ground Water and Drinking Water](#): Provides fact sheets, consumer and regulatory information, as well as local resources related to lead and lead exposure.

- [Lead-Safe Virginia Program](#) Virginia Department of Health, Office of Environmental Health: Provides resources on safe practices with lead, prevention tips, testing guidelines for children, and links to additional publications, materials, and resources.
- [EPA National Lead Information Center](#): provides the general public and professionals with information about lead, hazards, and prevention. Information is available on health issues for family, renovations and repairs, screening, testing for lead, and laws and regulations.

Underground Storage Tanks in Schools

Authorization

While there is no law specific to underground storage tanks in schools, users of this manual should contact the Virginia Department of Environmental Quality and their local building and fire officials for related laws and regulations.

Overview

Underground storage tanks containing heating oil or motor fuels may become an environmental concern. Such tanks, many of which are old and often made of steel, could have rusted and could leak their contents into the ground.¹⁵⁸ Many school districts that operate school buses own underground storage tanks for gasoline and diesel. Therefore, any leak or spill can create a serious problem and become an environmental hazard.

Recommendations

The safety of these underground storage tanks is dependent on their age and condition. The [Virginia Department of Environmental Quality](#) (804-698-4000) and the local code officials (building/fire) should be called if tanks become an environmental problem.

Pesticides

Authorization

U.S. Environmental Protection Agency (EPA). All pesticides legally sold in the United States must bear an EPA registration number on the front of the product label to show that they are registered. There are very few exceptions to this rule.

Virginia Department of Agriculture and Consumer Services. Only a pesticide applicator who is certified through the Virginia Department of Agriculture and Consumer Services, Office of Pesticide Services is allowed to apply any pesticide on school grounds, even those sold over the counter. In addition, any pesticide business applying pesticides commercially in Virginia must possess a valid Pesticide Business License. Finally, all pesticides sold or used in Virginia must be registered with the Virginia Department of Agriculture and Consumer Services.

Overview

If pests increase, they may threaten the health of people or cause damage to property. In this situation, pest management may be required. Pests may be managed or controlled by various means. Preventive measures include reducing and eliminating hiding or nesting places and food sources available to pests. It would also include efforts to exclude the pest. Pesticides are powerful tools for controlling pests. However, pesticides need to be used carefully and judiciously as one part of an integrated approach to control pests. They are placed into the environment or a site with the purpose of controlling a specific pest.

Recommendations

Pest Management.¹⁵⁹ Pest management in schools should be conducted as part of an integrated pest management (IPM) program. This includes the coordinated use of pest and environmental information with available pest management methods to prevent unacceptable levels of pest damage by the most economical means and with the least possible hazard to people, property, and the environment. A successful IPM program requires not only a skilled and knowledgeable pest management professional, but also the cooperation of building managers and occupants. Both the EPA and the state encourage IPM in schools. For further information, visit [Virginia Cooperative Extension](#) or [EPA's IPM in Schools](#).

Storage and Use.¹⁶⁰

- All pesticides must be stored in locked storage areas that are accessible only to authorized personnel.
- All pesticides must be used in accordance with registered label directions.
- Instructions on the safe and proper use of these chemicals should be clearly posted.

Resources

- Virginia Department of Agriculture and Consumer Services
 - [Office of Pesticide Services](#): This program certifies applicators, registers pesticide products and licenses pesticide businesses. These activities provide for the safe and effective control of pests that attack our crops, structures and health and that of our domestic animals. With regards to school and health, information is available regarding programs, laws and regulations, resources, and serves as a source of updated information directly from the EPA on the topic.
- [Virginia School IPM Program](#): A program developed by Virginia Tech to assist schools with an Integrated Pest Management program. Information is provided on techniques of IPM, policies, Virginia laws, and programs within Virginia, as well as links to additional resources. Contact Dr. Dini Miller, Department of Entomology, Virginia Tech for additional information.
- U.S. Environmental Protection Agency
 - [Office of Pesticide Programs: Links are provided to information on specific pests and pesticides as well as educational resources, and detailed discussion on specific topics.](#)

Toxic Art Supplies

Authorization

[Code of Virginia, Section 22.1-274.1 Criteria to Identify Toxic Art Materials; Labeling; Use in Certain Grades Prohibited.](#)

Excerpt:

The State Department of Education, in cooperation with the State Department of Health, shall develop criteria to identify toxic art materials.

After these criteria have been developed, the Department of Education shall require school divisions to evaluate all art materials used in schools and identify those which are toxic. All materials used in the public schools which meet the criteria as toxic shall be so labeled and the use of such materials shall be prohibited in kindergarten through grade five.

Regulation. [Virginia Administrative Code, Title 8 – Education, Agency 20 - State Board of Education, Chapter 530 - Regulations Governing Criteria to Identify Toxic Art Materials; Labeling; Use in Elementary Grades Prohibited.](#)

Excerpt: 8VAC20-530-10. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

“Art material” means any raw or processed material or manufactured product marketed or represented by the manufacturer or repackager, as suitable for use in demonstration or the creation of any work of visual or graphic art of any medium.

Visual or graphic art techniques employing art mediums may include, but should not be limited to, ceramics, drawing, enamels, glass, jewelry, leather, painting, photography, plastic sculpture, sculpture, stained glass, and textile goods.

Art materials shall include, but not be limited to acrylic paints, adhesives, chalks, charcoal, clays, crayons, drawing inks, drawing pencils, enamel colors, fabric dyes, felt tip markers, finger paints, fixatives, glazes, glues, lacquers, modeling materials, oils, oil paints, oil pastels, pastes, pastels, printing inks, screen printing inks, shellacs, silver solder, solvents, spray paints, tempera paints, varnishes, and watercolors.

The term does not include economic poisons subject to the Federal Insecticide, Fungicide and Rodenticide Act (7 USC §136 et seq.), or drugs, devices, or cosmetic subject to the Federal Food, Drug, and Cosmetic Act (21 USC §301 et seq.).

Art Materials Labeling Act. In October 1988, the U.S. Congress passed § 1277. Labeling of Hazardous Materials Act (Use with Children Under Age 12 Prohibited) Public Law 100-695, 15 U.S.C. that requires warning labels on art materials with chronic long-term health hazards. The law mandates a voluntary standard, ASTM D-4236¹⁶¹ as a mandatory labeling standard for art and craft materials.

Summary. The ASTM D-4236 standard requires labels for all art and craft materials determined to present a chronic health hazard. These products include solvents, spray paints, silk-screen inks, adhesives, and any other substance marked or represented as suitable for use in any phase of the creation of any work of visual or graphic art of any medium. The labels must provide:

1. A warning statement of the hazard.
2. Identification of the hazard.
3. Guidelines for safe use.

Under this standard, art material producers or repackers, including importers, must submit to the U.S. Consumer Product Safety Commission a written description of the criteria used to determine whether products can produce long-term health effects. While only hazardous art materials are required to have safety labeling, all art materials will have the statement “Conforms to ASTM D-4236,” “Conforms to ASTM Practice D-4236,” or “Conforms to health requirements of ASTM D-4236.” Products must be evaluated by a toxicologist at least every five years.

Note: Art educators are responsible for the art materials they order and the safe use thereof. Although there is no legislation prohibiting students older than age 12 from using toxic agents, there is the Hazard Communication Standard, VOSH 1910.1200, which addresses potentially hazardous materials in the workplace. (See previous section on Hazard Communication Standard.) All art educators in the field should have training in the usage, storage and disposal of each toxic agent they come in contact with while working.

Health Issues Related to Children Using Art Supplies ¹⁶²

Art and craft supplies can contain toxic ingredients that, when used or stored in a play area, create a risk to the health and well-being of children. Lead, asbestos and organic solvents are sometimes used to enhance pigmentation, preserve art products, and to improve application. These toxic ingredients can trigger asthma, allergies, headaches and nausea, especially if used in a poorly ventilated area. Research has shown that some inks, adhesives, pigments and clay may contain chemicals that can cause adverse health effects in adults after occupational exposures. While no studies have shown these negative health effects to occur in children with their limited exposures, care is needed if these supplies are used.

Children are uniquely vulnerable; it is important to purchase and use supplies that are certified as nontoxic. In addition, young children are more likely to have contact with products on skin, hair, mouth and eyes; as such, children in grade six and lower should only use non-toxic art and craft materials. Adult supervision is always recommended when young children are using any type art supplies.

How Are Children Exposed?

Inhalation: The dusts and vapors from art and craft materials can be inhaled and can damage developing lungs.

Ingestion: Children are especially vulnerable to ingesting chemicals from art supplies as they regularly put their hands into their mouths.

Skin Contact: Children tend to get art and craft materials on their skin during their creative play. Chemicals in art supplies can be irritating to the skin. Also, children's skin is more permeable than that of adults. Therefore, it is important to wash these products off children's skin immediately after use.

Recommendations ¹⁶²¹⁶²

Safe Guidelines for Using Art Supplies. Safe guidelines for using art supplies are listed below.

Tips for Safer Art & Crafts:

1. Use only non-toxic art supplies.
2. Read labels and identify precautions.
3. Keep the workspace ventilated with open windows and fans, or work outside.
4. Do not allow children to eat or drink while using art and craft materials.
5. Ensure children wear protective smocks and wash their hands thoroughly after using art and craft supplies.
6. Be sure children are closely supervised when using household supplies as art materials to avoid ingestion/improper use (e.g., liquid starch, shaving cream).

Products to Avoid:

1. Solvent Based Products (markers, oil-based paints and cements) may be extremely flammable and release toxic vapors.
2. Products that contain lead and other heavy metals (some paints, glazes and enamels).
3. Products that can be inhaled, or get into children's eyes, such as: clay in dry form, powdered paints, wheat paste, and aerosols (spray paint, hair spray).
4. Commercial Dyes.
5. Products that are not in original container or without proper labeling (including donated items).
6. Instant Papier-mâché (may contain asbestos fibers, lead or other metals from colored printing ink).
7. Permanent felt tip markers or scented markers (hazardous if inhaled or ingested).

Resources

- [Children's Environmental Health Network](#): Fact sheet providing information on safety and health with regarding to art supplies. Discussing exposure, safety, and product avoidance and offers links to additional resources.
- [Environmental Protection Agency, Teacher's Classroom Checklist: Fact sheet and checklist for teachers \(and other school personnel\) regarding the important areas to consider for maintaining a healthy classroom and good air quality.](#)
- For further information, contact the following:
Cherry Gardner, Principal Specialist of Fine Arts
Virginia Department of Education
Cherry.Gardner@doe.virginia.gov

Chapter 22: Laboratory, Industrial, and Vocational Hazards

Overview

Provisions should be made for the protection of students engaging in industrial arts, physical sciences, vocational education, or in any activities where hazardous chemicals, hazardous devices, or hazardous equipment are used. These provisions should include:

- The development and posting of operating instructions.
- The development and posting of regulations.
- The development and posting of procedures.
- A comprehensive safety program addressing issues that range from dangerous exposure to hot water and broken glassware to toxic exposures and fire.

Subsections

The following subsections provide information on specific safety regulations and recommendations associated with educational courses involving industrial, vocational, or laboratory activities.

- [Facilities](#)
- [Ventilation](#)
- [Equipment and Supplies](#)
- [Storage and Handling of Toxic or Hazardous Materials](#)

Facilities

Authorization

[Code of Virginia, Section 22.1-275, Protective Eye Devices](#)

Recommendations

Safety rules specific to the activities conducted in each laboratory classroom (academic and vocational), including proper attire and the use of personal safety equipment, should be posted and enforced. A list of possible issues to consider is listed below:

- Adequate bench space with necessary utilities should be provided. Class size should be small enough to allow proper supervision.
- Protective eye devices must be worn by all students participating in, observing, or in close proximity to any experiment or activity that could result in eye injury. Eye-protection glasses, goggles, face shields, and similar eye-protection devices should be issued clean and properly sanitized and stored in a protected place.
- An easily accessible, fire blanket should be provided in each laboratory or other areas where an open flame is used.
- Where there is exposure to skin contamination with poisonous, infectious or irritating materials, a hand washing facility should be available.
- An easily accessible, operational eyewash fountain should be provided in each laboratory or other areas where corrosives or irritating chemicals are used. The eyewash fountain should be clean and must be tested annually. The use of portable eyewash bottles as substitutes should not be permitted.
- An easily accessible, operational safety shower, capable of providing continuous flowing water, should be provided for each laboratory or other areas where corrosive or irritating chemicals are used. The safety shower can be centrally located to serve more than one area if doors are not locked and prompt access is available.
- Electrical equipment should be properly grounded and inspected regularly.
- Master gas valves and electrical shut-off switches should be provided in each laboratory or areas where power equipment is used. Electrical shut-off switches are not permitted to be located in fuse boxes.

Ventilation

Authorization

Threshold Limit Values and Biological Exposures Indices. All areas should be adequately ventilated so that exposures to hazardous or toxic materials are maintained at a safe level. In absence of more stringent guidelines, the most recent edition of the American Conference of Governmental Industrial Hygienists' publication [Threshold Limit Values and Biological Exposures Indices](#) should be used as a guide to determine safe levels.

Standards. Discharges from any exhaust hood should meet applicable *Virginia Air Pollution Standards*.

Recommendations.

- Local exhaust ventilation should be provided so that contaminants are carried away from the students and not through the breathing zone.
- Sufficient fume hood capacity ventilation should be used for any activity producing hazardous toxic or noxious gases, mists, vapors, or dusts.
- Hoods should exhaust directly to the outside and should be located a minimum of 10 feet from any building air-intakes or building openings.
- Fume hoods should be kept free of storage and routinely inspected and maintained.
- A minimum face velocity of 100 feet/minute for general laboratory hoods should be provided.
- Airflow of fume hoods should be tested at least once per school year.

Resources

There are varying suggestions and guidelines available regarding ventilation and fume hood testing. Specific questions should be directed to the local building/facilities coordinator and manufacturer.

Equipment and Supplies

Authorization

No specific regulations.

Recommendations

- Instructional, athletic, recreational, or other equipment used in or out of the classroom should be maintained in a clean¹⁶³ and safe condition.
- Toys and equipment should meet applicable state and local regulations.
- Gym equipment should be kept clean and in good repair.¹⁶³ Body contact equipment surfaces should be routinely cleaned with a sanitizer approved by the local school division.
- Equipment used in physical therapy and special education should be cleaned¹⁶³ after it is used.
- Facilities should be available for the proper storage of clean clothing and athletic, instructional, and recreational equipment and supplies to minimize health hazards and to facilitate cleaning.
- Cleaning materials, tools, and maintenance equipment should be provided and should be stored safely and secured in a locked area.
- Glassware should be properly constructed and designed for its intended use and should be handled and stored safely.
- Aspirators or suction bulbs should be used for drawing liquids into pipettes. The mouth should not be used directly on the pipettes.

Storage and Handling of Toxic or Hazardous Materials

Authorization

[National Fire Protection Association Codes & Standards](#). National Fire Protection Association Codes and Standards should be used as guidelines for the proper storage, handling, and use of chemicals in the school. Where refrigerators are used to store flammable compounds, they must be explosion proof.

Recommendations

- Toxic or hazardous materials should be stored in approved laboratory containers, separated by reactive group, and stored in a ventilated, locked, fire-resistant area or cabinet. (Note: The ventilation recommendations listed in the previous subsection, “Ventilation,” may not be called for where minimum quantities of such materials are stored for daily use.)
- Chemical storage should be based on ensuring that incompatible chemicals are not stored in proximity of one another. Some chemicals should be stored in a separate place from others. For example, strong oxidizers should not be stored in the same cabinet as flammable/combustible liquids. Strong caustics should not be stored in the same place as acids.
- Containers of chemicals, poisons, corrosive substances, and flammable liquids should be clearly labeled with the name of the material and the date the material entered the school. Exposure to noise or toxic liquids, dusts, gases, mists, vapors, or other hazards should be controlled to avoid health hazards.
- All chemicals, solvents, and hazardous substances should be inventoried by the school a minimum of once a year. The inventory should include the name of the compound, the amount, and the date it entered the school. Chemicals should be ordered in quantities only large enough for short-term needs.
- A current material safety data sheet should be provided for all poisonous, toxic, or hazardous substances and should be available for review upon request.
- A written plan for response to and cleanup of chemical spills should be provided by the school.
- A written plan that explains the proper storage, handling, and disposal procedures for all poisonous, toxic, or hazardous substances should be on file in each school and should be available for review upon request.
- A list of first aid procedures for accidental poisoning should be posted. The telephone number and location of the nearest poison control center should be posted near each telephone and is located under the “Poisonings/Chemical, Biological, Radiologic, Nuclear, or Explosive Events” tab in the *First Aid Guide for Child Care and School*

Emergencies, Virginia Department of Health (the flipbook should be kept in the school nurse's office or school health room). All incidents should be reported according to local policy.

- Pesticides and toxic or hazardous cleaning and maintenance chemicals and materials should be stored separately in a ventilated and locked cabinet or in an area accessible only to authorized personnel. The ventilation recommendation of this section may not be recommended in areas where minimum quantities of the above-mentioned materials are stored for daily use. Flammable or combustible materials should be stored in accordance with the most recent edition of the *National Fire Protection Association 30 Flammable and Combustible Liquids Code* (available from the National Fire Protection Association listed below).
- The storage, preparation, and consumption of food and drink are prohibited in any area where there are poisonous, toxic, or hazardous substances.

Resources

- For more information, contact the [National Fire Protection Association](#). This is a resource for information on fire safety, codes and standards, and training that can be utilized when developing a school safety plan or a plan for an individual student or classroom, or when issues related to fire and building safety come into question.
- Please also refer to the earlier subsection, Hazard Communication, for additional information.

Chapter 23: Health and Safety Recommendations

Overview

This section presents information on possible environmental concerns or risk areas in the school environment. Material is presented on guidelines for assessing or reducing the environmental risks in the identified areas.

Subsections

The following subsections highlight areas identified as high-risk areas or areas of concern:

- [Playground Safety](#)
- [Toilets, Lavatories, Drinking Fountains, and Bathing Facilities](#)
- [Animals in School](#)
- [Lighting](#)
- [Swimming Pools/Therapy Pools](#)
- [School Maintenance and Sanitation](#)
- [Sewage Disposal](#)
- [Refuse Disposal](#)
- [Recycling](#)

Playground Safety

Authorization

See local regulations.

Overview

The United States Consumer Product Safety Commission (2015)¹⁵³ reported that each year about 200,000 children are treated in U.S. hospital emergency rooms for playground equipment-related injuries. Most of the injuries are the result of falls, primarily falls to the ground below the equipment, but falls from one piece of equipment to another are also reported. The majority of the deaths are due to strangulation or falls.

Recommendations

Because of the injuries noted above, the U.S. Consumer Product Safety Commission (CPSC) provides specific recommendations in their [Public Playground Safety Handbook](#) to address the hazards that result in playground-related injuries and death. The following content is included in the handbook:

- Overview of playground injuries
- Types of surfaces for playgrounds
- Layout and design of playgrounds
- Selecting playground equipment
- Installation and maintenance of equipment
- Playground hazards
- Guidelines for platforms, guardrails, and protective barriers
- Guidelines for specific playground equipment, such as see saws and slides

Resources

- U.S. Consumer Product Safety Commission - Provides information for the public on current product recalls, safety education, regulations and laws, and educational programs.
 - [Recent Recalls](#)
 - Consumer Product Safety Hotline (800) 638-2772 or (301) 595-7054 (TTY)

Toilets, Lavatories, Drinking Fountains, and Bathing Facilities

Authorization¹⁶⁴

The Virginia Uniform Statewide Building Code regulates the general health, safety, and welfare of building occupants of public educational facilities in Virginia. Public school sites and buildings, new or renovated, as well as all educational programs, activities, or services offered at school facilities must meet the federal Americans with Disabilities Act (ADA). While the building code addresses life safety design issues, it does not offer any design guidance to school planners and educators as to how to meet their educational program needs. It is the responsibility of the local school board to determine school facility needs in the form of an architectural program.

Recommendations¹⁶⁴

The [Virginia Public School Facilities Guidelines](#) are intended to provide more detailed guidance for the planning and design of local public school facilities. The recommendations contained in the optional *Virginia Public School Facilities Guidelines* should be considered as a useful tool when planning school facilities projects. These guidelines include the following topic areas:

- Drinking Water Fountains/Coolers
- Health Unit/Health Service Facilities
- Showers
- Toilets and Lavatories
- Water Temperature

Resources

- Virginia Department of Education [Virginia Public School Facilities Guidelines](#)
- Virginia Department of Health, Office of Environmental Health Services
 - [Division of Onsite Sewage and Water Services](#): The mission of the Onsite Sewage and Water Services is to protect public health and ground water quality. Information can be found regarding new developments, regulations, and policy decisions with regarding to water quality, treatment, and wastewater.
- [Virginia Uniform Statewide Building Code](#)

Animals in School

Authorization

[Code of Virginia § 51.5-44. Rights of persons with disabilities in public places and places of public accommodation.](#)

The Virginia Department of Education provides the [Guidelines for School Division Policy and Procedures Regarding Service Animals in Virginia's Public Schools](#) to assist local school divisions as they consider issues related to service animals access.

Recommendations

- Animals used for instructional purposes should be maintained in a sanitary condition and in a manner to prevent health hazards or nuisance conditions and to conform to local school policy.
- The practice of keeping animals in schools is discouraged because of potential allergies, bites, and spread of disease.
- Animals kept at school must be adequately immunized, fed, sheltered, and kept clean. They are prohibited from food storage, preparation, service, and dining areas.
- Do not permit turtles, parrots, raccoons, bats, or wildlife known to carry rabies or other diseases.
- Be sure that no child in a class is allergic to animals.
- Animal areas must be cleaned frequently.
- Wash hands after handling or cleaning. Children who assist with pet cleaning and maintenance must learn proper hand washing procedures.
- Pest control/management should be a part of an integrated pest management program to maintain the facility free from vermin. Refer to the section on Pesticides, in Chapter 21, for additional information.

For information on rabies, please refer to Part VII, Chapter 32, *Selected Infectious Diseases*. For information on animal bites, reference the Virginia Department of Health "*First Aid Guide for Child Care and School Emergencies*".

Resources

- Virginia Department of Education-[Guidelines for School Division Policy and Procedures Regarding Service Animals in Virginia's Public Schools](#)

Lighting

Authorization

No specific regulations.

Overview

The provision of adequate interior and exterior school lighting is primarily the responsibility of illuminating engineers and architects. However, the administrator, classroom teachers, and the health staff must understand the basic principles of lighting in order to use available facilities properly and recommend change when needed. The administrator should not permit the standards to decline in the name of economics or energy savings.

Recommendations

While quantity of light is important, the quality of light is even more significant, as demonstrated in extensive research. In order to supply suitable light to all working surfaces for efficiency and comfort, the following items should be considered.

Control of Bright and Dark Areas. There should be control of both bright and dark areas to avoid glare. This is best accomplished by diffusion or light coming from many directions rather than a single source, whether artificial or natural. In addition, the reflective surfaces of desks, walls, woodwork, and so forth should be considered. The adverse effects of glare are cumulative. For a short time, glare is annoying—with prolonged exposure, a person becomes progressively fatigued and may develop eyestrain and headaches.

Room Colors. Room colors greatly influence the effectiveness of a lighting system. Color and texture determine how much light is reflected. Room colors also contribute to a variety of psychological reactions and have been described as, for example, warm, cool, neutral, or depressing.

Lighting Recommendations.¹⁶⁴ The electrical lighting system should be capable of the following minimum illumination levels given in footcandles (FC): 60-70 FC for science labs, kitchens; 55-60 FC for classrooms, media center, business, and studio; 30 to 50 FC for offices, and gymnasiums; 30 FC for computer labs; 20-40 FC for dining rooms; 10-30 FC for auditoriums; and 10-15 FC for corridors, and lobbies. Light level intensities should be measured at the task level or 30 inches from the floor.

Determination of Appropriate Lighting. Illumination deteriorates rapidly unless windows are kept clean and wall and ceiling surfaces are well maintained. As light bulbs are used, they blacken and give off less light. Dirt and dust reduce the reflecting and transmitting qualities of

lighting units. To help determine whether a classroom is appropriately lighted, the following questions should be answered.

- Is the room free from sharp shadows?
- Is it possible to exclude sunlight by adjustment of shades or blinds?
- Are walls, desktops, and chalkboards free from bright reflections?
- Are all lamps shielded so that bright light does not shine in the eyes?

Resources

Virginia Department of Education [Guidelines for School Facilities in Virginia Public Schools](#)

Swimming Pools/Therapy Pools

Authorization

12VAC5-462. Swimming Pool Regulations Governing the Posting of Water Quality Results

Excerpt:

This chapter has been promulgated by the State Board of Health to:

- 1.) Ensure that owners or operators of all public swimming pools post daily water quality test results and water quality standards so that users are informed of pool conditions that affect the public health, welfare, and safety.*
- 2.) Guide the owner or his agent in the requirements necessary to ensure safe pool maintenance including pH level, disinfectant type and concentration level, and water temperature.*
- 3.) Establish the recommended standards for the safe and sanitary maintenance of public swimming pools including the safe levels for: pH, chlorine, bromine, and water temperature for spas.*

Recommendations

Applies to structure, basin chamber, or tank located indoors or outdoors containing and artificial body of water intended to be used for swimming, wading, diving, or recreational bathing including spas and hot tubs, and having a water depth of 24 inches or more at any point.¹⁶⁵

- Test results and water quality standards shall be posted in a location where it is readily observable by users of the swimming facility.¹⁶⁶
- The test results and water quality standards shall be posted on durable waterproof material.¹⁶⁶
- The owner is responsible for meeting the requirements set forth in this chapter.¹⁶⁶
- The water quality tests shall be performed and posted at least once daily and as often as necessary to maintain the standards as set forth in this chapter. When more than one test is conducted during an operating day, the most recent test results shall be posted.¹⁶⁶
- Reference [12VAC5-462-290. Water Quality Standards](#), for recommendations on monitoring appropriate ranges of free chlorine and bromine residuals and pH values and temperature in pools and spas.

- Test kits for the measurement of all required chemistry parameters in this chapter shall be provided and maintained at each public swimming pool. The test kits shall be capable of measuring the disinfectant residuals accurately to within 0.5 ppm.¹⁶⁷

Resources

- Virginia Department of Health, Office of Environmental Health Services
 - [Division of Onsite Sewage and Water Services](#): The mission of the Onsite Sewage and Water Services is to protect public health and ground water quality. Information can be found regarding new developments, regulations, and policy decisions with regarding to water quality, treatment, and wastewater.
 - [Pool and Water Safety](#): Offers guidance and tips on safety in the pool and near the water for children and adults. Provides links to resources on drowning prevention and water safety advisories.
- Additional information and policies can be found through the local health department's Office of Environmental Health Services.

School Maintenance and Sanitation

Authorization

No specific regulations.

Overview

Cleanliness is an extremely important aspect of a healthful school environment. Proper sanitation consists of maintaining the building free of those conditions that could lead to the transmission of disease. Each area of the school has its own particular cleaning and disinfectant needs.

Recommendations

- Each school should develop a written policy and plan for the cleaning and sanitizing of each area and assign the responsibility for carrying out the plan to a specific person in the school.
- The least expensive and highly effective sanitizing agent is chlorine bleach. Deodorizers should not be used as they only mask the problem. Chlorine bleach used to sanitize food contact surfaces, equipment, and utensils must be EPA approved for food service sanitation. The container of approved chlorine will have specific labeling for food establishment use and an EPA registration number.
- There must be adequate housekeeping and maintenance equipment and cleaning supplies, and equipment should be appropriate for the task it is intended to do. For instance, a vacuum cleaner should have adequate capacity and be powerful enough to clean rugs. Vacuum cleaners must also have proper filters to eliminate the dust and other small particles from being expelled from the equipment. The equipment must be kept clean, in good working condition, and be stored safely. All cleaning supplies and toxic materials must be kept in containers that are properly labeled with their contents. In food areas, cleaners, sanitizers and toxic materials must be stored away from food items.

Sewage Disposal

Authorization

Regulations. In all new schools utilizing onsite sewage systems and schools modifying or expanding existing onsite sewage systems, an application must be submitted to the Virginia Department of Health in accordance with the [Sewage Handling and Disposal Regulations](#) or [Sewage Collection and Treatment Regulations](#). Contact information for the Virginia Department of Health (VDH), Division of Onsite Sewage and Water Services, and the Department of Environmental Quality (DEQ) are listed below.

Recommendations

Facilities. Facilities approved by the Virginia Department of Health must be provided and maintained for the treatment and sanitary disposal of sewage. Where a public sewer system is available, all plumbing fixtures and all building sewer lines must be connected thereto. If a public sewer system is not available, an onsite sewage disposal system meeting the requirements of the Virginia Department of Health must be provided and all plumbing fixtures and building sewer lines must be connected thereto.

Interruption of Service. Where a total interruption of sewer service occurs over an extended period of time, the school should be closed unless dismissal of the pupils would be detrimental to their physical well-being, or unless approved alternatives for the sanitary disposal of sewage are available.

Resources

For more information, please use the following contacts:

- Virginia Department of Health, Office of Environmental Health Services
 - [Division of Onsite Sewage and Water Services](#): The mission of the Onsite Sewage and Water Services is to protect public health and ground water quality. Information can be found regarding new developments, regulations, and policy decisions with regarding to water quality, treatment, and wastewater.
- [Virginia Department of Environmental Quality](#): Serves as a resource for state laws and regulations pertaining to the school and surrounding environments. DEQ's Office of Public Information and Outreach works closely with the Virginia Department of Education to provide information, professional development and curricula.
 - Program Engineer - [Jaimini \(Jimmy\) Desai, P.E.](#)
- Additional information can be found through the [local health department](#).

Refuse Disposal

Authorization

No specific regulations.

Overview

The storage, collection, transportation, and disposal of refuse should be conducted to control odors, insects, rodents, communicable disease, accidents, or other nuisance conditions.¹⁶⁸

Recommendations

Containers.¹⁶⁸ Durable, nonabsorbent, cleanable refuse containers should be provided, kept in a clean condition, and placed in readily accessible locations.

Universal Precautions. Use universal precautions when:

- Cleaning up blood and body fluids.
- Disposing of biohazard wastes, such as refuse from the health clinics or from cleaning of blood and body fluids.
- Disposing of all sharp-edged instruments, such as blades from X-Acto craft knives, blades from saws, or needles from hypodermic syringes.

Additional information on universal precautions is available in Part VII, Chapter 31.

Exterior Refuse Storage.¹⁶⁸ Exterior refuse storage areas should be kept in a clean, sanitary condition. Refuse receptacles for exterior storage of garbage or putrescible wastes should be provided with covers. Exterior refuse containers should be stored on a smooth surface on nonabsorbent material, such as concrete or asphalt. Exterior putrescible waste storage areas should be located a minimum of 25 feet from food services areas and classrooms.

Frequency of Removal.¹⁶⁸ Refuse should be removed from the buildings and removed from the premises as often as necessary but not less than twice weekly when putrescible wastes are stored.

Recycling

Authorization

No specific regulations.

Overview ¹⁶⁹

According to the U.S. Environmental Protection Agency (2019), in 2015, Americans generated about 262 million tons of trash and recycled and composted almost 91 million tons of this material, equivalent to a 34.7 percent recycling rate. On average, our individual solid waste generation was 4.48 pounds per person per day.

In 2015, paper and paperboard recycling was about 66.9 percent of 68 million tons of total municipal solid waste (MSW) recycling. Other recycling components included in this breakdown of total MSW recycling (by material) of 68 million tons included: metals (12.1%), glass (4.5%), plastics (4.69%), wood (3.9%), rubber, leather and textiles (5.9%).

Recommendations

Schools can take a leadership role in recycling. School recycling programs can help students learn to respect the environment, become aware of their impact on it, and develop positive attitudes and behaviors. The EPA encourages practices that reduce the amount of waste needing to be disposed of, such as waste prevention, recycling, and composting:¹⁷⁰

- [Source reduction](#), or waste prevention, is designing products to reduce the amount of waste that will later need to be thrown away and also to make the resulting waste less toxic.
- [Recycling](#) is the recovery of useful materials, such as paper, glass, plastic, and metals, from the trash to use to make new products, reducing the amount of virgin raw materials needed.
- [Composting](#) involves collecting organic waste, such as food scraps and yard trimmings, and storing it under conditions designed to help it break down naturally. This resulting compost can then be used as a natural fertilizer.

Resources

- U.S. Environmental Protection Agency
 - [Facts and Figures About Materials, Waste, and Recycling](#)-Overview of Municipal Solid Waste, links to resources for reduction of volume, data and statistics on waste in the United States, and a brief summary of conservation and waste prevention. Links to disposal and combustion regulations are also provided.
- Virginia Department of Environmental Quality
 - [Recycling](#): An overview of recycling in the Commonwealth of Virginia. Provides information on trends and programs and initiatives, as well as links to additional resources.

Several templates and guides are available online regarding starting a recycling program in the schools. Some resources include:

- [Green Education Foundation](#): A non-profit organization committed to creating a sustainable future through education. Sustainability education provides educators with the real-world applied learning models that connect science, technology, and math education with the broader human concerns of environmental, economic, and social systems. Curriculum and educational programs for students, as well as additional resources, are also available.
- [Recycle Works: a Program of San Mateo County](#): Program developed by San Mateo County, California. While much of the information is specific to the county, there is a great deal that can be utilized for program development and implementation, using their site as guidance. Information is provided on recycling at home, school, and in the community, gardening, composting, hazardous waste, and energy efficiency.

Chapter 24: Technology Related Health Concerns

Overview

This section provides information on areas of concern related to technology within the school environment.

Subsections

The following subsections are included:

- [Hazards from Video Display Terminals \(VDTs\)](#)
- [Photocopiers, Mimeograph, Equipment, and Other Machines](#)
- [Radiation Producing Devices](#)

Hazards from Video Display Terminals (VDTs)

Authorization

No specific regulations.

Overview ¹⁷¹

Visual problems such as eyestrain and irritation are among the most frequently reported complaints by VDT operators. These visual symptoms can result from improper lighting, glare from the screen, poor positioning to the screen itself, or copy material that is difficult to read. These problems usually can be corrected by adjusting the physical and environmental setting where the VDT users work. For example, workstations and lighting can and should be arranged to avoid direct and reflected glare anywhere in the field of sight, from the display screen, or surrounding surfaces. Many VDT jobs require long sessions in front of a display screen. Consequently, some people may need corrective lens to avoid eyestrain and headaches. Vision examinations should, therefore, be conducted to ensure early detection and correction of poor vision. Eye care specialists should be informed of computer use by VDT operators. VDT operators also can reduce eyestrain by taking rest breaks, after each hour or so of operating a VDT.

Resources

- American Optometric Association [Computer Vision Syndrome](#)
- United States Department of Labor [Occupational Safety and Health Administration \(OSHA\)](#): A resource for information pertaining to federal regulations on safety and environmental issues in the school setting, as well as issues pertaining to employee safety, training, health requirements. Sections on education and training, and further resources are also available.

Photocopier Equipment and Other Machines

Authorization

No specific regulations.

Recommendations

- The most important health consideration with photocopiers is location. Locating photocopiers in large, well-ventilated areas will reduce possible health concerns. This is especially important if workers have to share space with the photocopier or other machines.
- It is recommended that the glass-plate cover be closed while copying.
- Special attention should be given to the refilling and disposal techniques for toner in dry machines. The warnings on the additives for all machines should be read and followed.

Radiation Producing Devices

Authorization

Virginia Radiation Protection Regulations

Recommendations

Use of x-ray machines and other electronic devices producing ionizing or non-ionizing radiation and radioactive materials and equipment should conform to the most recent edition of the *Virginia Radiation Protection Regulations*, as amended and promulgated by the Virginia Board of Health.

Resources

- Virginia Department of Health
 - [Office of Radiological Health](#): The Office of Radiological Health Program is responsible for protecting the public health and safety from unnecessary radiation from a diversity of sources that spans a wide spectrum of applications in the healing arts, research and educational institutions, and industry. The regulation and emergency response involving sources of radiation require a staff with multi-disciplinary skills and extensive training.

End Notes

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PART VI: AUTHORIZATIONS AND LEGAL REQUIREMENTS

This section serves as a centralized reference to all relevant legal requirements and *Code of Virginia Citations*. External links to all resources are provided for quick access of the most current information.

Chapter 25: [Code of Virginia Citations](#)

Chapter 26: [Special Education Programs for Children with Disabilities](#)

Chapter 27: [CDC Recommended Childhood Immunization Schedule](#)

Chapter 28: [School and Daycare Minimum Immunization Requirements](#)

Chapter 29: [Reportable Diseases in Virginia](#)

Chapter 30: [Blue Ribbon Commission on School Health Survey](#)

Chapter 25: *Code of Virginia* Citations

Searchable Database on the Internet. A searchable database of the *Code of Virginia* is available online via the Virginia General Assembly, [Legislative Information System \(LIS\)](#). To search for a particular law, enter the Code number (example: 22.1-270) or search phrase (example: comprehensive physical examination) into the screen's search window and press submit.

Citations.

[§ 8.01-225. Persons rendering emergency care, obstetrical services exempt from liability.](#)

[§ 15.2-2823. Smoking in public buildings or facilities; exception.](#)

[§ 15.2-2824. Prohibitions on smoking generally; penalty for violation.](#)

[§ 15.2-2826. Designation of "No-Smoking" areas; smoking prohibited in "No-Smoking" areas; penalty for violation.](#)

[§ 15.2-2829. Mandatory provisions of ordinances. \(Related to smoking\)](#)

[§ 15.2-2832. Regulation of smoking; posting of signs.](#)

[§ 22.1-206. Instruction concerning drugs, alcohol, substance abuse, and tobacco and nicotine products.](#)

[§ 22.1-207. Physical and health education.](#)

[§ 22.1-207.1. Family life education.](#)

[§ 22.1-207.3. School breakfast programs.](#)

[§ 22.1-213. Definitions. \(Related to Special Education\)](#)

[§ 22.1-214. Board to prepare special education program for children with disabilities.](#)

[§ 22.1-253.13:2. Standard 2. Instructional, administrative, and support personnel. \(Related to Education Standards of Quality\)](#)

[§ 22.1-270. Preschool physical examinations. \(Related to school physical requirements\)](#)

[§ 22.1-271.1. Definitions. \(Related to immunization requirements\)](#)

§ 22.1-271.2. Immunization requirements.

§ 22.1-271.3. Guidelines for school attendance for children infected with human immunodeficiency virus; school personnel training required; notification of school personnel in certain cases.

§ 22.1-272. Contagious and infectious diseases.

§ 22.1-273. Vision and hearing of student to be tested; exceptions.

§ 22.1-273.1. Annual screening for scoliosis.

§ 22.1-274. School health services.

§ 22.1-274.1. Criteria to identify toxic art materials; labeling; use in certain grades prohibited.

§ 22.1-275. Protective eye devices.

§ 22.1-275.1. School health advisory board.

§ 22.1-279.3:1. Reports of certain acts to school authorities.

§ 22.1-279.8. School safety audits and school crisis, emergency management, and medical emergency response plans required.

§ 32.1-46. Immunization of children against certain diseases.

§ 32.1-47. Exclusion from school of children not immunized.

§ 54.1-2969. Authority to consent to surgical and medical treatment of certain minors.

§ 54.1-3000. Definitions. (Related to Professions and Occupations Regulated by Boards within the Department of Health Professions)

§ 54.1-3005. Specific powers and duties of Board. (Related to Professions and Occupations Regulated by Boards within the Department of Health Professions)

§ 63.2-100. (Effective Until July 1, 2019) Definitions. (Related to Social Services)

§ 63.2-1509. Requirement that certain injuries to children be reported by physicians, nurses, teachers, etc.; penalty for failure to report.

§ 63.2-1510. Complaints by others of certain injuries to children.

§ 63.2-1512. Immunity of person making report, etc., from liability.

§ 63.2-1518. Authority to talk to child or sibling.

§ 63.2-1520. Photographs and X-rays of child; use as evidence.

Chapter 26: Special Education Programs for Children with Disabilities

Information regarding definitions, disabilities, services, can be found in the Virginia Department of Education's [*Regulations Governing Special Education Programs for Children with Disabilities in Virginia*](#).

For information regarding implementation and the role of the school nurse and/or school clinic staff, please refer back to Part III, School Health Services.

Chapter 27: CDC Recommended Childhood Immunization Schedule

Please refer to the Centers for Disease Control and Prevention's [Vaccines & Immunizations](#) for the most current recommendations.

- [Infants and Children, Ages 0-6](#)
- [Preteens and Teens, Ages 7-18](#)

Chapter 28: School and Daycare Minimum Immunization Requirements

Authorization

[Code of Virginia, Section 22.1-271.2, Immunization requirements.](#)

Overview

For minimum immunization requirements for school and daycare entry, consult the [Virginia Department of Health, Division of Immunization](#). Please note that requirements are subject to change.

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations ([Code of Virginia, Section 32.1-46\(a\)](#)).

Children vaccinated in accordance with either the current harmonized schedule or the harmonized catch-up schedules (including meeting all minimum age and interval requirements) are considered to be appropriately immunized for school attendance.

Conditional Enrollment. Any student whose immunizations are incomplete may be admitted conditionally if that student provides documentary proof at the time of enrollment of having received at least one dose of the required immunizations accompanied by a schedule for completion of the required doses within 90 calendar days. If the student requires more than two doses of hepatitis B vaccine, the conditional enrollment period shall be 180 calendar days. The immunization record of each student admitted conditionally shall be reviewed periodically until the required immunizations have been received. Any student admitted conditionally and who fails to comply with his schedule for completion of the required immunizations shall be excluded from school until his immunizations are resumed.

Exemptions. No certificate of immunization shall be required for the admission to school of any student if (i) the student or his parent submits an affidavit to the admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices ([Form CRE-1](#)); or (ii) the school has written certification from a licensed physician, licensed nurse practitioner, or local health department that one or more of the required

immunizations may be detrimental to the student's health, indicating the specific nature and probable duration of the medical condition or circumstance that contraindicates immunization.

However, if a student is a homeless child or youth as defined in subdivision A7 of § [22.1-3](#) and (a) does not have documentary proof of necessary immunizations or has incomplete immunizations and (b) is not exempted from immunization pursuant to clauses (i) or (ii) of this subsection, the school division shall immediately admit such student and shall immediately refer the student to the local school division liaison, as described in the federal McKinney-Vento Homeless Education Assistance Improvements Act of 2001, as amended (42 U.S.C. § 11431 et seq.)(the Act), who shall assist in obtaining the documentary proof of, or completing, immunization and other services required by such Act.

The admitting official of a school shall exclude from the school any student for whom he does not have documentary proof of immunization or notice of exemption pursuant to subsection C, including notice that such student is a homeless child or youth as defined in subdivision A7 of § [22.1-3](#).

If there are questions regarding immunizations, please call your local health department of the Virginia Department of Health, Division of Immunization: 1-800-568-1929 or 804-864-8055 (in state only).

Chapter 29: Reportable Diseases in Virginia

Disease Reporting and Control in Virginia. The Virginia Department of Health's [Regulations for Disease Reporting and Control](#) describe what diseases must be reported to the health department and the methods to use to report, as well as who are required reporters. As noted on the [Virginia Reportable Disease List](#), all suspected and confirmed conditions must be reported within 3 days, except those listed in red, which must be reported immediately by the most rapid means available. Reports may be by computer-generated printout, [Epi-1 form](#), CDC surveillance form, or upon agreement with VDH, by means of secure electronic transmission.

Required Reporters. Individuals and professionals required to report suspected and confirmed infectious diseases in Virginia include:

- Physicians
- Directors of laboratories
- Persons in charge of a medical facility
- Persons in charge of a residential or day program, service, or facility licensed or operated by any agency of the Commonwealth, or a school, child care center, or summer camp
- Local health directors
- Persons in charge of hospitals, nursing facilities or nursing homes, assisted living facilities, and correctional facilities
- Employees, applicants, and persons in charge of food establishments

Excerpts from the [Regulations for Disease Reporting and Control, Commonwealth of Virginia, State Board of Health, November 2018](#)

12 VAC 5-90-90. Those Required to Report.

D. Persons in charge of a residential or day program, service, or facility licensed or operated by any agency of the Commonwealth, or a school, child care center, or summer camp. Any person in charge of a residential or day program, service, or facility licensed or operated by any agency of the Commonwealth, or a school, child care center, or summer camp as defined in §35.1-1 of the Code of Virginia shall report immediately to the local health department the presence or suspected presence in his program, service, facility, school, child care center, or summer camp of persons who have common symptoms suggesting an outbreak situation. Such persons may report additional information, including individual cases of communicable diseases that occur in their facilities. Any person so reporting shall be immune from liability as provided by § 32.1-38 of the Code of Virginia.

Please refer to the Regulations for a description of reporting requirements for physicians, directors of laboratories, persons in charge of a medical facility local health directors, persons in charge of hospitals, nursing facilities or nursing homes, assisted living facilities, and correctional facilities, and employees, applicants, and persons in charge of food establishments.

12VAC5-90-10. Definitions.

- “School” means i) any public school from kindergarten through grade 12 operated under the authority of any locality within the Commonwealth; ii) any private or religious school that offers instruction at any level or grade from kindergarten through grade 12; iii) any private or religious nursery school or preschool, or any private or religious child care center licensed by the Commonwealth.
- “Child care center” means a child day center, child day program, family day home, family day system, or registered family day home as defined by § 63.2-100 of the Code of Virginia, or a similar place providing day care of children by such other name as may be applied.
- “Epidemic” means the occurrence in a community or region of cases of an illness clearly in excess of normal expectancy.
- “Outbreak” means the occurrence of more cases of disease than expected.
- “Foodborne outbreak” means two or more cases of similar illness acquired through the consumption of food contaminated with chemicals or an infectious agent or its toxic products. Such illnesses include but are not limited to heavy metal intoxication, staphylococcal food poisoning, botulism, salmonellosis, shigellosis, *Clostridium perfringens* food poisoning, hepatitis A, and *Escherichia coli* O157:H7 illness.

Confidentiality. The health department protects the confidentiality of the information received, and anyone reporting information to the health department according to the provision of the regulations is immune from liability for so reporting.

For additional questions and information, please review the Regulations or contact your local health department.

Chapter 30: Blue Ribbon Commission Survey

Blue Ribbon Commission Survey

Ratings: For your school health program, please provide success ratings for the goal items provided. Please use the following code to indicate your school's level of success: (3) High, (2) Moderate, or (1) Some to indicate your school's level of success. If your school does not have a program component to address this particular goal, check the (0) not addressed, no program, no service category

Factors: Also for each of the nine programs, consider what factors you feel contribute most to the overall success of your program and what problem factors keep you from accomplishing your goals. The following are examples of success and problem factors.

Success Factors: staff skills, excellent curriculum, excellent planning

Problem factors: not in improvement plan, low priority, inadequate materials

Item No.	I. HEALTH EDUCATION - Health Knowledge, Skill, and Behavior Improvement Areas Addressed by School's Instructional Programs	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
	The school's health instruction program...						
1	Increases physical fitness knowledge and healthful behavior						
2	Increases consumer health knowledge and healthful practices						
3	Increase community and environmental health knowledge and healthful practices						
4	Improves conflict resolution skills						
5	Improves stress management skills						
6	Increase injury prevention knowledge and safe behavior skills						
7	Increases nutrition knowledge and healthful eating behavior						
8	Increases disease prevention and control knowledge and healthful behavior						
9	Increases knowledge of substance use/abuse and healthful behavior						
10	Increases human growth and development knowledge						

Item No.	II. HEALTH SERVICES - The school's health services program...	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
11	Provides for early detection of health problems that can interfere with learning						
12	Provides information to families to facilitate access to primary health care services						
13	Provides expert handling of emergency crisis medical situations						
14	Provides record keeping needed to facilitate timely immunization of students						
15	Provides screenings for identifying student health deficits (e.g., vision, hearing, motor, and speech deficits) to ensure timely linkage to appropriate remediation services						
16	Provides monitoring of communicable diseases to prevent their spread						
17	Provides case management services to address changing health and education needs of students with chronic medical conditions and/or disabilities						

Item No.	III. HEALTHFUL SCHOOL ENVIRONMENT- School Improvement Program School maintenance and improvement efforts ensure...	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
18	Safe physical plant (e.g., toxic substance management, building meets code requirements)						
19	Safe equipment (e.g., classroom and playground equipment)						
20	Safety of school area (e.g., crime prevention efforts, safety practices)						
21	Appropriate physical learning conditions (e.g., temperature, lighting, auditory conditions)						
22	Environment for meeting privacy needs in restrooms and locker rooms						

Item No.	IV. PARENT/COMMUNITY INVOLVEMENT IN SCHOOL HEALTH PROGRAMS - Parent /Community Involvement Activities	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
	School has...						
23	Consistent, proactive approaches for involving parents/families in all student health promotion programs						
24	Effective ways of communicating with parents about student and school health issues						
25	Cooperative ventures between the community and school to ensure health problems do not interfere with learning						
26	Student participation in community projects/programs designed to promote health						
27	Health curriculum support from community agencies and/or organizations						

Item No.	V. SCHOOL COUNSELING PROGRAMS - School Counseling Service Goals	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
	School counseling program...						
28	Helps students identify their educational goals						
29	Helps students identify their career goals						
30	Helps students identify their social goals						
31	Prepares students to function more effectively in the educational communities of their choice						
32	Provides services to help students resolve their developmental problems						

Item No.	VI. PSYCHOLOGICAL AND SOCIAL SERVICES - Psychological and Social Service Linkages	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
	School staff...						
33	Ensure that students showing early signs of social/psychological services are diagnosed						
34	Ensure that special needs students (disabled) have access to appropriate psychological and social services						
35	Ensure that students in crisis are linked with appropriate psychological and social services						
36	Facilitate linkages with case management services for students/families with complex psychological and social health needs						

Item No.	VII. NUTRITION SERVICES - Nutrition Services	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
	The school has...						
37	Meal time long enough to accommodate healthy eating habits for all children						
38	Meal time long enough to accommodate children with special feeding problems						
39	Balanced selections of foods that enable healthy eating practices at mealtime						
40	A nutrition program that provides a variety of healthy food choices to meet individual needs and preferences						
41	Nutritional drink and snack alternatives available in school's vending machines						
42	Staff trained to obtain/provide modified meals and nutrition support for children with special needs						

Item No.	VIII. HEALTH PROMOTION FOR STAFF - Health Promotion for Staff	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
	School improves...						
43	Faculty and staff health by providing adequate smoke-free space						
44	Faculty and staff by providing access to lockers and exercise facilities						
45	Faculty and staff by providing them access to food choices						
46	Faculty and staff by providing health promotion (wellness) programs						
47	Faculty and staff health by having a staff wellness program that spans the entire school year						
48	Faculty and staff health by providing an employee assistance program (EAP) that enables early access to treatment services (e.g., financial counseling, stress reduction, and psychological services)						
17	Provides case management services to address changing health and education needs of students with chronic medical conditions and/or disabilities						

Item No.	IX. PHYSICAL EDUCATION - Physical Education Program	Rate the overall success of your school health program in accomplishing the following goals in _____ (school year)				Contributing Factor(s)	
		High Success (3)	Moderate Success (2)	Some Success (1)	Not Addressed (0)	Success Factors	Problem Factors
	The school's physical education program...						
49	Helps students develop life skills to promote optimal health						
50	Promotes the physical fitness of all students						
51	Promotes in-class benefits for all students						
52	Accommodates the special needs of all students						

PART VII: UNIVERSAL PRECAUTIONS AND INFECTIOUS DISEASES

This section serves as an overview for disease prevention in the school setting, providing information on universal precautions, methods for avoiding contact with infectious material, and disposal methods. A review of commonly seen infectious diseases and conditions is also included, and covers a description of the condition, transmission, diagnosis, treatment, exclusion considerations, reporting and notification recommendations, and guidelines for prevention.

Chapter 31: [Universal Precautions](#)

Chapter 32: [Selected Infectious Diseases](#)

Chapter 31: Universal Precautions for Handling Blood/Body Fluids in School

Authorization

[Occupational Safety and Health Administration \(OSHA\) Bloodborne Pathogens Standard](#). The following guidelines are designed to protect persons who may be exposed to blood or body fluids of students or employees in a school. Refer to the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard for the most recent requirements.

Overview

Anticipating Potential Contact. Anticipating potential contact with infectious materials in routine and emergency situations is the most important step in preventing exposure to and transmission of infections. The use of universal precautions and infection control techniques is important in all situations that may present the hazard of infection. Diligent and proper hand washing, the use of barriers (e.g., latex or vinyl gloves), appropriate disposal of waste products and needles, and proper care of spills are essential techniques of infection control.

Implementing Universal Precautions. When implementing universal precautions for infection control, all blood and other potentially infectious material (OPIM) are treated as if they contain bloodborne pathogens, such as the Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Hepatitis B Virus (HBV). OPIM include:¹⁷²

- Any body fluid visibly contaminated with blood
- All body fluids in situations where it is difficult or impossible to differentiate between body fluids
- Any unfixed tissue or organ (other than intact skin) from a human (living or dead)
- HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions
- Blood
- Cerebrospinal fluid
- Synovial fluid
- Vaginal secretions
- Semen
- Saliva
- Pericardial fluid
- Breast milk¹⁷³
- Peritoneal fluid
- Amniotic fluid
- Pleural fluid

Hand Hygiene and Hand Washing^{174, 175}

Diligent and proper hand hygiene is an essential component of infection control. Hand hygiene is a general term that applies to hand washing, antiseptic hand wash, alcohol-based hand rub, and/or surgical hand hygiene/antiseptics. Hand washing refers to washing hands with plain soap and water. Hand washing with soap and water remains a sensible strategy for hand hygiene in non-healthcare settings and is recommended by CDC and other experts.

Despite the prevalence of alcohol-based hygiene in healthcare settings, hand washing remains the preferred method in the educational setting. Hands should be washed:

- When arriving for the day or when moving from one group of children to another
- Before and after eating or handling food
- Playing with water that is used by more than one person
- Handling pets or other animals
- Playing in sandboxes
- Cleaning
- Handling garbage
- Immediately before and after physical contact with a student (e.g., diaper changes, assisting with toileting, assisting with feeding, administering a medication)
- Immediately after contact with blood or body fluids or garments or objects soiled with body fluids or blood
- After contact with used equipment (e.g., stethoscope, emesis basin, gloves)
- After removing protective equipment, such as gloves or clothing
- Before leaving for the day

Procedures.

1. Remove jewelry and store in a safe place prior to initial hand washing (replace jewelry after final hand washing).
2. Wash hands vigorously with soap under a stream of running water for at least 20 seconds. Rub areas between fingers, around nail beds, under fingernails and jewelry, and on backs of hands.
3. Rinse hands well with running water, until free of soap and dirt. Leave water running while drying hands.
4. Dry hands with a clean, disposable paper towel or single-use cloth towel.
5. Turn off tap with a disposable paper towel or single-use towel.
6. If soap and water are unavailable, use an alcohol-based hand sanitizer that contains at least 60% alcohol to clean hands.

Resources

For detailed steps and materials outlining the steps of hand washing and hand hygiene, visit the following sites:

- Centers for Disease Control and Prevention
 - [Hand Hygiene Basics](#)
 - [Healthy Living: Wash Your Hands](#)

Avoiding Contact with Blood and Other Potentially Infectious Material (OPIM) Using Personal Protective Equipment (PPE) ¹⁷⁶

Gloves. When possible, avoid direct skin contact with OPIM. Disposable, single use, waterproof, latex or vinyl gloves should be available in school clinics. Vinyl gloves should be used with students who have a latex allergy or a high potential for developing a latex allergy, such as students with spina bifida. The use of gloves is intended to reduce the risk of contact with blood and OPIM for the caregiver as well as to control the spread of infectious agents from student to employee, employee to student, or employee to employee. Gloves should be worn when direct care may involve contact with any type of OPIM. Incidents when gloves should be worn include (but are not limited to): caring for nose bleeds, changing a bandage or sanitary napkins, cleaning up spills or garments soiled with body fluids, disposing of supplies soiled with blood, or any procedure where blood is visible. Gloves should also be worn when changing a diaper, catheterizing a student, or providing mouth, nose or tracheal care. After each use, gloves should be removed without touching the outside of the glove and disposed of in a lined waste container. After removing the gloves, the hands should be washed according to the hand washing procedure.

Protective Clothing. If spattering of body fluids is anticipated, the clothing of the caregiver should be protected with an apron or gown, and the face protected with a facemask, and eye goggles or face shield. The apron or gown should be laundered or disposed of after it is used and should not be used again until it is clean. The goggles and mask should be disposed of properly.

Shield for Rescue Breathing. If it is necessary to perform rescue breathing, a one-way mask or other infection control barrier should be used. However, rescue breathing should not be delayed while such a device is located.

Detailed instructions on donning and removal of protective equipment can be found via the Centers for Disease Control and Prevention, [Sequence for Donning Personal Protective Equipment \(PPE\)](#).

Disposal of Infectious Waste ¹⁷⁷

Contaminated Supplies. All used or contaminated supplies (e.g., gloves and other barriers, sanitary napkins, Band-Aids), EXCEPT syringes, needles, and other sharp implements, should be placed into a plastic bag and sealed. This bag can be thrown into the garbage, out of reach of children or animals.

Used Needles, Syringes, And Other Sharp Objects. Make arrangements to dispose of used needles, syringes, and other sharp objects at a local medical facility or health department. Needles, syringes, and other sharp objects should be placed **immediately after use** in a metal or other puncture-proof container that is leak proof on the bottom and sides. To reduce the risk of a cut or accidental puncture by a needle, NEEDLES SHOULD NOT BE RECAPPED, BENT, OR REMOVED FROM THE SYRINGE BEFORE DISPOSAL. Once it is full, the container should be sealed, bagged, and kept out of the reach of children until it can be disposed of properly.

Body Waste. Body waste (e.g., urine, vomitus, and feces) should be disposed of in the toilet. If such body fluids as urine and vomitus are spilled, the body fluids should be covered with an absorbent sanitary material, gently swept up, and discarded in plastic bags.

Clean Up

Spills of blood and body fluids should be cleaned up immediately with an approved disinfectant cleaner.

Procedures.

1. Wear gloves. (See "[Avoiding Contact with Blood and Other Potentially Infectious Material \(OPIM\)](#)" on previous page.)
2. Mop up spill with absorbent material.
3. Wash the area well, using the disinfectant cleaner supplied in the clinics or a 1:10 bleach solution (mix 1-part household bleach, sodium hypochlorite (5.25%-6.15%), in ten parts of water).¹⁷⁸ Replace solution daily.
4. Dispose of gloves, soiled towels, and other waste in sealed plastic bags and place in garbage, as already indicated.
5. Wash hands.

Routine Environmental Clean-Up Facilities. Routine environmental cleanup facilities (e.g., clinic and bathrooms) do not require modification unless contaminated with blood or body fluids. If so, the area should be decontaminated using the procedure outlined. Regular cleaning of non-contaminated surfaces, such as toilet seats and tabletops, can be done with the standard cleaning solutions or the 1:10 bleach solution described above. Regular cleaning of obvious soil is more effective than extraordinary attempts to disinfect or sterilize surfaces.

Cleaning Tools. Rooms and dustpans must be rinsed in disinfectant. Mops must be soaked in disinfectant, washed, and thoroughly rinsed. The disinfectant solution should be disposed of promptly down the drain.

Laundry. Whenever possible, disposable barriers (e.g., disposable gloves and gowns) should be used if contamination with blood or body fluids is possible. If sheets, towels, or clothing become soiled, they should not be handled more than necessary. Wash contaminated items in warmest temperatures recommended on the clothing label. Refer to clothing label for detergent instructions.¹⁷⁷ Presoaking may be required for heavily soiled clothing. The most important factor in laundering clothing contaminated in the school setting is elimination of potentially infectious agents by soap and hot water. Soiled student clothing should be rinsed using gloves, placed in a plastic bag, and sent home with appropriate washing instructions for the parents.

Accidental Exposure

Accidental exposure to blood, body products, or body fluids places the exposed individual at risk of infection. The risk varies depending on the type of body fluid (e.g., blood vs. respiratory vs. feces), the type of infection (e.g., salmonellae vs. haemophilus influenzae virus vs. HIV), and the integrity of the skin that is contaminated.

Procedures.¹⁷²

1. Always wash the contaminated area **immediately** with soap and water.
2. If the mucous membranes (i.e., eye or mouth) are contaminated by a splash of potentially infectious material or contamination of broken skin occurs, irrigate or wash area thoroughly.
3. If a cut or needle injury occurs, wash the skin thoroughly with soap and water.

In instances where broken skin or mucous membranes, or a needle puncture occur, the caregiver should document the incident. For instances of suspected faculty or staff exposure, the nurse should assist the person exposed to the infection to the extent possible. Staff should offer post-exposure medical evaluation by a healthcare provider at no cost to employees,¹⁷⁹ as well as notify the nursing supervisor for additional guidance on actions to take, follow up needed, and required reporting. In the event that a student is exposed, the student's parent or guardian should also be notified.

Pregnant Women

Pregnant women are at no higher risk for infection than other caregivers, as long as appropriate precautions are observed. There is, however, the possibility of in utero transmission of viral infections, such as cytomegalovirus (CMV), HIV, or HBV to unborn children.¹⁸⁰

Guidelines for Exposure Policy Development

All school divisions should have an exposure policy as outlined in OSHA's [Occupational Safety and Health Standards: 1910.1030, Bloodborne Pathogens](#). For additional information, contact the [Virginia Department of Labor and Industry](#) or the Virginia Department of Labor and Industry's Regional Office.

Chapter 32: Selected Infectious Diseases

The diseases described in the following sections are arranged alphabetically.

- [Abscesses/Boils/Cellulitis](#)
- [Bed Bugs](#)
- [Bites \(Human\)](#)
- [Campylobacteriosis](#)
- [Candidiasis \(Thrush\)](#)
- [Chicken Pox \(Varicella-Zoster\)](#)
- [Colds \(Acute Viral Rhinitis\)](#)
- [Conjunctivitis \(Pink Eye\)](#)
- [Cytomegalovirus \(CMV\) Infection](#)
- [Diphtheria](#)
- [E. coli Diarrhea \(*Escherichia Coli*\)](#)
- [COVID-19](#)
- [Fifth Disease \(Erythema Infectiosum\)](#)
- [Giardiasis](#)
- [Group A Streptococcal Infections \(*Streptococcus Pyogenes*\)](#)
- [Haemophilus Influenzae Type B \(Hib\), Invasive](#)
- [Hand, Foot, and Mouth Disease \(Coxsackievirus\)](#)
- [Hepatitis A](#)
- [Hepatitis B](#)
- [Hepatitis C](#)
- [Hepatitis E](#)
- [Herpes Simplex Infection](#)
- [HIV Infection and AIDS](#)
- [Impetigo](#)
- [Influenza](#)
- [Lyme Disease](#)
- [Measles \(Rubeola\)](#)
- [Meningococcal Disease](#)
- [Methicillin Resistant Staphylococcus aureus \(MRSA\)](#)
- [Molluscum Contagiosum](#)
- [Mononucleosis, Infectious](#)

- [Mosquito-Borne Diseases](#)
- [Mumps](#)
- [Otitis](#)
- [Pediculosis \(Lice\)](#)
- [Pertussis \(Whooping Cough\)](#)
- [Pinworm Infection \(Enterobiasis\)](#)
- [Pneumonia](#)
- [Polio \(Poliomyelitis\)](#)
- [Rabies](#)
- [Respiratory Syncytial Virus \(RSV\)](#)
- [Rocky Mountain Spotted Fever](#)
- [Roseola \(Roseola Infantum\)](#)
- [Rotavirus \(Rotavirus Enteritis\)](#)
- [Rubella \(German Measles\)](#)
- [Salmonellosis](#)
- [Scabies](#)
- [Sexually Transmitted Diseases](#)
- [Shigellosis](#)
- [Shingles \(Herpes Zoster\)](#)
- [Sports-Related Infectious Diseases](#)
- [Sty](#)
- [Tetanus](#)
- [Tinea \(Ringworm\)](#)
- [Tuberculosis \(TB\)](#)

Each subsection contains the following information pertaining to each disease.

- A brief description of the disease and those susceptible to the disease.
- Transmission.
- Diagnosis.
- Treatment.
- School Exclusion Recommendations (including communicability, case, and contacts).
- Reporting Requirements.
- Notification Guidelines.
- Prevention Guidelines.

Resources

Information on the **infectious diseases** below is compiled from the following:

- American Academy of Pediatrics [Healthychildren.org](https://www.healthychildren.org)
- Aronson, S., and Shope, T. (2016). *Managing infectious diseases in child care and schools: A quick reference* (4th.ed). Elk Grove Village, IL: American Academy of Pediatrics.
- Centers for Disease Control and Prevention
[Diseases & Conditions A-Z Index](#)
 - [Parasites](#)
- Virginia Department of Health, [Office of Epidemiology](#)
 - [Disease Fact Sheets](#)
 - [Virginia Reportable Disease List](#)

Additional information may be obtained through the following resources:

- *Virginia Department of Health*
Office of Epidemiology
[Communicable Disease Reference Chart for School Personnel](#)
[Regulations for Disease Reporting and Control](#)
- *Hamborsky, J., Kroger, A., and Wolfe, C. (Eds.) (2015). Epidemiology and prevention of vaccine-preventable diseases (13th. ed). Washington, DC: Public Health Foundation. (The Pink Book)*
- *Heymann, D.L. (Ed.) (2014). Control of communicable disease manual (20th. ed). APHA Press.*
- [Local Health Departments](#)

Abscesses/Boils/Cellulitis

These are common types of bacterial infections of the skin. Common skin bacteria that are normally present on the skin (staph and strep) may cause an infection when there is a break in the skin, or when the bacteria multiply and overpower the immune system. Many people carry the bacteria in their noses, throats, and on their skin and may pass it on to others. However, for an infection to occur, the bacteria must get through a break in the skin.

These infections often start from a small scratch or bug bite and then develop into a large red nodule filled with pus. Boils are typically superficial infections (penny or nickel sized) with a thin layer of skin over the fluid. Abscesses are usually larger and involve redness and painful swelling over an area filled with pus. Both abscesses and boils may drain when the covering skin is broken. Cellulitis is an infection within the skin and the area just below it. The skin is typically red and tender. Persons with cellulitis may experience a fever, and the area can spread rapidly. All skin infections can involve the area being warm to the touch, as this part of the body's reaction to an infection.

Transmission

The incubation period is unknown. Transmission occurs through direct contact with the pus or skin bacteria. Infected persons are contagious as long as the wound is open and draining.

School Exclusion Guidelines

Communicable: Skin infections are spread via direct person-to-person contact with pus and skin bacteria. The infection is contagious as long as the skin is open, and drainage is present.

Case: Exclusion from school is not indicated as long as the person feels well enough to attend school. If the lesion is draining and cannot be covered, the student or staff member should be excluded until the drainage has subsided.

Contacts: Exclusion from school is not indicated.

Diagnosis

Diagnosis is made by physical examination from a healthcare provider. Cultures of the site may be taken to determine the specific organism, for more appropriate treatment.

Treatment

Treatment will depend on the nature and severity of the lesion. Antibiotic therapy may be indicated. Antibiotics should be given exactly as prescribed.

Reporting Requirements

Abscesses, boils, and cellulitis are not reportable.

Notification Guidelines

Parents of the affected child should be notified and referred for treatment, as necessary.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. When students and staff suffer an injury that causes a break in the skin, wash the area thoroughly with soap and water and dry it completely.
3. When there is a risk of skin infection, wash the rash with soap and water and cover it loosely with gauze, a bandage, or clothing.
4. Be sure those who touch the rash wash their hands well. Dispose of any soiled tissues or bandages carefully and keep any possibly contaminated clothing in a plastic bag.
5. Contact the student's parents and advise them to have the student examined by their health care provider.

Bed Bugs

Bed bugs (*Cimex lectularius*) are small, flat, parasitic insects that feed solely on the blood of people and animals while they sleep. Bed bugs are reddish-brown in color, wingless, range from 1mm to 7mm (roughly the size of Lincoln's head on a penny), and can live several months without a blood meal. Bed bugs are found across the globe from North and South America, to Africa, Asia and Europe. Although the presence of bed bugs has traditionally been seen as a problem in developing countries, it has recently been spreading rapidly in parts of the United States, Canada, the United Kingdom, and other parts of Europe. Bed bugs have been found in five-star hotels and resorts and their presence is not determined by the cleanliness of the living conditions where they are found.

Bed bug infestations usually occur around or near the areas where people sleep. These areas include apartments, shelters, rooming houses, hotels, cruise ships, buses, trains, and dorm rooms. They hide during the day in places such as seams of mattresses, box springs, bed frames, headboards, dresser tables, inside cracks or crevices, behind wallpaper, or any other clutter or objects around a bed. Bed bugs have been shown to be able to travel over 100 feet in a night but tend to live within 8 feet of where people sleep.

Unless the bed bugs are seen or there are signs of infestation, it can be difficult to recognize the bites. When bed bugs bite, they inject an anesthetic and an anticoagulant that prevents a person from realizing they are being bitten. Most people do not realize they have been bitten until bite marks appear anywhere from one to several days after the initial bite. The bite marks are similar to that of a mosquito or a flea -- a slightly swollen and red area that may itch and be irritating. The bite marks may be random or appear in a straight line. Other symptoms of bed bug bites include insomnia, anxiety, and skin problems that arise from profuse scratching of the bites. Because bed bug bites affect everyone differently, some people may have no reaction and will not develop bite marks or any other visible signs of being bitten. Other people may be allergic to the bed bugs and can react adversely to the bites. These allergic symptoms can include enlarged bite marks, painful swellings at the bite site, and, on rare occasions, anaphylaxis.

Transmission

Bed bugs are experts at hiding. Their slim flat bodies allow them to fit into the smallest of spaces and stay there for long periods of time, even without a blood meal. Bed bugs are usually transported from place to place as people travel. The bed bugs travel in the seams and folds of luggage, overnight bags, folded clothes, bedding, furniture, and anywhere else where they can hide. Most people do not realize they are transporting stow-away bed bugs as they travel from location to location, infecting areas as they travel.

A bed bug bite affects each person differently. Bite responses can range from an absence of any physical signs of the bite, to a small bite mark, to a serious allergic reaction. Bed bugs are not

considered to be dangerous; however, an allergic reaction to several bites may need medical attention.

School Exclusion Guidelines

Communicable: Bed bugs should not be considered as a medical or public health hazard. Bed bugs are not known to spread disease. Bed bugs can be an annoyance because their presence may cause itching and loss of sleep. Sometimes the itching can lead to excessive scratching that can sometimes increase the chance of a secondary skin infection.

Case: School exclusion is not indicated if the person is well enough to attend school.

Contacts: School exclusion is not indicated.

Diagnosis:

One of the easiest ways to identify a bed bug infestation is by the tell-tale bite marks on the face, neck, arms, hands, or any other body parts while sleeping. However, these bite marks may take as long as 14 days to develop in some people, so it is important to look for other clues when determining if bed bugs have infested an area. These signs include:

- Bed bugs' exoskeletons after molting,
- Bed bugs in the fold of mattresses and sheets,
- Rusty-colored blood spots due to their blood-filled fecal material that they excrete on the mattress or nearby furniture, and
- A sweet musty odor.

Treatment:

Bed bug bites usually do not pose a serious medical threat. The best way to treat a bite is to avoid scratching the area and apply antiseptic creams or lotions and take an antihistamine. Bed bug infestations are commonly treated by insecticide spraying. If you suspect that you have an infestation, contact your landlord or professional pest control company that is experienced with treating bed bugs. The best way to prevent bed bugs is regular inspection for the signs of an infestation.

Reporting Requirements

Bed bugs are not a reportable disease.

Notification Guidelines

When bed bugs occur within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified. Parents and family of the infected student should be notified so that treatment and remediation can occur.

Prevention Guidelines

The most effective prevention for bed bug infestation is routine inspection. For detailed guidelines on inspection, tips for travel, and other ideas to minimize the risk of bed bugs, review the Virginia Department of Agriculture and Consumer Services, [Bed Bugs: How to Protect Yourself and Your Home.](#)

Bites (Human)

Biting is common among young children, but rarely leads to infectious disease concerns. If this skin is broke, this is a chance for bacteria to be introduced into the wound and cause an infection. If there is an exchange of blood there is a risk for blood-borne disease transmission such as Hepatitis B virus, human immunodeficiency virus (HIV), and Hepatitis C. The risk of virus transmission, however, is very low.

Transmission

As noted above, transmission of infectious disease is rare, and is possible only where there is a break in the skin and/or exchange of blood or body fluids.

School Exclusion Guidelines

Communicable: Although rare, transmission of certain communicable diseases via human bite is possible.

Case: Exclusion from school is not indicated as long as the person feels well enough to attend school.

Contacts: Exclusion from school is not indicated.

Diagnosis

Diagnosis is made by report and observation/examination, depending on the circumstances. Blood work may be done to check for transmission of certain blood-borne pathogens.

Treatment

Bites should be cleaned thoroughly with soap and water for 5 minutes. Treatment will depend on the size/location/severity of the bite, nature of the bite, and the presence of potential infectious/communicable diseases.

Reporting Requirements

Human bites are not reportable.

Notification Guidelines

Parents of the affected child should be notified and referred for treatment, as necessary, according to school policy.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Try to understand the circumstances surrounding the human bite. Identify the behaviors and develop a plan, with the student's parents, to prevent future occurrences.

Campylobacteriosis

Campylobacteriosis is an intestinal bacterial disease caused by *Campylobacter*. Symptoms include diarrhea with fever, stomach cramps, vomiting, and malaise in adults and children. The diarrhea may be severe and bloody. Usually, symptoms disappear without treatment within a week, but there may still be bacteria in the stool of infected individuals for several weeks. Treatment can lessen the contagious period, and relapse may occur without treatment. *Campylobacter* is one of the most common bacterial causes of diarrheal illness in the United States.

Transmission

Bacteria that cause campylobacteriosis are transmitted by ingestion of the organisms in undercooked chicken and pork, contaminated food, water, or raw unpasteurized milk from contact with infected pets (especially puppies and kittens) or infected farm animals or infected infants. Contamination of milk most frequently occurs from fecal-carrier cattle; people and food can be contaminated from poultry, especially from cutting boards. The incubation period may last from 2 to 5 days after exposure.

School Exclusion Guidelines

Communicable: Campylobacteriosis is transmissible as long as the bacteria are excreted in the stool of infected persons. Individuals not treated with antibiotics excrete organisms for a few days to several weeks after recovery.

Case: Exclude from school until cessation of acute diarrhea. Stress importance of proper hand washing. Infected food handlers who are asymptomatic do not pose a risk for disease transmission and do not need to be excluded from work if proper hygiene measures are maintained.

Contacts: School exclusion and stool cultures are not indicated in the absence of symptoms. Consult local health department for suspected outbreaks.

Diagnosis

A stool culture must be performed to confirm a case of campylobacteriosis.

Treatment

Persons infected with *Campylobacter* will usually recover without medical treatment. An antibiotic can be given early on and shortens the duration of the illness and prevents relapse.

Reporting Requirements

Campylobacter infection must be reported to the local health department within three days of diagnosis.

Notification Guidelines

When campylobacteriosis occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.
3. Family and household members in contact with a person with campylobacter diarrhea should be made aware of their possible exposure to the bacteria, especially if the individuals are involved in food preparation and handling.

Candidiasis (Thrush)

Candidiasis (thrush) is a yeast infection produced by *Candida albicans* organisms causing a mouth infection. Thrush is characterized by white patches on the inside of cheeks, gums, and the tongue, as well as redness of the infected area. Thrush may be painful and make it difficult to swallow, as well as lead to cracking at the corners of the mouth. It is most common in infants under one month, the elderly, and those with weakened immune systems. People with HIV/AIDs, receiving cancer treatment, organ transplant recipients, and those with dentures, diabetes, or using corticosteroids or broad spectrum antibiotics are also at higher risk.

Transmission

Candida albicans is common in the environment and is normal in the intestinal tracts and mucous membranes of healthy people. However, certain situations, such as antibiotic use, can cause an overgrowth of the yeast, which results in thrush. Yeast also thrives in a warm, moist environment. Person to person transmission may occur from a woman to her infant when the woman has a yeast infection in her vagina during childbirth. Babies and mothers can also pass the infection to one another during breastfeeding.

School Exclusion Guidelines

Communicable: Thrush can be transmitted by direct person to person contact in certain circumstances, as outlined above.

Case: Not indicated, unless the infected person does not feel well enough to participate in activities.

Contacts: Not indicated.

Diagnosis

A healthcare provider diagnoses the infection based on symptoms, physical assessment, and by taking a scraping of the affected areas to examine under a microscope. A culture may also be performed; however, because *Candida* organisms are normal inhabitants of the human mouth, a positive culture by itself does not make the diagnosis.

Treatment

Candida infections of the mouth and throat are usually treated with prescription antifungal medication. The type and duration of treatment depends on the severity of the infection and patient-specific factors such as age and immune status. Untreated infections can lead to a more serious form of invasive candidiasis. Oral candidiasis usually responds to topical treatments such as clotrimazole, miconazole or nystatin suspension (nystatin “swish and

swallow”). Systemic antifungal medication such as fluconazole may be necessary for oropharyngeal infections that do not respond to these treatments.

Reporting Requirements

Candidiasis is not a reportable disease.

Notification Guidelines

Suspected thrush should be reported to the parents who can seek treatment from a healthcare professional.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Proper hand washing and cleanliness should be encouraged at all times.
3. Discourage sharing of mouth toys between children without washing and sanitizing in between.
4. Wash and sanitize all toys, bottles, and pacifier nipples after they have been mouthed.
5. Good oral hygiene practices may help to prevent oral thrush in people with weakened immune systems. People who use inhaled corticosteroids may be able to reduce the risk of developing thrush by washing out the mouth with water or mouthwash after using an inhaler.

Chickenpox (Varicella-Zoster)

Chickenpox (primary varicella) is an acute generalized disease caused by varicella-zoster virus, a member of the herpes virus group. The illness is characterized by a generalized, itchy, blister-like rash, with mild fever and fatigue. The rash usually appears first on the head, then the trunk and extremities, as small red spots and bumps which quickly become blistered, ooze and then crust over. New spots continue to appear for about three to four days. The spots will dry up and scab over before falling off. The disease is usually more serious in adults than in children. Typically, the rash is more pronounced on the trunk than other parts of the body. Other symptoms may include fever, runny nose, and cough.

A variety of complications can occur with chickenpox. These include infections ranging from impetigo to severe skin infections with toxic shock syndrome. Secondary pneumonia can occur. Less common complications can involve the blood, joints, brain, and kidney. Reyes Syndrome can follow chickenpox. Severe chickenpox can occur in newborn babies whose mothers develop chickenpox within five days before and two days after birth. Persons with weakened immune systems or who are taking drugs that suppress their immune systems are at increased risk of developing a severe form of chickenpox.

Transmission

Chickenpox is highly contagious and is transmitted from person to person by direct contact, droplet, or airborne spread of vesicle fluid or secretions of the respiratory tract of chicken pox cases. Chickenpox is also transmitted by handling articles that are freshly soiled by the infected person's chickenpox lesions. Even a brief exposure or shared airflow poses a high risk of infection for people who have not had the disease or are not (fully) vaccinated. The incubation period is usually 14 to 16 days; may be prolonged after passive immunization against varicella and in the immunodeficient.

School Exclusion Guidelines

Communicable: A person is communicable for as long as 5 days (usually 1 to 2 days) before an eruption of vesicles and continues for another 5-7 days after the appearance of the first crop of vesicles.

Case: Exclude from school for at least 5 days after eruptions first appear or until vesicles become crusted over and dry. Avoid exposure of women in early stages of pregnancy that have not had chickenpox disease and/or the vaccine. Note: Students and staff with *shingles* carry the virus that causes chickenpox and could cause an outbreak. Therefore, unless the shingles rash can be completely covered, it is advisable that individuals with shingles remain out of school until the rash is crusted over and dry.

Contacts: On appearance of symptoms, exclude from school.

Diagnosis

Chickenpox can be presumptively diagnosed by the signs and symptoms. The virus can be isolated from a blister-like lesion during the first three to four days of the eruption for microscopic evaluation.

Treatment

Individuals with chickenpox should discuss treatment options with their health care provider.

Reporting Requirements

Chickenpox must be reported to the local health department within three days of diagnosis.

Notification Guidelines

When a case of chickenpox (varicella) occurs in the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, [§ 22.1-271.1](#), [§ 22.1-271.2](#), and [§ 32.1-46](#). Please refer to the Centers for Disease Control and Prevention for the most current [Immunization Schedule](#).
2. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
3. Make sure all students and staff exhibiting symptoms associated with the illness are excluded from school based on guidelines described earlier.
4. Identify high-risk individuals (e.g., pregnant women, immunocompromised individuals) and refer them to their health care provider immediately.
5. Watch closely for early symptoms in others for 3 weeks following the most recent case.

Colds (Acute Viral Rhinitis)

The common cold is a mild viral infection of the upper respiratory tract (nose and throat) caused by many different viruses. Rhinovirus infection is the most frequent cause of the common cold. (Rhinoviruses may also be involved in bronchitis, sinusitis, otitis media, and lower respiratory tract disease in children). Cold symptoms include stuffy or runny nose, sore throat, coughing, sneezing, watery eyes, fluid in the ears, and general fatigue. Note: Fever associated with colds is uncommon in children over 3 years old and rare in adults.

Transmission

The viruses that cause the common cold are transmitted presumably by direct person-to-person contact or by inhalation of airborne droplet. More importantly, the viruses are transmitted indirectly by hands and articles freshly soiled by discharges of the nose and throat of an infected person. Rhinovirus and other similar viruses are transmitted by contaminated hands carrying viruses to the mucous membranes of the eye or nose. Students and staff have already spread viruses before they begin to feel ill.

Diagnosis

Diagnosis is generally presumptive based on symptoms. Laboratory tests are available but are expensive and generally not indicated.

Treatment

Treatment is aimed at relieving the symptoms. There is no medication to cure viral illnesses. Health care providers generally suggest rest and plenty of fluids. If a cold persists for greater than 7 to 10 days and is accompanied by high fever, persistent cough, and/or complaint of ear pain, the individual may have a secondary bacterial infection and should be advised to see their health care provider to determine if additional treatment is required. Parents should be advised that aspirin or products containing salicylate should **never** be administered to children for fever control in viral infections because of the rare association with Reyes Syndrome, a serious illness.

School Exclusion Guidelines

Communicable: The period of communicability varies but correlates with the shedding of virus in the nose and mouth secretions, which is about 7 to 10 days (as long as 3 weeks).

Case: School exclusion is not indicated as long as a student or staff member feels well enough to attend school.

Contacts: School exclusion is not indicated.

Reporting Requirements

The common cold is not a reportable disease.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Proper hand washing and cleanliness are essential to stop the spread of all respiratory tract diseases.
3. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.

Conjunctivitis (Pink Eye)

Conjunctivitis (or pink eye) is an inflammation of the mucous membranes that line the eyelids, most often caused by a virus but occasionally caused by bacteria, allergies, or chemical exposure. With this inflammation, the white part of the eye becomes pink, itchy, and the eye produces lots of tears and discharge. In the morning, discharge may make the eyelids stick together. Discharge may be green or yellow in color, and one or both eyes may be affected, depending on the type of conjunctivitis.

Transmission

Organisms that cause conjunctivitis are transmitted by direct contact with discharge from the conjunctivae (mucous membranes that line the eyes) or upper respiratory tracts of infected people. The organisms are also transmitted from contaminated fingers, clothing, or other articles (e.g., shared eye makeup, washcloths, towels, or paper towels). The incubation period is dependent on the type of conjunctivitis, but is typically as long as symptoms are present, or until 24 hours of treatment have been completed.

School Exclusion Guidelines

Communicable: Conjunctivitis is transmissible during the course of active infection.

Case: Exclude from school while symptomatic if activity at school includes close contact with other people. With healthcare provider approval, students with conjunctivitis but do not have fever or other symptoms may be allowed to remain at school.

Contacts: School exclusion is not indicated.

Diagnosis

Conjunctivitis is diagnosed by the typical appearance of the eye(s). However, it is often difficult to tell if the cause is bacterial or viral. Occasionally, the doctor will examine the discharge under a microscope or culture it.

Treatment

Parents of students who have symptoms of conjunctivitis and staff who have symptoms of conjunctivitis should be advised to contact their health care provider to decide whether medication is needed.

Reporting Requirements

Conjunctivitis is not a reportable disease.

Notification Guidelines

When conjunctivitis occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Have affected individuals keep their eyes wiped free of discharge.
3. Teach everyone to wash their hands after wiping their eyes.
4. Be sure articles that may touch the students' eyes (e.g., prisms, binoculars, pieces of microscope, cameras) are cleaned appropriately. Consideration should be given to avoiding the use of such instruments during an outbreak.

COVID-19

There are many types of human coronaviruses including some that commonly cause mild upper-respiratory tract illnesses. COVID-19 is a new disease, caused by a coronavirus that has not been seen in humans before January 2020.

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear **2-14 days after exposure to the virus**. People with these symptoms may have COVID-19:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19. [COVID-19 Symptoms](#)

Look for emergency warning signs for COVID-19. If someone is showing any of these signs, seek emergency medical care immediately:

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion
- Inability to wake or stay awake
- Bluish lips or face

Transmission

The virus that causes COVID-19 spreads from person to person, mainly through respiratory droplets produced when an infected person coughs, sneezes, or talks. These droplets can land in the mouths or noses of people who are nearby and can be inhaled into the lungs. The virus is more likely to spread when people are in close contact with one another (within about 6 feet for at least 15 minutes).

School Exclusion Guidelines

[CDC Guidance for Schools](#)

Communicable: Person can spread the virus as long as 14 days after they have been infected.

Case: On appearance of symptoms, exclude from school and instruct parents to follow the algorithm [VDH - Child - School COVID-19 Algorithm](#) and refer to a healthcare provider. Students and staff will need to self – quarantine for 14 days. They will need to seek emergency care if symptoms worsen. A Symptom-based strategy – excluded from school until at least 10 days have passed since symptoms first appeared, no fever for 24 hours without the use of fever reducing medication and other symptoms have improved such as cough and shortness of breath. Student and staff who have been vaccinated do not need to quarantine. Follow the current federal, state, and local guidance. CDC guidance is updated frequently and the most update information is located [CDC.Gov/Coronavirus Quarantine-vs-Isolation Infographic](#) and [CDC.Gov/Coronavirus/If-You-Are-Sick/End-Home-Isolation](#).

Contacts: On notification of possible exposure to COVID-19, exclude from school, self – quarantine for 14 days and contact health care provider. The individual will need to monitor symptoms and follow guidance from the local health department and their health care provider. Students and staff who have been vaccinated do not need to quarantine. Refer symptomatic students and staff to seek medical care from a healthcare provider.

Diagnosis

Two kinds of tests are available for COVID-19: tests for current infection (viral tests) and tests for past infection (antibody tests). Information can be found here: [Test for COVID-19](#).

A viral test tells you if you have a current infection by looking for parts of the virus. Swabs that take samples from the nose or throat, or saliva, are used for these tests. Currently, there are two main viral tests used to detect the SARS-CoV-2 virus (the virus that causes COVID-19): Molecular tests (also called PCR tests) that look for the virus’s genetic material, and Antigen tests that look for a specific protein that is part of the virus. Antigen tests can be easy to run and may cost less than molecular tests, but are not always as accurate as molecular tests. An antibody test tells you if you had a past infection by looking for antibodies in the blood. The test uses a blood sample to look for antibodies made in response to the virus that causes COVID-19. It usually takes 1-3 weeks for people to make antibodies in response to an infection. Antibody tests have limited ability to diagnose COVID-19, and should not be used alone for this purpose.

Treatment

A COVID vaccine is available to prevent disease. Most people who become sick with COVID-19 will have a mild illness and are able to recover at home. Students and staff who have symptoms or have been exposed to COVID-19 are advised to contact their healthcare provider. For more information about [Managing symptoms at home, follow the CDC’s guidance. Learn more about - emergency warning signs \(including trouble breathing\)](#), get emergency medical care immediately.

Reporting Requirements

Reporting of a person confirmed or suspected of having COVID-19 must be reported immediately by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification Guidelines

When a case of COVID-19 occurs in the school population, contact your local health department for guidance. School health personnel (e.g., schoolnurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified. Additional information and resources can be found on the [VDOE School Health Services Website](https://www.vdoe.org/school-health-services) and [vdh.virginia.gov/coronavirus/schools website](https://vdh.virginia.gov/coronavirus/schools-website).

Prevention Guidelines

1. A [COVID vaccine](#) is available to prevent disease.
2. Non-pharmaceutical interventions include: physical distancing (staying six feet away from others), hand hygiene, use of mask/ cloth face coverings, cleaning and disinfecting are important both in school and in the surrounding community.
3. Students and staff should be encouraged to stay at home when sick.
4. Seek medical care from a health care provider, if you have symptoms or have been exposed to someone who has COVID-19. Contact your local health department for guidance.

Every Layer Protects Us

No layer is perfect, but together they improve success. Protect yourself and the ones you love by continuing to use these COVID-19 layers of protection. The more layers you use, the easier it will be to stop the spread of COVID-19.

PREVENT

- Vaccinate
- Mask
- Distance
- Wash

CONTAIN

- Test
- Trace
- Isolate

YOU **PEOPLE YOU LOVE**

VDH VIRGINIA DEPARTMENT OF HEALTH
VACCINATE VIRGINIA

Vaccinate.Virginia.gov | 877-VAX-IN-VA (877-829-4682)

Cytomegalovirus (CMV) Infection

While infection with cytomegalovirus (CMV) is very common, it rarely produces symptoms in children. When the manifestations of CMV infection do occur, they vary with the age and immunocompetence of the host. Occasionally, children or adults with CMV will experience infectious mononucleosis-like syndrome with prolonged fever, sore throat, body aches, and fatigue.

Although unrecognized exposure to individuals asymptotically shedding CMV virus is likely to be frequent, concern arises when immunocompromised or pregnant women (especially in the first trimester) are exposed to children with clinically recognizable CMV infection. The fetus of the pregnant woman may become infected, and in rare cases, the fetus may suffer mental retardation, hearing loss, vision disturbances, or other serious problems. Immunocompromised children and adults, such as those with human immunodeficiency virus (HIV) or those being treated with immunosuppressive drugs, infected with CMV virus may experience pneumonia (inflammation of the lungs) and retinitis (inflammation of the retina in the eye).

Transmission

Infection in humans is caused almost entirely by human CMV. Human CMV is everywhere and transmitted by direct person-to-person contact with virus-containing secretions and from mother to infant before or after birth. Young children can transmit CMV to their parents and other caregivers. In adolescents and adults, sexual transmission also occurs. Spread of the virus requires direct contact with infected fluids (saliva, tears, blood, urine, seminal and cervical fluids) that are then transferred to a mucous surface (inside the mouth, genital tract, or lining of the eye) or into the bloodstream through a break in the skin, needle stick, or blood transfusion. The incubation period for nearly all CMV infections is between 4-16 weeks. Once a person is infected with CMV, the virus stays in the body for life and can reactivate.

School Exclusion Guidelines

Communicable: Transmission is person-to-person by direct contact with infected body fluids. The virus can survive several hours on surfaces outside the body.

Case: School exclusion is not indicated.

Contacts: Pregnant personnel and immunocompromised staff and students who may be in contact with CMV infected persons should be urged to contact their health care providers for counseling about the potential risks of acquisition.

Diagnosis

Most individuals with CMV infection are not diagnosed because they show no symptoms. Diagnosis of CMV virus can be made from culture of infected fluids or blood tests.

Treatment

Since infection is largely asymptomatic, no treatment is offered. There is a special treatment offered for symptomatic immunocompromised patients.

Reporting Requirements

CMV infection is not a reportable disease.

Notification Guidelines

Notify pregnant personnel and immunocompromised staff and students who may be in contact with CMV infected persons so they can contact their health care providers for counseling about the potential risks of acquisition.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.
3. Make sure that everyone (especially women trying to become pregnant, pregnant women, and immunocompromised persons) use universal precautions. (See previous section on "[Universal Precautions](#)"). If any individuals have contact with urine, saliva, stool, or blood and are not wearing gloves, they should wash their hands immediately.
4. All women who work with young children with special health care needs and who might become pregnant should be referred to their health care provider or the health department for information as to the risk of infection with CMV in that setting.

Diphtheria

Diphtheria is a rare, very serious bacterial disease, caused by *Corynebacterium diphtheriae*, involving primarily the nose and throat. Occasionally, other mucous membranes, skin, conjunctivae, or genitalia may be involved. Diphtheria can cause a sore throat, mild fever, chills, fatigue, nasal discharge, and swollen tonsils; with a characteristic patch or patches of an adherent grayish covering and swollen neck glands. It can lead to severe throat obstruction that can block breathing. The bacteria also produce a toxin (a type of poisonous substance) that can cause severe and permanent damage to the nervous system and heart.

Transmission

The bacteria that cause diphtheria are transmitted by contact with a patient or carrier. More rarely, the organism is transmitted by contact with articles soiled with discharges from lesions of infected people. Raw milk has served as a transmission vehicle. The incubation period is usually 2 to 5 days, occasionally longer.

School Exclusion Guidelines

Communicable: Communicability in untreated persons usually lasts for 2 weeks or less, and seldom more than 4 weeks. The rare chronic carrier may shed organisms for 6 months or more. Effective antibiotic therapy promptly terminates shedding.

Case: Exclusion from school is mandatory until documentation of two cultures—taken not less than 24 hours apart and not less than 24 hours after completion of antimicrobial therapy—fail to show presence of disease. If cultures are not possible, isolation may be ended after 14 days of appropriate antibiotic treatment.

Contacts: All close contacts (usually household members) irrespective of their immunization status should be:

1. Kept under surveillance for 7 days for evidence of disease.
2. Cultured and treated with a course of antibiotic from their health care provider.

Immunization with DTaP, DT, Tdap, or Td may be appropriate depending on the immunization status of the contact. Please consult with the local health department or the patient's health care provider.

Diagnosis

Diagnosis is made from cultures of the nose, throat, and any lesions.

Treatment

Diphtheria is treated primarily with an antitoxin, along with antibiotics. Antibiotics are given to the carriers of the diphtheria bacteria.

Reporting Requirements

Reporting of a person confirmed or suspected of having diphtheria must be made immediately by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification Guidelines

When diphtheria occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § [22.1-271.1](#), § [22.1-271.2](#), and § [32.1-46](#). Please refer to the Centers for Disease Control and Prevention for the most current [Immunization Schedule](#).
2. Booster doses of diphtheria toxoid, every 10 years after finishing the childhood primary immunization series, are needed to maintain protection.
3. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
4. Make sure all staff and students exhibiting symptoms associated with the illness consult a health care provider and the local health department is notified if another person develops diphtheria.

E. coli Diarrhea (*Escherichia coli*)

Escherichia coli (also called *E. coli*) are bacteria that normally live in the intestines of humans and animals such as cows. Most strains of the *E. coli* bacteria do not cause illness. However, strains that produce toxins, referred to as Shiga toxin-producing *E. coli* (STEC), can cause serious illness. *E. coli* O157:H7 is the most common type of STEC, but other types exist. Anyone can get STEC, but young children and older adults are more likely to have severe illness. Complications of *E. coli* infections that can arise are bleeding from irritation of the bowel, kidney damage, and hemolytic uremic syndrome. Symptoms include loose stools (may be watery or bloody), abdominal pain, and fever.

Transmission

STEC has to enter the mouth to cause infection. People and animals infected with STEC shed the bacteria in their feces (stool). The feces can then contaminate surfaces, food, or water. People can become infected by touching contaminated surfaces, getting the bacteria on their hands and then putting their hands in their mouths, or by eating contaminated food or drinking contaminated water. Infected food handlers can contaminate food if they do not wash their hands properly after going to the bathroom and handle food that other people eat. The bacteria can also be spread in settings such as daycare centers, where hands contaminated while changing diapers can spread the disease.

STEC has also been associated with people eating contaminated products, such as undercooked ground beef and produce (e.g., sprouts, lettuce, and spinach), or drinking unpasteurized (raw) milk or juice. It has also been associated with people swimming in water that has been contaminated with feces. Animal-to-human spread can occur by hand-to-mouth contact with contaminated surfaces or animals (e.g., at agricultural fairs, petting zoos, or farm visits). Symptoms may appear anywhere from 1-10 days after exposure, but usually appear around 3-4 days after exposure.

School Exclusion Guidelines

Communicable: Infected persons are considered contagious until diarrhea resolves and 2 consecutive stool cultures are negative (for *E. coli* O157:H7).

Case: Persons confirmed infected with *E. coli* O157:H7 should be excluded until no longer contagious. In addition, children should be excluded if the diarrhea cannot be contained in a diaper, is causing accidents for toilet-trained children, or are not well enough to participate in activities. Stress importance of proper hand washing and diligent hand washing practices.

Contacts: School exclusion and stool cultures are not indicated in the absence of symptoms. Contact local health department for advice during suspected school outbreaks.

Diagnosis

Special laboratory testing of a stool sample is needed to confirm that a person has STEC.

Treatment

Persons with diarrhea should drink plenty of liquids to prevent dehydration. Most people get well within one week without being seen by a physician, but it is important for anyone with bloody diarrhea to seek medical attention. Antibiotics or drugs that stop diarrhea (e.g., Imodium) should not be used.

Reporting Requirements

Shiga toxin-producing *E. coli* infections should be reported to the local health department within three days of diagnosis.

Notification Guidelines

When *E. coli* infections occur within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.
3. Follow hand washing and cleanliness procedures. Careful attention to good personal hygiene, hand washing, and environmental cleaning and sanitation is very important in reducing the spread of influenza.
4. Cook all ground beef thoroughly to an internal temperature of 160°F.
5. Use only pasteurized milk and apple juice products. Prevent contamination with human and animal feces.

Fifth Disease (Erythema Infectiosum)

Fifth disease (Erythema Infectiosum) is a mild viral disease caused by human parvovirus B19. It is called “fifth disease” because it was the fifth of six similar rash-causing illnesses. The illness may begin with mild systemic symptoms—fever, headache, fatigue, and muscle aches, followed by a few days without symptoms. The next stage is the appearance of a bright red rash on the cheeks that gives a “slapped cheek” appearance, which fades and recurs. This may be followed by a “lacy” rash on the trunk, arms and legs. The rash last 5-10 days but may reappear briefly weeks or months later in response to environmental changes (e.g., sunlight, temperature, and stress).

Arthralgia (joint pain) and arthritis (inflammation of a joint) is rare in children but common in adults.

The disease is usually mild with children and adults recovering without problems. Rarely infected persons may temporarily stop producing new red blood cells, leading to a condition called aplastic crisis. People with blood disorders, such as sickle cell anemia, and other hemoglobinopathies and those with weakened immune systems may develop more severe symptoms. Women who develop fifth disease during pregnancy may pass the infection to their unborn fetus, causing miscarriages and stillbirths.

Transmission

The virus that causes fifth disease is primarily transmitted through contact with infected respiratory droplets or secretions (saliva or sputum); also from mother to fetus, and rarely by transfusion of blood products. Outbreaks frequently occur in elementary and middle schools in the late winter and early spring months. Secondary spread among susceptible household members - adults or children - is common, occurring in about 50 percent of contacts. The incubation period is variable: 4 to 21 (typically 4 to 14 days) days to development of rash or symptoms of aplastic crisis.

School Exclusion Guidelines

Communicable: This illness is most transmissible before the onset of symptoms. After the appearance of the rash and other symptoms the individual is unlikely to be infectious. However, people with blood disorders and immunosuppressive illnesses who are ill with fifth disease may be infectious for a longer period of time.

Case: Exclusion from school is not indicated.

Contacts: Exclusion from school is not indicated. Exposed pregnant women and immunosuppressed persons should seek medical advice.

Diagnosis

The diagnosis in children can be presumptively based on symptoms and skin findings. For those at high risk, a laboratory test can detect newly formed antibodies to the parvovirus B19, documenting current or recent disease.

Treatment

There is no specific treatment for fifth disease; care is supportive.

Reporting Requirements

Fifth disease is not a reportable disease.

Notification Guidelines

When fifth disease occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Diligent hand washing, especially after handling discharge from the nose and throat and before eating or handling food, is the most effective deterrent to spreading this illness.

***SPECIAL NOTE FOR PREGNANT WOMEN:** Pregnant women should be advised of the potential risk of acquiring the infection, as well as the potential risk of complications to the fetus that can include miscarriage and stillbirths. Pregnant women should consult with their healthcare providers if they suspect exposure to the virus.

The decision to try to decrease any person's risk of infection by not attending a school environment where there is an outbreak should be made by the person after discussion with family members, health care providers, public health officials, and employers. A policy to routinely exclude members of high-risk groups is not recommended.

Giardiasis

Giardiasis is a parasitic infection principally of the upper small intestine caused by *Giardia lamblia*. It is a fairly common cause of diarrheal illness. Infections with *giardia* may vary from no symptoms to mild, severe, or chronic diarrhea accompanied by cramping and bloating of the abdomen, pale and foul-smelling stools, decreased appetite, and weight loss.

Transmission

The parasite that causes giardiasis is transmitted person to person by hand-to-mouth transfer of the organism from the feces of an infected individual (usually due to poor hand washing practices), especially in institutions and day-care centers; this is the principal mode of spread. Localized outbreaks may occur from ingestion of the organism in fecally contaminated water and less often from fecally contaminated food. The incubation period is usually 1 to 3 weeks.

School Exclusion Guidelines

Communicable: Transmission occurs as long as the infected person excretes the *giardia* in the feces, often months.

Case: Exclude from school until cessation of acute diarrhea. Stress importance of proper hand washing and diligent hand washing practices.

Contacts: School exclusion and stool cultures are not indicated in the absence of symptoms. Contact local health department for advice during suspected school outbreaks.

Diagnosis

Giardiasis diagnosis can be difficult, and more than one stool specimen may be needed. Special stool testing as well as stool microscopy are employed.

Treatment

Individuals with giardiasis who are ill and/or have diarrhea should receive medication prescribed by their health care provider. Infected individuals who do not have symptoms are not routinely treated.

Reporting Requirements

Giardiasis must be reported to the local health department within three days of diagnosis.

Notification Guidelines

When giardiasis occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.

Group A Streptococcal Infections (Streptococcus Pyogenes)

Group A Streptococcus (Group A Strep) are bacteria that are often found in the throat and on the skin. These bacteria might be present and not cause any illness, or they can infect different parts of the body and cause disease that can range from mild to severe. The most common infections caused by Group A Strep are strep throat and wound infections. Symptoms of Group A Strep infection usually appear within one to three days after exposure to the bacteria. Serious disease can result when the bacteria invade internal parts of the body, such as the bloodstream, which is called invasive Group A Strep disease. A brief description of four invasive Group A Strep diseases - impetigo, streptococcal throat, scarlet fever, and rheumatic fever - are presented below.

Group A Strep infections can result in no illness at all, mild illness (strep throat or a skin infection such as impetigo) or severe illness (necrotizing fasciitis or streptococcal toxic shock syndrome) that can cause death. Necrotizing fasciitis (occasionally described by the media as "the flesh-eating bacteria") destroys muscles, fat, and skin tissue. Streptococcal toxic shock syndrome (STSS), causes blood pressure to drop rapidly and organs (e.g., kidney, liver, lungs) to fail. STSS is not the same as the "toxic shock syndrome" frequently associated with tampon usage.

Impetigo. Streptococcal skin infection is a common skin infection. (See [Impetigo](#).)

Strep Throat. Streptococcal sore throat is typically characterized by sudden onset, fever, sore, beefy red throat, and tender and swollen lymph nodes (called glands by some people). In school-age children, strep throat may be accompanied by headache, nausea, abdominal pain, and vomiting. Rheumatic fever can result when strep throat is untreated or incompletely treated.

Scarlet Fever (also called Scarlatina). Scarlet fever is a form of streptococcal disease characterized by a skin rash. Clinical characteristics may include all those symptoms associated with strep throat. The rash appears 12 to 48 hours after the onset of fever. The rash begins in areas of warmth and pressure (neck, chest, armpits, groin, inner surfaces of the knees, thighs, and/or elbows), spreads rapidly to involve the entire body below the chin, and reaches its maximum in 1 to 2 days. The rash usually consists of fine red bumps with sandpaper-like texture, and fades with pressure. The rash is followed, at the beginning of the second week, by a peeling of the skin, beginning at the fingertips. The tongue appears coated at first, peeling and then beefy red.

Rheumatic Fever. Rheumatic fever may occur as a complication following infection with Group A *streptococcus* like strep throat or scarlet fever. Rheumatic fever is the most common cause of symptomatic, acquired childhood heart disease (abnormalities of the heart valves and

inflammation of the joints), caused by untreated Group A Beta Hemolytic Strep. Specific guidelines (Jones Criteria) have been developed for the diagnosis of this illness.

Transmission

Anyone can get a Group A Strep infection. Strep throat is particularly common in children. Few people who come in contact with the bacteria will develop invasive Group A Strep disease. Although healthy people can get invasive Group A Strep disease, people with chronic illnesses like cancer, diabetes, and chronic heart or lung disease, and those who use medications such as steroids have a higher risk. Persons with skin lesions (such as cuts, chickenpox, and surgical wounds), the elderly, and adults with a history of alcohol abuse or injection drug use also have a higher risk for disease.

These bacteria are spread by direct contact with body fluids (i.e., coughing, sneezing), such as secretions from the nose and throat or a wound of an infected person. Casual contact (as in work and school) and household items (like plates, cups, toys, etc.) rarely play any role in spreading the bacteria. The risk of spread of Group A Strep is greatest when an individual is ill; people who carry the bacteria but have no symptoms are much less contagious. Infected persons are no longer contagious after they have been treated with an appropriate antibiotic for at least 24 hours; however, it is important to take all of the antibiotics as prescribed.

School Exclusion Guidelines

Communicable: Untreated strep infections can be transmissible for weeks to months.

Case: Exclude from school until 24 hours of antibiotic treatment and no longer have fever.

Contacts: Exclusion from school is not indicated. Observe carefully for symptoms.

Diagnosis

Throat cultures are used to diagnose strep infections. Rapid strep tests that test for the presence of the strep germ are available. The rapid tests are reliable when positive (a throat culture is not needed). A throat culture should be done when the rapid strep test is negative since the sensitivity of the rapid test is low.

Treatment

Group A Streptococcus infections can be treated with antibiotics. In addition, treatment in an intensive care unit and sometimes surgery are often necessary for invasive disease. Early treatment may reduce the risk of death, but it is not always possible to prevent death in every case. A student should be expected to show improvement within 48 hours of antibiotics and is no longer contagious after 24 hours of antibiotic therapy if the student does not have a fever.

Reporting Requirements

Group A streptococcal infections that are invasive or of toxic shock nature must be reported to the local health department within three days of diagnosis.

Notification Requirements

When strep infections occur within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
2. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.
3. If there is a case of strep throat in school, refer students and staff with sore throats to their health care providers for evaluation.
4. Be alert to an outbreak. If there are any cases associated with rheumatic fever, kidney disease or toxic shock, consult with the local health department about having all students and staff cultured.

Haemophilus Influenzae Type B (Hib), Invasive

Haemophilus influenzae is a type of bacteria that is commonly found in the nose and throat of children and adults. A particular type, *Haemophilus influenzae* serotype b (Hib), can invade and cause serious infections. Hib may cause meningitis (inflammation of the coverings of the spinal column and brain), bloodstream infections, pneumonia, arthritis, epiglottitis, and infections in other parts of the body. Despite its name, this disease has nothing to do with the influenza (flu) virus.

Hib disease can occur at any age. Although Hib was once the leading cause of bacterial meningitis among young children, few childhood cases are reported now due to widespread use of Hib vaccination. Hib disease is more commonly seen in unimmunized or incompletely immunized children, especially those less than 5 years of age, and in people with weakened immune systems.

Symptoms of meningitis may include fever, headache, vomiting, nausea, listlessness, and a stiff neck or back. Pneumonia symptoms may include shortness of breath, fever, lack of energy, chest pain, and cough. Other symptoms depend upon the part of body infected. Symptoms generally appear in less than 10 days after exposure and more commonly within 2-4 days.

Transmission

The bacteria that cause Hib disease are transmitted presumably person to person, by direct contact (e.g., kissing) with infected fluids, or by sharing eating utensils, drinking cups, straws, etc., since the bacteria may persist for hours (particularly in the cold and low humidity). Bacteria can also be passed if infected secretions are touched by people who then put their hands in their mouth, nose, or eyes. It is also spread by breathing in infected droplets of respiratory secretions containing the organisms. Airborne spread occurs predominantly among crowded populations in enclosed spaces, such as school buses. The exact period of communicability is unknown but may be for as long as the organism is present in the upper respiratory tract. The incubation period is unknown but probably is short - 2 to 4 days.

Spread is more likely among children under age 4 years. Disease is most common in children 3 months to 3 years of age. In a household or group care center where there are young children and everyone is in close contact, there is an increased risk of a second infection following a first case. Unvaccinated children, particularly those younger than 4 years of age who are in prolonged close contact (such as in a household) with a child who has developed invasive disease caused by H influenzae type B, are at increased risk for serious infection from this organism. Other factors predisposing an individual to invasive H influenzae type B include sickle cell disease, asplenia, and certain immunodeficiency syndromes, including HIV infection and malignancies.

School Exclusion Guidelines

Communicable: The exact period of communicability is unknown but may be as long as the organism is present in the respiratory tract.

Case: Students with Hib disease should not return to school until they are well and after they have finished taking the antibiotic for 1 to 2 days.

Contacts: Students who are not ill with Hib disease may return to school when antibiotic treatment has begun. Students or staff who are ill should be excluded while they are ill and until they have taken the antibiotic for 1 to 2 days.

The school health personnel, collaborating with the local health department, should decide when students and staff should be required to take a prescribed antibiotic when one case of Hib disease occurs in school.

Diagnosis

These illnesses are diagnosed by culturing an infected person's blood, spinal fluid, middle ear fluid, or other infected fluid. It may take up to 72 hours to grow and identify the bacteria. Early diagnosis may be able to be made by examination of the infected fluid under a microscope.

Treatment

Haemophilus influenzae disease, including Hib disease, is treated with antibiotics, usually for 10 days. Most cases of invasive disease (when bacteria invade parts of the body that are normally free from germs) require hospitalization. Even with antibiotic treatment, 3%-6% of all children with Hib meningitis die from the disease. When *Haemophilus influenzae* bacteria cause a non-invasive infection, like bronchitis or an ear infection, antibiotics may be given to prevent complications.

A child with *Haemophilus influenzae* disease, including Hib, may not develop protective levels of antibodies. This means that someone could develop a *Haemophilus influenzae* infection again. Children younger than 24 months of age who have recovered from invasive Hib disease should not be considered protected and should receive Hib vaccine as soon as possible.

Sometimes *Haemophilus influenzae* bacteria spread to other people who have had close or lengthy contact with a patient with *Haemophilus influenzae* disease. In certain cases, people in close contact with that patient should receive antibiotics to prevent them from getting the disease. This is known as prophylaxis. A doctor or local health department will make recommendations for who should receive prophylaxis.

Reporting Requirements

Reporting of a person confirmed or suspected of having *Haemophilus influenzae* infection, invasive, must be made immediately by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification Guidelines

When Hib disease occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § [22.1-271.1](#), § [22.1-271.2](#), and § [32.1-46](#). Please refer to the Centers for Disease Control and Prevention for the most current [Immunization Schedule](#).
2. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
3. Inform parents and staff that antibiotics do not give 100 percent protection against disease. Therefore, any child or adult who becomes ill with fever, headache, or stiff neck, should be seen promptly by a health care provider. (Children less than 2 years old are at greatest risk of developing serious Hib disease.)
4. Monitor the situation closely for 2 to 3 weeks. Make sure all ill students—particularly those with fever, headache, stiff neck, and other symptoms associated with the illness—are seen by their health care provider and that the school is notified if another person develops Hib infection.
5. The time of greatest risk of others becoming ill is the first week following the first case. Some risk exists for up to 2 months.
6. Notify parents of any new student enrolled in the school within 2 months of the last case.

Hand, Foot, and Mouth Disease (Coxsackievirus)

Hand, foot, and mouth disease (HFMD) is caused by viruses that belong to the Enterovirus genus (group). This group of viruses includes polioviruses, coxsackieviruses, echoviruses, and enteroviruses. HFMD is a common viral illness that usually affects infants and children younger than five years old; however, it can sometimes occur in adults. HFMD usually starts with a fever, poor appetite, a vague feeling of being unwell (malaise), and sore throat. One or two days after fever starts, painful blistered sores usually develop in the mouth and a skin rash may appear. The rash is usually on the palms of the hands and soles of the feet; it may also appear on the knees, elbows, buttocks or genital area. Symptoms usually appear three to six days after exposure.

Transmission

HFMD is generally spread from person to person through direct contact with respiratory secretions, droplets, contact with stool of infected person, or spread when infected persons touch objects/surfaces that are touched by others. Infected persons are most contagious during the first week of the illness. The viruses that cause HFMD can remain in the body for weeks after symptoms have gone away. This means that infected people can still pass the infection to others, even though they may appear well. Some people who are infected and shedding the virus, including most adults, may have no symptoms.

School Exclusion Guidelines

Communicable: The virus is contagious before symptoms begin and continues to be transmissible as long as the virus is shed in the stool.

Case: School exclusion is not indicated if the person is well enough to attend school.

Contacts: School exclusion is not indicated.

Diagnosis

Hand, foot and mouth disease is one of the many infections that cause mouth sores. Health care providers are able to determine whether the mouth sores are caused by hand, foot and mouth disease by considering the age of the patient, what symptoms are reported and by the appearance of the mouth sores. Additionally, depending on how severe the symptoms are, samples from the throat or stool may be collected and sent to a laboratory to test for the virus.

Treatment

No specific anti-viral treatment is available. Care is supportive.

Reporting Requirements

Hand, foot, and mouth disease is not a reportable disease.

Notification Guidelines

When hand, foot, and mouth disease occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Particular attention should be given to hand washing and personal hygiene as well as environmental cleaning and sanitation.

Hepatitis A

Hepatitis A (formerly infectious hepatitis) is a viral infection of the liver caused by the hepatitis A virus (HAV). The disease is fairly common. Anyone who has not been infected with HAV previously or has not been vaccinated against Hepatitis A can become infected and ill from the Hepatitis A virus. About 3,000 cases of hepatitis A are reported in the United States each year.

The symptoms of Hepatitis A may appear 2 to 6 weeks after exposure (usually within 4 weeks) and in adults include fatigue, loss of appetite, nausea, fever, and jaundice. Urine may become darker in color, and then jaundice (a yellowing of the skin and the whites of the eyes) may appear. These symptoms usually last from 1 to 2 weeks. In infants and pre-school children, most infections are either asymptomatic or cause mild non-specific symptoms without jaundice. Not everyone who is infected with Hepatitis A will have all of the symptoms. An individual who has recovered from Hepatitis A is immune for life and does not continue to carry the virus.

Transmission

The Hepatitis A virus is transmitted person to person by the fecal-oral route. It enters through the mouth, multiplies in the body, and is passed in the feces (stool). The virus can then be carried by an infected person's hands and can be spread by direct contact or by consuming food or drink that has been handled by the individual. Outbreaks from one common source have been related to contaminated water; food contaminated by food handlers, including sandwiches that are not cooked or are handled after cooking; raw or undercooked mollusks harvested from contaminated waters; and contaminated produce such as lettuce and strawberries. Although rare, instances have been reported of transmittal by transfusion of blood/blood products. Since most young children with Hepatitis A do not become ill, the first sign of infection in a school, daycare, or baby-sitting setting is often a jaundiced parent or staff member. The incubation period is from 15 to 50 days, depending on dose; average 28 to 30 days.

School Exclusion Guidelines

Communicable: Viral shedding and probably the contagious period lasts 1 to 3 weeks. The stools of infected people are the most highly contagious 1 to 2 weeks before the onset of illness, during which time patients are most likely to transmit infections. Communicability decreases from this point.

Case: Exclude from school until health care provider advises return. Convalescence maybe prolonged.

Contacts: School exclusion is not indicated. Stress importance of proper hand washing. Exposure at school generally does not pose a significant risk of infection, and contacts need not be excluded from school. However, IG (immune globulin) may be given to those who have close personal contact with the infected person.

Diagnosis

Signs and symptoms are the same for all types of acute viral hepatitis, including Hepatitis A. As a result, acute Hepatitis A must be diagnosed by a specific laboratory test on a sample of blood.

Treatment

There are no special medicines or antibiotics that can be used to treat a person once the symptoms appear. Generally treat symptoms, rest, good nutrition, and fluids is all that is needed for persons to recover from Hepatitis A.

Reporting Requirements

Reporting of a person confirmed or suspected of having Hepatitis A must be made immediately by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification Guidelines

When Hepatitis A occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. The single most effective way to prevent spread is careful hand washing after using the toilet, changing diapers, or before eating or preparing food.
3. If a case of Hepatitis A occurs in a kindergarten, first grade, or pre-school class where hygiene may not be optimal (e.g., hand washing is poor, diapering may be needed), more stringent control measures, including the use of IG (immune globulin), may be indicated. The local health department can provide recommendations.
4. Disinfection of 'clean' surfaces with a 1:100 dilution of household bleach in water (i.e., approximately ¼ cup of 5.25% bleach in one gallon of water) or cleaning solutions containing quaternary ammonium and/or hydrogen chloride (including concentrations found in many toilet cleaners) are effective in inactivating HAV.
5. Avoid eating raw shellfish taken from potentially contaminated waters. Also, infected people should not handle foods during the contagious period.
6. The Hepatitis A vaccine is effective at preventing infection with HAV.

7. Close contacts of an infected person should call a doctor or the health department to determine if they should obtain a shot of vaccine or immune globulin (IG) to reduce their chance of becoming ill.
8. For students and staff at increased risk for Hepatitis A, the Hepatitis A vaccine may be recommended.

Hepatitis B

Hepatitis B (formerly serum hepatitis) is a viral infection of the liver caused by the Hepatitis B virus (HBV). The disease is fairly common. HBV infection in children is symptomatic in less than 10 percent of cases. When it is symptomatic the typical signs and symptoms include fever, fatigue, loss of appetite, nausea, vomiting, abdominal pain, light-colored stools, dark colored urine, and jaundice (yellowing of the skin and whites of the eyes). Pain in joints and rashes can occur early in the course of the infection. Illness can range from infection without symptoms, to mild symptoms with jaundice to severe illness with jaundice to rapid liver failure and death.

Hepatitis B virus can cause chronic infection with persistent shedding of the virus into body fluids including blood in up to 90 percent of infants who become infected by perinatal transmission (from mother to fetus during pregnancy or birth), 25 to 50 percent of children up to age 5, and 2-6 percent adults who acquire HBV infection. Chronically infected persons are at increased risk for developing chronic liver disease (e.g., cirrhosis, chronic active hepatitis, and chronic persistent hepatitis) or liver cancer later in life. Persons infected as infants or young children appear to be at higher risk of death from liver disease than those infected as adults.

Transmission

The virus is transmitted through blood or body fluids, such as infected discharge from a wound, semen, cervical secretions, and saliva. Blood and serum contain the highest quantities of virus; saliva contains the least. HBV is spread when blood or body fluids containing the virus get into broken skin or onto mucous membranes inside the mouth, eyes, rectum, or genital tract. HBV spread requires contact with infected fluid through the skin via a needle stick, contamination of a cut, blood transfusion (now rare in the United States as the result of current donor screening practices), sharing or reusing of unsterilized needles, and sexual activities. HBV can survive in the dried state for 1 week or longer. Therefore, contact of exposed skin and mucous membranes with contaminated inanimate objects may transmit infection. HBV is not transmitted by the fecal-oral route. The incubation period is from 6 weeks to 6 months; symptoms typically appear within three months.

Most infected persons in the United States acquire their infection as adolescents or adults. Infection is associated with other sexually transmitted diseases, including syphilis. Groups at highest risk for infection with HBV include users of intravenous drugs, persons with multiple heterosexual partners, and homosexual men. Others at increased risk include those with occupational exposure to blood or body fluids, staff of institutions and nonresidential childcare programs for the developmentally disabled, persons receiving hemodialysis, and sexual or household contacts of persons with an acute or chronic infection.

School Exclusion Guidelines

Communicable: School transmission is rare. HBV infection is transmitted by direct contact with infected body fluids, not casual contact. A person is considered contagious as long as the virus is present in their blood (this can be for the lifetime, and the person then becomes a chronic carrier). The virus can survive, dried up, for 1 week on inanimate objects.

Case: Persons with acute HBV infection are advised to follow the advice of their primary health care provider or local health department. Exclusion from school of HBV carriers is not indicated. The risk of HBV spread in a school setting is considered very low and does not justify exclusion of the hepatitis B carrier or routine screening of children prior to enrollment. However, in schools the risk of spread is higher from an infected person with behavior and/or medical problems, such as biting behavior that draws blood, or oozing skin sores. These behaviors may increase the possibility of transfer of infected fluid. A student or staff member with chronic HBV who has open, oozing sores that cannot be covered should remain at home until the skin sores are healed.

Contacts: School exclusion is not indicated.

Diagnosis

Hepatitis B is diagnosed using various laboratory tests and the presence of certain symptoms. There are many different blood tests available to diagnose Hepatitis B. They can be ordered as an individual test or as a series of tests.

Treatment

There is no treatment for acute HBV. Generally, rest and diet modifications are all that are needed for uncomplicated cases. Several medications are available for the treatment of chronic HBV infection. Questions and concerns about management of acute and chronic Hepatitis B infection should be addressed with a healthcare provider.

Reporting Requirements

Hepatitis B must be reported to the local health department within three days of diagnosis.

Notification Guidelines

Parents should be encouraged to notify the school nurse if their child is a known Hepatitis B carrier. Parents of other students attending the school do not need to be informed. When Hepatitis B occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § [22.1-271.1](#), § [22.1-271.2](#), and § [32.1-46](#). Please refer to the Centers for Disease Control and Prevention for the most current [Immunization Schedule](#).
2. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
3. Use universal precautions. (See previous section on "[Universal Precautions](#).") Make sure all staff receive regular training on prevention of bloodborne disease. Age-appropriate education should be provided to students on transmission of bloodborne diseases, including sexual transmission and procedures for hand washing and cleanliness at school. (*Code of Virginia*, § 22.1-271.3, requires that "Every school board shall ensure that all school personnel having direct contact with students receive appropriate training in the etiology, prevention, transmission modes, and effects of blood-borne pathogens, specifically, hepatitis B and human immunodeficiency viruses...")
4. Do not permit sharing of personal items that may become contaminated with blood or body fluids, such as toothbrushes, razors, eating utensils, or any other object that can be mouthed.
5. Cover open sores or wounds.
6. If an individual has been exposed to hepatitis B (such as by a needle stick, a bite that has drawn blood, or sexual contact with an acutely infected person), hepatitis B immune globulin (HBIG) should be given. If the exposed person has not already been vaccinated, it is recommended they also receive the vaccine series after the immune globulin injection. Contact the local health department and health care provider for immediate advice.
7. Place disposable items contaminated with blood or body fluids in plastic bags in covered containers. (See previous section on "[Universal Precautions](#).")
8. Store clothing or other washable items stained with blood and/or body fluids separately in a plastic bag and send them home with the owner for appropriate cleaning. Clothing stained with blood or other body fluids should be washed with hot water in a regular cycle wash.
9. Wash and sanitize surfaces of toys contaminated with blood or body fluids with a diluted bleach solution (i.e., 1.5 cups of 5.25% bleach freshly made up on a daily basis or disinfect objects by boiling them for 10 minutes).
10. Discourage aggressive behavior (e.g., biting, scratching) at the school and supervise closely to avoid these behaviors.

Hepatitis C

Hepatitis C (formerly Hepatitis Non-A Non-B) is a viral infection of the liver caused by the Hepatitis C virus (HCV). It often has signs and symptoms indistinguishable from Hepatitis A or B infection. In most cases the signs and symptoms are not as severe. Most people do not have any symptoms at all. When illness occurs, it can range from a mild illness lasting a few weeks to a serious, lifelong illness. Symptoms might include fever, fatigue, yellow-colored skin (jaundice), dark urine, and light-colored stools. Chronic Hepatitis C is a serious disease that can result in long-term health problems, including liver damage, liver failure, liver cancer, or even death. It is the leading cause of cirrhosis and liver cancer and the most common reason for liver transplants in the United States. Approximately 15,000 people die every year from Hepatitis C-related liver disease. In children most infections are asymptomatic. Hepatitis C can be either acute (short-term) or chronic (long-term). Approximately 75-85% of people who become infected with HCV develop chronic infection.

Transmission

HCV lives in the blood. Hepatitis C is spread when blood of someone with Hepatitis C enters the body of another person. This can happen when people who inject drugs share needles, syringes, or other equipment with each other or when a healthcare worker accidentally gets stuck with a needle from a patient who has HCV in the blood. HCV can also be transmitted to the baby of an infected mother during delivery; it is not spread by breastfeeding. The risk of Hepatitis C from sexual contact is believed to be low, but this risk is increased for those who have multiple sex partners, have a sexually transmitted disease, engage in rough sex, or are infected with HIV. HCV is not spread by sneezing, hugging, coughing, food or water, sharing eating utensils or drinking glasses, or casual contact. The risk of Hepatitis C is higher in anyone who has ever injected drugs, people who had a blood transfusion before 1992, healthcare workers with a blood exposure (e.g., by an accidental needle stick), children born to mothers with HCV infection, long-term dialysis patients, and persons with HIV infection. The incubation period for acute HCV ranges from 2 weeks to 6 months; most commonly 6 to 7 weeks. The effects and symptoms of chronic Hepatitis C can take years or decades to appear.

School Exclusion Guidelines

Communicable: Infected persons can spread the virus beginning one or more weeks before the onset of symptoms and throughout the course of the disease. Chronic carriers may spread the virus indefinitely.

Case: School exclusion is not required. Persons who have Hepatitis C should be educated about their carrier status and observe universal precautions.

Contacts: School exclusion is not indicated. All students and staff should adhere to universal precautions.

Diagnosis

HCV is diagnosed by screening the blood for antibodies to Hepatitis C in those who have symptoms and abnormal liver function tests suggestive of Hepatitis. Some individuals will test positive for Hepatitis C but will not display symptoms. These individuals can still spread the disease.

Treatment

For acute Hepatitis C, doctors recommend resting and drinking plenty of fluid. People with chronic Hepatitis C should be monitored regularly for signs of liver disease and evaluated for treatment. The treatment most often used for Hepatitis C is a combination of two or more medicines, given over several months. Not every person with chronic Hepatitis C needs or will benefit from treatment. In addition, the drugs may cause serious side effects in some patients. Persons with Hepatitis C should be vaccinated to prevent Hepatitis A and Hepatitis B. They should also avoid alcohol or medications or supplements that can damage the liver.

Reporting Requirements

Hepatitis C must be reported to the local health department within three days of diagnosis.

Notification Guidelines

Parents should be encouraged to notify the school nurse if their child is a known Hepatitis C carrier. Parents of other students attending the school do not need to be informed. When Hepatitis C occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. All students and staff should adhere to strict universal precautions. (See previous section on "[Universal Precautions.](#)")
3. Students and staff who have Hepatitis C should be aware that their blood and possibly other body fluids may carry the virus and should take care not to expose others through sharing of needles, razors, toothbrushes, or other items that may be contaminated.
4. Students and staff who might be exposed to blood in their job need to wear gloves and follow strict universal precautions.

Hepatitis E (Enterically Transmitted Non-A, Non-B Hepatitis)

Hepatitis E virus (HEV) is the major causative organism of enterically transmitted non-A, non-B Hepatitis. HEV is an acute, self-limiting illness, presenting with jaundice (yellowing of the skin, whites of eyes, mucous membranes, and body fluids), fatigue, anorexia, fever, abdominal pain, and arthralgia (pain in a joint). HEV is widespread in the developing world. Though rare in developed countries, locally acquired HEV infection can result in acute Hepatitis with tendency to progress to chronic Hepatitis mainly among solid organ transplant recipients.

Transmission

Hepatitis E virus is usually spread by the fecal-oral route. The most common source of infection is fecally contaminated drinking water. In developed countries sporadic outbreaks have occurred following consumption of uncooked/undercooked pork or deer meat, or consumption of shellfish. There is a possibility of zoonotic spread of the virus. HEV RNA had been extracted from meat and organ of some animal species including pigs, boar, and deer. HEV infection is more common in adults than children and has an unusually high case-fatality rate in pregnant women. HEV infection is not endemic to the United States, but cases have occurred in travelers from the United States to endemic areas (including Asia, Africa, and Mexico) usually related to contaminated water. The incubation period is approximately 2 to 8 weeks.

School Exclusion Guidelines

Communicable: The period of communicability after acute infection is unknown, but virus shedding in the stool and the presence of virus in the blood occurs for about 2 weeks after the onset of jaundice. Chronic infection does not occur.

Case: Persons diagnosed with HEV should be excluded from school until symptoms have resolved.

Contacts: School exclusion is not indicated. Students and staff should adhere to careful sanitation and hygiene practices.

Diagnosis

Diagnosis is established by exclusion of Hepatitis A, B, C, D, and other viral causes of acute hepatitis. No diagnostic test is available.

Treatment

There is no anti-viral medication available for the treatment of HEV. Care is supportive.

Reporting Requirements

Hepatitis E must be reported to the local health department within three days of diagnosis.

Notification Guidelines

When Hepatitis E occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Promote hand washing after using the bathroom and before preparing food.
3. Ensure that bathrooms have an adequate supply of soap, running water, paper towels, and toilet paper.
4. Staff caring for students in diapers should be sure to use universal precautions. (See previous section on "[Universal Precautions](#).")
5. Pay attention to environmental cleaning and sanitation.
6. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.

Herpes Simplex Infection

Herpes simplex viral (HSV) infections are characterized by skin blisters or sores that can be very itchy and painful. Once a person is infected, these viruses remain in nerve cells, and HSV tends to recur at the same places on the body again and again. There are two types of herpes simplex virus: HSV-1 (usually found in the mouth) and HSV-2 (usually found on the genitals).

HSV-1 is extremely common. The first infection typically occurs in childhood. It is mild and often goes unnoticed. It may come in the form of gingivostomatitis - fever accompanied by widespread painful ulcerations (sores) in the mouth. HSV usually recurs as cold sores—single or multiple blisters around the lip. In rare cases, HSV may be spread by direct contact and cause infection on a finger (herpetic whitlow - painful, recurrent blisters of a finger) or in the eye (herpetic keratitis - recurrent ulcerations of the cornea) or other places on the skin. HSV-1 dermatitis/conjunctivitis (herpes gladiatorum) has been diagnosed in wrestlers and other contact-sport participants. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.

HSV-2 is the cause of most cases of genital herpes. It is sexually transmitted. The first infection is often characterized by painful genital blisters and ulcers accompanied by fever and can last 2 weeks. Recurrence is common, usually as localized, less painful ulcers that go away in 7 to 10 days and are not accompanied by fever. Recurrence may also be asymptomatic.

Herpes of the newborn occurs when the infant passes through an infected birth canal. The resulting illnesses range in severity from skin blisters to total body disease resulting in severe brain damage or death. Herpes infection in children is generally caused by HSV-1, and while uncomfortable, is rarely serious. People who have severe eczema (atopic dermatitis) or immune system problems may experience more severe symptoms of herpes infection. Children should be cautious about HSV spread to hands and eyes. Touching lesions should be discouraged as much as possible. Young children with HSV lesions also need to be monitored to avoid spread to newborn infants.

Transmission

HSV-1 is probably transmitted mostly by contact with the virus in the saliva of carriers but is also transmitted through direct contact with open sores. HSV-1 is most common in young children. HSV-2 is usually transmitted by sexual contact and is more common in adolescents and adults. HSV-2 may be diagnosed in children in unusual circumstances or as a result of sexual abuse. Both HSV type 1 and 2 may be transmitted to various sites by oral-genital, oral-anal, or anal-genital contact. The incubation period is from 2 to 12 days.

Because Herpes viruses can survive as long as 4 hours on any surface, mouthed objects contaminated by virus-containing saliva may transmit infections of the mouth.

School Exclusion Guidelines

1. Students or staff with open, oozing skin sores (including herpetic whitlow) that cannot be covered should not attend school.
2. If individuals typically put their fingers in their mouth, they should be excluded until the lesions are crusted over.
3. In the case of students who are drooling or have biting behavior, permit them to return to school settings when blisters are crusted over.
4. Students or staff with skin blisters that cannot be covered should be permitted to return when the blisters are crusted over.
5. Do not exclude students or staff with mouth sores or skin blisters that can be covered or those with genital herpes.
6. Students or staff with herpetic whitlow should be permitted to attend school if lesions are covered.

Diagnosis

Diagnosis is usually made based on the history and distinctive appearance of the blisters or sores. Microscopic exam and/or viral cultures are available.

Treatment

Anti-viral therapy for HSV infections is available. Treatment is given for genital herpes and more serious HSV disease, such as infections of the brain or eye. Anti-viral therapy may shorten the length of some less serious HSV infections (e.g., cold sores).

Reporting Requirements

There is no requirement to report HSV infections either type 1 or type 2 unless they occur in newborn babies.

Notification Guidelines

None.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.

2. Make sure that staff who may come in contact with blisters on students wear gloves and use universal precautions during diapering or changing of a dressing. (See previous section on "[Universal Precautions.](#)")
3. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.
4. To control spread of Herpes gladiatorum, educate athletes and trainers about the risk, conduct routine examinations before wrestling contacts, exclude wrestlers with suspicious lesions, and refer them for diagnosis and treatment. Sanitizing of mats with a dilute bleach solution (1 tablespoon bleach to 1 quart of water) and airing of mats is also recommended as a standard precaution.

HIV Infection and AIDS

Authorization

[Code of Virginia. Section 22.1-271.3 Guidelines for school attendance for children infected with human immunodeficiency virus; school personnel training required; notification of school personnel in certain cases.](#)

The *Code of Virginia* provides guidelines for school attendance for students who are infected with the human immunodeficiency virus (HIV). These guidelines include requirements for training of school personnel and requirements for notification of school personnel in certain cases of students with HIV infection.

Overview

HIV/AIDS. Human immunodeficiency virus (HIV) is the virus that causes the acquired immunodeficiency syndrome (AIDS). Human immunodeficiency virus type-1 (HIV-1) infection in children attacks the immune system, resulting in a progressive deterioration of the immune system. Ultimately, this impairment of the body's defense system leads to opportunistic infections (any infection that results from a defective immune system that cannot defend against bacteria normally found in the environment), malignancies, and other conditions associated with acquired immunodeficiency syndrome (AIDS) - the most severe disease state caused by HIV. With early testing and appropriate treatment, children in the United States rarely develop the severe symptoms of HIV infection. If the infection is acquired before or during birth from infected mothers, infants typically develop signs or symptoms between 12 and 18 months, although many remain symptom free for more than 5 years. With treatment, most children live into adulthood.

Signs and Symptoms. It is not unusual for an HIV-infected person to feel healthy for a long time, without displaying signs and symptoms of illness. However, this individual can still transmit the virus to other people. The appearance of symptoms may signal deterioration of the immune system and the onset of a progressive course of HIV infection.

Signs/Symptoms of HIV. Signs/symptoms of HIV infection may include:

- Generalized lymphadenopathy (disease of the lymph nodes).
- Hepatomegaly (an enlargement of the liver).
- Splenomegaly (enlargement of the spleen).
- Failure to thrive.
- Oral candidiasis also called thrush (a yeast infection of the oral mucous membranes).
- Recurrent diarrhea.

- Parotitis (inflammation of the parotid gland).
- Nephropathy (disease of the kidney).
- Central nervous system (CNS) disease (including developmental delay, which may be progressive).
- Lymphoid interstitial pneumonia.
- Recurrent invasive bacterial infections.
- Opportunistic infections.
- Specified malignancies.

Clinical Manifestations in Children with Perinatally Acquired HIV. In children who have acquired HIV perinatally, the most common early clinical manifestations include:

- Failure to thrive or wasting.
- Failure or delay in meeting developmental milestones.
- Swelling of the salivary glands.
- Chronic or recurrent diarrhea without specified cause.
- Generalized lymphadenopathy.
- Hepatosplenomegaly (enlargement of the liver and spleen);
- Persistent or recurrent oral candidiasis.
- A variety of recurrent infections, including otitis media, pneumonia, and meningitis (usually of bacterial origin but may be caused by viral, fungal, or parasitic microorganisms).

Infections in HIV-Infected Children. In older children, acute and complicating infections may be interspersed with periods during which the child functions relatively normally. As the disease progresses, involvement of multi-organ systems and the occurrence of multiple infections are as common as it is in younger children.

Pneumocystis pneumonia (interstitial plasma cell pneumonia [PCP]) is the most common, serious opportunistic infection in children with HIV infection and is associated with high mortality. This illness most frequently occurs in infants peaking at 3 to 6 months who acquired the disease before or at birth. Other common opportunistic infections in children include:

- Candida esophagitis (inflammation of the esophagus caused by a fungus).
- Disseminated cytomegalovirus infection.
- Chronic disseminated herpes simplex.
- Varicella zoster virus infections.

CNS Disease. The degree of CNS disease associated with HIV infection correlates with the severity of the disease. In the infant or young child CNS disease may present as developmental delay or loss of milestones. Older children may show evidence of learning disabilities or attention deficit disorders.

AIDS. Acquired immunodeficiency syndrome (AIDS) is the “late stage” of infection with the human immunodeficiency virus (HIV). Separate disease classifications have been developed by the Centers for Disease Control and Prevention (CDC) for both children and adults that relate clinical and immunological status and describe the parameters of disease.

An understanding of HIV infection and AIDS by school health personnel can promote a comprehensive approach by various school disciplines to ensure each student receives the appropriate education testing, academic, and when necessary, mental health services to ensure an optimum educational experience.

Civil Rights Laws. Federal civil rights laws, particularly [Section 504 of the Rehabilitation Act of 1973](#) and the [Americans with Disabilities Act of 1990 \(ADA\)](#), protect the rights of people with disabilities and prohibit discrimination. The U.S. Congress has defined HIV infection, with or without symptoms, as a disability. Section 504 regulations mandate that every student with a disability be provided a “free, appropriate public education.” It is incumbent upon school personnel to work with families and students with HIV infection to ensure these students receive the appropriate and mandated services.

Education of Staff and Students. The [Code of Virginia, § 22.1-271.3](#), requires that “Every school board shall ensure that all school personnel having direct contact with students receive appropriate training in the etiology, prevention, transmission modes, and effects of blood-borne pathogens, specifically, hepatitis B and human immunodeficiency viruses...” In addition, education of staff and students about HIV infection and AIDS can promote implementation of prevention strategies and provide personal and professional approaches for all individuals whose lives are touched by a student or staff member with this illness.

The National Association of State Boards of Education has made available a publication entitled [Someone at School Has AIDS: A Complete Guide to Education Policies Concerning HIV Infection](#). The publication provides school divisions with a variety of information including:

- Sample school policy guidelines.
- Education and prevention program ideas.
- Legal requirements and responsibilities.
- Addressing specific issues (e.g., infection control, HIV and athletics).
- Resources.

Schools are encouraged to use this publication in conjunction with the information provided in this section.

Transmission

Routine social or community contact with an HIV-infected person carries no risk of transmission; only sexual exposure and exposure to blood or tissues carries a risk. The routes of transmission of HIV are analogous to those of Hepatitis B virus (HBV).

Epidemiological evidence indicates that HIV can be transmitted person to person through sexual contact, the sharing of HIV-contaminated needles and syringes, and transfusion of infected blood or its components. While the virus has on occasion been found in saliva, tears, urine, and bronchial secretions, transmissions after contact with these secretions has not been reported.

From 25% to 35% of infants born to HIV-infected mothers are infected before, during, or shortly after birth; treatment of pregnant women results in marked reduction of infant infections.

Breastfeeding by HIV-infected women can transmit infection to their infants.

After direct exposure of healthcare workers to HIV-infected blood through injury with needles and other sharp objects, the rate of seroconversion is less than 0.5%, much lower than the risk of HBV infection (about 25%) after a similar exposure. In summary, established modes of transmission in the U.S. are via:

- Blood-to-blood contact, by use of HIV-contaminated needles during intravenous drug injection.
- A mucous membrane exposure.
- A penetrating injury with a needle or sharp object containing HIV-infected blood.
- Tissue or organ transplantation.
- Blood transfusion. Transfusion of blood, blood components, or clotting factor concentrates is now rarely a mode of HIV transmission in the U.S. because of exclusion of infected donors, viral inactivation treatment of clotting factor concentrates, and the availability of recombinant clotting factors.
- Unprotected sexual intercourse, including anal intercourse (regardless of the gender or sexual orientation of the partner), vaginal intercourse, or oral intercourse. HIV is transmitted through semen (including pre-ejaculatory fluid), vaginal fluids (including menstrual blood, cervical discharge, and the natural fluids that lubricate the vagina), and blood.
- Mother-to-infant, before or around the time of birth and during breastfeeding.

HIV has been isolated from blood and other body fluids, such as cerebrospinal fluid, pleural fluid, human milk, semen, cervical secretions, saliva, urine, and tears. However, only blood, semen, cervical secretions, and human milk are implicated in the transmission of the infection.

HIV is **NOT** transmitted through:

- Casual contact, such as touching, kissing, saliva, tears, and hugging a person with HIV.
- Animal or bug bites.
- Eating food handled, prepared, or served by a person with HIV infection.
- Sharing toilets, telephones, or clothes.
- Sharing forks, spoon, knives, drinking glasses, food or drink.
- Attending school or other public places with persons infected with HIV.

School Exclusion Guidelines

Communicable: Transmission of HIV is by direct contact with infected blood or body fluids.

Case: Follow the advice of the student's health care provider and local health department. The need for a more restricted environment for some infected children should be evaluated on a case-by-case basis with consideration of conditions that pose an increased risk to others, such as an aggressive biting behavior or presence of exudative, weeping lesions that cannot be covered. These conditions may increase the possibility of transfer of infected fluid. A student or staff member with HIV who has open, oozing sores that cannot be covered should remain at home until the skin sores are healed.

Contacts: School exclusion is not indicated.

Diagnosis

The diagnosis of symptomatic HIV and AIDS is based on the clinical, serologic (blood), and immunologic findings and exclusion of other causes of immunodeficiency (a depressed immune system). Other than infants born of infected mothers, persons infected with HIV usually develop serum antibody to HIV 6 to 12 weeks after infection. Tests for HIV include:

- Enzyme immunoassays (EIA) widely used to screen for serum HIV antibody. Although this test is highly sensitive and specific, repeat testing of the initial reactive specimens is required to reduce the likelihood of laboratory error.
- Western blot or immunofluorescent antibody tests should be used for confirmation.

A positive HIV antibody test in a child 18 months of age or older usually is indicative of infection. If an HIV antibody test is negative, no antibodies were found, and the person does not have antibodies at the time of the test, individuals should refrain from all risky behavior to be sure of their sero-negative status and be retested in 3 to 6 months. Even after a negative test, an individual who puts him or herself at risk may become infected with HIV. Additional information on testing is available on the Centers for Disease Control and Prevention website on [HIV/AIDS](#).

Treatment

Children with HIV infection need close medical supervision with monitoring of their clinical, neurologic, and immunologic status. The child with HIV infection should receive routine childhood care, including immunizations (exceptions below), and should be evaluated promptly if infection or fever occurs. Therapy for HIV infection includes prophylaxis against pneumocystis pneumonia and other infections, antiretroviral therapy, and in certain instances, intravenous gamma globulin.

The current recommendation for immunizations and treatment of HIV-infected children are outlined in the [*Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Exposed and HIV-Infected Children*](#), published by the NIH.

HIV-infected students are expected to be in compliance with an immunization schedule ([Code of Virginia § 22.1-271.2](#)). Students who are HIV infected or have AIDS, may get an exemption as outlined in the Code.

Reporting Requirements

Acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection must be reported to the local health department within three days of diagnosis.

Disclosure and Confidentiality

No one except the student and/or student's parent(s) or guardian(s) necessarily need to know of a student's HIV or AIDS diagnosis. They are not obligated to disclose this information to anyone in the educational system. Although it is difficult for some people to accept, there is no reason school authorities must know if a student or staff member has HIV or AIDS. School policy should respect the privacy of people with HIV infection and their families to:

- Protect them from potentially hurtful stigma or hostility if the information becomes public.
- To prevent harmful distractions to learning due to misinformation and rumors.
- To promote an environment in which families, students and staff with HIV or AIDS may come forward to discuss private matters with school officials if that becomes necessary.
- To respect the decisions of parents who may have chosen to withhold information about an HIV or AIDS diagnosis from a student who they feel has not reached a level of maturity to understand their illness.
- To promote an environment in which confidentiality is the norm so that those in need of antibody testing, especially adolescents, will be more likely to be tested as they will not fear exposure.
- Because the information is not needed to promote safety.

Prevention through strict enforcement of infection guidelines, use of universal precautions, and education is a more effective policy than the need to disclose confidential information.

Disclosure. Since individuals with HIV infection and AIDS who do not engage in high-risk behavior are of no risk to others in the school, their medical information must be treated in a very confidential manner. Voluntary disclosure to the school superintendent, principal, or school health personnel can benefit the person with HIV infection. Upon learning a student is HIV infected or has AIDS, school personnel should consult with the family, their health care provider, and/or a person from the local health department to determine whether the student is well enough to attend school. These professionals are in a position to coordinate with others to provide necessary services.

Confidentiality. School physicians, school nurses, and school administrators, if made aware of a student's HIV or AIDS diagnosis, can inform others in the school of the situation on a **"Need to Know" basis with written consent of the parent/guardian.** For further information, refer to the [Code of Virginia § 32.1-36.1, Confidentiality of test for human immunodeficiency virus, civil penalty, individual action for damages or penalty.](#)

Nationally, the Family Educational Rights Privacy Act of 1974 (FERPA), places certain privacy restrictions on student records maintained by schools that receive federal funds. School personnel should consult this document when developing school policy.

Staff Members as Resource Person. Staff members who are well briefed on confidentiality and record keeping policies should be consulted on handling situations in which someone unexpectedly discloses HIV infection. Staff members may be approached by a student disclosing the positive HIV status of a family member, an adolescent might share results of recent HIV testing or fears related to the testing, or a special education planning team could find out about HIV infection from a medical evaluation. A staff member in this situation may be an invaluable resource to the person sharing this type of information. In this situation, a staff member may:

- Discuss the ramifications of further disclosure.
- Help locate an HIV/AIDS resource organization, teen crisis center, or hotline for the individual.
- Explain the positive health care advantages of informing school health personnel or school administrators, while stressing that disclosure is a personal decision and that confidentiality is mandatory.

The staff member who has become aware of this type of information may wish to talk to a counselor themselves, without revealing the identity of the person who has confided in them, in order to cope with their own feelings.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Use of universal precautions. (See previous section on “[Universal Precautions.](#)”)
3. Educate students, according to school policy, about preventing HIV infection and AIDS.

Resources

Students in grades K-12 can receive information designed specifically for their developmental and educational level. The curriculum provided in this publication is designed to be used in conjunction with the Virginia Department of Education [Standards of Learning Objectives for Health Education, Family Life Education](#). In addition, the publication [Someone at School Has AIDS: Sample School Policy](#) provides information on sample programs for HIV prevention education.

Additional resources include:

- [Centers for Disease Control and Prevention: HIV/AIDS](#)
- [Elizabeth Glaser Pediatric AIDS Foundation](#)
- [National Institutes of Health](#)
- [Virginia Department of Health: Epidemiology](#)

Impetigo

Impetigo is a common skin infection caused by streptococcal (“strep”) or staphylococcal (“staph”) bacteria. The first indication of infection may be discharge from an open, injured spot on the skin, such as an insect bite, cut or burn, where the bacteria are introduced. The bacteria can be easily spread by the individual’s hands to other areas of their skin. Skin lesions usually begin as small blisters and red, fluid filled, rounded bumps that ooze and may have a flat honey-colored crust and may be itchy. The blisters may break easily leaving raw, red “oozing” skin exposed. The incubation period is variable. Secondary infection with staphylococci bacteria is common. Serious but rare complications from secondary staphylococcal infection include cellulitis (inflammation of the skin, spreading through the tissue) and kidney disease.

Transmission

The bacteria that cause impetigo are transmitted by contact with a person who has a draining lesion or who is an asymptomatic (usually nasal) carrier of a pathogenic strain of bacteria, or from contaminated surfaces. Airborne spread is rare. While Impetigo can occur year-round, it is most common in warm weather with cut and scraped skin, and also occurs in cold weather when the skin around the nose and face is damaged by runny nasal secretions and nose wiping. The contagious period lasts until at least 24 hours of antibiotic treatment is completed or the crusting lesions are no longer present.

School Exclusion Guidelines

Communicable: As long as purulent lesions continue to drain, or the carrier state persists. See above under “Transmission.”

Case: Exclude from school until lesions are healed or 24 hours of antibiotic treatment has been completed.

Contacts: Exclusion from school is not indicated. Observe carefully for symptoms.

Diagnosis

Impetigo is diagnosed by history and exam. Culture can be obtained to support the diagnosis.

Treatment

Impetigo treatment consists of appropriate skin care and antibiotic ointment, and/or oral antibiotic.

Reporting Requirements

Impetigo is not a reportable disease.

Notification Guidelines

When Impetigo occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. When students and staff suffer an injury that causes a break in the skin, wash the area thoroughly with soap and water and dry it carefully.
3. When there is a risk of impetigo, wash the rash with soap and water and cover it loosely with gauze, a bandage, or clothing.
4. Be sure those who touch the rash wash their hands well. Dispose of any soiled tissues or bandages carefully and keep any possibly contaminated clothing in a plastic bag.
5. Contact the student's parents and advise them to have the student examined by their health care provider.

Influenza

Influenza (commonly referred to as the “flu”) is a viral disease of the respiratory tract. There are two main types of Influenza virus: A and B. Each type includes many different types that change each year. Influenza symptoms can include a sudden onset of fever, headache, chills, cough, sore throat, runny nose, and body aches. In children, vomiting and diarrhea might occur. Although most people are ill for less than a week, some people have complications and may need to be hospitalized. Anyone can get influenza, but it is more likely to cause serious illness in young children, pregnant women, older persons, people with chronic illnesses (e.g., lung disease, heart disease, cancer, or diabetes) or those with weakened immune systems. Influenza occurs most often in the late fall and winter months.

Transmission

The viruses that cause Influenza are highly communicable - the organisms are readily transmitted from one individual to another. Influenza spreads mainly by droplets from the nose or throat that are released when an infected person coughs or sneezes. Influenza can spread from one person to another beginning about one day before symptoms start through about a week after onset, but it may last longer in young children and those with weakened immune systems. Infection with the “flu” does not make a person immune. The viruses that cause Influenza frequently change, and people may be infected with a new strain. The incubation period is short, usually 1 to 4 days.

Diagnosis

Diagnosis is generally made presumptively based on symptoms. However, laboratory tests can be obtained to confirm this diagnosis.

Treatment

Rest, liquids, and over-the-counter medicines for fever and discomfort are the usual treatments. Prescription antiviral drugs are available and may reduce the severity of influenza. Aspirin should not be given to children with fever-causing illnesses because of the possibility of a complication called Reye’s syndrome.

School Exclusion Guidelines

Communicable. Children probably transmit Influenza virus for up to 7 days. Adults probably transmit the virus for 3 to 5 days.

Case. School exclusion is not indicated as long as a student or staff member is without fever for 24 hours and feels well enough to attend school.

Contact. School exclusion is not indicated. High-risk populations should be advised to consult with their health care provider for possible treatment with prophylaxis antibiotics.

Reporting Requirements

All confirmed Influenza must be reported to the local health department within three days of diagnosis. Influenza A, Novel Virus, and all influenza-associated deaths in children < 18 years of age must be reported immediately by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification Requirements

None.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Follow hand washing and cleanliness procedures. Careful attention to good personal hygiene, handwashing, and environmental cleaning and sanitation is very important in reducing the spread of influenza.
3. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.
4. All persons aged six months or older should be vaccinated against influenza each year. Particular effort should be made to immunize people at higher risk for influenza infection or complications, including:
 - a. Pregnant and postpartum women, or those who will be pregnant during the influenza season
 - b. Persons over 65 years of age, including residents of nursing homes and long-term care facilities
 - c. People who have chronic lung or heart problems, including asthma
 - d. People who have other serious medical conditions, such as diabetes, kidney disease, cystic fibrosis, anemia, cancer, weak immune systems (including those with HIV), or a seizure disorder.

To help prevent the spread of influenza to people in high-risk groups, those who live with people in a high-risk group and healthcare workers who provide care to high-risk patients should also receive an annual influenza vaccine. Travelers to countries outside of the U.S. may also need to consider influenza vaccination.

Lyme Disease

Lyme disease is a tick-borne illness caused by infection with the bacteria *Borrelia burgdorferi*. The Lyme agent is transmitted to persons only through the bites of infected blacklegged ticks. Lyme disease is the most common tick-borne disease in Virginia. In most people, the first symptom of Lyme disease is a skin lesion called erythema migrans (EM) or “bull’s eye” rash - a red bump that expands to form a large red ring, with partial central clearing - at the site of a recent tick bite. The presentation of EM can vary in size and shape, appearing anywhere from 3 to 30 days after being bitten by an infected tick (usually within 7 days). Multiple secondary circular lesions, red blotches and circles, and conjunctivitis and swelling around the eye can develop. Fever, fatigue, headache, mild neck stiffness, and joint pain may occur as the illness progresses. These symptoms occur intermittently during a period of several weeks in untreated individuals. In some cases, those first symptoms do not occur.

If untreated or improperly treated in the early stage of illness, some patients may develop one or several of the following symptoms: multiple EM rashes on their body, intermittent arthritis (pain and swelling) in their large joints (e.g., knees), facial palsy, heart palpitations, severe headaches/neck stiffness (due to inflammation of spinal cord), or neurological problems (shooting pains or numbness and tingling in hands and feet, or memory problems) months to years after the initial illness. Pain and swelling in large joints will occur in about 60% of untreated patients and neurological symptoms occur in about 5% of untreated patients. Arthritis and neurological problems may last for years after the infection.

Transmission

The bacteria that causes Lyme disease is only transmitted through the bites of infected blacklegged ticks (deer ticks). The tiny, blacklegged tick nymphs cause most cases of infection. Since blacklegged nymphs can be very small and because its bite produces little itch or irritation, most people never realize they have been bitten unless the tick attaches to a part of the body that is in plain sight. Lyme disease is not transmitted from one person to another.

School Exclusion Guidelines

Communicable: Lyme disease is transmitted by the affected ticks that carry the *Borrelia burgdorferi* bacteria. There is no evidence of natural transmission from person to person.

Case: School exclusion is not indicated

Contact: School exclusion is not indicated.

Diagnosis

The diagnosis of Lyme disease is based primarily on signs and symptoms of illness. Laboratory tests for Lyme disease antibody may be done on a patient's blood to confirm the diagnosis, but if blood is collected too early in the course of illness, an infected person may not yield an antibody response. If laboratory confirmation is desired, re-testing may be necessary.

Treatment

When Lyme disease is detected early and treated with an appropriate antibiotic (e.g., doxycycline), it is easily cured.

Reporting Requirements

Lyme disease must be reported to the local health department within three days of diagnosis.

Notification Guidelines

If Lyme disease has occurred, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents and staff should be notified so that they will watch for ticks as well.

If a tick bites a student during the day, remove it as outlined below. Notify the parents of that student so that they can inform their health care provider. Tell them what the tick looked like. If the student develops the symptoms described, particularly a skin rash and/or flu-like symptoms, ask the parents to see a health care provider promptly for evaluation and treatment.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Advise persons who spend time outdoors in an area with ticks to (1) wear long-sleeved shirts and long pants, (2) keep shirts tucked securely into pant legs and pant legs tucked into socks, (3) wear sneakers or hiking boots instead of open sandals, and (4) wear light-colored clothing. Ticks are dark in color and will be easier to see against a light background.
3. Conduct a daily tick check. Ticks removed within 24 hours of attachment are unlikely to transmit Lyme disease. Ticks are most often found on the neck, scalp, behind the ears, thigh, flank, armpits, underarm, groin, and legs, and are very small.

4. If a tick is found on a person, remove it immediately. Deer ticks are very small and hard, about the size of a pinhead. They are orange-red or black, depending on their stage of growth, and prefer to attach themselves to a human host under the hair. Dog ticks are larger, ranging from 1/10 to 1/4 inch in length. They are brown and prefer to attach themselves under the hair or on protected parts of the body.
5. To remove a tick:
 - Wear gloves. Use universal precautions. (See previous section on "[Universal Precautions.](#)")
 - Using tweezers, grasp tick as close to the skin as possible and gently, but firmly pull tick straight out. Avoid any jerking or twisting motion that may break off the mouthparts in the skin.
6. Insect repellents containing diethyltoluamide (DEET®, Autan®) applied to skin can be effective against ticks but should be used cautiously. The pesticide permethrin is available as a clothing spray; it is not to be used on the skin. A combination of diethyltoluamide applied to skin and permethrin-treated clothes may provide the best protection against tick and mosquito bites. Follow these guidelines:
 - Use repellents no more than one to two times per day. Do not treat skin with permethrin under clothing.
 - Particularly with children, avoid using high concentrations of diethyltoluamide products. Never use on damaged skin.
 - Avoid inhaling the product. Keep out of eyes, and do not apply to parts of student's hands that are likely to have contact with their eyes or mouth.
 - After returning indoors, wash treated skin with soap and water.
 - If a student is suspected to be having a reaction to an insect repellent, wash skin and call the student's parents and advise them to contact their health care provider for follow-up care.

Measles (Rubeola)

Measles is a highly communicable viral disease. It is spread very easily from person to person and can cause outbreaks of illness. Before the vaccine became available, most people contracted measles during childhood. Now the disease is rare in the United States but is still common in many countries. Although measles usually is considered a childhood disease, people of any age can get it. In the United States, most cases are in unvaccinated infants, children, and teens. Adults at increased risk include college students, international travelers, and health care personnel. The disease is more severe in infants and adults than young children.

Measles symptoms usually appear in two stages. In the first stage, most people have a fever, runny nose, redness of the eyes, and cough. The second stage begins around days 3-7 when a red blotchy rash begins to appear on the face and spreads over the entire body. The rash generally lasts 5-6 days. Small white spots, called Koplik spots, also may be seen on the gums and inside of the cheeks. Middle ear infections, pneumonia, croup, and diarrhea commonly occur in young children. Encephalitis (inflammation of the brain) can occur in a small percentage of cases. Death due to measles is very rare in the United States and occurs in 1-2 of every 1,000 cases. Measles can also cause miscarriages or premature delivery in pregnant women.

Transmission

The virus that causes measles is transmitted airborne by droplet spread or direct contact with nasal or throat secretions of infected people and less commonly, by utensils freshly soiled with nose and throat secretions. Measles can remain in the air for up to 2 hours after a person with measles has left the area. Symptoms may begin within 7-21 days after exposure with an average of 10 days after exposure. The rash usually appears within 14 days of exposure. A person can spread the measles virus from just before the onset of the fever (usually 4 days prior to rash onset) to about 4 days after the appearance of the rash. Immunocompromised patients may spread the virus for the duration of their illness.

School Exclusion Guidelines

Communicable: The period of communicability is typically from about 4 days before the appearance of the rash through 4 days after the appearance of the rash.

Case: Exclude from school until at least 4 days after the appearance of the rash. (The rash should be fading, and the infected person should be without fever.)

Contacts: Check immunization records. Measles vaccine, if given within 72 hours of exposure, may provide protection. Immunoglobulin may be used within 6 days of exposure for susceptible household or other contacts for whom risk of complications is very high (particularly contacts under 1 year of age, pregnant women or immunocompromised persons) or for whom measles vaccine is contraindicated. Students and staff should be excluded from school immediately with signs of initial stages of the disease.

Diagnosis

Illness can be presumptively diagnosed by the signs and symptoms; however, a blood test, to look for antibodies that are evidence of recent infection, is required in order to confirm a preliminary diagnosis of measles.

Treatment

Treatment focuses on relief of symptoms as the body fights the virus. This may include fluids, medications to control fever or pain, antibiotics to treat secondary infections from bacteria, and vitamin A supplements.

Reporting Requirements

Reporting of a person confirmed or suspected of having measles (Rubeola) must be made immediately by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification

When measles occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § [22.1-271.1](#), § [22.1-271.2](#), and § [32.1-46](#). Refer to the CDC for updated [Immunization Schedules](#).
2. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
3. All reports of suspected measles cases should be investigated promptly. A measles outbreak exists in a community whenever one case of measles is confirmed. Once this occurs, preventing the spread of measles depends on prompt vaccination of susceptible persons.
4. A program of re-vaccination with MMR vaccine is recommended during outbreaks in childcare centers; elementary, middle, junior, and senior high schools; and colleges and other institutions of higher education in those students without a prior documented case of measles or in those students who have received only one dose of the vaccine.
5. Make sure all students and staff exhibiting symptoms associated with the illness are seen by their health care provider and the school is notified if another person develops measles. Advise parents of the time of greatest risk of others becoming ill.

Meningococcal Disease (*Neisseria Meningitidis*)

Meningococcal disease is a serious illness caused by the bacterium *Neisseria meningitidis* (also known as "meningococcus"). A small proportion of infected people can develop a serious form of illness, such as meningitis (inflammation of the lining of the brain and spinal cord) or a bloodstream infection (septicemia). Anyone can get meningococcal disease, but it is more common in infants, children, adolescents and young adults. Other persons at increased risk include household contacts of a person known to have had this disease, people with immune system problems, and people traveling to certain parts of the world where Meningococcal meningitis is prevalent.

The symptoms depend on where the infection is located. Meningococcal meningitis is characterized by a sudden onset of fever, headache, stiff neck, sensitivity to light, confusion, nausea, and vomiting. In newborns and infants, these symptoms may be absent or difficult to notice. The infant may appear to be slow or inactive, irritable, vomiting or feeding poorly. A less common but more severe form of meningococcal disease is meningococcal septicemia. The symptoms of meningococcal septicemia may include fatigue, vomiting, cold hands and feet, cold chills, severe pain in the muscles, joints, chest or abdomen, rapid breathing, diarrhea, and a dark purple rash.

Transmission

Neisseria meningitidis bacteria are spread through the exchange of respiratory and throat secretions. An infected person can spread the bacteria by coughing or sneezing directly into the face of others, kissing a person on the mouth, or sharing cups, water bottles, eating utensils, cigarettes, lipstick, or toothbrushes. A person may transmit the bacteria as long as they are present in the nose or throat, especially during the three days before symptoms begin. The bacteria are not spread by casual contact or by simply breathing the air where a person with the disease has been. Symptoms of infection may appear two to ten days after exposure, commonly three to four days.

School Exclusion Guidelines

Communicable: Individuals are considered infectious for 24 hours after beginning antibiotics. The bacteria are transmissible until they are no longer present in discharges from the nose and mouth.

Case: Exclude from school during acute illness. Case is non-communicable after 24 hours of appropriate drug therapy.

Contact: School exclusion is not indicated. Observe carefully for symptoms, especially fever. Parents of day care/nursery school contacts should be advised to check with their child's health care provider concerning prophylactic treatment with rifampin. Discuss with local health department. Certain contacts should receive prophylactic antibiotics from their health care

provider or the local health department as soon as possible—preferably within 24 hours of the diagnosis of the primary case. For additional information on circumstances where prophylaxis may be indicated, refer to the [CDC’s Manual for the Surveillance of Vaccine-Preventable Diseases, Chapter 8](#).

Diagnosis

Cultures of blood and cerebrospinal fluid (CSF) are indicated in persons with suspected invasive meningococcal diseases.

Treatment

Meningococcal disease requires immediate treatment with antibiotics. Depending on how serious the infection is, other treatments may also be necessary, such as breathing support, medications to treat low blood pressure, and wound care for parts of the body with damaged skin.

Reporting Requirements

Reporting of a person confirmed or suspected of having meningococcal infection must be made immediately by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification Guidelines

School health personnel (e.g., school nurses or consulting physician), in consultation with the local health department and school administrators, should develop a system for immediate notification of parents, staff, and the proper health authorities, if a student or staff member becomes ill with meningococcal illness.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § [22.1-271.1](#), § [22.1-271.2](#), and § [32.1-46](#). Please refer to the Centers for Disease Control and Prevention for the most current [Immunization Schedule](#).
2. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases. The best way to prevent spread of meningococcal disease is to alert everyone that a case has occurred so that appropriate preventive measures can begin.

3. Preventive treatment with antibiotics for household members, roommates, or anyone with direct contact with a patient's oral secretions (saliva or spit) can reduce the risk of infection.
4. Good hygiene can reduce the risk of infection as well, such as hand washing, covering noses and mouths when sneezing or coughing, and not sharing cigarettes, straws, cups, glasses, or eating utensils.
5. Monitor the situation closely. Make sure all ill students and staff are seen by their health care provider and that the local health department is notified if another person develops the illness.

Methicillin-resistant *Staphylococcus aureus* (MRSA)

Staphylococcus aureus (“staph”) is a common type of bacteria (germ) that is often found on the skin and in the nose of healthy people. It can also grow in wounds or other sites in the body, sometimes causing an infection. Antibiotics are drugs used to treat infections caused by bacteria. Sometimes bacteria can change so that particular drugs will no longer kill the germs. When this happens, these germs are called “antibiotic resistant”. Over time, staph bacteria have become difficult to treat with antibiotics related to penicillin (e.g., methicillin, amoxicillin). These resistant forms of staph are called methicillin-resistant *Staphylococcus aureus*, or MRSA. The illnesses that MRSA causes are similar to those caused by other staph; the difference is in how they are treated. Just like normal staph bacteria, MRSA normally does not cause disease unless it enters an opening in the skin.

Many people carry staph bacteria on their skin or in their bodies without any symptoms. This is called being “colonized”. A person may be colonized for a long time before getting sick or may never get sick. Symptoms of a MRSA or other staph infection depend on where the infection is located. Infections of the skin are the most common, and can cause redness, warmth, pus, and a wound that does not heal. A MRSA skin infection may be mistaken for a spider or insect bite. More serious MRSA infections can also develop in the blood, bladder, lungs, or other sites. Symptoms there will depend on the site of infection but include fever and pain at the site of infection.

Some people are at higher risk for carrying MRSA or becoming infected with this type of staph. Serious MRSA infections more often occur in people in hospitals and other types of healthcare facilities. MRSA infection can also occur outside healthcare settings in people who receive multiple antibiotics, as well as in people who have close contact with a person carrying the germ or by touching objects contaminated with MRSA (e.g., towels, athletic equipment, sauna benches, bandages, etc.).

Transmission

Staph bacteria (including MRSA) are most often spread by direct person-to-person contact, usually on hands. Staph may also be spread by contact with contaminated items (e.g., towels, razors) or environmental surfaces (e.g., athletic benches or mats).

School Exclusion Guidelines

Communicable: MRSA most commonly causes infections through a break in the skin. Persons who have actively draining sores are more contagious.

Case: School exclusion is not required. However, the student or staff member may be advised to remain home while feeling ill and not able to participate in their daily routine.

Contact: School exclusion is not indicated.

Diagnosis

Usually, a sample will be obtained from the infection site (e.g., the skin, blood, urine, or sputum) and sent to the laboratory for testing. If staph is isolated, more laboratory tests are needed to determine which antibiotics will be effective for treating the infection. If the bacteria are resistant to certain antibiotics (including oxacillin, penicillin, and amoxicillin), a diagnosis of MRSA is made.

Treatment

Many staph skin infections, including those caused by MRSA, can be treated with appropriate wound care at home by keeping them clean and covering them with bandages. Additional treatment from a healthcare provider is needed if wounds are not healing properly or are draining (e.g., drainage of pus with warm compresses or incision). Antibiotics (not related to penicillin) may also be used. If antibiotics are prescribed by your healthcare provider, it is very important to finish taking all the pills and to call your doctor if the infection does not get better. More serious infections, like those in the blood, or surgical wound infections, may require hospitalization and/or the use of intravenous (IV) antibiotics. Except in special circumstances, no treatment is needed for people who carry MRSA but do not have any symptoms.

Reporting Requirements

MRSA is not a reportable disease.

Notification Guidelines

Parents should be notified of a child with red or draining skin lesions; recommendations should be made to seek medical attention from the child's health care provider.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Make sure all toys and objects are properly washed and sanitized.
3. Discourage the use of sharing objects such as towels and other personal items.
4. Open wounds and draining sores should be covered.
5. Encourage diligent hand washing and personal hygiene.

Molluscum Contagiosum

Molluscum contagiosum is an infection caused by a [poxvirus](#) (molluscum contagiosum virus). The result of the infection is usually a benign, mild skin disease characterized by lesions (growths) that may appear anywhere on the body. Within 6-12 months, Molluscum contagiosum typically resolves without scarring but may take as long as 4 years. The lesions, known as Mollusca, are small, raised, and usually white, pink, or flesh-colored with a dimple or pit in the center. They often have a pearly appearance. They're usually smooth and firm. In most people, the lesions range from about the size of a pinhead to as large as a pencil eraser (2 to 5 millimeters in diameter). They may become itchy, sore, red, and/or swollen. Mollusca may occur anywhere on the body including the face, neck, arms, legs, abdomen, and genital area, alone or in groups. The lesions are rarely found on the palms of the hands or the soles of the feet.

Transmission

The virus is transmitted person-to-person via close contact, or through the sharing of inanimate objects, such as towels, clothing, pool toys, or bath sponges. Molluscum in adults can also be spread through sexual contact. Although it is a viral infection, it is only mildly contagious and more often spread to other areas of the affected child's body, rather than to other people. It is often spread by children, who scratch the bumps when they start itching and then touch other surfaces or people. The virus remains in the top layer of skin (epidermis) and does not circulate throughout the body; therefore, it cannot spread through coughing or sneezing. Since the virus lives only in the top layer of skin, once the lesions are gone the virus is gone it cannot spread it to others. The incubations period is usually between 2 to 7 weeks but may be as long as six months.

School Exclusion Guidelines

Communicable. Spread person-to-person through close contact and through sharing of inanimate objects such as towels, clothing, or toys. The contagious period is unknown.

Case. School exclusion is not required. However, the student or staff member may be advised to remain home while feeling ill and not able to participate in their daily routine.

Contact. School exclusion is not indicated.

Diagnosis

Diagnosis of Molluscum Contagiosum is made by physical examination.

Treatment

Molluscum usually goes away on its own in a few months as the person develops antibodies to the virus. Alternative treatments may be used, though there is little agreement on what has been proven effective. The most significant symptom is itching, which can be significantly relieved through the application of cold compresses. Sores do not ooze, and there is no requirement for covering the bumps. Treatment for molluscum is usually recommended if lesions are in the genital area (on or near the penis, vulva, vagina, or anus). Treatment can be achieved through physical removal of the warts, topical, or oral therapy.

Reporting Requirements

Molluscum Contagiosum is not a reportable disease.

Notification Guidelines

None.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Make sure all toys and objects that are potentially infectious due to children are properly washed.
3. Discourage the use of sharing objects such as towels other items that might come into contact with the bumps.
4. Encourage infected children not to scratch, as this can cause spread of the bumps to another site (autoinoculation).
5. Encourage diligent hand washing and hygiene for the individual and all persons that come into contact with him/her.

Mononucleosis, Infectious

Infectious mononucleosis is an acute viral syndrome typically caused by the Epstein-Barr virus. Its symptoms include sore throat, tiredness, fever, enlarged lymph nodes, and sometimes enlargement of abdominal organs (liver and/or spleen). It occurs most frequently in adolescents or young adults. While infants and young children can be affected by the disease, they frequently have no symptoms. Individuals with this disease can experience symptoms ranging from no illness or mild illness to severe illness. Infection can occasionally be accompanied by a rash. Most cases of infectious mononucleosis resolve without treatment in 2 to 3 weeks. During the course of the illness, patients often have days when they feel well, alternating with days when they feel ill.

Transmission

Both children and adults can get infectious Mononucleosis. The virus is transmitted from person to person through saliva. Young children may be infected by saliva on the hands of caregivers. Spread between children can also occur by sharing mouthed objects, drinking cups, or toys that have infected saliva on them. Kissing can increase spread among young adults. Infectious Mononucleosis in adolescents is common in group settings such as in schools. Spread may also occur via blood transfusions, organ transplantation, and through blood and semen during sexual contact. The disease is not seasonal, and the shedding of the virus can occur for many months after infection. The incubation period is estimated to be 4 to 6 weeks, but the time an individual is contagious is unknown.

School Exclusion Guidelines

Communicable: Spread of this virus is person-to-person through saliva. The time an individual is contagious is unknown.

Case: School exclusion is not required. However, the student or staff member may be advised to remain home while feeling ill and not able to participate in their daily routine.

Contact: School exclusion is not indicated.

Diagnosis

The diagnosis of this illness is based on symptoms and laboratory blood tests.

Treatment

Care includes comfort measures in treating the symptoms. The majority of infectious mononucleosis cases resolve in one to three weeks (albeit, some symptoms can last longer in some children). Individuals with this disease can be as active as they feel they are able.

Students and staff may return to contact sports or heavy lifting upon the recommendation of their health care provider.

Reporting Requirements

Infectious Mononucleosis is not a reportable disease.

Notification Guidelines

None.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Make sure all toys and objects that are potentially infectious due to children placing them in their mouths are properly washed.

Mosquito-Borne Diseases

Mosquito-borne diseases are spread by infected mosquitos. In the United States, these are most commonly viruses. Parasitic infections, such as malaria are uncommon except in international travelers. Examples of viruses include West Nile virus, eastern equine encephalomyelitis (EEE), St Louis encephalitis (SLE), La Crosse encephalitis, west equine encephalomyelitis (WEE), and Zika. Most of these infections produce no signs or symptoms, or only a mild headache and fever. In periods of outbreaks, more severe symptoms are often seen. These symptoms include fever, headache, body aches, nausea, vomiting, rash, neck stiffness, convulsions, coma, and paralysis. Persons with underlying medical issues or compromised immune systems are at a higher risk for more serious illness. It can take weeks to months for recovery, and in some cases, there will be permanent neurological damage.

Transmission

These diseases are spread through the bite of an infected mosquito. (Note: The Zika virus may also be passed through unprotected sex, from a pregnant woman to her fetus, and through blood transfusions and organ donation.) Incubation periods vary for each virus, but are generally as follows:

- West Nile virus: 2 to 14 days
- EEE: 3 to 10 days
- SLE: 4 to 14 days
- La Crosse encephalitis: 5 to 15 days
- WEE: 2 to 10 days
- Zika: 3 to 14 days

School Exclusion Guidelines

Communicable: These diseases are not contagious. West Nile virus can be transmitted via blood transfusion and organ donation, though this is highly unlikely in the developed countries, where screening is done on blood and organ tissue.

Case: School exclusion is not required. However, the student or staff member may be advised to remain home while feeling ill and not able to participate in their daily routine.

Contacts: School exclusion is not indicated.

Diagnosis

Diagnosis is made through a review of history and physical examination by a healthcare provider. Blood tests will help determine the exact disease.

Treatment

Treatment is dependent on the exact virus, symptoms, and severity of illness. There are no vaccines, and most treatment is supportive in nature.

Reporting Requirements

Mosquito-borne diseases are not reportable.

Notification Guidelines

When mosquito-borne disease occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Empty standing water from wading pools, buckets, pet dishes, flowerpots, and other sources that can attract mosquitoes.
3. Check windows to make sure there are no holes or gaps that would allow mosquitoes to get indoors.
4. Stay inside during dusk and dawn, when mosquitoes are most active. If it is necessary to be outdoors during these times, wear long pants and shirts that cover the skin.
5. Use insect repellent containing diethyltoluamide (DEET) when outdoors.

Mumps

Mumps is a systemic viral disease, characterized by swelling of the salivary (parotid) glands.

The most common signs and symptoms of Mumps include fever, headache, muscle aches, fatigue, and swelling and tenderness of one or more salivary glands under the ears or jaw on one or both sides of the face (parotitis). Swelling of the testicles occurs in up to 10% of males who have reached puberty; this does not usually result in sterility. Complications from Mumps are rare but are more common in people who have reached puberty. These include central nervous system disorders such as encephalitis (inflammation of the brain) and meningitis (inflammation of the covering of the brain and spinal column), oophoritis (inflammation of the ovaries), miscarriage of a pregnancy, arthritis, pancreatic involvement, or deafness. Approximately one-third of infections do not cause clinically apparent salivary gland swelling, and one in five infected persons exhibit no clinical signs or symptoms. Incidence rates are higher in school-age children.

Transmission

The virus is transmitted by droplet spread and by direct contact with the saliva of an infected person. The period of communicability is usually 1 to 2 days but has been reported as many as 7 days before the onset of parotid swelling and is usually 5 days (although occasionally as many as 9 days) after onset. The incubation period is about 12 to 25 days, commonly 18 days.

Most adults, particularly those born before 1957, are likely to have been infected naturally and may be considered immune, even if they did not have recognized disease. Mumps may be seen in unimmunized children or adolescents and young adults who graduated from school prior to laws requiring mumps immunizations or may have received an earlier, less effective vaccine. At risk for complications are children under the age of 12 months, pregnant women, persons who have weakened immune systems, and susceptible adolescent and adult males.

Diagnosis

The illness can be presumptively diagnosed by the signs and symptoms. However, it must be confirmed by a blood test to look for antibodies that are evidence of recent infection.

Treatment

No specific anti-viral treatment is available. Care is based on symptoms and is supportive.

School Exclusion Guidelines

Communicable: The period of communicability can be as long as 7 days before onset of symptoms (usually 1 to 2 days) to 9 days after (usually 5 days).

Case: Exclude from school for 9 days after the onset of parotid swelling.

Contacts: School exclusion is not indicated. However, if a community outbreak of mumps occurs, exclusion of susceptible (non-immunized) students from both affected schools and schools judged by local health authorities to be at risk should be considered. Excluded students can be readmitted immediately after vaccination. Students who have been exempted because of medical, religious, or other reasons should be excluded until at least 26 days after the onset of gland swelling in the last person with mumps in the affected school.

Reporting Requirements

Mumps must be reported to the local health department within three days of diagnosis.

Notification

When Mumps occur within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § [22.1-271.1](#), § [22.1-271.2](#), and § [32.1-46](#). Please refer to the Centers for Disease Control and Prevention for the most current [Immunization Schedule](#).
2. Develop a policy, in consultation with local health department, for responding to cases of communicable diseases.
3. Make sure all students exhibiting symptoms associated with the illness are seen by their health care provider and that the school is notified if another person develops mumps. Advise parents of the time of greatest risk of others becoming ill.

Otitis (Ear Infection)

Although otitis (i.e., otitis media and otitis externa) is not contagious, a description is included here because of the frequency of occurrence among school-age children.

Otitis Media (Middle Ear Infection). Otitis media is an inflammation of the middle ear (pea-sized, air-filled cavity behind the eardrum) that occurs as the result of a middle ear infection. Otitis media is caused by bacteria or viruses that enter from the nose or throat and ascend the eustachian tube to reach the middle ear. This occurs when the eustachian tube is not functioning properly, often because it is inflamed from a cold, sinus or throat infection, or allergy attack.

Otitis media can be acute, chronic, or recurrent. Symptoms of otitis media include ear pain, frequently accompanied by systemic symptoms, including fever, a runny nose, cough, difficulty sleeping, fatigue, decreased appetite, drainage from the ear, and diarrhea. Most cases resolve without medical intervention in a couple of days. Parents should be encouraged to talk with their healthcare provider about recommendations and when to seek medical attention. Typically, children under age 2 are encouraged to seek treatment to avoid possible complications such as hearing loss and delayed language development.

Otitis Externa (Swimmer’s Ear). Otitis externa, also known as “swimmer’s ear,” is an inflammation of the outer ear canal, which extends from the eardrum to the outside. Otitis externa is usually caused by a bacterial infection but can be fungal. It can be caused by swimming in dirty water, frequent swimming in chlorinated pools, or too much moisture in the ear from any cause. A frequent problem is related to using cotton swabs to clean the ear canal, which could result in packed earwax. If a cotton swab [e.g., Q-tip®] is used to clean ears, use only as directed—stroke swab gently around the outer surface of the ear, **without entering the ear canal**. The most common symptom is pain. Other symptoms are pain when the earlobe is pulled, itching, drainage, or slight fever.

Transmission

Both forms of otitis are not communicable (“non-contagious”) - they cannot be transmitted directly or indirectly from one individual to another. Otitis media is often associated with colds, particularly in the pre-elementary age groups.

School Exclusion Guidelines

Communicable: Otitis media is not contagious.

Case: Staff and students with otitis media and otitis externa should not be excluded from school, unless they pose a risk to others due to uncontrolled drainage from the ear canal.

Contacts: School exclusion is not indicated.

(Other systemic symptoms that have previously been defined as contagious and are present with a diagnosis of otitis media should determine the need for school exclusion for cases and contacts.)

Diagnosis

Diagnosis of otitis media and otitis externa is made by physical examination by the person's health care provider. Cultures of the particular bacterial agent are usually reserved for cases of otitis resistant to usual antibiotic treatment.

Treatment

Oral antibiotics, pain medication, and other supportive measures are given for otitis media. Most ear infections will resolve spontaneously within a couple of days, thus antibiotics are not always indicated. Recurrent or chronic otitis media may require surgical placement of ear tubes. Otitis externa is treated by gentle cleansing of the ear canal with application of medicated eardrops and pain medication.

Reporting Requirements

Otitis is not a reportable disease.

Notification Guidelines

None.

Special Care Notes for Students with Frequent Ear Infections and/or Ear Tubes

- Never put a cotton swab and anything else into a person's ear canal. Do not allow a student to put anything in their ear(s).
- Be especially alert for any signs of hearing or speech problems. Refer the student to their health care provider or other community resource if either of these conditions are present.
- Parents should inform the school of any specific care that is needed for a student who has ear tubes in place.

Pediculosis (Lice)

Pediculosis. Pediculosis is an infestation of the head, the hairy parts of the body, and clothing (especially along the seams of inner surfaces) with adult lice, nymphs, and nits (eggs), which results in severe itching and excoriation (abrasion) of the scalp or both. Secondary infection may occur with ensuing regional lymphadenitis (inflammation of the lymph nodes), especially cervical. Crab lice usually infest the pubic area; they may also infest hair of the face (including eyelashes), axillae, and body surfaces. There are three types of lice: (1) *Pediculus humanus capitis*, the head louse; (2) *Pediculus h. corporis*, the body louse; and (3) *Phthirus pubis*, the crab louse.

Head Lice. Head lice are tiny insects (about an 1/8 of an inch long) that live in human hair and feed on human blood. They multiply rapidly, laying little silvery-colored oval-shaped eggs (called nits), which they glue to the base of the hair, close to the scalp. Although it is hard to see head lice, a person can see the nits if they look closely. Nits are most often found in the hair behind the ears and at the back of the head and neck. Nits should not be confused with dandruff. Dandruff can easily be flicked off the hair; nits cannot because they are firmly attached to individual hairs. One telltale sign of head lice is a persistent itching of the scalp, which is caused by the bite of the louse, and that is sometimes accompanied by infected scratch marks or what appears to be a rash. A secondary bacterial infection can occur, causing oozing or crusting. Swollen neck glands may also develop.

Anyone can get head lice. They are not a sign of being dirty and should not be considered a sign of an unclean house. Head lice are easily spread from person to person by direct contact and are often found in school settings and group settings such as sports teams and camps. Head lice do not spread any disease.

Transmission

Head lice have no wings and do not fly, hop, or jump; they crawl. They are transmitted through direct contact with the hair of a person infested with head lice, or with shared items, such as combs, brushes, towels, pillowcases, hats, headphones, other headgear, and clothing. Shared lockers and wall hooks may permit the spread of head lice. Head lice need human blood to survive. They usually do not survive for more than 2 days away from the human body. The nits (louse eggs) cannot hatch at the lower temperatures found away from the scalp.

The life cycle is composed of three stages: eggs, nymphs (3 stages), and adults. Under optimal conditions, the eggs of lice hatch in 7 to 10 days. The nymphal stages last about 7 to 12 days depending on temperatures. The egg-to-egg cycle averages about 3 weeks.

School Exclusion Guidelines

Communicable: Transmission is possible as long as lice or eggs remain alive on the infected person or on articles.

Case: Current recommendations suggest that children can remain in school until the end of the day and be referred for treatment. In such cases, children should avoid any activities involving head-to-head contact or sharing of any headgear. “No nit” policies are no longer recommended as a method of exclusion.

Contacts: Close contacts should be checked to determine if they are infested. School exclusion is not indicated in the absence of infestation.

Diagnosis

Head lice infestation is diagnosed by finding a live, crawling louse on the scalp or hair of a person. A fine-tooth comb and magnifying glass might be needed in order to see them. If crawling lice are not seen, finding nits attached firmly within $\frac{1}{4}$ inch of the base of hair shafts suggests, but does not confirm, the person is infested. Nits frequently are seen on hair behind the ears and near the back of the neck. Nits that are attached more than $\frac{1}{4}$ inch from the base of the hair shaft are almost always hatched or dead. Misdiagnosis of head lice infestation is common because nits can be confused with other particles found in hair such as dandruff, hair spray droplets, and dirt particles. If no nymphs or adults are seen, and the only nits found are more than $\frac{1}{4}$ inch from the scalp, then the infestation is probably old and no longer active and does not need to be treated.

Treatment

Treatment consists of getting rid of the lice from infested individuals, their surroundings, and their personal items. Nits may persist after treatment, but successful treatment should kill all crawling lice. All household members and individuals with close physical contact should be examined for lice and if infested, treated with one of the recommended shampoos or hair rinses. Preventive treatment in the absence of lice is not recommended.

In recent years, lice have become more resistant to conventional treatments. It is important to follow treatment directions exactly as instructed and apply a second treatment if indicated. If the lice persist, despite home treatment, students should be advised to be evaluated by their pediatrician for additional treatment options.

For individuals who have head lice:

Persons diagnosed with an active infestation and usually their bedmates should be treated with a medicine that is effective against lice (called a pediculicide). All household members and other close contacts should be checked and everyone found to be infested should be treated on

the same day. Detailed guidelines for [head lice treatment](#) can be found through the Centers for Disease Control and Prevention.

Four critical steps should be followed to control an infestation of head lice:

1. Using an effective head louse treatment. Doctors can recommend a medicated shampoo, cream, or lotion to kill head lice. These may be over-the-counter or prescription medications and need to be applied according to the instructions contained in the box or printed on the label. Retreatment is generally recommended for most prescription and non-prescription (over the-counter) drugs after 7-9 days in order to kill any surviving hatched lice before they produce new eggs.
2. Removing nits from the head (combing). Remaining eggs should be removed from the hair shafts with a special nit comb or fine-tooth comb often found in the product package (metal combs are much more effective than plastic). Many flea combs made for cats and dogs are also effective. Checking the hair, a small section at a time under a bright light or lamp that can be directed at the area being worked on and using a magnifying glass makes the nits easier to find. Tissues to clean the comb, a plastic bag for the discarded tissues, and hair clips to pin up the sections of hair that have been combed are also helpful. This may take an hour or more, so an entertaining video may help keep the child occupied.
3. Removing lice and nits from the household by vacuuming, storing, washing, or freezing objects suspected of being infested. All clothing, bed linens, and other items that an infested person used during the 2 days before treatment should be washed using the hot water laundry cycle and the high heat drying cycle. Items that are not machine-washable should be dry cleaned or sealed in a plastic bag for two weeks (enough time for any eggs to hatch and the lice to die). Vacuum the floor and furniture, particularly where the infested person sat or laid.
4. Checking heads daily and removing nits until infestation is gone followed by weekly head checks to detect re-infestation. Every 2-3 days comb the hair with a nit comb to remove nits and lice to decrease the chance of self-reinfestation. This should continue for 2-3 weeks to be sure that all lice and nits are gone.

If, after 8-12 hours of treatment, no dead lice are found and lice seem as active as before, the medicine may not be working. Speak with your healthcare provider; a different medicine may be necessary. If your healthcare provider recommends a different product, carefully follow the treatment instructions contained in the box or printed on the label.

Suffocation of head lice with olive oil, mayonnaise, butter, margarine, or any similar food-grade product is not recommended. In addition, do not use motor or machine oils, or kerosene, as these materials can be harmful. Pet shampoo should not be used to treat a lice infestation.

To Keep the Lice from Coming Back or Spreading to Others in the Household:

Head lice can be prevented by avoiding head-to-head contact during play and other activities and not sharing personal items such as clothing, combs, brushes, hats, scarves, barrettes, helmets, or towels. To prevent re-infestation and spread of head lice, the hair of everyone in the household should be checked when anyone is found to have head lice. Everyone with head lice, as well as any persons who share the same bed with actively infested individuals, should be treated on the same day. Individuals should be able to return to school/daycare and their usual activities after the first treatment. "No-nits" policies that require a child to be free of nits before they can return to school/childcare facility should be discontinued per the American Academy of Pediatrics and the National Association of School Nurses.

Reporting Requirements

Pediculosis is not a reportable disease.

Notification Guidelines

When pediculosis occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of infestation outbreaks.
2. Learn to recognize head lice and nits, and regularly check students' heads and hair when there is a case of head lice diagnosed in the classroom. Teach parents to recognize head lice and nits and to check family's hair periodically. Because outbreaks of head lice occur periodically in almost all schools and because parental concern may exceed the threat of head lice to health, this is a prime area for preventive education and information. A well-organized and prompt response to the first few cases can prevent a widespread problem and avoid the spread of misinformation.
3. If a case is identified, follow recommended treatment procedures closely. If a parent finds nits, it should be reported to the school nurse, who can check close contacts.
4. Remind students not to share combs, brushes, hair accessories, headphones, hats, helmets, towels, clothing, bedding, and so forth.

Pertussis (Whooping Cough)

Pertussis is a highly contagious bacterial disease involving the respiratory tract caused by *Bordetella pertussis*. It begins with mild cold symptoms and gradually progresses over 1 to 2 weeks into repeated attacks of severe coughing that can last 1 to 2 months or longer. The classic “whoop” (or high pitched crowing) sound may not occur in young infants, adolescents, and adults. Pertussis can occur at any age but is most often diagnosed in young children. It most commonly occurs in very young children who have not been vaccinated. Protection from vaccination wanes over time so even vaccinated persons can get pertussis.

Pertussis in older children and adults often causes milder illness that may not be diagnosed. The disease can be very serious in infants (less than 1 year old), where it can lead to pneumonia and, less often, seizures or inflammation of the brain. In rare cases (1 out of 200), pertussis can result in death (especially in children less than 1 year of age). In recent years in the United States, pertussis in adolescents and young adults has varied in severity. Many of these cases occur in previously immunized persons, indicating waning immunity. Symptoms usually appear 4 to 21 days after exposure, and the total course of the disease is from 6 to 10 weeks.

Transmission

The bacterium that causes pertussis is found in the nose and throat of infected people. These bacteria spread through the air in droplets produced by sneezing and/or coughing. Persons in the early stage of illness are the most contagious. Older children and adults are often the source of infection for infants with whom they have close contact. Antibiotics will shorten the length of time the illness can be spread.

Children should be kept out of childcare or school until they have been treated with antibiotics for at least 5 days and are well enough to return. Adults with pertussis also should stay home from work until they have been treated with antibiotics for at least 5 days. The incubation period can range from 4 to 21 days, typically lasting 7 to 10 days.

School Exclusion Guidelines

Communicable: The period of greatest risk of spread is during the first week. Thereafter, communicability gradually decreases and becomes negligible in about 3 weeks for non-household contacts.

Case: Exclude from school until a health care provider advises return (usually 5 days after initiation of antibiotic treatment). Discuss with local health department.

Contacts: Check immunization record. Exclude students or staff from school on first signs and symptoms of the illness.

Diagnosis

Diagnosis is based on identification of the pertussis germ through special tests and/or cultures obtained as early in the course as possible.

Treatment

Certain antibiotics may make the illness less severe if started in the early stage of the disease.

Infants younger than 6 months of age and persons with severe cases may need to be hospitalized for treatment.

Reporting Requirements

Reporting of a person confirmed or suspected of having pertussis (Whooping cough) should be made immediately by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification Guidelines

When pertussis occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § [22.1-271.1](#), § [22.1-271.2](#), and § [32.1-46](#). Please refer to the Centers for Disease Control and Prevention for the most current [Immunization Schedule](#).
2. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
3. Make sure all staff and students exhibiting symptoms associated with the illness consult a healthcare provider and the local health department is notified if another person develops pertussis.
4. Preventive antibiotic is recommended for all household contacts and other close contacts irrespective of age and vaccination. School or classroom wide prophylaxis should be considered on a case-by-case basis with consultation from a physician and the health department.

Pinworm Infection (Enterobiasis)

Pinworm infection is caused by a small, white intestinal worm called *Enterobius vermicularis*, which is about ¼ inch long and lives in the rectum of humans. In an infected person, female worms leave the intestine through the anus and deposit eggs on the surrounding skin. Symptoms include perianal itching (which ranges from mild to severe), disturbed sleep, irritability and sometimes a secondary infection of the scratched skin. Contrary to commonly held beliefs, pinworms do not cause teeth grinding or bed-wetting and are generally not dangerous, just irritating.

Transmission

Pinworms are transmitted by direct transfer of infected eggs by hand from anus to mouth of the same person or another person, or indirectly through clothing, bedding, food, or other articles contaminated with eggs of the parasite. The life cycle requires 4 to 8 weeks to be completed. Symptomatic disease with high worm burden results from successive reinfections occurring within months after initial exposure.

School Exclusion Guidelines

Communicable: Transmission is possible as long as gravid females are discharging eggs on perianal skin. Eggs remain infective in an indoor environment for about 2 to 3 weeks.

Case: Students and staff should be excluded from school until 24 hours after treatment is started.

Contacts: School exclusion is not indicated.

Diagnosis

The worms can sometimes be seen at night when they are laying their eggs on perianal skin. A health care provider can make the diagnosis by performing a “tape test” examination for pinworms.

Treatment

Several prescription medications are available for treatment of this infection (pyrantel pamoate, albendazole, or mebendazole; given in a single dose and repeated in 2 weeks). The health care provider may choose to treat the whole family if one member of the family has pinworms. Families should be informed that recurrence is common due to a high incidence of reinfection.

Reporting Requirements

Pinworms are not a reportable disease.

Notification Guidelines

When pinworm infection occurs within the school population, school health personnel (e.g., school nurses and consulting physician), in consultation with school administrators and local health department should determine whether some or all parents and staff should be notified so they may watch for symptoms in themselves and/or their children.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Follow hand washing and cleanliness procedures. Careful attention to good hygiene, handwashing, and environmental cleaning and sanitation is very important in reducing the spread of this infection.
3. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.

Pneumonia

Pneumonia is an inflammation of the lungs most commonly caused by a viral infection (less commonly by a bacterial infection). The infection can range from mild to severe illness and often secondary to an upper respiratory infection that spreads to the lungs. Bacterial pneumonia can start in the lungs as a result of bacteria in the bloodstream. Those with heart or other underlying medical conditions, as well as smokers, are at greater risk. Pneumonia is more common during the fall, winter, and early spring months. The incubation period is dependent on the causal organism. Symptoms include cough, fast, difficult breathing, fever, muscle aches, loss of appetite, and lethargy.

Transmission

Pneumonia does not spread; only the organism can spread if a person is still infectious. Spread is through direct or close contact with mouth and nose secretions and through touching contaminated objects.

School Exclusion Guidelines

Communicable. The contagious period of pneumonia depends on the causal organism.

Case. Not indicated unless the individual is not feeling well enough to participate.

Contact. Not indicated.

Diagnosis

Pneumonia is diagnosed by a physical examination from a healthcare provider, typically including an X-ray of the lungs. Blood work may be done to identify the presence of a bacterial infection.

Treatment

Antibiotics are only indicated for bacterial pneumonia. For viral pneumonia, treatment is often supportive in nature. Tamiflu may less the severity and duration of the infection in some cases.

Reporting Requirements

Pneumonia is not a reportable disease.

Notification Guidelines

Suspected pneumonia should be reported to the parents who can seek treatment from a healthcare professional.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § [22.1-271.1](#), § [22.1-271.2](#), and § [32.1-46](#). Please refer to the Centers for Disease Control and Prevention for the most current [Immunization Schedule](#).
2. Encourage an annual influenza vaccine for all children 6 months to 18 years, adult close contacts of these children, and high-risk adults.
3. Diligent hand washing, personal hygiene and cleanliness are essential to stop the spread of all respiratory tract diseases.
4. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.

Polio (Poliomyelitis)

Poliomyelitis is a highly contagious viral infection caused by three types of poliovirus. It is most often recognized by the acute onset of flaccid paralysis. Most polio infections are asymptomatic. Symptoms range in severity from a mild, nonspecific illness, with low-grade fever and sore throat, to aseptic meningitis (inflammation of the covering of the brain and spinal cord) to paralysis and death. There have been no cases of polio originating in the United States since 1979, as a result of widespread polio vaccination in this country. Rarely, polio can occur as vaccine-associated paralytic poliomyelitis (VAPP). A single case of poliomyelitis is considered a public health emergency and needs to be given top priority.

Transmission

Polio usually is spread from person to person primarily through the fecal-oral route. The virus is transmitted from the feces (stool) of an infected person to the mouth of another person from contaminated hands, food, water, or contaminated objects. It also is spread through droplets from an infected person's throat from a sneeze or cough. Transmission of polio is possible as long as the virus is excreted. Cases are most infectious during the first few days before and after onset of symptoms. Certain immunodeficient individuals are more likely to acquire VAPP from another individual who has recently received oral polio vaccine. VAPP does not occur after the inactivated polio vaccine. The incubation period is commonly 7 to 14 days for paralytic cases, with a reported range of 3 to possibly 35 days.

School Exclusion Guidelines

Communicable: Polio is most infectious from 7 to 10 days before and after onset of symptoms. Although not precisely defined, transmission is possible as long as the virus is present in the throat or feces.

Case: Individuals with polio can potentially excrete the virus in stool for several weeks or occasionally, months.

Contacts: Persons exposed to polio should have their immunization records checked by a health care provider and subsequently undertake the recommendations for polio vaccine.

Diagnosis

Poliovirus can be recovered from the stool, throat, and rarely, from CSF (cerebral spinal fluid).

Treatment

There is no specific anti-viral therapy. Care is supportive.

Reporting Requirements

Reporting of a person confirmed or suspected of having poliomyelitis must be made immediately by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification Guidelines

When polio occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § [22.1-271.1](#), § [22.1-271.2](#), and § [32.1-46](#). Please refer to the Centers for Disease Control and Prevention for the most current [Immunization Schedule](#).
2. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
3. Make sure all students and staff exhibiting symptoms of the illness consult a health care provider and the local health department is notified if another person develops polio.

Rabies

Rabies is an acute viral infectious disease of mammals, especially carnivores, caused by a neurotropic virus often in the saliva and brain of rabid animals. Rabid animals infected with rabies virus characteristically produce an acute illness with rapidly progressive central nervous system (brain and spinal cord) symptoms, including anxiety, dysphagia (difficulty swallowing), muscles spasms, seizures, paralysis, coma and progresses to death.

Animals with rabies often behave strangely after the virus attacks their brains. Rabid animals may attack people or other animals for no real reason, or they may lose their fear of people and seem to be unnaturally friendly. Not all rabid animals act this way; some may become withdrawn or may even act normally.

Transmission

The virus is transmitted where virus-laden saliva of a rabid animal is introduced by a bite or scratch (or, very rarely, into a fresh break in the skin or through intact mucous membranes). It can be transmitted through a bite or by getting saliva or brain tissue in the eyes, nose, mouth, or in an open wound. Transmission from person to person is theoretically possible since the saliva of the infected person may contain virus, but this has never been documented. All mammals, including humans, can get rabies. Wild animals in the United States (particularly skunks, bats, raccoons, and foxes) harbor rabies, and in some instances these wild animals infect domestic animals (dogs, cats, ferrets, and livestock). Raccoon rabies is established in all East Coast states. In recent years, most cases of human rabies cases in the U.S. resulted from bat bites. Most dogs, cats, and ferrets show symptoms by the time they are shedding rabies virus in their saliva. Rarely do they appear healthy for several days while shedding the virus, but no case of rabies in the U.S. has been attributed to a dog or cat that has remained healthy throughout the standard 10-day period of confinement.

The incubation period is usually 3 to 8 weeks, but may last weeks to months; depends on the severity of the wound site, site of the wound in relation to the richness of the nerve supply and its distance from the brain, amount and strain of virus introduced, protection provided by clotting and other factors. The acute period of disease generally ends after 2 to 10 days.

School Exclusion Guidelines

Communicable: Rabies virus is transmitted through a bite of a rabid animal or by getting the saliva or brain tissue of a rabid animal in a wound or in the eye or mouth. In dogs and cats, the period of communicability is usually for 3 to days before onset of clinical signs (rarely over 4 days) and throughout the course of the disease. In one study, bats shed virus for 12 days before evidence of illness, in another study, skunks shed virus for at least 8 days before onset of clinical signs.

Case: Consult with the person's health care provider or local health department.

Contacts: School exclusion is not indicated. Casual contact with an infected person (e.g., by touching a person with rabies) or contact with non-infectious fluids or tissue (e.g., urine or feces) does not alone constitute an exposure.

Diagnosis

Rabies is diagnosed in animals through testing a sample of brain tissue after they are dead. In humans suspected of having rabies, special tests are done of the blood, spinal fluid, and brain, but the diagnosis may not be confirmed until after death.

Treatment

Once symptoms have developed, no drug or vaccine improves the prognosis. Post-exposure treatment with RIG (rabies immune globulin) and rabies vaccine (HDCV, RVA, or Rabovert) is recommended for a person bitten by a wild or domestic animal that may be infected. Make sure the exposed individual is up to date on tetanus vaccine.

Exposures other than bites rarely result in infection. However, post-exposure treatment is recommended for persons who report having an open wound or mucous membrane contaminated with saliva or other potentially infectious material (e.g., brain tissue) from a rabid animal.

Reporting Requirements

Reporting of a person or an animal confirmed or suspected of having rabies, must be made immediately by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

All animal bites should be reported to the local health department and the local animal control office for follow up. Dogs, cats, and ferrets that bite people must be observed for 10 days for signs of rabies.

Notification Guidelines

When a student is bitten or scratched by an animal, school personnel should notify the student's parents, the local health department, and local animal control office. Parents should be advised to contact a health care provider for evaluation of the exposure.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.

2. There is an effective vaccine for dogs and cats and certain other domestic animals to prevent them from getting rabies. All pets should be vaccinated and not allowed to roam free.
3. Avoid contact with wildlife and strays.
4. If a sick or strange-acting animal is noticed around the school, the local animal control official should be called immediately.
5. If a person is bitten or scratched by any animal, wash the wound immediately with warm soapy water for 10 minutes and contact the person's health care provider and the local health department. Use universal precautions; wear gloves. (See previous section on "[Universal Precautions.](#)")
6. Discourage wild animals from depending on humans for food and shelter. Fasten trashcan lids tightly. Cap chimneys (common nest-sites for raccoons) and seal openings into houses, barns, and garages.
7. If a pet has been bitten or scratched by another animal, wash the wounds promptly with soap and water. Use universal precautions; wear gloves. (See previous section on "[Universal Precautions.](#)") A veterinarian should be contacted.
8. Teach students about preventing bites from animals.
9. Do not allow common vectors for rabies to have direct contact with students in school projects and exhibits.

Respiratory Syncytial Virus (RSV)

RSV is a virus that causes the common cold and other respiratory signs or symptoms. It is most common in the winter and early spring but can occur year-round. In children, it most often presents as cold-like symptoms. Very young infants may experience irritability, poor feeding, lethargy, cyanosis, and can have such complications as bronchiolitis and pneumonia. Children with weakened immune systems, prematurity, or heart and lung problems are at higher risk for complications with RSV. People of any age can get another RSV infection, but infections later in life are generally less severe. Premature infants, children younger than 2 years of age with congenital heart or chronic lung disease, and children with compromised (weakened) immune systems due to a medical condition or medical treatment are at highest risk for severe disease. Adults with compromised immune systems and those 65 and older are also at increased risk of severe disease.

Transmission

RSV is spread through direct or close contact with mouth or nose secretions. Direct contact with the virus can occur, for example, by kissing the face of a child with RSV. Indirect contact can occur if the virus gets on an environmental surface, such as a doorknob, that is then touched by other people. Direct and indirect transmissions of virus usually occur when people touch an infectious secretion and then rub their eyes or nose. RSV can survive on hard surfaces such as tables and crib rails for many hours. RSV typically lives on soft surfaces such as tissues and hands for shorter amounts of time. The infected person is contagious before symptoms appear.

School Exclusion Guidelines

Communicable. The incubation period is commonly 4 to 6 days but can range between 2 and 8 days. Children are typically contagious for 3 to 8 days, although infants may shed the virus for 3 to 4 weeks.

Case. School exclusion is not indicated unless the child is experiencing symptoms that do not allow them to participate.

Contact. Not indicated.

Diagnosis

RSV is diagnosed through a physical examination by a healthcare professional. This may include monitoring of oxygen saturation levels. Blood tests can be used to check white blood cell counts or to indicate the presence of a virus. A swab of nasal secretions can be analyzed to confirm RSV.

Treatment

There is no specific treatment. Most children will recover on their own with supportive care. A drug called palivizumab is available to prevent severe RSV illness in certain infants and children who are at high risk. The drug can help prevent development of serious RSV disease, but it cannot help cure or treat children already suffering from serious RSV disease and it cannot prevent infection with RSV. Children with weakened immune systems or who develop complications should seek medical attention.

Reporting Requirements

RSV is not a reportable disease.

Notification Guidelines

None.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Develop a plan for students who are immunocompromised to detail notification, and assistance in avoiding contact with infected individuals, as necessary.
3. Diligent hand washing, personal hygiene and cleanliness are essential to stop the spread of all respiratory tract diseases.
4. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.

Rocky Mountain Spotted Fever

Rocky Mountain spotted fever (RMSF) is a systemic, febrile disease caused by the parasite *Rickettsia rickettsii*. RMSF has a characteristic petechial (small pinhead bruises) rash usually occurring by the sixth day, resulting from a bite of a dog tick infected with the bacteria *Rickettsia rickettsii*. Anyone who has exposure to infected ticks can get RMSF. The disease is most often reported among males, American Indians, and people 50-69 years of age. People with frequent exposure to dogs and who reside near wooded areas or areas with high grass are more likely to come in contact with ticks.

The rash begins on the wrists and ankles and spreads to the trunk and the other areas of the body within hours. The palms of the hands and soles of the feet are typically involved. High fever, chills, headache, and muscle pain usually appear 3 to 10 days after the tick bite. In some cases, the rash fails to develop or develops only late in the illness. The disease can last as long as 3 weeks and can affect the central nervous system (brain and spinal cord), heart, lungs, kidneys, and other organs. In severe cases, disseminated intravascular coagulation illness and shock can occur, leading to death.

Transmission

RMSF is transmitted to humans most often by the bite of an infected American dog tick, but the Rocky Mountain wood tick and the brown dog tick have also caused the disease. Other types of *Rickettsia* can cause similar illnesses. As a group these illnesses are referred to as the “spotted fever rickettsioses”. Contamination of breaks in the skin or mucous membranes with crushed tissues or feces of the tick may also lead to infection. The incubation period ranges from 2 to about 21 days.

School Exclusion Guidelines

Communicable: RMSF is not transmitted from person to person. It is transmitted by ticks carrying *Rickettsia rickettsii* bacteria.

Case: School exclusion is not indicated.

Contact: School exclusion is not indicated.

Diagnosis

Diagnosis is made by history and physical examination findings. It is confirmed by laboratory tests.

Treatment

Rickettsial infections can be treated with certain antibiotics. Prompt treatment may decrease the chance of developing serious illness. Early treatment supportive measures is based on clinical findings and geography; treatment should not be withheld due to lack of tick bite history.

Reporting Requirements

RMSF is not a reportable disease.

Notification Guidelines

When RMSF occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

If a student is bitten by a tick during the day, remove it as outlined below. Notify the parents of that student so they can inform their health care provider. Tell them what the tick looked like. If the student develops the symptoms described, particularly a skin rash and/or flu-like symptoms, ask the parents to see a health care provider promptly for evaluation and treatment.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Advise persons who spend time outdoors in area with ticks to (1) wear long-sleeved shirts and long pants, (2) keep shirts tucked securely into pant legs and pant legs tucked into socks, (3) wear sneakers or hiking boots instead of open sandals, and (4) wear light-colored clothing. Ticks are dark in color and will be easier to see against a light background.
3. Conduct a daily tick check. Ticks removed within 24 hours of attachment are unlikely to transmit RMSF disease. Ticks are most often found on the thigh, flank, arms, underarm, and legs, and are very small. Look for new “freckles.”
4. If a tick is found on a person, remove it immediately. Deer ticks are very small and hard, about the size of a pinhead. They are orange-red or black depending on their stage of growth and prefer to attach themselves to a human host under the hair. Dog ticks are larger, ranging from 1/10 to 1/4 inch in length. They are brown and also prefer to attach themselves under the hair or on protected parts of the body.
5. To remove a tick:

- a. Wear gloves. Use universal precautions. (See previous section on "[Universal Precautions.](#)")
 - b. Using tweezers, grasp tick as close to the skin as possible and gently, but firmly pull tick straight out. Avoid any jerking or twisting motion that may break off the mouthparts in the skin.
6. Insect repellents containing diethyltoluamide (DEET®, Autan®) applied to skin can be effective against ticks but should be used cautiously. The pesticide permethrin is available as a clothing spray; it is not to be used on the skin. A combination of diethyltoluamide applied to skin and permethrin-treated clothes may provide the best protection against tick and mosquito bites. Follow these guidelines:
- a. Use repellents no more than one to two times per day. Do not treat skin with permethrin under clothing.
 - b. Particularly with children, avoid using high concentrations of diethyltoluamide products. Never use on damaged skin.
 - c. Avoid inhaling the product. Keep out of eyes, and do not apply to parts of a person's hands that are likely to have contact with their eyes or mouth.
 - d. After returning indoors, wash treated skin with soap and water.
 - e. If a student is suspected to be having a reaction to an insect repellent, wash skin and call the student's parents and advise them to contact their health care provider for follow-up care.

Roseola (Roseola Infantum)

Roseola infantum (exanthem subitum) is an acute viral disease, usually in children under 4 (most common between ages 6 and 24 months), caused by human herpesvirus-6 (HHV-6). The illness starts with a high fever (103 degrees F.) and irritability, lasting 1 to 5 days (average 3 days). The fever then falls to normal and a rash appears, faint red in color, with flat spots, first appearing on the chest and abdomen then spreads to the face lasting 1 to 3 days. Febrile seizures are an infrequent complication and are associated with the rapidly rising temperature. The disease occurs most often in the spring.

Transmission

The virus is spread by person-to-person contact. Virus sometimes exists in nose or throat secretions of healthy people who have had the disease in the past. The most likely source of transmission to children is healthy adults. The period of communicability is not known but is probably the greatest during the febrile period, before the appearance of the rash. The incubation period is about 10 days.

School Exclusion Guidelines

Communicable: The period of communicability is not known but is probably greatest during the febrile period before the appearance of the rash.

Case: Students may attend school when the rash is gone, and when they feel well enough.

Contacts: School exclusion is not indicated.

Diagnosis

Diagnosis is based mainly on clinical findings, particularly if other cases are present in the community.

Treatment

There is no specific treatment for roseola, other than supportive care.

Reporting Requirements

Roseola infantum is not a reportable disease.

Notification Guidelines

When a case of roseola occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Students with roseola should not be exposed to other students while they are ill.
3. Diligent hand washing, personal hygiene and cleanliness are essential to stop the spread of all respiratory tract diseases.
4. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.

Rotavirus (Rotavirus Enteritis)

Rotavirus is a sporadic or seasonal (frequently occurring in cooler months), often severe gastroenteritis of infants and young children, caused by rotavirus. The infection is characterized by diarrhea, often with vomiting and low-grade fever. The illness is a common cause of dehydration in young children and can be fatal. Symptoms last for an average of 3 to 8 days.

Transmission

Rotavirus is probably transmitted by contact with infected persons through the fecal-oral route (the organism is typically found on toys and hard surfaces). Respiratory transmission is also thought to occur. Rotavirus is very common in young children. The incubation period is approximately 1 to 3 days. The virus is present before diarrhea begins and can persist for greater than one week after the illness.

School Exclusion

Communicable: Person-to-person probably via fecal-oral and sometimes respiratory spread. The individual is communicable during the acute stage of disease, and later while virus shedding continues.

Case: School exclusion is appropriate during the period of diarrhea and vomiting.

Contacts: Contacts should continue in school unless they develop symptoms.

Diagnosis

Rotavirus infection can be confirmed by laboratory tests.

Treatment

No specific medication is available. Treatment includes supportive care with oral hydration techniques and sometimes hospitalization for intravenous fluids.

Reporting Requirements

Rotavirus enteritis is not a reportable disease.

Notification Guidelines

None.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § [22.1-271.1](#), § [22.1-271.2](#), and § [32.1-46](#). Please refer to the Centers for Disease Control and Prevention for the most current [Immunization Schedule](#).
2. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
3. Follow hand washing and cleanliness procedures. Careful attention to good hygiene, hand washing, and environmental cleaning and sanitation is very important in reducing the spread of this infection.
4. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.

Rubella (German Measles)

Rubella is usually a mild viral illness, caused by Rubella virus (*Rubivirus*). The illness rarely causes noticeable symptoms in children, but can be characterized by a flat, red rash that often begins on the face or upper trunk and extends over the rest of the body. The rash usually lasts about 3 days and is often accompanied by a slight fever and lymph gland swelling in the back of the neck. There can be joint pain especially in children and adolescents. Adults may have a low-grade fever, fatigue, headache, red eyes and temporary swelling and pain in the joints.

Pregnant women who get infected with rubella virus also expose their babies, which may result in serious complications. The rubella virus can cause babies to be born with defects such as cataracts, deafness, heart defects, and mental retardation, or the pregnancy can end in a miscarriage or stillbirth. Rubella is not the same as measles (rubeola), though the two illnesses do share some characteristics, including a red rash. Rubella is caused by a different virus than measles and is neither as infectious nor as severe as measles. Rubella occurs more often in persons who have never been vaccinated against rubella. Although few cases occur in the United States, rubella is still common in other countries. The virus can be brought into the U.S. at any time by visitors who have rubella. Also, unvaccinated U.S. residents traveling abroad can become infected and unknowingly bring the disease back home with them.

Transmission

Rubella virus can be found in nose and throat secretions, such as saliva, sputum, or nasal mucus, of infected people. You can spread the virus to others through sneezing or coughing. Persons with rubella are most infectious when the rash is erupting, but they can shed virus from 7 days before to 7 days after rash onset. Rubella may be transmitted by persons with mild or no symptoms (up to 50% of all rubella virus infections). Infants with Congenital Rubella Syndrome (CRS) shed large quantities of virus from body secretions for up to 1 year and can therefore transmit rubella to persons caring for them who are susceptible to the disease. The incubation period is usually 17 days but may range from 12 to 23 days.

School Exclusion Guidelines

Communicable: The period of communicability appears to be seven days before to 7 days after onset of rash.

Case: Exclude from school for 7 days after onset of rash. Avoid exposure to women in early pregnancy. Discuss with local health department. Students with congenital rubella syndrome should be considered contagious until they are 1 year old, unless they have two negative nasal and saliva cultures and urine cultures for rubella.

Contacts: Check immunization records of all students. Those who are pregnant and not immunized should be urged to seek medical advice.

Diagnosis

The illness can be presumptively diagnosed by the signs and symptoms. Serologic testing is useful in confirming the presence of infection. Other tests are available in specific situations.

Treatment

No specific anti-viral treatment is available. Care is based on symptoms and is supportive.

Reporting Requirements

Reporting of any person with or suspected to have Rubella (German measles), including congenital rubella syndrome, must be made immediately by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Notification Guidelines

When rubella occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § [22.1-271.1](#), § [22.1-271.2](#), and § [32.1-46](#). Please refer to the Centers for Disease Control and Prevention for the most current [Immunization Schedule](#).
2. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
3. Make sure parents of all students who exhibit symptoms associated with the illness consult a health care provider and that the local health department is notified if another person develops rubella.
4. Pregnant staff and pregnant students should notify and seek advice from their health care provider.

Salmonellosis

Salmonellosis is an enteric (intestinal) bacterial disease caused by numerous types of *Salmonella*. It usually affects the intestinal tract and occasionally the blood stream. *Salmonella* bacteria can cause outbreaks due to food poisoning. Symptoms include mild or severe diarrhea accompanied by stomach cramps/pain, fever, headache, and occasionally vomiting. These symptoms usually develop in less than 24 hours after bacteria are ingested but may not develop until 72 hours and may disappear untreated in 2 to 5 days. Age-specific attacks of *Salmonella* infection are highest in those younger than 5 years of age and the elderly, and peak in the first years of life. Invasive infections and mortality are more frequent in infants, the elderly, and those with an underlying disease, such as sickle cell disease, cancer, and illnesses causing suppression of the immune system.

Transmission

Salmonellosis is transmitted by ingestion of the organisms in food derived from infected food, animals, or contaminated by feces of an infected animal or person. This includes raw or undercooked (inadequate cooking time to a given temperature) eggs and egg products, raw milk and raw milk products, poultry and poultry products. In addition, pet turtles, iguanas, and chickens, and unsterilized pharmaceuticals of animal organs are potential sources of these bacteria.

Salmonella bacteria can be transmitted person-to-person via the fecal-oral-route. Infected persons can spread this disease by not washing their hands after going to the bathroom and then handling food that other people will eat. *Salmonella* can be shed in the stool for many weeks. Individuals with the illness are infectious until the bacteria are no longer present in their stool. The excretion of *Salmonella* in the stool is longer in younger children than in older children and adults. The duration of excretion can be prolonged by antimicrobial therapy.

Symptoms may appear anywhere from 6 hours to 3 days after exposure, but usually appear within 12 to 36 hours. The illness generally lasts 4 to 7 days.

School Exclusion Guidelines

Communicable: *Salmonella* is transmittable as long as the bacteria are shed in the stool of an infected person (several days to several weeks to as long as a few months).

Case: Students and staff with salmonellosis should be excluded from school until a health care provider advises return. In high risk situations - students in daycare and adults involved in food handling and patient or child care - cases need to be excluded until cessation of diarrhea and negative stool cultures are obtained.

Contacts: School exclusion and stool culture are not indicated in asymptomatic persons.

Diagnosis

Diagnosis is made by a stool culture.

Treatment

Most individuals recover without treatment; thus, antimicrobial therapy is usually not prescribed for uncomplicated salmonellosis. Antimicrobial therapy is warranted for *Salmonella* infection occurring in persons with an increased risk of invasive disease and other complications, including infants younger than 3 months of age; persons with sickle cell disease, cancer, acquired immune deficiency syndrome (AIDS), or other immunosuppressive illnesses; persons on immunosuppressive therapy; and persons with chronic gastrointestinal tract disease or severe colitis.

Reporting Requirements

Salmonellosis must be reported to the local health department within three days of diagnosis.

Notification Guidelines

When salmonellosis occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Inform family and household members in contact with a person with *Salmonella* diarrhea of their possible exposure to the bacteria, especially if the people are involved in food handling or preparation. If they develop diarrhea, they should immediately see their health care provider and get a stool culture.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.

Scabies

Scabies is a highly contagious parasitic disease of the skin caused by a mite called *Sarcoptes scabiei*, which infects only humans. The female mite burrows under the skin to lay her eggs, which hatch and start the infestation cycle. Symptoms include an intense itchy (worse at night) rash, with red bumps and characteristic mite burrows - gray or white, wavy, thread-like lines—that are generally obliterated by scratching long before the person sees the health care provider. In adults and older children, the mite burrows are typically seen between fingers and toes; in the flexor areas of the wrist; around the elbows; under the arms; and around the belt line, thighs, naval, penis, nipples, abdomen, and buttocks. In infants younger than 2 years of age, eruption is often blister-like and occurs on the head, neck, palms, and soles of feet. These areas are usually spared in older children and adults. Symptoms appear within 4 to 6 weeks of exposure in previously unexposed persons and 1 to 4 days in repeat exposures.

Transmission

Scabies is transmitted by direct skin-to-skin contact; it can be acquired during sexual contact. Transfer of parasites from undergarments and bedclothes occurs only if these have been contaminated by infested persons immediately beforehand. The mites do not jump from person to person. Scabies can be transmitted as long as the person remains infected and untreated, including the interval before symptoms develop. The incubation period is from 2 to 6 weeks before onset of itching in people without previous exposure. People who have been previously infested develop symptoms 1 to 4 days after re-exposure.

School Exclusion Guidelines

Communicable: The mite survives only a few days off the human body. Transmission occurs most often by close personal contact. Scabies is transmittable until mites and eggs are destroyed by treatment, ordinarily after 1 or occasionally 2 courses of treatment, a week apart.

Case: Exclude from school until 24 hours of antibiotic treatment has been completed.

Contacts: Direct inspection of body. School exclusion is not indicated in the absence of infestation.

Diagnosis

Scabies is usually diagnosed by the typical appearance of the rash and accompanying symptoms and by examining skin scrapings under a microscope to detect the mite or its eggs.

Treatment

Skin lotions containing permethrin, lindane, or crotamiton are available by prescription for the treatment of scabies. Medications should be used exactly as described by the healthcare provider. Fingernails should be trimmed and cleaned underneath to remove any mites or eggs.

Persons who have had skin contact with an infested person (including family members, roommates, and sexual contacts) should also be treated at the same time as the infested person. Sometimes, itching may persist for as long as two to four weeks after effective treatment. Antihistamine or steroid medicines may reduce the itching. Skin infections may require antibiotic therapy. Washable belongings of persons infested with scabies, including bed linens and clothing worn should be washed in hot water and dried in a hot dryer. Articles that cannot be washed may be dry cleaned or bagged in plastic for at least 3 to 4 days.

Reporting Requirements

Scabies is not a reportable disease.

Notification Guidelines

When scabies occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of infestation outbreaks.
2. Wash and rinse on the hot cycle and use hot dryer all washable items that have come in contact with an infected individual's skin.
3. Store difficult-to-wash items, such as stuffed toys and pillows, in tightly closed plastic bags for at least 3 to 4 days before using again.
4. Thoroughly vacuum all carpets and upholstered furniture.
5. Consult with the school health care personnel if there seems to be a major problem with scabies because it may be prudent and necessary to treat all students and adults in the group once.

Sexually Transmitted Diseases

The descriptions below define these illnesses and their symptoms primarily as they relate to infections in adolescents and adults. Sexual abuse must be suspected in all children diagnosed with a sexually transmitted disease. Infections are also possible in newborns due to transmission during birth from mother to newborn.

Overview

Sexually Transmitted Diseases. Sexually transmitted diseases are transmitted when an infected person has unprotected sexual intercourse or other intimate physical contact with another person. Sexual intercourse includes when a penis is inserted into a vagina, as well as oral and anal intercourse. The table below presents the most common STDs and associated symptoms. For additional information, please click on the links below, or refer to the CDC's Sexually Transmitted Diseases (STDs) [main page](#).

Symptoms Associated with Sexually Transmitted Diseases	
Diseases	Symptoms
Chlamydia	May cause discharge or pain in males while urinating. For females, vaginal discharge, odor, or pain are common symptoms. In most cases, there are no symptoms present.
Genital Herpes	Painful, itchy sores on the genitals caused by the herpes simplex type 1 (HSV-1) and herpes simplex type 2 (HSV-2) virus. (For additional information see Herpes Simplex Virus .)
Genital Warts	These wart-like growths, caused by human papilloma virus (HPV), on the genitals are associated with cancer of the cervix in women. Some individuals complain of itching and pain accompanying genital warts.
Gonorrhea	For males, pain and discharge while urinating are common symptoms. Females may be asymptomatic or experience pain from urethritis (inflammation of the urethra), endocervicitis (inflammation of the mucous lining of the cervix uteri), and pelvic inflammatory disease (infection of the uterus, fallopian tubes, and adjacent pelvic structures), or have vaginal discharge and odor.
Viral Hepatitis	Weakness, abdominal pain, nausea, vomiting, dark urine, and jaundice are symptoms associated with this illness. (See Hepatitis B).

Symptoms Associated with Sexually Transmitted Diseases

Diseases	Symptoms
HIV infection and AIDS	Onset of illness includes swollen lymph nodes, weight loss, chronic diarrhea, fever, and fatigue. (See HIV Infection and AIDS.)
Syphilis (acquired)	Infection with acquired syphilis can be divided into stages. The primary syphilis infection is accompanied by a painless, firm, round sore (chancre) on or around the penis, vulva, vagina, perineum, mouth, or anus. The secondary stage is characterized by a generalized rash, most frequently on the palms and soles; fatigue; generalized enlargement of lymph nodes; sore throat; headache; joint pain; and a flat, gray, mucous like patch characteristic of syphilis around the external genitalia or anus (condylomata lata). Latent and late stage syphilis begin when all other symptoms disappear. Late (tertiary) stage occurs 10–30 years after the infection began. Symptoms of the late stage of syphilis include difficulty coordinating your muscle movements, paralysis (not able to move certain parts of your body), numbness, blindness, and dementia (mental disorder). In the late stages of syphilis, the disease damages your internal organs and can result in death.
Trichomoniasis	Is primarily a sexually transmitted disease and frequently coexists with other infections, particularly gonorrhea. Females experience a frothy, vaginal discharge and itching. Pain when urinating and abdominal pain may occur. Infected males may experience pain while urinating, but the majority of males are asymptomatic.

Dangers Associated with Lack of Symptoms. People can be infected with a STD and be asymptomatic. Even so, the dangers of these diseases persist, and the infection can still be transmitted. Anyone who thinks they may have been exposed to a STD should see a health care provider immediately. Infection with one STD may indicate the need to test for other STDs. If untreated, STDs may cause serious physical and reproductive damage or even death. STDs are particularly dangerous to infants whose infected mothers are not treated during pregnancy. Infected infants may be born mentally retarded or physically deformed, or they may die.

Transmission

Individuals who have unprotected sex, especially with many partners, are at risk of exposure to STDs. Some STDs can be transmitted directly from an infected person to another by sharing contaminated needles. Any mind-altering substance increases the chances that an individual will engage in behavior that places them at increased risk of exposure to harmful consequences.

Diagnosis

Diagnosis is made by physical examination, microscopic exam of genital secretions, cultures, and blood tests.

Treatment

Bacterial STDs can be treated with antibiotics administered either orally or by intramuscular injections. There are several local treatments (chemical cryotherapy, laser) for treating warts. There are no cures for viral infections although Hepatitis B may resolve itself. Hepatitis B can be prevented with a vaccine, as well as HPV4, the virus that causes Genital Warts. Genital herpes may be treated with acyclovir. For specific treatment guidelines by disease and additional information, please refer to the Centers for Disease Control and Prevention's [2010 STD Treatment Guidelines](#).

An infected person may consult their health care provider or the state health department-sponsored agencies that provide comprehensive STD services. These clinics, open to all, have highly trained and sensitive staff, and there are no restrictions to access based on age, race, sex, ethnicity, ability to pay, residence, country of origin, or immigrant status. By law, minors can be treated in STD clinics without parental consent.

Reporting Requirements

Refer to [List of Reportable Diseases in Virginia](#) for specific disease reporting requirements.

Notification Guidelines

None.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § [22.1-271.1](#), § [22.1-271.2](#), and § [32.1-46](#). Please refer to the Centers for Disease Control and Prevention for the most current [Immunization Schedule](#).
2. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
3. The best way to prevent sexually transmitted diseases is to refrain from sexual intercourse and exposure to genital secretions. Students who are sexually active should be encouraged to discontinue this practice. These students should be referred to the local health department or their health care provider for evaluation, examination, and counseling.
4. Inform students who may not seek health care—for fear of information being given to their parents—of the law allowing them to be diagnosed and treated confidentially and without parental consent.
5. Educate students, according to school policy, about preventing STDs.

Shigellosis

Shigellosis is an acute bacterial disease involving the intestinal tract caused by *Shigella*. People with shigellosis may experience mild or severe diarrhea, often with fever and traces of blood or mucus in the stool. Some infected individuals will also experience nausea and vomiting, while others may not show any symptoms at all. Symptoms may appear anywhere from one to seven days after exposure, but usually appear within one to three days after exposure.

Transmission

Shigella is transmitted mainly by direct or indirect fecal-oral route from an infected person. This could unintentionally happen when diapering children. Other modes of transmission include ingestion of contaminated food or water and contact with a contaminated, inanimate object. Infection is most common in children ages 1 to 4.

Anyone can get shigellosis, but it is recognized more often in young children. Those at greater risk for infection include children in day care centers and persons living in institutions. Outbreaks are most often associated with poor hygiene, crowded living conditions, and contaminated food or water. Few bacteria can cause ingested shigella infection. People with this illness are infectious until the bacteria are no longer present in their stool. The incubation period is from 1 to 7 days (usually 1 to 3 days).

School Exclusion Guidelines

Communicable: *Shigella* is communicable during acute illness and until the infectious agent is eliminated from the stool, usually within 4 weeks after illness.

Case: Students and staff with shigellosis should be excluded from school until the diarrhea ceases.

Contacts: School exclusion is not indicated in asymptomatic persons. The stool of symptomatic (diarrheal stools) contacts who are high risk should be cultured. Exclusion from school is required until diarrhea stops.

Diagnosis

Shigellosis is diagnosed by performing laboratory testing on feces. The laboratory can also do special tests to determine which antibiotics, if any, would be best for treating the infection.

Treatment

Most people with shigellosis will recover without treatment. Persons with diarrhea should drink plenty of fluids. In more serious cases, fluids may be given intravenously. Antibiotics are occasionally used to treat severe cases or to shorten the time the bacteria are present in the stool, particularly for food handlers, children in daycare, or institutionalized individuals.

Reporting Requirements

Shigellosis must be reported to the local health department within three days of diagnosis.

Notification Guidelines

When shigellosis occurs in the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Family and household members in contact with the person with shigellosis should be informed of possible exposure to the bacteria, especially if they are involved in food handling or preparation. If they develop diarrhea, they should immediately see their health care provider.

Prevention Guidelines:

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Particular attention should be given to hand washing and personal hygiene as well as environmental cleaning and sanitation.
3. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.

Shingles (Herpes Zoster)

Once a person has been infected with the varicella-zoster virus and gets chickenpox, the virus remains (without symptoms) in the body's nerve cells. In some people, the virus reactivates later and is called shingles or zoster, for reasons that are not fully understood. This virus is not the same one that causes genital herpes. Shingles is a painful rash that develops on one side of the face or body. The rash forms blisters that typically scab over in 7 to 10 days and clears up within 2 to 4 weeks. Prior to the appearance of the rash (typically 1 to 5 days), people often have pain, itching, or tingling in the area where the rash will develop. Most commonly, the rash occurs in a single stripe around either the left or the right side of the body. In other cases, the rash occurs on one side of the face. In rare cases (usually among people with weakened immune systems), the rash may be more widespread and look similar to a chickenpox rash. Shingles can affect the eye and cause loss of vision. Other symptoms may include: fever, headache, chills, and upset stomach. People who develop shingles typically have only one episode in their lifetime. However, a person can have a second or even a third episode. People at greater risk for getting shingles include those who are immunocompromised or are receiving immunosuppressive drugs.

The most common complication of shingles is a condition called post-herpetic neuralgia (PHN). People with PHN have severe pain in the areas where they had the shingles rash, even after the rash clears up. Although the pain may be severe and debilitating, it usually resolves in a few weeks or months in most patients, although some individuals can experience pain for many years. Older individuals are more likely to develop PHN, and the severity of the pain is likely to be worse. Shingles may also lead to serious complications involving the eye, pneumonia, hearing problems, blindness, brain inflammation (encephalitis) or death. The virus shed in the blisters of the rash can cause chickenpox in a person who has not had it, if that person had direct contact with the infected shingles blisters.

Transmission

Shingles cannot be passed from one person to another. However, the virus that causes shingles, the varicella zoster virus, can be spread from a person with active shingles to another person who has never had chickenpox. The virus is spread through direct contact with fluid from the rash blisters caused by shingles. Shingles is less contagious than chickenpox and the risk of a person with shingles spreading the virus is low if the rash is covered.

The virus can remain in the body in an inactive state for many years after the original chickenpox infection, and the disease can occur at any point after a Chickenpox infection when the virus reactivates.

School Exclusion Guidelines

Communicable: A person with active shingles can spread the virus when the rash is in the blister-phase. Infected individuals are not infectious before the blisters appear. Once the rash has developed crusts, the person is no longer contagious.

Case: Since students and staff with *shingles* carry the virus that causes chickenpox and could cause an outbreak, infected individuals should be excluded if the shingles rash cannot be completely covered. Exclusion is not otherwise indicated, unless the infected person does not feel well enough to participate.

Contacts: On appearance of symptoms, exclude from school using the guidelines above.

Diagnosis

Shingles can be presumptively diagnosed by the signs and symptoms. Laboratory testing is available for confirmation or diagnosis in the absence of a rash, or in atypical presentations.

Treatment

Individuals with chickenpox and shingles should discuss treatment options with their health care provider. Antiviral medications are available, which can shorten the length of illness, as well as lessen the severity. In order to attain maximum benefit, these medications must be started as soon as possible after the appearance of the rash. Comfort measures such as wet compresses, lotions, and pain medications can also reduce discomfort in affected individuals.

Reporting Requirements

Shingles is not a reportable disease.

Notification Guidelines

When a case of shingles occurs in the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § [22.1-271.1](#), § [22.1-271.2](#), and § [32.1-46](#). Please refer to the Centers for Disease Control and Prevention for the most current [Immunization Schedule](#).
2. Since the virus that causes shingles is the same one that causes Chickenpox, vaccine of susceptible individuals is the best method of prevention, and also can decrease the severity of the illness in infected persons. Note that the virus is currently licensed for those aged 50 and older and recommended for those 60 and older.

3. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
4. Make sure all students and staff exhibiting symptoms associated with the illness are excluded from school based on guidelines described earlier.
5. Identify high-risk individuals (e.g., pregnant women, immunocompromised individuals) and refer them to their health care provider immediately.

Sports-Related Infectious Diseases

Infectious diseases do propagate and are easily transmitted in the sports environment. Contact sports and those with heavy amounts of equipment are more prone than others for transmission. The [NFHS Sports Medicine Advisory Committee](#) and [VHSL Sports Medicine Advisory Committee \(SMAC\)](#) have established guidelines to educate the sporting and medical communities about their presence and means to reduce transmission of sports related infections diseases ([NFHS Sports Medicine Handbook](#)).

Transmission

The specific of transmission vary by disease, but most infections are a result of direct person-to-person contact or contact with items containing the infectious organism, such as equipment or clothing.

School Exclusion Guidelines

Communicable: The contagious period is dependent on the particular infection. Student athletes may be communicable until treatment has been started, or until drainage or other symptoms dissipates.

Cases: School exclusion is generally not indicated. In certain circumstances, if a wound cannot be covered, exclusion may be necessary.

Contacts: Contacts should not be excluded from school. Examination of siblings, other household contacts, and athletic contacts may be indicated.

Diagnosis

Diagnosis may be made by review of history and physical examination. Depending on the circumstances, microscopic exam, laboratory blood work, or cultures may be needed for confirmation and to guide treatment.

Treatment

Depending on the disease, antibiotic therapy or other interventions may be necessary.

Reporting Requirements

Reporting requirements may vary depending on the infectious disease. Please refer to the [Virginia Reportable Disease List](#).

Notification Guidelines

When sports related infectious disease occurs, school health personnel (e.g., school nurses or consulting physician) and school athletic personnel, in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Keep the environment as clean, dry, and cool as possible since ringworm fungi grow easily on moist, warm, surfaces.
3. Follow general cleanliness and hand washing guidelines.
4. When necessary, keep affected areas of the body loosely covered with gauze, bandages, or clothing to prevent shedding of infected scales, wound drainage, and disease transmission.
5. Students and staff should be discouraged from sharing ribbons, combs and brushes, towels, sheets, or other personal items.
6. Athletes should be encouraged to shower immediately after practices or games, keep all gear and uniforms clean, and to avoid sharing equipment with other players.
7. Students and staff with certain infections should be discouraged from using swimming pools, locker rooms, and shower rooms without wearing footwear as these areas are conducive to transmission of this infection.
8. Refer to Part III, Chapter 16, *Infectious Disease Control*, for additional information.

Sty (Stye)

A sty (or hordeolum) is a mild infection in the eyelid at the base of the eyelashes or near the edge of the eyelid, often as the result of a blocked gland presenting as a small, red, painful bump.¹⁸¹ A chalazion is a bump on the eyelid that results from blockage of the eyelid's oil gland.¹⁸¹ Chalazions generally are not painful or red, and develop further back on the eyelid.¹⁸¹

Styes occur when a gland in or on the eyelid becomes plugged or blocked. Nearly all styes are caused by a bacterial infection. The first signs and symptoms of a sty are usually redness, tenderness, and pain in the affected area. The eye may feel irritated or "scratchy." Later signs and symptoms may include swelling, watering of the eye, sensitivity to light, and a small, yellowish pus spot at the center of the bump.¹⁸¹

Transmission

Styes are not typically transmitted from person to person, although it is possible that if infected and draining, that transmission could occur via contact.

School Exclusion Guidelines

Communicable. Styes may drain pus that contain bacteria. This could be contagious, although the drainage period is brief.

Case. Infected individuals do not to be excluded unless the eye is actively draining or is unable to participate activities.

Contacts. School exclusion is not indicated.

Diagnosis

Diagnosis of a sty is made through physical examination.

Treatment

Sties will resolve most quickly by applying warm compresses for 10 minutes, 3-4 times a daily. This may result in drainage, though it typically resolves quickly. Occasionally, a sty may progress to cellulitis. If spreading of redness or swelling of the eyelid is noticed, the individual should seek immediate medical attention. Particularly large or infected sties can be incised or injected with steroids, to promote faster healing.¹⁸¹ Infections may be treated with oral antibiotics.¹⁸¹ Recurrence can be prevented through treatment of the underlying cause.

Reporting Requirements

Sty is not a reportable disease.

Notification Guidelines

None.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Encourage infected children not to touch or rub the eye.
3. Encourage diligent hand washing and hygiene for the individual and all persons that come into contact with him/her.

Tetanus

Tetanus (lockjaw) is an acute infectious disease due to the toxin (poisonous substance) *Clostridium tetani* bacteria, which enters the body through a break in the skin such as a cut or open wound. The toxin causes muscles to go into painful spasms. Early symptoms include muscular stiffness in the jaw (lockjaw), stiffness in the neck and abdomen, and difficulty in swallowing. Later symptoms include severe muscle spasms often lasting for several weeks. Paralysis and death can result.

Transmission

Tetanus is transmitted by introducing the organism into the body, usually through a puncture wound contaminated with soil, street dust, or animal or human feces; through lacerations, burns, and trivial or unnoticed wounds; or by injected contaminated street drugs. Tetanus is not transmissible from person to person. Tetanus occurs more often in persons who have never been vaccinated against tetanus or who have not had a booster dose in the past 10 years. Tetanus occurs worldwide but is more common in agricultural regions of warmer climates, especially where contact with animal manure is more likely. Neonatal tetanus frequently occurs in developing countries when access to vaccine and maternity care is limited.

The incubation period is usually 3 to 21 days, although it may range from 1 to several months, depending on the character, extent, and location of the wound; average 10 days. Most cases occur within 14 days. In general, shorter incubation periods are associated with more heavily contaminated wounds, more severe disease, and a worse prognosis.

School Exclusion Guidelines

Communicable: Tetanus is not directly transmitted from person to person.

Case: Infected persons should be excluded from school until they feel well.

Contacts: School exclusion is not indicated.

Diagnosis

The wound should be cultured. However, diagnosis is made clinically by excluding other possible diagnoses.

Treatment

Wounds should be thoroughly cleaned. Tetanus Immune Globulin (TIG) is recommended followed by vaccination with tetanus toxoid. Supportive care and airway maintenance are critical. Maintaining up-to-date tetanus vaccination is the single most important measure to prevent tetanus. Effective vaccine called tetanus toxoid (contained in Tdap, DT, DTaP, and Td

vaccines) is recommended for all ages. A tetanus booster shot is recommended every 10 years throughout life.

Reporting Requirements

Tetanus must be reported to the local health department within three days of diagnosis.

Notification Guidelines

Even though tetanus is not spread person to person, if a case occurs, officials may want to use this opportunity to remind others to check their immunization records and if necessary, get boosters. After the initial immunization series, most persons are protected for 10 years. Boosters need to be given as soon as possible after injury, as determined by a health care provider.

When tetanus occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Assure immunization compliance as required by the *Code of Virginia*, § [22.1-271.1](#), § [22.1-271.2](#), and § [32.1-46](#). Please refer to the Centers for Disease Control and Prevention for the most current [Immunization Schedule](#).
2. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
3. Make sure all cuts, scrapes, and puncture wounds are cleaned well with soap and water; individuals who have sustained deep or severe wounds should be referred for medical attention.

Tinea (Ringworm)

Tinea and ringworm are general terms used to describe various fungal diseases that involve the scalp, body, feet, and groin. There are six types of tinea: (1) tinea capitis, ringworm of the scalp; (2) tinea corporis, ringworm of the body; (3) tinea cruris, ringworm of groin and perianal region; (4) tinea pedis, ringworm of the foot; (5) tinea barbae, ringworm of the beard; and (6) tinea unguium, ringworm of the nails. Descriptions of tinea of the scalp, body, groin, and foot are presented on the following pages. The following school exclusion guidelines, reporting requirements, notification guidelines, and prevention guidelines are presented for all the tineas.

School Exclusion Guidelines

Communicable: All tinea infections are transmissible as long as the fungus is present in the infected area. Viable fungus may persist on contaminated materials for long periods. The fungus is no longer present when the lesion starts to shrink.

Cases: School exclusion is not indicated as long as infected area can be covered or student is being treated by a health care provider. In tinea corporis, the student or staff should be excluded until 24 hours after drug therapy. During treatment, the student or staff should be excluded from the gym and swimming pools.

Contacts: Contacts should not be excluded from school. Examination of siblings and other household contacts for evidence of tinea capitis is recommended.

Reporting Requirements

Tinea infections are not reportable diseases.

Notification Guidelines

If more than one person in a class develops ringworm, school health personnel (e.g., school nurses or consulting physician), in consultation with school administrators and the local health department, should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. Keep the environment as clean, dry, and cool as possible since ringworm fungi grow easily on moist, warm, surfaces.
3. Follow general cleanliness and hand washing guidelines.

4. Keep affected areas of the body loosely covered with gauze, bandage, or clothing to prevent shedding of infected scales.
5. Students and staff should be discouraged from sharing ribbons, combs and brushes, towels, sheets, or other personal items.
6. Athletes should be encouraged to shower immediately after practices or games, keep all gear and uniforms clean, and to avoid sharing equipment with other players.
7. Students and staff with active athlete's foot (tinea pedis) should be discouraged from using swimming pools, locker rooms, and shower rooms without wearing footwear as these areas are conducive to transmission of this infection.

Tinea Capitis (Ringworm of the Scalp)

This fungal disease occurs most often in children; although, it can occur at any age.

Transmission

Tinea capitis is transmitted by direct skin-to-skin contact or indirect contact especially from the backs of theater seats, shared personal items (such as combs and hairbrushes) or clothing and hats contaminated with hair from infected persons or animals. The incubation period is from 4 to 14 days.

Diagnosis

Typically, the diagnosis is made by its appearance. Tinea capitis can appear as scaly, itchy, red patchy areas of dandruff-like scaling, with broken hairs or areas of hair loss.

Treatment

Treatment with prescription antifungal medication is required, as topical antifungal products are ineffective for treatment of tinea capitis. Many experts consider griseofulvin to be the drug of choice. Terbinafine is also FDA-approved for the treatment of tinea capitis in patients four years of age and older. Itraconazole and fluconazole have been shown to be safe and effective but are not FDA-approved for this indication. Selenium sulfide shampoos can be used as adjunctive therapy.

Tinea Corporis (Ringworm of the Body)

This fungal disease is most common in children but can occur in any age.

Transmission

Tinea corporis is transmitted by direct or indirect contact with skin and scalp lesions of infected persons; lesions of animals; contaminated floors, shower stalls, and benches; and towels, bedding, clothing, and similar objects. The incubation period is from 4 to 14 days.

Diagnosis

Typically, the diagnosis is made by its appearance. Microscopic exam is used when there is a question. The lesions start as flat and ring-shaped. The edges of the circle are usually reddish and may be raised, scaly, and itchy. The center of the circle is often clear.

Treatment

The treatment for ringworm depends on its location on the body and how serious the infection is. Some forms of ringworm can be treated with non-prescription (“over-the-counter”) medications, but other forms of ringworm need treatment with prescription antifungal medication. Unresponsive cases may require (prescription) oral anti-fungal medications.

Tinea Cruris (Ringworm of Groin “Jock Itch”)

This condition is a fungal disease that rarely occurs before puberty, except in babies. Tinea cruris occurs predominantly in adolescents and adult males, and thrives in warm, moist areas.

Transmission

Tinea cruris is transmitted by direct or indirect contact with skin lesions of infected persons; lesions of animals; contaminated floors, shower stalls, and benches; and towels, bedding, clothing and similar objects. It is transmissible as long as the infection is present. The incubation period is from 4 to 14 days.

Diagnosis

Typically, the diagnosis is made by its appearance. Microscopic exam is used when there is a question. Itchy, reddish, and scaly lesions occur in the groin area and/or on the adjacent thighs.

Treatment

Usual treatment consists of over-the-counter antifungal products. Patients who have tinea cruris should be advised to keep the groin area clean and dry and to wear cotton underwear. Persons who have extensive or recurrent infections may require systemic antifungal therapy.

Tinea Pedis (Ringworm of the Foot “Athlete’s Foot”)

This condition is a fungal disease that rarely occurs before puberty. There are three types: (1) interdigital (between the toes), (2) vesicular (generally affects the instep), and (3) the moccasin type (both feet are affected by a widespread, scaling rash). This infection is aggravated by heat and sweating. Symptoms include red, itchy, peeling and swelling of the skin.

Transmission

Tinea pedis is transmitted by direct or indirect contact with skin lesions of infected persons or contaminated floors, shower stalls, and other articles used by infected persons. The incubation period is from 4 to 14 days.

Diagnosis

Typically, the diagnosis is made by its appearance. Microscopic exam is used when there is a question.

Treatment

Athlete’s foot can usually be treated with over-the-counter topical antifungal products; terbinafine appears to be most effective, but other agents can also be used. Chronic or extensive tinea pedis may require treatment with oral antifungal agents such as miconazole, clotrimazole, terbinafine, or tolnaftate. In addition, chronic tinea pedis may require adjunctive therapy such as foot powder or talcum powder to prevent skin maceration.

Tuberculosis (TB)

Tuberculosis (TB) is a bacterial disease caused by the organism *Mycobacterium tuberculosis*. It can affect any organ of the body - although the lungs are the most commonly involved. Two TB related conditions include TB infection and TB disease. TB infection is defined by a person who generally does not feel ill, has not symptoms, and cannot spread TB to others. TB disease is defined as person with infection in whom signs and symptoms are present and they can spread the disease to others.

In adults, this distinction between disease and infection is fairly clear, but it is less so in children. The most common symptom is a cough, often one that lasts for weeks and can result in coughing up mucous and/or blood. The disease may also cause chest pain, fever, weakness, loss of appetite, swollen glands, growth delay, and night sweating.

Transmission

TB is transmitted person to person through the air when the person with infectious TB coughs, sneezes, spits, or sings, and releases infected droplets of mucous. These droplets remain viable and suspended in the air for several hours. TB is not spread by kissing, sharing utensils, or other objects, such as books or clothing. Direct invasion of the TB germ through mucous membranes or breaks in the skin may occur but is rare.

Several factors determine how the germ is transmitted. The presence of cough and of sputum that is smear and culture positive for TB increases risk. Prolonged sharing of indoor air with a person who has infectious TB increases risk. Children younger than 12 generally are not infectious because they have little cough and sputum production. Therefore, childhood disease represents transmission from an adult or adolescent. The incubation period from exposure to either findings on exam or a positive skin test is 2 to 10 weeks. The risk of developing disease is highest in the first 2 years following infection. Infected persons with suppressed immune systems (HIV) have a higher risk for disease.

School Exclusion Guidelines

Communicable: Theoretically, a person is communicable as long as viable *Mycobacterium tuberculosis* are being discharged from the sputum. Some untreated or inadequately treated persons may be sputum-positive intermittently for years. Effective antimicrobial chemotherapy usually eliminates communicability within a few weeks, at least in the household setting. Children with primary tuberculosis are generally not infectious. See above under "Transmission".

Case: Persons with active TB disease may need to be isolated while contagious to prevent spreading the disease.

Contacts: Contacts should be evaluated for level of exposure and treated as indicated by obtaining a history and physical examination, TB skin testing, and X-ray evaluation through the health care provider and/or the local health department.

Diagnosis

Individuals meeting certain criteria (available through the [CDC's Tuberculosis Fact Sheets](#)) should be evaluated further for potential TB infection. The person's health care provider should choose which TB test to use. Factors in selecting which test to use include the reason for testing, test availability, and cost. Generally, it is not recommended to test a person with both a TST and an IGRA. If the TB test is positive, the person likely has TB infection. Additional tests such as a chest x-ray and a sample of sputum may be needed to determine if the person has TB infection or active TB disease.

Tuberculin skin test (TST): The TB skin test (also called the Mantoux tuberculin skin test) is performed by injecting a small amount of fluid (called tuberculin) into the skin in the lower part of the arm. A person given the tuberculin skin test must return within 48 to 72 hours to have a trained health care worker look for a reaction on the arm. The health care worker will look for a raised, hard area or swelling, and if present, measure its size using a ruler. Redness by itself is not considered part of the reaction.

The skin test result depends on the size of the raised, hard area or swelling. It also depends on the person's risk of being infected with TB bacteria and the progression to TB disease if infected.

- **Positive skin test:** This means the person's body was infected with TB bacteria. Additional tests are needed to determine if the person has latent TB infection or TB disease. A health care worker will then provide treatment as needed.
- **Negative skin test:** This means the person's body did not react to the test, and that latent TB infection or TB disease is not likely.

Children with a positive TST test result will need a chest x-ray.

For additional information, refer to the CDC's [Classification of the Tuberculin Skin Test Reaction](#).

Treatment

A person with TB infection can take drugs to kill the bacteria and prevent getting active TB disease in the future. There are several medicines used to treat TB infection in children that involve taking one or more medications for 1-9 months.

Children with TB disease must take several drugs for 6 to 9 months or longer. It is very important for people with TB disease to finish the medicine and take the drugs exactly as ordered. Children who stop taking the drugs too soon can become sick again. If people do not take the drugs correctly, the bacteria may become resistant to the TB drugs.

Reporting Requirements

Reporting of persons confirmed or suspected of having active tuberculosis disease must be made immediately by the most rapid means available, preferable that of telecommunication, to the local health director or other professional employee of the local health department.

Tuberculosis infection (Mantoux skin test reaction ≥ 10 mm) must be reported to the local health department within three days of diagnosis.

The local health department will contact the Virginia Department of Health, Division of Tuberculosis Control ([804] 786-6251) within 24 hours. The Division of Tuberculosis Control, in conjunction with the local health department, will help determine if screening of staff and students is required.

Notification Guidelines

When TB disease occurs within the school population, school health personnel (e.g., school nurses or consulting physician), in consultation with the local health department should determine whether some or all parents should be notified.

Prevention Guidelines

1. Develop a policy, in consultation with the local health department, for responding to cases of communicable diseases.
2. A person with active TB disease may need to be isolated while contagious to prevent spreading the disease. When out of isolation for medical appointments, TB patients should cover the mouth and nose when coughing and may need to wear a mask. People with active TB disease must take all the TB medicine exactly as prescribed by the physician.
3. If a person is told that he or she is a contact to someone with active TB disease, the person should follow through with evaluation, testing, and treatment if needed.

Every effort should be made to adequately educate the community through a joint effort by the schools, local health department, and the Virginia Department of Health, Tuberculosis Control Program, when a case of TB disease occurs within the school population.

End Notes

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¹⁷⁵ Aronson, S., and Shope, T. (2016). *Managing infectious diseases in child care and schools: A quick reference guide*. (4th.ed). Elk Grove Village, IL: American Academy of Pediatrics.

¹⁷⁶ Centers for Disease Control and Prevention. (2019). *Guidance for the selection and use of personal protective equipment (PPE) in healthcare settings*. Retrieved from <https://www.cdc.gov/HAI/pdfs/ppe/PPEslides6-29-04.pdf>

¹⁷⁷ Centers for Disease Control and Prevention. (2019). *Environmental infection control guidelines*. Retrieved from <https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf>

¹⁷⁸ Centers for Disease Control and Prevention. (2019). *Disinfection and sterilization*. Retrieved from <https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html>

¹⁷⁹ Centers for Disease Control and Prevention. (2019). *Information for employers: complying with OSHA's bloodborne pathogen standard*. Retrieved from <https://www.cdc.gov/niosh/docs/2009-111/>

¹⁸⁰ Silasi, M., Cardenas, I., Racicot, K., Kwon, J., Aldo, P. & Mor, G. (2015). Viral infections during pregnancy. *American Journal of Reproductive Immunology*. 73(3), 199-213.

¹⁸¹ American Academy of Ophthalmology. (2019). *What are chalazia and styes?* Retrieved from <https://www.aao.org/eye-health/diseases/what-are-chalazia-styes>

APPENDIX A: FIRST AID GUIDE FOR CHILD CARE AND SCHOOL EMERGENCIES

The First Aid Guide for Child Care and School Emergencies is a quick reference guide for administering emergency care to an injured or ill individual. It contains practical, step-by-step instructions that describe what to do when caring for an injured or ill person. This chart is designed for use by teachers, school nurses, clinic aides, and other staff members who are responsible for the health and safety of students and others in the school setting.

How to Use This Flip Chart. The flip chart should be posted in a place that is easily accessible to all staff members. It is recommended that **all** staff become familiar with the contents of the flip chart **prior** to the necessity for handling an emergency situation. The most recent version is available electronically through the [Virginia Department of Health, Family Health Services](#). Hard copies of this flip chart are also available.

APPENDIX B: RELEVANT FORMS

The following is a list of pertinent school forms and any accompanying form instructions. Utilize the link provided to obtain the most current copy of each form and/or instructions.

- [Athletic Participation Parental Consent Physical Examination Form](#)
 - **Note:** This is a Virginia High School League form, not a VDH/VDOE form. Direct any questions regarding the use of this form to the [VHSL](#)
- [Certificate of Religious Exemption, Commonwealth of Virginia \(CRE-1\)](#)
- [School and Daycare Minimum Immunization Requirements](#)
- [Commonwealth of Virginia School Entrance Health Form MCH 213G \(Instructions\)](#)
- [Commonwealth of Virginia School Entrance Health Online Fillable Form](#)
- [Scoliosis Report, Virginia Department of Education \(Rev. 4/08\)](#)
- [Student Immunization Status Report: Instructions](#)
- [Vision and Hearing Screening: Summary Report, Virginia Department of Education \(Rev. 1/08\)](#)

APPENDIX C: RISK MANAGEMENT OF ACCIDENTS, INCIDENTS, AND INJURIES IN THE SCHOOL SETTING

This appendix provides a review of managing risks from accidents, incidents, and unintentional injuries in the school setting. It includes a brief overview of report forms used for accidents, incidents, and injuries; discussion on proper use; and record maintenance. Additionally, information is provided on concussions including an overview, treatment, and resources for the school nurse.

- [Accident, Incident, and Injury Reports](#)
- [Concussion Management](#)

Accident, Incident, and Injury Reports

Overview

The purpose of this section is to educate school nurses, school and clinic personnel on the purpose of reports. Clarification is provided on variations in the titling of reports, their intended use, and distribution.

For specific guidelines on what constitutes a reportable situation, required distribution, or required reports, refer to your local school division policies and procedures.

Variations in Titling

Report titles and wording can vary between school divisions. Many localities will have more than one report form that can be used, depending on the circumstances. Possible titles may include incident, variation, accident, situation, unusual occurrence form or report.

Accident: is an undesirable or unfortunate happening that occurs unintentionally and sometimes results in harm, injury, damage, or loss.¹⁸²

Incident: is an unplanned, undesired event that hinders completion of a task.¹⁸³

Many school systems and divisions use an incident report to indicate a situation where there was an unplanned event or outcome, but one that did not result in injury. Accident and injury reports are often used for the same purpose, which is to document an injury sustained by a student. A sample report form is provided at the end of this section.

Use of Reports

Reports should be used to describe the nature and details of the situation in a factual, objective accounting of what happened, and should include the care provided, follow up action taken, and what resources were used.¹⁸⁴ Staff who witnessed or are most familiar with the accident or incident should make every effort to fill out the report on the same day, once safety is assured and appropriate care of the student and staff has been provided. Accident and injury report forms should be legible, grammatically correct, and without spelling errors.¹⁸⁵ They can be completed electronically, or written forms should be completed in blue or black ink.¹⁸⁵ The report form should contain the following information:¹⁸⁵

- Name of injured student, birth date, grade, and gender
- Name of student's parent/guardian, if contacted, information shared, and parent/guardian response
- Documentation of student information communicated to any additional parties
- Location where accident/injury occurred

- Time and date accident/injury occurred
- Description of the accident/injury
- Nature/type of injury and location on student's body
- Emergency assistance provided to student
- Future medical assistance recommended to student and/or parent/guardian
- Student disposition-care of student transferred to parent/guardian, or EMS.

Disposition of Report and Record Maintenance

Reports and information pertaining to the accident or incident should be distributed to individuals who require the information to fulfill the report's purpose (for example: risk management, school administrators, and school nurse supervisors). Local school division policies and procedures should dictate the specific content of the report and exact distribution.

It is important to note that under the [Family Educational Rights and Privacy Act \(FERPA\)](#), health and medical records are considered part of a student's educational record; thus, are confidential and not divulged unless permitted under FERPA. This also includes student accident and injury report.¹⁸⁵

Resources

Resha, C.A. & Taliferro, V.L. (2017). *Legal resource for school health services*. Nashville, TN: SchoolNurse.com.

Concussion Management

Authorization

On January 22, 2015, the Virginia Board of Education adopted the [*Guidelines for Policies on Concussions in Student-Athletes*](#), pursuant to:

- [*Code of Virginia, Section 22.1-271.5. Guidelines and policies and procedures on concussions in student-athletes*](#)
- [*Code of Virginia, Section 22.1-271.6. School division policies and procedures on concussions in student-athletes*](#)

Overview ¹⁸⁶

A concussion is a type of brain injury that changes the way the brain normally works. Concussions can be caused by a bump, blow or jolt to the head, as well as a blow to the body that causes the head and brain to move rapidly back and forth. It is important to know that a concussion can occur without a loss of consciousness. Concussions are classified as a Traumatic Brain Injury (TBI).

Signs and Symptoms

Concussion results in symptoms that interfere with school, social and family relationships and participation in sports. Signs and symptoms center around four aspects: 1) physical 2) cognitive 3) emotional and 4) sleep activity. Symptoms may not occur until several hours after the episode, and many young athletes may not be forthcoming of their symptoms, as they fear activity restrictions.

Reported Signs and Symptoms. ¹⁸⁷

- Headache or pressure in the head
- Nausea or vomiting
- Balance problems or dizziness, or double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Confusion, or concentration or memory problems
- Just not “feeling right,” or “feeling down”

Observed Signs and Symptoms.¹⁸⁶

- Can't recall events *prior to* or *after* a hit or fall
- Appears dazed or stunned
- Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (*even briefly*)
- Shows mood, behavior, or personality changes

Treatment and Care

Proper recognition and response can prevent further injury and can help with recovery. Cognitive and physical rests are the mainstay of management. However, untreated concussions can have serious consequences:¹⁸⁶

- **Post Concussion Syndrome:** a series of symptoms that can be experienced for weeks, months or more than a year after the concussion.
- **Second Impact Syndrome:** a rare condition in which a second, often mild, impact occurs when someone is still suffering from an initial concussion that results in 50% of the cases ending in death and the other half in permanent brain damage.
- **Chronic Traumatic Encephalopathy (CTE):** a progressive degenerative disease resulting from multiple concussions.

The Virginia Board of Education's [Guidelines for Policies on Concussions in Student-Athletes](#), provide protocols for returning to the classroom, returning to play, and required training.

Resources

- American Academy of Pediatrics
[Healthychildren.org: Concussions](https://www.healthychildren.org/Healthy/ByTopic/HealthyLiving/Concussions) - Overview of symptoms, prevention, and management of concussions in children. Emphasis is aimed at providing information to parents and families.
- Centers for Disease Control and Prevention
[HEADS UP to Schools: Know Your Concussion ABCs](https://www.cdc.gov/schools/traumatic-brain-injury-prevention/) - Resources and reference materials developed for various school professionals to help identify and respond to concussions among K-12 students.
- [ACE Care Plan](#) – Acute Concussion Evaluation (ACE) Care Plan. School version resource material.
- Virginia Department of Health, Office of Family Health Services
[Traumatic Brain Injury Prevention](#) - The Injury Prevention Program works to prevent traumatic brain injuries among children by supporting the implementation of proven prevention, diagnosis and management strategies related to concussions.
- Virginia Department of Education
 - [Brain Injury and the Schools: A Guide for Educators](#) - This manual, designed primarily for school personnel, provides an overview of brain injury, resources for the academic setting and strategies for addressing the issues these students may have relative to education.
 - [Division of Special Education & Student Services: Traumatic Brain Injury \(TBI\)](#) – Provides access to state and external resources, including the Virginia TBI teams, which serve to help meet the need of students with Traumatic Brain Injury (TBI). This includes students who have suffered from a concussion, which by definition is a mild TBI.

HENRICO COUNTY PUBLIC SCHOOLS Student Injury Report Form

(This form is for documentation purposes only and a file copy should be maintained by the school and a copy sent to School Health Services)

This form is to be completed by school administrator, teacher, or other staff member at the time of student injury at school or during a school –sponsored activity. Be sure to provide as much information about the accident as you can.

1. Student's name: _____ 2. Date of birth: ____/____/____ 3. Grade: _____
 4. Parent/Guardian name: _____ 5. Parent/Guardian contact phone _____
 6. School name: _____ 7. Male Female
 8. Person in charge at time of incident _____ 9. Date of injury: ____/____/____ 10. Time of injury: _____ a.m. p.m.
 11. Title _____ 12. Where incident occurred if not at home school: _____

13. Incident Response:(check all that apply)

- | | | | |
|---|--|---|-----------------------------|
| 1. <input type="checkbox"/> First aid administered | Time: _____ | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | By whom: _____ |
| 2. <input type="checkbox"/> Called 911 | _____ | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | By whom: _____ |
| 3. <input type="checkbox"/> Parent /guardian notified | _____ | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | By whom: _____ |
| 4. <input type="checkbox"/> Unable to contact parent/guardian | _____ | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | By whom: _____ |
| 5. <input type="checkbox"/> Parent/Guardian deemed no medical action necessary | <input type="checkbox"/> Returned to class | <input type="checkbox"/> Sent/taken home | Days of school missed _____ |
| 6. <input type="checkbox"/> Taken to health care provider/clinic/hospital/urgent care | Diagnosis: _____ | _____ | Days of school missed _____ |
| 7. <input type="checkbox"/> Hospitalized | Diagnosis: _____ | _____ | Days of school missed _____ |
| 8. <input type="checkbox"/> Restricted school activity | Explain: _____ | Length of time restricted _____ | Days of school missed _____ |
| 9. <input type="checkbox"/> Underlying medical condition | <input type="checkbox"/> yes <input type="checkbox"/> no | Specify: _____ | |

14. Nature of Injury:(check all that apply)

- | | | | |
|---|--|---|--|
| 1. <input type="checkbox"/> Abrasion/Scrape | 5. <input type="checkbox"/> Cut/Laceration | 9. <input type="checkbox"/> No Pulse | 13. <input type="checkbox"/> Shortness of Breath |
| 2. <input type="checkbox"/> Bump/Blow/Contusion | 6. <input type="checkbox"/> Dislocation (possible) | 10. <input type="checkbox"/> Not Breathing | 14. <input type="checkbox"/> Sprain/Strain/Tear |
| 3. <input type="checkbox"/> Burn/Scald | 7. <input type="checkbox"/> Fracture/Broken (possible) | 11. <input type="checkbox"/> Pain/Tenderness Only | 15. <input type="checkbox"/> Swelling/Inflammation |
| 4. <input type="checkbox"/> Concussion (possible) | 8. <input type="checkbox"/> Loss of Consciousness | 12. <input type="checkbox"/> Puncture | 16. Other _____ |

15. Area affected:(check all that apply)

- | | | | | | | | | |
|--|--|---|---------------------------------------|---|---|------------------------------------|---|-----------------------------------|
| Head | | | Trunk | | | Extremities | | |
| 1. <input type="checkbox"/> Chin/Cheek | 4. <input type="checkbox"/> Forehead | 7. <input type="checkbox"/> Nose | 10. <input type="checkbox"/> Stomach | 13. <input type="checkbox"/> Chest/Ribs | 16. <input type="checkbox"/> Internal | 19. <input type="checkbox"/> Ankle | 22. <input type="checkbox"/> Finger/Thumb | 25. <input type="checkbox"/> Knee |
| 2. <input type="checkbox"/> Ear | 5. <input type="checkbox"/> Mouth/Tongue/Lip | 8. <input type="checkbox"/> Head | 11. <input type="checkbox"/> Back | 14. <input type="checkbox"/> Collarbone | 17. <input type="checkbox"/> Pelvis/Hip | 20. <input type="checkbox"/> Arm | 23. <input type="checkbox"/> Foot | 26. <input type="checkbox"/> Leg |
| 3. <input type="checkbox"/> Eye | 6. <input type="checkbox"/> Neck/Throat | 9. <input type="checkbox"/> Tooth/Teeth | 12. <input type="checkbox"/> Buttocks | 15. <input type="checkbox"/> Genitalia | 18. <input type="checkbox"/> Shoulder | 21. <input type="checkbox"/> Elbow | 24. <input type="checkbox"/> Hand/Wrist | 27. <input type="checkbox"/> Toe |

16. Activity:(check all that apply)

- | | | | | | |
|--|--|--|--|---|---|
| 1. <input type="checkbox"/> Baseball/Softball | 6. <input type="checkbox"/> Dodge ball | 11. <input type="checkbox"/> Jumping/Skipping | 16. <input type="checkbox"/> Roughhousing | 21. <input type="checkbox"/> Standing | 26. <input type="checkbox"/> Wrestling |
| 2. <input type="checkbox"/> Basketball | 7. <input type="checkbox"/> Fighting | 12. <input type="checkbox"/> Kickball | 17. <input type="checkbox"/> Setting up/Moving equipment | 22. <input type="checkbox"/> Swinging | 27. <input type="checkbox"/> Athletic competition |
| 3. <input type="checkbox"/> Bicycling | 8. <input type="checkbox"/> Flag/Touch football | 13. <input type="checkbox"/> Lab/Shop activities | 18. <input type="checkbox"/> Sliding | 23. <input type="checkbox"/> Tennis | 28. <input type="checkbox"/> Athletic practice |
| 4. <input type="checkbox"/> Classroom activity | 9. <input type="checkbox"/> Football | 14. <input type="checkbox"/> Riding Bus | 19. <input type="checkbox"/> Sitting | 24. <input type="checkbox"/> Volleyball | 29. Other _____ |
| 5. <input type="checkbox"/> Climbing bars | 10. <input type="checkbox"/> Gymnastics/Tumbling | 15. <input type="checkbox"/> Running | 20. <input type="checkbox"/> Soccer | 25. <input type="checkbox"/> Walking | |

17. Description of the incident / care provided: _____

18. Follow up: _____

19. Signature of staff member completing form: _____ Date/Time: _____

b. Nurse's signature: _____ Date/Time: _____

c. Principal's signature: _____ Date/Time: _____

For internal use only: School Health Supervisor signature/date _____ Follow up: YES NO

HENRICO COUNTY PUBLIC SCHOOLS INJURY REPORT

Henrico County Public School provides the following Student Injury Report Form and guidelines as an example for schools to use in tracking the occurrence of school-related injuries. Please complete this form when an injury leads to any of the following:

1. The student misses $\frac{1}{2}$ day or more of school
2. The student seeks medical attention (health care provider office, urgent care center, emergency department)
3. EMS 9-1-1 is called

Schools are encouraged to review and use the information collected on the injury report form to influence policies and procedures as needed to remedy hazards.

Instructions

Item #

1-14. Self-explanatory

15. Check the box(es) to indicate the nature of the injury.
16. Check the body area(s) where the student was injured. Include all body areas that apply.
17. Check the activity the student was involved in when the injury occurred.
18. Provide a detailed description of the incident and care provided. Attach another sheet if more room is needed.
19. Provide a detailed description of any follow up actions taken. Please include any suggestions for what might prevent this type of incident in the future.
- 20 a. Staff member signs the completed form.
 - b. The school nurse reviews and signs the completed form
 - c. The Principal reviews and signs the completed form

A copy must be sent to HCPS School Health Services and a copy is placed in student's health file

End Notes

¹⁸² Dictionary.com. (2019). *Accident*. Retrieved from <https://www.dictionary.com/browse/accident>

¹⁸³ Safeopedia. (2019). *Incident*. Retrieved from <https://www.safeopedia.com/definition/384/incident-occupational-health-and-safety>

¹⁸⁴ Selekman, J. (2013). *School nursing: A comprehensive text* (2nd. ed). Philadelphia, PA: F.A. Davis Company.

¹⁸⁵ Gilsbach, T.E. (2017). Accident and injury reporting. In C.A. Resha & V.L. Taliaferro (Eds.), *Legal resource for school health services* (pp. 451-455). Nashville, TN: SchoolNurse.com.

¹⁸⁶ Virginia Department of Health. (2019). *Traumatic brain injury prevention*. Retrieved from <http://www.vdh.virginia.gov/ofhs/prevention/tbi/#concussion>

¹⁸⁷ Centers for Disease Control and Prevention. (2019). *HEADS UP to schools*. Retrieved from <http://www.cdc.gov/headsup/schools/index.html>